Community Mental Health Journal (2019) 55:553–560
https://doi.org/10.1007/s10597-018-0325-x

ORIGINAL PAPER

Development and Implementation of Psychiatric Services in a Student-Operated Clinic

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Received: 1 August 2017 / Accepted: 9 August 2018 / Published online: 14 August 2018

Abstract

This article chronicles the development and implementation of Monday Psychiatry Clinic, a psychiatry component of a medical student-operated free clinic (The Monday Clinic) in Dallas, Texas, providing assessment data systematically collected in the clinic. The established clinical purpose of Monday Psychiatry Clinic is to assess common psychiatric disorders and refer patients in need to appropriate sources of care. This clinic provided leadership education and volunteering opportunities to medical students who learned to interact with patients with psychiatric concerns, established clinical interviewing skills, and became familiar with psychiatric diagnostic criteria. More than one-third of the patients screened positive for depression, alcohol, or drug problems, and one-fourth of the patients with a positive screen were diagnosed with one of these disorders. All patients with identified problems were referred for the appropriate level of care.

Keywords Student-operated free clinic · Medical education · Psychiatric assessment · Depressive disorders · Alcohol and drug use disorders · Medical student leadership

Introduction

It is well established that the burden of mental illness is increasing in the United States, as is functional disability related to mental illness (Charara et al. 2016; Global Burden of Disease Study 2013 Collaborators 2015; Purtle et al. 2016; Substance Abuse and Mental Health Services Administration 2014). The 2013 Global Burden of Disease Study (2015) found that major depressive disorder (MDD) alone was second in amount of years lived with disability by U.S. residents, and anxiety disorders were fourth. The increasing prevalence of mental illness in the U.S. has far-reaching implications on public health, beyond the bounds of psychiatry; those who have a mental illness also have increased risk of cardiovascular disease, obesity, injuries, substance abuse, and premature death (Purtle et al. 2016; Formann-Hoffman et al. 2014).

Although these trends are observed nationwide, one subset of the U.S. population is particularly vulnerable to psychiatric suffering. Uninsured people in America suffer a disproportionate burden of mental illness. The basis of this inequity is multifactorial. Compared to people without mental illness, those with mental illness are more likely to be living in poverty and thus less likely to have insurance

Electronic supplementary material The online version of this article (https://doi.org/10.1007/s10597-018-0325-x) contains supplementary material, which is available to authorized users.

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(Rowan et al. 2013; Sturm and Wells 2000; Vick et al. 2012). Inadequate access to psychiatric care is a major issue; uninsured individuals with psychiatric disorders are less likely than their insured counterparts to obtain necessary psychiatric care, largely because of prohibitive costs (Rowan et al. 2013; Wells et al. 2002). Uninsured immigrants to the U.S. are less likely than uninsured nonimmigrants to obtain psychiatric care because of inability to pay, language barriers, and lack of awareness (Derr 2016; Liberman et al. 2011).

Medical student-operated free clinics (SOFCs) have the potential to play a role in addressing this disparity. In recent decades, SOFCs have been a growing component of the healthcare safety net in the U.S., providing a healthcare option for uninsured populations as well as offering valuable educational opportunities for medical students (Simpson and Long 2007; Taylor et al. 2016; Smith et al. 2014; Zucker et al. 2011; Batra et al. 2009; Ouyang et al. 2013). More than half of all U.S. medical students are involved in more than 110 SOFCs across the nation, and studies have established the clinical value of and patient satisfaction with these clinics (Simpson and Long 2007). Despite the proliferation of such clinics, only a minority has established procedures for assessing psychiatric illness or providing referrals to mental health care (Liberman et al. 2011; Simpson and Long 2007). A few SOFCs have recently implemented systematic mental health screening, psychiatric referrals, and/or on-site psychiatric treatment (Liberman et al. 2011; Simpson and Long 2007; Batra et al. 2009; Soltani et al. 2015). One SOFC achieved psychiatric outcomes that were superior to outcomes reported by local commercial and public insurance plans (Liberman et al. 2011). These developments indicate that SOFCs have the potential to address mental illness among uninsured Americans.

Although the existing literature has focused on the quality of psychiatric care provided by student-operated clinics, there is no specific guidance in the academic literature on procedures for developing and operating psychiatric services in student-operated clinics (Liberman et al. 2011). A grant funded by the American Psychiatry Institute for Research and Education supported the creation of a psychiatric assessment component at an existing UT Southwestern student-operated medical clinic known as The Monday Clinic. This established the Monday Psychiatry Clinic (MPC), which began in 2009. This article chronicles the development and implementation of MPC and presents psychiatric assessment data collected as part of this effort.

Methods

The Monday Clinic is a UT Southwestern student-operated evening clinic that serves non-acute medical needs of the local uninsured population. It is housed at North Dallas Shared Ministries in a predominately low-income Hispanic area. Founded in the fall of 2006, this clinic has functioned continuously to the present. Beginning in the fall of 2009, MPC was added to The Monday Clinic. It shared an operating space, schedule, and patients with The Monday Clinic but had a formal protocol created specifically for the MPC. From early 2013 to early 2014, MPC was suspended for approximately a year to revise its operational procedures. Thereafter, MPC continued to operate until the current year.

The mission of MPC is to provide the following: (1) high-quality free screening and diagnostic evaluation to the underserved population of North Dallas, regardless of demographic characteristics or ability to pay; (2) an interactive learning environment for medical students and psychiatrists, thereby allowing them to develop clinical and leadership skills; and (3) development of student investment in understanding psychiatric diagnosis. Educational goals for MPC are to introduce students to: (1) interact with patients in a clinical setting, practice psychiatric interviewing skills, gain familiarity with local referral resources, and network with faculty and other trainees; (2) gain clinical exposure to psychiatric illness and learn procedures for diagnostic assessment; (3) interface with a culturally diverse local population with various psychiatric concerns and expressions; (4) develop leadership and organizational skills in the psychiatric specialty of medicine; and (5) engage in program quality assessment and research in community health and psychiatric services.

Procedures

The clinic is coordinated by a clinic manager, who is a second-year medical student. The clinic manager's job is to ensure smooth functioning of the clinic through operational adherence to the clinic's protocol, organize the schedule of volunteers, solicit student and attending volunteers, stock the supply screening, diagnostic, consent and referral forms before each clinic session, orchestrate the flow of the patients through the psychiatry assessments, educate all volunteers on clinic procedures, communicate with the medical clinic manager about psychiatric recommendations for the patients, confirm that forms are completed correctly and that all clinical notes were written, and store all paperwork properly and securely. Two psychiatry faculty advisors provide guidance and oversight to decisions about clinical operations. At every clinic session, one preclinical student, one clinical student, and one psychiatry attending participate. Eight attendings were recruited to volunteer so that each attending assist approximately once every 2 months.

A volunteer signup procedure was established online for medical students and attendings to choose dates to participate. Student volunteers are recruited through presentations at student orientation week and various student

organizations, as well as through efforts of a student-run committee that promotes all university-affiliated student-run clinics.

The MPC operates on Monday evenings beginning with the arrival of the psychiatry clinic manager at 4:15 p.m. followed by arrival of the preclinical and clinical students at 4:45 p.m. The MPC manager stocks all the clinic forms in preparation for the clinic's activities and sets up examination rooms. The MPC manager welcomes the preclinical and clinical students and explains the procedures. As patients arrive, the preclinical student begins screening them, and then the clinical student completes diagnostic templates for those with positive screens. If any patients have a positive psychiatric screen, the attending is notified and arrives at 6:00 p.m. and reviews the patient findings with the students and evaluates patients with positive screens. The attending provides psychiatric education about the patients' presentations, answers questions, explains general principles of psychiatry, and model psychiatric mentorship for the students. Patient assessments and recommendations are generally completed by about 8:30 or 9:00 p.m. The number of patients assessed in any clinic session is generally capped at 7, subject to the judgment of the attending based on time elapsed and situational factors. When students were not conducting diagnostic assessments, most of their time was filled in with relevant educational experiences including conducting psychiatric screening, teaching of the preclinical students by the clinical students, and engaging in conversation with the attending regarding psychiatry, clinical practice, and career advice.

The established clinical purpose of MPC is to assess common psychiatric disorders and refer patients in need to appropriate sources of care, but psychiatric treatment is not intended to be a function of this clinic. MPC functions in tandem with The Monday Clinic. All patients over the age of 18 who present to The Monday Clinic for medical concerns are offered an opportunity to receive a mental health assessment by students on the MPC team; this assessment occurs after the medical evaluation is completed or while the patient waits for the medical team. Few if any Monday Clinic patients declined participation in the MPC assessment. Patients not eligible to participate in the MPC assessments are children and patients in active physical distress, with unstable or emergent medical conditions who are incapable of participating in a psychiatric interview, or those who are already currently engaged in psychiatric care. The purpose and procedures involved in the MPC assessments are explained to the patients.

The MPC psychiatric assessment consists of two main procedures: screening for common potential mental health problems and diagnostic assessment of a limited number of psychiatric illnesses. For Spanish-speaking patients, all of the screening and diagnostic template guides have been translated into Spanish, and interviews are conducted through an interpreter.

The initial screening, conducted by a preclinical medical student, consists of a series of general mental health questions covering history of psychiatric illness or treatment including alcohol or drug problems, current concerns about mental health or alcohol or drug problems, current feelings of depression, current alcohol and drug use, lifetime history of trauma exposure (added to the screening procedure in the second year), and current domestic safety concerns. The rationale for the choice of psychiatric disorders including MDD, alcohol use disorder, drug use disorder specific to stimulants, and post-traumatic stress disorder, and domestic safety is that depressive and substance use disorders were anticipated to be the most prevalent disorders, and trauma-related concerns were considered to be important in this population. Because the screening needed to be a brief procedure, only a few disorders could be considered. The screening procedure lasts approximately 5–15 min, depending on the amount of discussion the patient provides.

Screening for depression inquires about a current episode of low mood or loss of interest occurring nearly every day, most of the day, or for at least 2 weeks. The basis for this inquiry is that it is the basic stem query for the diagnosis of MDD in the Diagnostic Interview Schedule, precisely following the DSM criteria for this disorder. Screening for alcohol use inquires about number of alcoholic beverages used in an average week, the largest number of alcoholic drinks at one time in the last month, and recency of use; the four CAGE questions screen for problems with drinking. A positive screen for depression is a report of a current episode of low mood or loss of interest as described above. A positive screen for alcohol problems is a report of 7 drinks per week for women and 14 drinks per week for men, 4 drinks a day for women and 5 for men, or a positive answer to any of the CAGE questions. A positive drug screen was report of use of recreational stimulant substance use in the last month. A positive screen for history of trauma exposure is a traumatic event posing a threat of serious injury or death to the patient or a sexual assault. A positive screen for domestic safety concerns is acknowledgment of an intimate partner who has threatened or hurt the patient or whom the patient believes has this potential. Finally, any patient expressing a general mental health concern or a request to discuss mental health concerns is considered to have a positive screen.

The diagnostic assessment is conducted by the clinical student under direct supervision of the psychiatry attending for assessing diagnostic criteria for psychiatric disorders including: MDD, alcohol use disorder, drug use disorder specific to stimulants, and post-traumatic stress disorder. Patients who screen positive for depression, alcohol use, stimulant use, or trauma are administered a diagnostic template interview including only diagnoses corresponding to

the sections with the positive screen. No diagnostic template is administered for patients with a positive domestic safety screen. When MPC first began, the current diagnostic criteria were from the fourth edition/text revision of the American Psychiatric Association Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR) (American Psychiatric Association 2000). When the criteria were revised to the fifth edition (DSM-5) in 2013, the new criteria were used for this project (American Psychiatric Association 2013). The diagnostic templates were created for this project to guide students through the process of asking about all of the diagnostic criteria for the diagnoses assessed and to record the responses quantitatively for subsequent ease of transfer to a database for analysis. The content of the diagnostic templates follow the diagnostic criteria carefully, using language from a structured diagnostic interview, the Diagnostic Interview Schedule (Robins et al. 1999). The Diagnostic Interview Schedule is a fully structured and well validated diagnostic instrument that systematically assesses the complete diagnostic criteria for psychiatric disorders as established in the Diagnostic and Statistical Manual for Mental Disorders, and it has been used extensively in landmark prevalence studies and in studies of diverse populations. An advantage of using language from this interview to construct the diagnostic template and screening tools for this project was that the formally structured questions in it are well established and tested for the collection of reliable and valid data for the diagnostic criteria (Robins et al. 1981).

Following the diagnostic criteria, the template for current MDD first establishes an episode lasting at least 2 weeks with either low mood or loss of interest and pleasure most of the time nearly every day. If no such episode is acknowledged, assessment of this diagnosis is stopped and the disorder is determined not to be present. If the patient acknowledges such an episode, an additional seven characteristic symptoms of MDD are assessed. Further, clinical significance or impairment are assessed through questions about treatment or interference of the symptoms with ability to function, and the etiology of the symptoms in medical conditions or substances is ruled out. Scoring instructions are provided to allow the student to determine the presence of a depressive episode, as defined above, plus at least five of nine possible symptoms during the episode, as well as clinical significance or impairment not attributable to medical conditions or substances. Current alcohol and stimulant use disorders are similarly assessed through a series of questions about the criterion symptoms as provided by the diagnostic manuals, such as using more than intended, inability to quit or cut down on use, cravings, and tolerance or withdrawal. Beginning in the second year, current post-traumatic stress disorder criteria were assessed in patients with a positive trauma exposure screen, but the trauma exposure screen and the section of the diagnostic template were discontinued after 3 years because this procedure added little substance to the referral process. The sections of the diagnostic template each require approximately 15–20 min to complete.

Operational procedures have been developed to guide the clinical flow of these assessment activities through a series of consecutive steps (see Fig. 1): (1) a brief review of the patient's Monday Clinic chart for demographic information and reason for the visit; (2) a brief screening interview conducted by a preclinical student accompanied by a clinical student observer; (3) presentation of the results of the screening interview by the preclinical student to the clinical student; (4) for patients with positive screens, a diagnostic template interview by a clinic student; (5) presentation of the diagnostic interview to the attending by the clinical student; (6) interview of the patient by the clinical attending in the presence of the preclinical and clinical students; (7) discussion of the case by the team and formulation of a disposition; (8) provision of referral recommendations to the patient; and (9) generation of a clinical record note by the clinical student describing the assessment and the referral recommendations for patients who received the diagnostic template interview, with an accompanying clinical record note signed by the attending.

Patients with a negative mental health screen who do not request to speak with a psychiatrist and who have no other apparent indicators for further psychiatric assessment are informed of the negative result of their screening and thanked for their participation. For patients requesting referrals for further psychiatric care and for those with psychiatric treatment needs identified, referrals are made to the appropriate local clinics serving the indigent population. Patient referral forms with patient contact information and referral information are completed, with signed consent to release medical information.

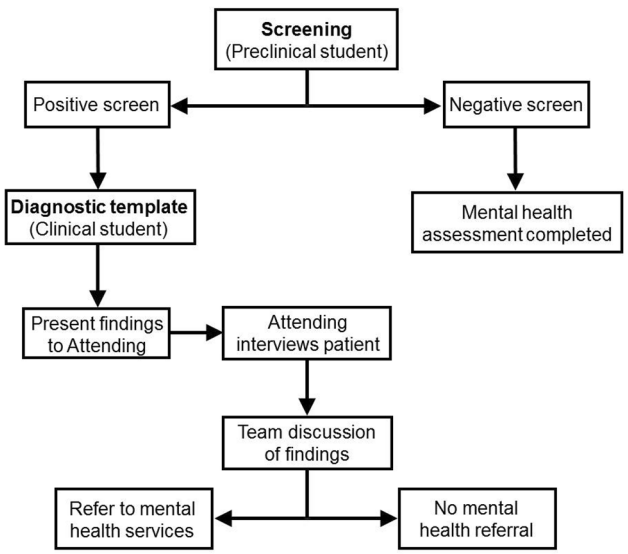

Fig. 1 MPC procedural flow diagram

Copies of the referral form and the clinical summary are faxed to the referral site, and a copy of the referral form is given to the patient. The medical team is informed of the psychiatric assessments results. The clinic manager then records summary information for all patients on a master log sheet including screening result, diagnoses made, and referrals given. The completed screening and diagnostic template forms for each patient assessed in the clinic are carefully stored in a data file along with the completed master log sheets for each clinic session. These forms provided the source for data used by this study to present results.

An MPC manual was developed as a complete guidance system for clinic operations and to secure institutional memory as it is passed on to new managers and students every year. The manual provides a brief history of the clinic; a mission statement; a description of the scope of the clinic; patient eligibility for clinic services; roles and responsibilities of the clinic managers, preclinical and clinical students, and attendings; flow of the clinic; patient care procedures including screening, diagnostic assessment, and referral processes; safety procedures; and contact information. This manual is available as an online supplement to this publication upon request to the corresponding author.

Data Analysis

Information from the screening forms and diagnostic templates completed by the student interviewers was entered into a Microsoft Windows Excel spreadsheet. Variables were created in the spreadsheet for each item in the forms. Information from the managers log sheets was also entered into the spreadsheet. The Excel database was then imported into SAS 9.4 (Cary, NC) for analysis. The data were cleaned by establishing logical skip patterns in the data and inspecting the data to ensure that all values were within accepted ranges. Data entry errors, including missing data, were corrected by consulting the raw data in the original clinical forms.

Code for diagnostic algorithms was created in SAS for diagnoses of MDD, alcohol use disorder, stimulant use disorder, and post-traumatic stress disorder (PTSD) using accepted criteria for psychiatric diagnoses. Separate code was written for DSM-IV-TR and DSM-5 to reflect the change in established criteria in 2013, which was incorporated into the diagnostic template forms used in MPC. Descriptive findings in the data are presented through counts, percentages, means, and standard deviations.

Results

The UT Southwestern Institutional Review Board (IRB) determined that IRB review was not required for this project. A total of 346 MPC patients had available data from this project. Data are not available prior to the Fall of 2010, yielding a database that included approximately 69 patients per year over 5 years of MPC operations. These numbers represent approximately half of the total number of patients served in TMC over this period. Specific records were not kept describing the circumstances by which patients seen in TMC were not also assessed in MPC, but anecdotally the main reasons for non-assessment by MPC were complicated medical problems precluding psychiatric assessment, non-availability of psychiatric physicians, departure of patients prior to MPC assessment, and patient decline to participate in MPC.

Although data obtained from the screening and diagnostic assessments of the patients served by MPC do not provide an epidemiologic portrait of a patient sample that could be generalizable from this particular setting, the findings are presented to illustrate the results of this particular clinic's experience. Table 1 describes the demographic characteristics of all the patients served by MPC. The patient sample was two-thirds female and averaged about 40 years of age. The vast majority was Hispanic and three-fourths were Spanish-speaking only.

Table 2 lists the numbers and percentages of patients who were evaluated and who had positive screens and diagnostic assessments. Approximately one-third of the patients screened were determined to screen positive for depression, alcohol, drug use, trauma exposure, or domestic violence. One-half of the patients with a positive depression, alcohol, drug, or trauma screen received a diagnostic template assessment for the corresponding diagnosis, and approximately one-fourth of the patients with a positive screen who received the diagnostic template assessment met full criteria for at least one psychiatric disorder.

Approximately one-fourth of the patients had a positive screen for depression, but very few met criteria for MDD based on the diagnostic template interview. Referral data were available for 27 of the 39 patients with a positive

Table 1 Demographic information

	Percent (n/N)	Mean (SD), range
Male sex	37 (183/500)	
Age		39.4 (11.7), 18–82
Ethnicity		
White	7 (32/484)	
Black	6 (30/484)	
Hispanic	85 (409/484)	
Asian	1 (5/484)	
Other	2 (8/484)	
Language		
Spanish	76 (378/496)	
English	24 (118/496)	

Table 2 Results of mental health screening and diagnostic template assessment for psychiatric disorders

Topic assessed	Received screen	Screened positive	Received diagnostic template	Positive diagnosis	
				Of those with positive screen	Of all patients
Depression	338	80 (24%)	39 (49%)	1 (3%)	1 (< 1%)
Alcohol	338	44 (13%)	25 (58%)	10 (40%)	10 (3%)
Stimulant drug	334	6 (2%)	3 (50%)	1 (33%)	1 (< 1%)
Trauma screen	215	21 (10%)	7 (33%)	5 (71%)	5 (2%)
Domestic safety	337	5 (1%)	–	–	–
Any diagnosis	346	121 (35%)	61 (50%)	16 (26%)	17 (6%)

depression screen, and all but 1 of these 27 patients received a referral to psychiatric care (see Table 2). Only a fraction of the patients screened positive for alcohol or stimulants, but about one-third of those who received a diagnostic template interview for alcohol or drug use disorders met diagnostic criteria. One out of ten patients screened positive for trauma exposure, and the majority of those assessed with the diagnostic template for PTSD met criteria for the disorder. Very few patients acknowledged any domestic safety concerns. Despite the many positive screening assessments, very low proportions (0–3%) of the patients evaluated by MPC were found to meet diagnostic criteria for a psychiatric disorder using the diagnostic template interview.

Discussion

MPC was developed as a student-operated psychiatry clinic to identify unaddressed psychiatric needs of patients served in a student-run medical clinic and to promote awareness and education about psychiatric illness for preclinical and clinical medical students. In several ways, the model presented here met those missions. From a service perspective, approximately one-third of patients assessed were identified to have a psychiatric concern deserving full evaluation, demonstrating an unmet need in this underserved community. From an educational perspective, this clinic provided preclinical students with the opportunity to interface with patients for the first time in their medical careers, began learning how to ask psychiatric questions, and gained greater awareness of psychiatric issues in medical patients. When volunteering with MPC, clinical students experienced a systematic procedure for assessing full diagnostic criteria, learning how to conduct efficient diagnostic interviews with patients. The repetition of interviews based in diagnostic criteria and the procedures of analyses of data to construct psychiatric diagnoses in the data set provided students with solid knowledge of the criteria and their application. Furthermore, MPC provided leadership opportunities for students who served as managers as they developed and implemented a full-fledged clinic operation. Finally, MPC provided opportunities for medical students of all levels to interface with psychiatry attendings and spend time immersed in discussion relevant to psychiatry. All of this was accomplished through service to a disadvantaged population, promoting better understanding of the needs of an underserved community instilling a value system that includes volunteerism and public service.

In spite of these benefits, MPC had many shortcomings. Located in a predominantly Hispanic neighborhood, the clinic attracted a patient clientele that was predominately Spanish-speaking. This aspect of the patient population posed a challenge for our MPC volunteers, who were largely non-Spanish speaking. Our clinic offered student interpreters in the way of language support, but interpreter skill and experience varied widely; protocols regarding their role in the psychiatric interview were not always clear and variably applied by student managers. In this way, MPC failed to offer sufficient language support for our patients. MPC volunteers could not always appreciate the nuanced, complicated responses of the Spanish-speaking patients they assessed, not only because most volunteers were not fluent in Spanish, but also because they were novices to the field of psychiatry as a whole. Moreover, from anecdotal experience, patients could be frustrated with the communication difficulties as well; being misunderstood is particularly detrimental in the vulnerable setting of a psychiatric interview. From a learning perspective, we found MPC volunteers spent more time navigating the language barrier than engaging with psychiatric principles. Between the variability of student interpreters and the inexperience of our MPC volunteers, our lack of language services hindered psychiatric assessments from both clinical and educational perspectives. MPC did not have the infrastructure to bridge this language gap.

In addition to this language barrier, the Hispanic MPC patient population had additional complexities that novice medical student volunteers were not prepared to meet. As noted by other authors, patients of Hispanic origin are significantly more likely to underreport depression and domestic safety concerns (Sorkin et al. 2011; Lewis-Fernández et al. 2005). We believe this conclusion is borne out in our results. Approximately one-fourth of the patients assessed in the MPC had a positive screen for depression. About one in ten

screened positive on the alcohol and trauma sections of the screener. Very few patients acknowledged domestic safety concerns. One-third or more of the patients who screened positive on the alcohol or drug sections of the screener also met diagnostic criteria for the corresponding psychiatric disorder and more than two-thirds of those who screened positive on the trauma section of the screener met diagnostic criteria for PTSD. However, only 3% of the patients with a positive depression screen met full criteria for MDD using the diagnostic template. The very low proportion of patients meeting diagnostic criteria for MDD is likely a vast underestimate and could have arisen for a variety of reasons, especially potential roles of stigma, culture, and language barriers. A previous study has found that Hispanic patients were less likely than non-Hispanic whites to be diagnosed with MDD and they reported greater distrust of providers (Sorkin et al. 2011). This under recognition of depression may have resulted from educational and language barriers and cultural stereotypes surrounding depression (Lewis-Fernández et al. 2005).

Noteworthy limitations of this study include the representation of only one site for the initial development and implementation of this clinic and the high nonparticipation rate in the psychiatric assessment procedures among the patients visiting TMC. Another limitation is that only three psychiatric disorders were systematically assessed; however, patients who presented with other psychiatric concerns were provided appropriate mental health referrals. One procedure not included in this project was a follow-up procedure to determine patient outcomes such as actual utilization of referral site services.

In spite of these limitations, this particular project has a number of strengths. The first is its longevity, yielding data on more than 300 patients over 5 years. Other major strengths of the project are the systematic procedures and evaluation tools that were developed for this study to provide initial screening followed by full diagnostic assessment according to current DSM criteria. Thus, analysis of data was able to yield DSM diagnoses whose criteria were fully assessed in a systematic fashion.

Some recommendations emerge from the development and implementation of this clinic that could provide direction for students planning to develop similar psychiatric services in student-operated clinics at their own institutions. First, it will be helpful, if not essential, to have a clinic manual providing organizational structure and function. Second, systematic templates that incorporate diagnostic criteria provide a foundation for conducting psychiatric assessments in the clinic. Third, from the experience of developing and implementing this clinic, a recommendation emerging is that student managers carefully assess the language needs of their patient population. During the MPC experience, it became clear that for a student-operated psychiatric arm to serve both the clinical needs of patients and the educational needs of novice volunteers, either students should share the language of their patient population or robust, standardized translation services must be in place. Fourth, the clinic must be prepared to provide community mental health resources for patients who are identified to have psychiatric needs. Finally, systematic collection of psychiatric assessment results assessing full diagnostic criteria will familiarize students with diagnostic criteria for psychiatric disorders and provide insight into the psychiatric needs of the patient population being served. Data obtained from these activities will enable programs to refine the implementation of their assessment procedures.

A main goal of student operated clinics that have a specific focus on psychiatric issues is to provide a positive mental health experience and to further students' interest in psychiatry and community work. This project did not specifically collect data to address how well this goal was met, and therefore a next step in future studies of these kinds of clinical experiences is to examine the degree to which student participation increases their interest in community psychiatry.

Funding A Grant from the American Psychiatry Institute for Research and Education.

Compliance with Ethical Standards

Conflict of interest None of the authors have any known conflicts of interest.

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