



# A Student-Run Free Mental Health Clinic for the Immigrant and Refugee Population in Clarkston, Georgia

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## Abstract

Immigrant and refugee populations have high rates of mental health diagnoses but typically access services at lower rates than the general population because of cultural and structural impediments. Comprehensive health care is essential for future societal success of this population. This article discusses the establishment of a monthly mental health clinic at a pre-existing health center catering primarily to refugee and immigrant populations. In addition to its primary goal of meeting a need for low-cost mental health services, a secondary goal was to provide medical students and psychiatry residents with an opportunity to treat diverse populations and thereby increase their ability to provide culturally sensitive care. This article outlines the clinic's operations, to date, as well as successes and challenges faced.

## Background

Historically, the United States (US) has been a world leader in immigration and refugee resettlement. In 2015, there were over 43 million foreign-born people in the US, comprising 13.4% of the population.<sup>1</sup> Over 3 million refugees have arrived in the US since 1975.<sup>2</sup> Refugees are defined by the United Nations as those who have had to leave their home country for "reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection."<sup>3</sup>

### *Mental Health Care of Immigrants and Refugees*

Most refugees have endured traumatogenic experiences before and during their migration. Even after arriving in the host country, their psychological state often deteriorates due to factors including separation from family, cultural and language barriers, as well as poor access to medical care.<sup>4</sup> A meta-analysis by Bogic et al. in 2015 investigated the prevalence of mental health symptoms in long-term, resettled war refugees and found higher rates of post-traumatic stress

disorder (PTSD) (12.9-86%), depression (6.2-80%) and anxiety (20.3-88%) compared to the general population in the US, although there was large variation in prevalence among the studies.<sup>5</sup> The prevalence of suicidal behavior in refugee populations has been estimated to range from 3–34%.<sup>6</sup>

The prevalence of mental health diagnoses in immigrant populations is less clear. Studies have typically found lower rates of mental health disorders in immigrants than in their US-born counterparts, although evidence suggests the prevalence of mental health disorders increases the longer immigrants have resided in the US.<sup>7</sup>

Despite the high need in this population, immigrants and refugees access mental health care at lower rates as compared to the general population. Cultural barriers contributing include stigma, differing beliefs about mental illness, and distrust of providers, while structural barriers include language difficulties and lack of insurance.<sup>8</sup> In one study, cost of services was the most commonly cited barrier with 60% of participants naming it as a deterrent to seeking mental health treatment.<sup>9</sup> Additionally, unintended negative outcomes may occur when providers from high-income countries treat patients from low- and

middle-income countries without an appreciation of the interplay between a patient's individual culture and health. This is particularly true for mental health care, in which there is a critical interplay between culture and presentation of illness.<sup>10,11</sup> Therefore, effective mental health care in immigrants and refugees requires not only affordable, linguistically-matched services, but also delivery in a culturally sensitive and humble manner.

#### *Clarkston Community Health Center*

The town of Clarkston, Georgia (GA), located approximately 10 miles northeast of Atlanta, GA, has welcomed more than 40,000 refugees over the past 25 years.<sup>12</sup> A recent survey estimated that over 46% of the population is foreign born.<sup>13</sup> Clarkston Community Health Center (CCHC) was founded in 2013 to provide primary care services to the low-income, uninsured population in the area. In addition, a variety of subspecialty clinics have been created, including dental, ophthalmology, dermatology, and women's health. Although several patients presented to the clinic each week with mental health and somatic concerns, until recently, CCHC offered no formal mental health services. To address this need, clinic leadership collaborated with medical students at Emory University School of Medicine to establish a monthly student-run mental health clinic.

### **Mental Health Clinic Overview**

In June 2017, a group of Emory University medical students and CCHC leadership met to discuss the establishment of a mental health clinic. The immediate goal of this clinic was to address the need for mental health services in CCHC's patient population. An additional goal was to provide medical students and resident physicians at Emory University School of Medicine with domestic opportunities for working with ethnically and culturally diverse patients. Since the set-up of this clinic was effectively a 'pilot study', we also planned to utilize our experiences during the initial period of the clinic's operations to identify challenges and highlight resource deficiencies for improvement of the services provided, specifically tailored toward the immigrant and refugee populations.

Patients were screened at the weekly primary care clinic using the Patient Health Questionnaire-2 (PHQ-2),<sup>14</sup> Generalized Anxiety Disorder 7 (GAD-7),<sup>15</sup> and Primary Care PTSD Screen for the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition (PC-PTSD-5).<sup>16</sup> We defined a positive screen as 1 or greater on the PHQ-2 for depression, 5 or greater on the GAD-7 for anxiety, or the presence of trauma history with at least 1 persistent symptom on the PC-PTSD-5 for PTSD. Although these cut-offs are lower than typically used for PHQ-2 (score  $\geq 3$ )<sup>14</sup> and PC-PTSD-5 (trauma history and  $\geq 3$  persistent symptoms),<sup>16</sup> a lower threshold was utilized since these tools are not specifically designed for a diverse population, such as that at CCHC.

Interpretation services were provided by clinic volunteers, who spoke a variety of languages, including Hindi, Arabic, Urdu, Swahili, and Gujarati. If no one was available to interpret, patients were instructed to leave the screening form blank.

Providers at the mental health clinic included two attending psychiatrists and several third- and fourth-year psychiatry residents from Emory University School of Medicine. Residents received supervision from an on-site attending psychiatrist who reviewed patients' histories and proposed treatment plans. Each provider (residents and attendings) was scheduled to see three patients over two hours and provide a combination of psychotherapy and medication management when indicated.

Medical students coordinated the mental health clinic. At the CCHC primary care clinic each Sunday, medical students were responsible for screening patients and were available to speak with primary care providers about referrals. They also scheduled patients and providers for the monthly mental health clinics. Students also provided psychoeducation to patients and their family members at both the primary care and mental health clinics.

### **Pilot Results**

From October 2017 to November 2018, a total of 664 patients were screened. Of the 664, 283 (42.6%) screened positive for at least one psychiatric diagnosis, including 86.7% (241/278) for major depression, 59.4% (168/283) for generalized

anxiety, and 26.2% (72/275) for PTSD. Approximately two additional patients per week were identified by a primary care provider as potentially benefitting from mental health services and referred to the clinic despite an initial negative screen.

Nine mental health clinics have been held since December 2017, each lasting approximately 2 hours. To date, there have been 45 total patient visits, including 32 initial visits and 13 follow-up visits. Twenty one out of 32 (65.6%) received prescriptions for medications at the initial patient visit. All received psychotherapeutic intervention, including behavioral, psychodynamic, and supportive psychotherapy.

To address the patients' complex psychological, legal and, social needs, we partnered with a nonprofit organization that offers additional support, including more extensive trauma-specific psychotherapy and case management. Six patients have been referred to receive services through this nonprofit organization. In addition, patients were referred to receive outpatient services through Grady Health System in Atlanta. We have also collaborated with a new asylum clinic at Emory that performs evaluations on refugees seeking asylum.

For the clinic's secondary goal of providing opportunities to work with ethnically and culturally diverse patients, to date, five psychiatry residents and twelve medical students from Emory have volunteered at the clinic.

## **Discussion**

We consider the 'pilot' period after the clinic's establishment in December 2017 a success. Nine clinics have been held to date with 45 total patient visits, and there continues to be a steady demand for mental health services. We attribute this demand to several factors, including our location within an established community health clinic and the lack of affordable mental health services in the area. Additionally, we have been successful in our goal of providing medical students and psychiatry residents experience working with immigrant and refugee populations. Psychiatry resident volunteers gained experience assessing the role of culture in perception, presentation, and treatment of psychiatric

symptoms. Medical student volunteers gathered experience in mental health screening, psychoeducation, and coordination of care. These basic skills can be used in community-level mental health care to allow students to gain some competency in population-based approaches to health.<sup>17</sup> These skills have the potential to assist medical trainees in future international health rotations in low-income countries and in working in low resource areas domestically.<sup>18</sup>

## *Challenges*

We have encountered several challenges in the development of this mental health clinic. These challenges stem from a lack of financial resources, linguistic diversity of our patient population, providers' busy schedules, competing demands within the clinic, and lack of expertise in cultural psychiatry.

## *Future Directions*

Next steps include securing funding, which will primarily be used to secure interpreters. While our providers are fluent in several languages, we do not have language-matched providers for many of our patients and therefore are unable to screen or provide effective services to them. We are also in the process of recruiting clinical psychologists and social workers to increase the scope and reach of our services. We currently cannot accommodate the increasing number of patients who request services and require follow-up with our monthly clinics. Recruiting more providers will allow us to see more patients, provide more regular follow-up, and expand the variety of services provided.

We are seeking to address the mental health needs of our patient population more effectively by honoring the wide cultural diversity that we see in the CCHC. Currently, our primary care providers are using the same screening tool for all patients regardless of their identification as refugees, immigrants, or American-born. In the future, we hope to provide distinct screening tools that are culturally and linguistically appropriate for immigrant and refugee populations. Additionally, because of the diversity of our patient population, it is impossible for providers and students to understand the intricacies of all patients' backgrounds and cultures. Rather than

assuming that we can reach a final level of “cultural competency,” we hope to instill a sense of cultural humility in students and providers so that they may elicit an individual patient’s viewpoint on cultural identity, as well as challenge the students’/providers’ own beliefs and how these may impact the care they provide.<sup>19</sup> We hope the mental health clinic at CCHC can serve as a springboard for formal didactic and group discussions on topics in cultural anthropology.

A recommendation for future groups establishing similar clinics is ensuring that providers receive formal instruction on cultural psychiatry before or during their clinical experiences, as culture and language differences likely have a stronger influence on mental health care than on other types of medical care. Although Emory psychiatry residents receive formal lectures on cultural psychiatry in the required didactic seminars that include material on working with immigrant and refugee populations, we hope to develop further instruction for both residents and medical students that is tailored to their work at this clinic. Particular emphasis should be placed on the ways power dynamics impact care of patients from low- and middle-income countries to help ensure care is provided in a way that is both ethical and effective.

## Conclusion

In summary, there are many factors to consider when providing mental health care for a culturally diverse population. We hope our experiences at CCHC will be useful and may serve as a model for other student-run free clinics looking to implement mental health services.

## Disclosures

The authors have no conflicts of interest to disclose.

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