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Designing and Implementing a Mental Health Promotion Station into a Preventive Medical Clinic

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Abstract

Statistics show a significant decline in mental health nationally, particularly during and following the COVID-19 pandemic. In response, a mental health promotion station was designed and implemented into the Health Promoter Program (HPP) – a preventive medicine program encompassing five medical clinics serving minority undocumented and/or under/uninsured communities in the Philadelphia area and run by the Institute of Clinical Bioethics (ICB) at Saint Joseph's University. Staffed by ICB research fellows and graduate psychology students, the mental health station expands upon the HPP's philosophy of preventive medicine through offering psychoeducational materials in addition to screenings for Major Depressive Disorder, Generalized Anxiety Disorder, and suicide risk. After implementing the station at five health promoters in Philadelphia, PA, variable patient interest in mental health screenings across the different communities was noticed. Of the patients who attended the health promoters, an average of 0.72% of the Hispanic patients, 5% of the Asian patients, 6.67% of the African patients, and 11.76% of the Philadelphia-local patients participated in screenings offered at the mental health station. This aligns with data from existing literature on the prevalence of stigma against mental health among minority communities in the United States.

INTRODUCTION

Depression and Anxiety on the Rise in the U.S.

Since the start of the COVID-19 pandemic, mental health in the United States has suffered a substantial impact. The prevalence of both anxiety and depressive symptomatology has increased notably among the general population, rising from about 10% of adults in 2019 to about 40% of adults during the pandemic (Adams & Grupa, 2021). Populations such as essential workers endure the brunt of these symptoms, reporting the highest rates of mental health distress at the beginning of the pandemic (Grooms, Ortega, & Vargas, 2021). Unfortunately, many essential workers are employed in lower-income occupations despite the critical nature of their work during the pandemic and beyond – often encompassing jobs such as home health aides, food preparation workers, and cashiers. A report published in the Journal of the American Medical Association (JAMA) found that the increase in prevalence of psychopathology after COVID-19's onset is associated with several pandemic-related factors, including financial insecurity (Ettman et al., 2020). The pandemic has created an even larger disparity in the mental health status among U.S. workforces, as significantly lower wages and fewer benefits are already entwined with essential jobs as compared to other occupations.

Mental Health Status Among Minority Communities in the U.S.

Data from the U.S. Bureau of Labor Statistics shows that minority groups are more likely to be employed in essential services (U.S. Department of Labor, 2023), and emerging evidence suggests that the COVID-19 pandemic has disproportionately impacted mental health across many communities of color. When evaluated across race and ethnicity, symptoms of anxiety are reported disproportionately more in Black essential healthcare workers, while symptoms of depression are reported disproportionately more in Hispanic essential workers (Grooms, Ortega, & Vargas, 2021). However, there appears to be a significant relationship between being either a Black or a Hispanic essential non-healthcare worker and possessing higher levels of distress related to both anxiety and depression (Grooms, Ortega, & Vargas, 2021).

Asian and Pacific Islander (AAPI) groups surpass other

minority communities in their experienced detrimental psychological impacts from the pandemic. Representing a significant portion of the overall essential workforce in the U.S., AAPI community members face exposure to distinct stressors such as anti-Asian hate and violence that were heightened during the pandemic, which, in turn, exacerbated anxiety, depression, and trauma within these communities (Zhou, Banawa, & Oh, 2021). Although AAPI communities remain some of the most psychologically troubled due to COVID-19, their mental health challenges do not align with their likelihood of seeking treatment, as they remain one of the least likely minority groups to do so (Abe-Kim et al., 2007).

Large U.S. urban cities like Philadelphia are home to an array of such minority communities. Neighborhoods such as Chinatown, Germantown, and Kensington are home to a diverse mix of communities that include large populations of Black, Hispanic, and AAPI residents. Due to the intersection of race and class identity, there exists a pressing need for affordable and accessible mental health services in communities of color who are facing poverty, economic stress, and insurance issues – especially in the post-pandemic world.

Lack of Access to Screening/Therapy Services

In addition to socioeconomic barriers preventing residents in marginalized neighborhoods from accessing mental health screening and treatment, systemic and cultural stigma-related barriers remain in place as well. Both historical and ongoing racism and discrimination have contributed to disparities in access to psychological services and treatment outcomes and have resulted in minority groups' significant distrust of healthcare authorities. In some cases, such distrust has deterred them from seeking any healthcare treatment whatsoever (Cénat, 2020). Furthermore, professional mental health services are not commonly available within minority neighborhoods, prompting residents who may not have the means to do so to travel long distances (Health Resources and Services Administration, 2023). Additionally, the prevalent stigma surrounding mental health diagnosis and treatment among minorities causes them to view psychopathology as a sign of weakness or a source of shame. Literature from the American Psychological Association's Monitor on Psychology Journal cites cultural stigma as a severe hinderer of mental health service utilization among minority groups (Clay, 2019). Consequently, there is a critical demand for more culturally competent clinicians and other mental healthcare providers who are aware of these barriers and consider the cultural contexts of minority communities.

HEALTH PROMOTER PROGRAM (HPP)

The Health Promoter Program (HPP) run by the Institute of Clinical Bioethics at Saint Joseph's University is a community health-equity initiative inspired by the philosophy of preventive medicine and already existent health promoter (HP) template models, particularly those of Partners in Health (PIH), the Dominican Sisters in the Dominican Republic, and Creighton University's Institute for Latin American Concern (ILAC).

As an international non-profit, PIH strives to make the fruits of modern medical science available to populations most in need of them and to promote health as a fundamental right rather than a privilege. PIH's HP template is founded on preventive medicine and education, operating in Rwanda, Haiti, Peru, Liberia, Kazakhstan, Mexico, Russia, Malawi, Sierra Leone, and Lesotho (Clark & Surry, 2007). Meanwhile, the Dominican Sisters' HP model operates in Las Cruces De Arroyo Hondo in the Dominican Republic, relying on community solidarity and proper education to increase health awareness and strengthen basic medical infrastructure. Likewise, Creighton University's ILAC's model is a systematic initiative that offers members of the Santiago community in the Dominican Republic primary medical care in addition to preventive health services (Clark & Surry, 2007).

Established in 2012 in response to an increasing undocumented African population in Philadelphia, PA, the HPP's mission is to bridge the gap between the uninsured/underinsured/undocumented communities and basic healthcare services. The program started out as a monthly general medical clinic serving small communities of uninsured Hispanic and African immigrants. Since then, the HPP has expanded to encompass five medical clinics, now called Health Promoters (HPs), setting up monthly at more than six different sites scattered throughout Philadelphia and its greater area. Named after the communities the clinics target, the Asian, African, BIPOC, Hispanic, and migrant farm worker HPs collectively admit an average of 3,360 patients annually.

Unlike staffing at traditional medical clinics, HPs are partially run by undergraduate ICB research fellows, some of whom run the stations while others coordinate the clinics' logistics such as marketing, inventory checks, and recruitment of undergraduate volunteers as well as

Philadelphia-local medical, dental, and health professionals. A designated medical resident serves as each clinic's medical coordinator, ensuring the clinic runs smoothly and the services offered are in accordance with national healthcare standards.

As for the gratis services offered, patients at HPs have access to height, weight, and Body Mass Index (BMI) measurements, blood pressure and blood-oxygen saturation measurements, blood glucose and total cholesterol level testing, occupational and physical therapy (provided by Saint Joseph's School of Health Professions), breast, cervical, colorectal, lung, and prostate cancer screenings (offered by Penn Oncology), in addition to HIV, Hepatitis B, and Hepatitis C testing (offered by Drexel Hope and Hepatitis B Foundation). Furthermore, patients may opt for drug-reconciliation services with SJU PharmD. candidates and consultations with medical residents from Mercy Catholic Medical Center (MCMC) and/or Jefferson Health Northeast, among many other services. Under the umbrella of preventive medicine, patients are also offered basic dental care services (e.g. fluoride treatments), prenatal, child, and adult vitamins, Pack N' Plays for expecting or pregnant women, naloxone, immunoassay test strips for xylazine and fentanyl, and reading glasses, alongside other products. Moreover, wound-care services are offered during HPs run in areas in which local communities face prevalent substance-use disorder.

However, all the aforementioned services pertain to physical, not mental, well-being. Hence, in response to a national decline in mental health, the ICB has sought to introduce a mental health and wellness station to the HPs to link HP patients to basic psychiatric services.

MENTAL HEALTH STATION'S OBJECTIVES

In addition to pursuing a more holistic care at the HPs, the mental health station's objectives include increasing immigrant communities' accessibility to basic mental health screening. Based on 2019 census data, approximately 8.98 million immigrants in the U.S. do not have health insurance, without which their access to health care, including mental health care, is greatly diminished (Ijioma, 2024).

Another objective of this project is to challenge the negative stigma prevalent among immigrant communities in the U.S. regarding seeking mental health aid or even admitting to struggling with mental health by presenting before communities as advocates of mental self-introspection. Immigrant status in and of itself poses unique barriers to an individual's access to healthcare, including financial strain, lack of information, racism or discrimination, language barriers, feeling isolated and unheard by service providers, and stigma (Tulli et al., 2020). The stigma experienced by immigrant populations in the U.S. leading to their underutilization of mental health services results in unmet needs negatively impacting not only their mental health, but also their overall wellness (Douglas et al., 2022).

A third objective is to ensure HP patients have a continuity of mental healthcare. This is made possible by collaborating with external outpatient clinics to which patients identified as needing further mental health services can be referred, as well as providing patients with a list of locations they can contact for psychiatric help.

Finally, the mental health station serves a clinical educational role. Volunteering at the mental health station can be considered an experiential learning opportunity for undergraduate ICB research fellows and volunteers at the HPs so that they will be better equipped to discuss mental health with HP patients and have a positive impact on those struggling with mental challenges or illnesses.

MENTAL HEALTH STATION RESOURCES/MEASURES

Screening Tools & Interpretation of Scores

Our mental health station is designed to screen for symptoms of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) – two of the most common psychopathologies among minority communities. The first tool we use is the Patient Health Questionnaire (PHQ-9), a commonly used measurement for the severity of depression and depressive symptoms, that has been found to have sufficient internal consistency (α = .77-.89). Drawing its foundation from the diagnostic criteria for MDD as outlined in the DSM-IV, the PHQ-9 serves as a 9-item self-report questionnaire (Alreshidi, 2023). On a 4-point Likert scale, participants are prompted to assign ratings (0 = not at all, 1 = a few days, 2 = more than half the days, and 3 = almost every day) to indicate how frequently they have experienced or recognized depressive symptoms in the last two weeks. Participants' individual responses are collected, and a total score is computed, which can range from 0 to 27. Mild depression is defined as a score between 0 and 14 (inclusive), moderate depression defined as a score between 15 and 19 (inclusive), and scores between 20 and 27 (inclusive) indicate severe depression.

The second tool used is the General Anxiety Disorder-7 (GAD-7), an instrument designed to assess the presence and severity of GAD. The GAD-7 is a self-administered questionnaire with seven items that describe the prominent diagnostic features of the original DSM-IV diagnostic criteria for GAD (Dhira et al., 2021). Similar to the format of the PHQ-9, participants are asked how often they have experienced anxiety symptoms (i.e., feeling nervous, having trouble relaxing) in the past two weeks with a 4-point Likert scale as a response option (0 = not at all, 1 = several days, 2 = more than half the days, and 3 = nearly every day). When the scores from all seven items are aggregated, the total GAD-7 score will range from 0 to 21. Generally, a score between 5 and 9 (inclusive) indicates mild anxiety, 10 and 14 (inclusive) indicates moderate anxiety, and 15 and 21 (inclusive) indicates severe anxiety levels (Dhira et al., 2021). The overall GAD-7 scale suggests excellent reliability (α = 0.895).

Risk Assessment Tool/Risk Management Protocol

Participants with PHQ-9 scores greater than or equal to 20 and participants who indicate passive or active suicidal ideation on the screening, regardless of their numerical score, are given a follow-up screener, the Colombia-Suicide Severity Rating Scale (C-SSRS). The C-SSRS is an instrument designed to assess both suicidal ideation and behavior to identify those at risk and to track treatment response (Posner et al., 2011). The C-SSRS has demonstrated sufficient to excellent internal consistency in multiple studies (α = 0.73-0.95). The tool aims to measure four key constructs related to suicidal ideation and behavior: severity of ideation, intensity of ideation, behavior subscale, and lethality subscale. The severity of ideation subscale is based on a 5-point Likert scale measuring the seriousness of suicidal thoughts, ranging from a wish to be dead ("1") to suicidal intent with a plan ("5"). The intensity of ideation subscale comprises of 5 items (frequency, duration, controllability, deterrents, and reason for ideation), each also rated on a 5-point scale designed to evaluate the intensity of suicidal thoughts. The behavior subscale is rated nominally, assessing various suicidal behaviors including actual, aborted, and interrupted attempts, as well as preparatory actions and non-suicidal self-injurious behavior. Finally, the lethality subscale measures the actual lethality of previous attempts on a 6-point scale. If former attempts prove non-lethal, the lethality subscale assesses the former attempts' potential for lethality on a 3-point scale (Posner et al., 2011). The C-SSRS allows for different assessment periods depending on clinical need, including a lifetime assessment of the most severe ideation, which could be a stronger predictor of future suicide than current ideation(s). Scale items assessing both the severity of ideation and the intensity of the ideation were based on factors effectively predicting suicide attempts and suicide identified in previous literature.

For participants indicating a high risk for suicidality after completing the C-SSRS, meaning they scored a 4 or 5 on the severity of ideation subscale or were found to have a history of suicide attempts on the behavior subscale, emergency services are contacted, and the participant is referred to an on-site medical resident for a more comprehensive psychiatric evaluation. For less severe cases, a safety plan, which includes coordinating both emergency resources (e.g. crisis centers, hotlines) and other means of elevated care, is devised with the high-risk participant.

Educational Material on Various Mental Illnesses (from NIMH)

Participants who successfully complete each screening are instructed about the interpretations of their scores and are then given psychoeducational pamphlets published by the National Institute of Mental Health (NIMH) and translated to their community's respective language (See Figure 1 for example pamphlet). These pamphlets consist of basic warning signs and symptoms of general anxiety and major depressive disorders as well as information specific to pregnant or postnatal women populations. Information on cost-effective methods of taking care of one's mental health comprises its own pamphlet and is also given out to HP patients.

In addition to psychoeducational materials from the NIMH, participants are also allocated a referral sheet of addresses and contact information of local therapy and crisis service centers (See Appendix II). Multiple treatment centers listed in the referral sheets offer both cost-effective and culturally sensitive services to the respective communities served at the HPs.

RISK ASSESSMENT TRAINING

In recognizing the sensitivity and difficulties of facilitating mental health screenings, especially at health promoters tailored to many undocumented and/or under/uninsured individuals, undergraduate students must first undergo three training courses before being assigned to the mental health station.

Mental Health First Aid Training

Students must become certified mental health first aiders by successfully completing the Mental Health First Aid (MHFA) course offered by the National Council for Mental Wellbeing. The MHFA training offers trainees basic literacy in identifying and approaching people who may be struggling with a mental health challenge or illness/disorder. Other MHFA training objectives include understanding the rationale behind MHFA and the role of mental health first aiders, recognizing early and worsening signs of mental health challenges, identifying and responding to common signs and symptoms of prevalent psychopathologies, responding to crisis situations, and seeking mental health self-care after offering another person MHFA. In addition, the MHFA training introduces trainees to ALGEE – a five-step MHFA action plan – and aims at educating them on how to conscientiously apply it in crisis and non-crisis situations.

MFHA training consists of five to six lecture hours, supplemented with group activities and/or case studies to help mental health first aiders practice identifying signs and symptoms of mental health challenges or disorders. MHFA trainees are expected to also devise plans on how to offer people MHFA and ensure the latter receive appropriate psychiatric treatment and/or care. An MHFA certification remains valid for three years post its issue.

"Recognizing and reporting child abuse" Training

Although minors, on average, constitute less than 15% of the community members attending a HP, the rate of child abuse in the state of Pennsylvania reached 14.5 cases per 100,000 individuals under the age of 18 in 2022 (Child Protective Services, 2023). While child abuse can take many forms (e.g. physical abuse, neglect, sexual assault, etc.), depression, fear and anxiety are common symptoms that victims develop (Choi, DiNitto, Marti, & Segal, 2017). Therefore, undergraduates must also complete the "Recognizing and Reporting Child Abuse: Mandated and Permissive Reporting in Pennsylvania Online Training", a 3 hour long online training offered by the University of Pittsburgh and approved by the Pennsylvania Department of Human Services and Department of State. Training objectives include understanding what child abuse entails legally in Pennsylvania, pinpointing signs of child abuse, being aware of Pennsylvania's child protection resources, and understanding one's role as a mandated reporter. Within the context of HPs, volunteers who had successfully undergone the online training are considered permissive child abuse reporters, familiar with electronic reporting and report writeups to the Pennsylvania Department of Human Services, county agency, and/or local law enforcement.

Language Sensitivity Training

Undergraduate volunteers must also attend a one to two-hour-long training course on language sensitivity through which they are trained in conversing with individuals interested in being screened at the mental health station. Training objectives center on effectively facilitating the administration of the C-SSRS while learning how to alleviate any discomfort individuals may feel during the screening.

Considering the diverse communities HPs serve monthly, undergraduate volunteers are also required to shadow medical residents, PsyD students, and/or other graduate psychology students for three to four hours at the HP site at which the undergraduates wish to volunteer. This requirement is for volunteers to internalize the mental health screening protocol. They are required to observe how people are introduced to the services offered at the mental health station but are to remain distant and not engage in the screening process unless the patient authorizes otherwise for the sake of preserving patient privacy. Lastly, volunteers are shown how to refer patients with scores suggesting an underlying mental health challenge or illness to presiding medical residents for professional patient guidance and referral to appropriate therapy and/or other psychiatric services.

MENTAL HEALTH STATION IMPLEMENTATION & FINDINGS

Summer Health Promoters: Locations and Served Communities

Between August 3, 2024, and September 21, 2024, the mental health station was implemented at five different HPs, each serving either the Asian, Hispanic, African, or African American communities in Philadelphia. Overall, the percentage of HP patients participating in screenings at the mental health station was highest at the HP serving the Philadelphia-local African American community (11.76%) while that of patients seen at the HP serving the Hispanic community in Philadelphia was the lowest (avg. 0.72%). Moreover, the percentages of HP patients participating in screenings at the mental health station during the African

and Asian HPs were 6.67% and 5%, respectively (See table 1 & graph 2).

QUALITATIVE FINDINGS

By the end of the fifth HP at which the mental health station was implemented, we noticed inter-community discrepancies in people's willingness to approach the mental health station or be screened.

Observations at the Hispanic HPs

Hispanic patients often skipped the mental health station and moved onto other stations. Hispanic medical students told us that this stigma is quite prevalent in their culture, especially among males. Of the patients at both Hispanic HPs, only one patient participated in screenings at the station. The patient scored high on the GAD-7, acknowledging his struggle with anxiety. Overall, patient engagement was minimal.

Observations at the Asian & African HPs

By contrast, we observed stronger patient engagement at the HPs catering to the Indonesian, Vietnamese, African, and African American populations. However, a few patients at each of the three HPs still denied the services offered at the mental health station, claiming that they do not deal with mental health issues.

While serving the Indonesian and Vietnamese communities at St. Thomas Aquinas Catholic Church, the interpreter working at our station told us that many of her fellow Indonesian and Vietnamese friends experiencing symptoms of anxiety and/or depression often work through their problems by talking to close friends. This is indicative of a strong community support system, as they feel comfortable discussing their mental health status with friends and family. However, it can also become problematic if their mental condition were to worsen to a point whereby talking through their problems with friends no longer helps, yet they are unwilling to seek help from professionals outside of their friend group. With this being said, we referred several patients interested in follow up mental health services to the Holy Redeemer Chinese Catholic Church in Philadelphia's Chinatown, at which Sidney Kimmel Medical College offers free-of-charge weekly medical services, including psychiatric services, for the underserved immigrant communities.

Observations at the Mobile HP

We had the highest turnout rate at the HP run in West-Philadelphia for local community members. Over 11% of the total number of patients at the HP participated in screenings at the mental health station.

Many patients introduced themselves and stated how important mental health is before sitting down for the screeners. One patient who came to the station shared his experience of recently struggling with a crippling depression. He told us that he visited a psychiatric outpatient clinic to discuss his mental status. The healthcare provider he spoke to there confirmed that he had depression, but the psychiatrist followed up almost 8 months later, disregarding the patient's concerns. As a retired therapist himself, the patient was frustrated with how "patients with mental illnesses are often mistreated in [the U.S.]" and described the provider's attitude as insincere. He urged us to "be sincere and make sure [we] really care about God's people" if we decide to pursue careers in therapy or psychiatry.

Table 1

A Data Table Showing the Total Number and Percentage of Patients Who Completed the PHQ-9 and GAD-7 Screeners at Different HPs.

Clinic's name	Date	Community served	Total number of patients seen at HP	Number of HP patients who completed the PHQ-9 and GAD-7 screeners	Percentage of HP patients who completed the PHQ-9 and GAD-7 screeners
Hispanic HP	8/3/2024	Guatemalan immigrants	70	1	1.43%
Asian HP	8/24/2024	Indonesian and Vietnamese immigrants	200	10	5%
Hispanic HP	9/7/2024	Mexican immigrants	60	0	0%
African HP	9/8/2024	African immigrants	60	4	6.67%
Mobile HP	9/21/2024	Philadelphia locals	85	10	11.76%

DISCUSSION

Possible Explanations

The low patient engagement at the Hispanic HPs may be attributed to the stigma held by Hispanics against admitting to struggling with mental health or seeking help from people outside of their social network. The location at which the mental health station was set up within the clinics may have also influenced the turnout rate. These HPs were held at confined spaces within the Guatemalan Consulate, often using employees' offices for extra space. While the initial intent was to set up the mental station away from heavy

patient traffic for purposes of patient privacy and confidentiality, we were short-handed and only one volunteer served as a patient advocate, explaining to patients what the mental health station entails and guiding them to the station.

By contrast, the slightly higher turnout rates at the Asian and African HPs compared to the Hispanic HP may be attributed to having set up the mental health station directly adjacent to the medical residents' station which often experiences heavy traffic. However, cultural stigma surrounding mental health may also explain the low patient interest in mental health services at both HPs.

Lastly, when compared to the other four HPs, the heighted turnout at the Mobile HP may be due to the lack of a language barrier between student volunteers and the patients, as linguistic boundaries and the need for translators/interpreters at the other HPs may have deterred patients from opting for or even approaching the station. Another possible explanation may be a lessened stigma towards mental health in this local-Philadelphian community compared to first-generation immigrant communities.

Limitations of Qualitative Findings

Many impediments/limitations may explain the low patient engagement at the mental health station across the five HPs. Firstly, there were language barriers between HP patients, most of whom are immigrants and are not fluent in English, and volunteers working at the mental health station. While recruiting non-professional interpreters to the station did help in overcoming those barriers, we, as well as the HP patients, felt somewhat distanced from one another while discussing mental health with third-party assistance. There's also fear that the interpreters have not properly communicated nor properly interpreted the screening questions on the PHQ-9, GAD-7, and C-SSRS over to patients. We attempted to minimize any windows for miscommunication by first educating the interpreters on the purpose of the mental health station, the screening protocol, and what is intended behind each question on the PHQ-9, GAD-7, and C-SSRS.

Another limitation was a patient-expressed lack of privacy when discussing mental health issues at the non-Hispanic HPs. Aside from the Guatemalan Consulate, most other HP sites are open spaces, which is problematic from the perspective of preserving patient confidentiality. Additionally, the mental health station was run only once at each HP. Thus, it is possible for us to have a higher turnout rate as the station's services are offered more in the future.

Finally, while medical residents were present, neither a psychiatry resident nor a clinical psychologist was in attendance or on call for any of the HPs where the mental health station was run. Up to this point, we have not encountered a patient who met criteria for hospitalization; however, having a more specialized professional available would be optimal in the instance that we encounter such a high-risk patient.

FUTURE DIRECTIONS & CONCLUSION

While current qualitative findings reflect a variable aversion to mental health screenings among underserved communities in Philadelphia, PA, the mental health station remains in its early stages, with much room for enhancements in psychoeducation, crisis response, continuity of care, and service expansion.

With regards to continuity of care, the Institute of Clinical Bioethics (ICB) currently has partnerships with Philadelphia-local non-profit organizations, such as Horizon House and Esperanza Health Center, and outpatient mental health centers that offer discounted or free-of-charge psychiatric services to referred patients. For instance, individuals screened for GAD and MDD at the mental health station during the BIPOC HP and deemed in need of psychotherapy may be referred to the Esperanza Health Center for up to 10 free sessions. However, a few of the referral sites are disproportionately farther away from one community we serve compared to another. Therefore, we intend to pursue further partnerships with other external institutional organizations and mental health centers local to the communities the HPs serve as to facilitate patients' access to recommended or necessary psychotherapy and other mental health services.

In terms of expanding offered services, the ICB is looking into partnering with Philadelphia-local psychiatry residency and graduate psychology programs to have psychiatrists and psychologists attend the HPs and offer patients more comprehensive psychoeducation on depression and anxiety. While undergraduate volunteers at the mental health station are limited to handing out NIMH-published psychoeducational sheets, professionals are equipped to communicate with HP patients on more advanced next steps such as suggesting appropriate modalities of therapy if needed, advising lifestyle changes to combat psychiatric symptoms, or even providing brief, time-oriented

psychotherapy services on site. Hosting psychiatrists and psychologists would also help expand the scope of screening services offered at the station, as these professionals could offer more difficult screenings such as BSTAD, SLUMS, etc.

In addition to screening services, the ICB is looking to address the prevalence of dual diagnoses, especially in Philadelphia's Kensington neighborhood. As of August of 2024, HP patients presenting to the mental health station with a documented dual diagnosis or showing signs of substance abuse while scoring high on the PHQ-9 and/or GAD-7 can be connected with subsidized or free temporary housing and rehabilitation services provided by Project Home – a non-profit that aims at combating local poverty by offering individuals with no housing a temporary lodging and employment opportunity as part of a local social recovery initiative. However, there are only 12 available housing units for individuals in need of rehab. Thus, the ICB plans on extending partnership opportunities to more Philadelphia-local nonprofits that offer similar services.

As for additional test runs, the mental health station will be set up at an average of four HPs per month for an entire year and will cater to the Indonesian, Vietnamese, Mexican, Guatemalan, BIPOC, Nigerian and French-speaking West African communities in the Philadelphia area.

In conclusion, the mental health station, in its current design, serves as a rudimentary step towards bridging the undocumented, underinsured and/or uninsured communities in Philadelphia with free-of-charge or relatively low-cost psychotherapy, counseling, and other mental health services. In offering screenings for MDD, GAD, and the risk of committing suicide to HP patients, the mental health station is also an advent to achieving more comprehensive preventive medical care at HPs, addressing both patients' physical and mental needs.

APPENDIX

Figure 1

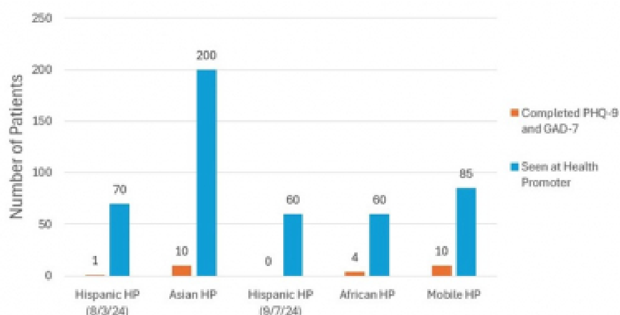
Sample of NIMH Psycho-educational Material Handed Out at Health Promoters

Figure 2

Referral Sheets Handed Out at the Mental Health Station at Health Promoters

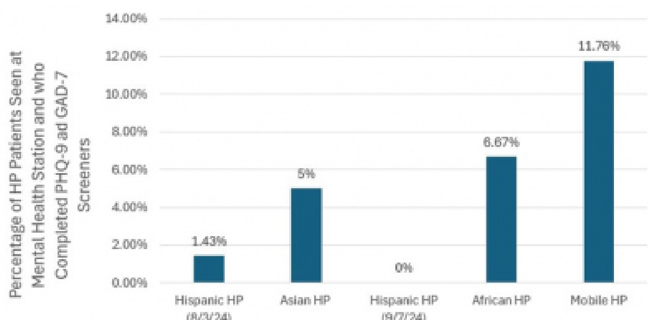
Graph 1

A Bar Graph Comparing the Total Number of Patients Seen With That of Those Who Underwent the PHQ-9 and GAD-7 at the Mental Health Station at Different HPs.



Graph 2

A Bar Graph Showing the Percentage of HP Patients Who Participated in the PHQ-9 and GAD-7 Screeners at Different HPs.



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