THE POWER OF COMMUNITY

How Trained Entry-Level Workers Can Solve our Mental Health Crisis

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SUMMARY

An epidemic of untreated mental illness is ravaging American communities today, fueled by worsening risk factors like loneliness, isolation, addiction, and screen dependence. At one end of the problem is a persistent nationwide shortage of trained mental health professionals. At the other is the reluctance of patients — especially patients from underserved communities — to seek help at all, a factor research suggests may be an even larger contributor to our gaping access gap[1]. As a result, every week, Americans read of new studies and official warnings from leading institutions like the *Journal of the American Medical Association*, the Centers for Disease Control and Prevention, and the American Academy of Pediatrics signaling a terrifying storm gathering over our national wellness and an unprecedented crisis in youth mental health[2-4].

But even under the darkening clouds, rays of hope are breaking through. Long-term investments in mental health infrastructure — from both public and private sectors — are on the rise. Across the country, the clinical workforce is being boosted by innovative payback programs. Systemic barriers to insurance coverage are falling. Care is being integrated into trusted community entry points like schools, workplaces, law enforcement, and safety-net programs.

There is also promise for the nearer term if we know where to look for it. One of those places is in local communities where bonds run deep, and individuals share beliefs and culture. Trained mental health workers — drawn from their own communities — inspire trust, a skill that cannot be taught. Through the power of community, disenfranchised people can find their way through the confusing, broken mental health care system with the aid of a trusted guide.

Two facts suggest trained helpers could make a difference that is both quick and profound. First, the barriers to market entry that trained mental health workers face are relatively low, so patient uptake could be swift and considerable. Second, research has found that trained mental health workers with the right mix of personal qualities and familiar backgrounds can offer patients significant improvement across a range of settings[5].

The policy community has already taken note. In 2020, RAND issued a report for the Department of Health and Human Services, addressing the need for a sustained pipeline of such workers[6].

While America struggles to close the care-access gap, philanthropists have a chance to make an impact on mental health now by investing in trained mental health workers. Their investments now can also shape a better system for the future.

BACKGROUND

For generations, communities in developing countries have overcome gaps in their health care infrastructure through the empowerment of trained lay helpers, often called community health workers or *promotores de salud*, although their integration into the U.S. medical system is more recent. Both formally and lightly trained workers have a long history of promoting health and reducing mortality, especially in rural settings and low-income countries[7].

For instance, China's "Barefoot Doctors" — health workers without formal credentials and training — have provided basic primary care, health literacy, and first aid training in the nation's remote villages for more than a century[8]. New York has recently begun experimenting with "Friendship Benches," a community mental health approach native to Zimbabwe, in which lightly trained lay people — typically grandmothers — sit on a bench in a public space and offer problem-solving support to people who seek them out[9].

Models in the U.S. are also working for various chronic illnesses. American cancer patients and doctors have long relied on the work of both trained paraprofessional and professional "navigators" — persons who aid the patient in care coordination, disease prevention, health education, and offer an empathetic contact point in a scary time. Navigators are now used in other chronic diseases including diabetes, HIV, dementia, chronic kidney disease, and cardiovascular disease[10]. Through the Collaborative Care Model, trained "behavioral health coordinators" are supporting primary care doctors and connecting patients in need to mental health specialty providers and treatment. And more than half of states now cover entry-level "community health workers" for physical health, although training in mental health is limited.

Several models have also proven effective for special groups of people with mental illness. Peer recovery specialists, drawn from communities of people who have experienced substance use disorder, are aiding recovery through their lived-experience, and are now covered by 80% of state Medicaid programs[11]. "Clubhouse" programs have been successfully integrating peer support, case management, and housing assistance for people with serious mental illness for 80 years, leading to increased treatment compliance and a reduction in homelessness[12]. Lay counselors from communities of faith are providing a mix of spiritual and psychological counseling in houses of worship.

And while the peer movement, born out of President George W. Bush's Access to Recovery program, has shown promise at the recovery end of the spectrum, it's also important to promote resilience and prevent pathology in the first place. The fact is half of all mental health patients see their first symptoms by the age of 14, and three-quarters before their brains stop developing at 25[13]. The undeniable links between childhood trauma and grief and future illness — both mental and more broadly — also underscore the need for early intervention[14]. Because youth and adult populations inhabit different worlds, complete with unique truths, insurance nuances, and justice systems, a smart approach will invest in young people early. Family navigators and youth peer-to-peer are two promising approaches tailored to young people.

In a nutshell, trained navigators have played a pivotal role in simplifying the complex medical system for patients in this country for the past thirty years, particularly in cancer and HIV/AIDS care, transitional care, and care for the underserved. Their impact has been so far-reaching that patient navigation is now mandated for hospital accreditation, required by the Affordable Care Act, and covered by Medicaid for physical health[15]. Moreover, innovative models like peer support specialists, lay counselors, family navigators, community health workers, clubhouse models, and community-initiated approaches have already shown the potential of extending this concept into mental health.

All these models have flaws: they lack flexibility, and reimbursements are low. On the other hand, they

reduce disparities, boost prevention, and cut costs, showing the potential impact of scaling these models to address the nation's mental health crisis[16]. And their runaway popularity has raised the question of whether trained mental health workers could help improve mental health access and outcomes at scale.

OPPORTUNITY FOR PHILANTHROPY

1 POLICY CHANGE

Philanthropists can contribute to national policy by funding a process to establish national consensus guidelines around a multi-tiered scope of practice. Such an approach would include the medical, worker and professional communities, including the major guilds like American Psychiatric Association, National Association of Social Workers, and American Association of Nurse Practitioners, with a careful look at where clinical supervision is needed, using a consensus-based approach. Such "national guidelines" would also accelerate scaling by enabling a plethora of curricula, many scalable through digital trainings, each meeting the needs of specific communities and traditions.

This process may include a philanthropist-funded blue chip analysis of some of the more successful models, in an effort to tease apart from them the essential functions and traits of mental health workers, and building on this analysis, ways to eliminate regulatory barriers and accelerate scaling. The study could also address reimbursement, which may not be a big motivator for volunteers in more well-heeled communities, but which research has shown is essential for lay helpers to feel valued in their work[18].

Once guidelines are established, that are both medically credible and respectful of communities and their traditions, priority would shift to advocacy to build support from state legislatures, state regulators and state-based payers. A paired national outreach effort would build support with accreditors, commercial payers, and the Centers for Medicare & Medicaid Services.

In brief, philanthropists can support the development of smart policy in deliberation with the medical and worker community and follow through with both national and state advocacy to bring the initiative home.

2 PRACTICE CHANGE

To make a case for financing and reimbursement with both private and public payers, it will be necessary to demonstrate success in a real-world implementation project across multiple states. This effort should lead to evidence of adaptability based on communities of various sizes, socioeconomic statuses, races, ethnicities, geographies, faith and cultural traditions, and programs.

Regional philanthropists can aid this effort by bringing local leaders together around a change agenda and can influence key stakeholders and inject capital at key inflection points. Anchor regional implementation partners, identified from the existing funding portfolios of regional philanthropists or through a common RFP, developed with other philanthropists, can work in practice sound local implementation science to implement efforts to incorporate mental health workers in a range of settings.

National philanthropists can also fund an external evaluation that assesses the success of programs using common metrics across all sites.

Starting from the premise that there are multiple local models that are already working, a regional scaling effort will allow local leaders to learn from one another about what is working in their own backyards. Such an effort could also help establish essential practices that can be adapted across geographic, socioeconomic, cultural, and ethnic divides.

"…trusted and close relationships among community institutions, with "warm handshakes" connecting individuals to health and social services. Building on this, there needs to be a more conscious strategy aimed at creating the best environment for the growth and replication of these entry-point community institutions." –Stuart Butler, Brookings Institution

3 LEVERAGE OF EXISTING INFRASTRUCTURES

Trained mental health care workers could fill needs in three distinct types of settings — all of which leverage existing infrastructures. Many of these are places philanthropists are already giving gifts; in other words, extending additional philanthropic support to explore the use of mental health workers in these settings will in many cases be a natural extension of current grantmaking. These include:

1. **Medical Infrastructures:** Trained workers are ideal candidates to be "patient navigators" in established medical infrastructures like hospitals, primary care offices, Federally Qualified Health Centers (FQHCs), and Certified Community Behavioral Health Clinics (CCBHCs), which are staffed by medical professionals who can diagnose and prescribe medicine. Navigators help professionals through *task-shifting* in these settings by freeing professionally trained individuals to focus on the highest needs cases.

2. **Non-Medical Infrastructures:** Mental health workers can also aid in non-medical settings where mental health professionals like social workers or psychologists — in some but not all cases — are already providing supervision. Among these are a growing number of schools, some workplaces, and some houses of worship. In these settings as well, navigators can help patients through *task-shifting* by freeing professionally trained individuals to focus on the highest needs cases.

3. **Re-purposed Community Infrastructures:** Even in existing infrastructures where there is no provider or professional oversight, mental health care workers can play a catalytic role by *spotting* people in need, *educating* them to counteract stigma, and *encouraging them* to seek help. Trained community-based mental health workers are already engaging in settings as diverse as libraries, community centers, churches, Boys and Girls clubs, and even neighborhood barber shops. By taking on the lower need patients and lessening the load, these workers can ease the nation's current workforce shortage.

Studying and evaluating these local grants together, in the context of a philanthropic learning collaborative, will allow philanthropists an opportunity to learn from each other, and in doing so, move forward the field.

4 DIGITAL SUPERVISION

Training programs reflecting a range of cultural traditions can be scaled very successfully online, and the innovative use of digital technology to connect mental health workers with health systems holds great promise. Digital tools can also be a resource to helpers, providing frequently updated resources about food banks, housing resources, Federally Qualified Health Centers, and Medicaid assistance. Digital technology can also connect the many different caseworkers in complex family and youth cases, ensuring the child and family's needs are foremost and communication is ongoing.

Powerful digital tools are emerging that will allow various infrastructures that have not traditionally had medical supervision to

incorporate supervision into their workflows, whether from medical professionals or social workers and psychologists. Still others provide ways for trained mental health workers to interact with the formal systems used by schools or workplaces to obtain enough information to help patients, without accessing information that compromises confidentiality.

These digital tools face regulatory hurdles, but the level of investment in mental health apps – billions over the past several years with no signs of abating – suggests they have a golden chance of redrawing the lines around which sites are considered appropriate for medical or counseling intervention, and who is considered a mental health professional.

Incorporating novel technologies into training and practice sites is another way of encouraging scale Because much of this work will be inexpensive — relying on local volunteers and digital training — scaling may be less dependent on big funding, as it is on evangelization, catching fire through the spread of a widely embraced idea.

CONCLUSIONS

Philanthropists have always shone at finding and magnifying successful models. They can also help foster a compassionate culture that strengthens personal relationships and healing through the local communities they serve. Effective place-based philanthropy is the key to successful national and local partnerships. It's more than just targeting certain zip codes. It's a mindset that philanthropy's purpose is to spend money for the benefit of specific communities with respect for their local values and under the guidance of their local leaders. A donor collaborative built on these principles will encourage radical local autonomy and empower regional philanthropists.

Philanthropists are well positioned in this emerging area of mental health workforce transformation to help shape policy, pave the way for sustainability, and provide inspiration on how to build communities of hope and healing across the nation.

RECOMMENDATIONS

Putting it all together, philanthropists may be best served by engaging in a regional scaling initiative in tandem with a policy effort, with both efforts learning from and informing each other. Below are some specific additional recommendations for philanthropic engagement.

1. **Philanthropic learning collaborative:** A philanthropic learning collaborative can act as an organizing effort, mobilizing national and local philanthropic leaders around shared vision, knowledge and understanding, and paving the way for a joint initiative founded on shared goals, objectives, and beliefs.
2. **Essential National Policy:** A robust national policy plan should include clear definitions of varying scopes of practice and national-level certification standards, training, and reimbursement, including frameworks for how these scopes can fit together in a stepped manner with each practicing at the top of their skillset.
3. **Regional Scaling Network:** To become sustainable, it's essential to prove out real-world success across multiple states, and adaptability to communities of different sizes, socioeconomic status, races, and geography,

and to sites both with and without formal clinical supervision. Local philanthropists can help identify and empower regional champions — in faith settings, health settings, and philanthropy — to pave the way for success.

4. **Workforce Education:** Many helper-model sites require clinical supervision and would benefit from a dedicated pipeline of trained, culturally aligned supervisors, including those serving spirituality and faith communities. This also allows for more effective engagement in at-risk communities. Many philanthropists already making gifts to schools, both professional schools and community colleges that fast-track programs for entry level workers. Philanthropists can learn from each other what's working best.

5. **State-level Outreach:** While the research supporting a trained helper care model is strong, the message must also be carried directly to state legislators, regulators, and other health care stakeholders.

6. **Outreach to Stakeholders, Patients, and the Public:** Engage in education and outreach to target audiences (policy/political, medical, faith-based, general) through direct outreach, events, and mainstream media outlets.

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