Annotated Bibliography

Contextualizing the Scope of Mental Illness & Mental Health Workforce Shortage in the U.S.

- Before the COVID-19 pandemic, approximately 11.3% of U.S. adults reported symptoms of anxiety and depression (1).
- Before the pandemic, the Health Resources and Services Administration projected deficiencies in several mental health workers: psychiatrists, psychologists, and addiction counselors (2).

Task-Sharing

- In task-sharing, the tasks are shared across different cadres of providers; in task-shifting, the tasks are moved to providers with more abbreviated training, including non-specialized physicians, non-physician clinicians (midlevel providers), nurses, and lay or community health workers (3).
- In the Confess Project, barbers and stylists are trained to build awareness around mental health and reduce stigma within Black communities (4).

Collaborations with Religious Leaders

- Community members often understand mental health conditions through religious and spiritual lenses and prefer approaching religious leaders when facing mental health problems (5).
- This is particularly true for racial/ethnic minorities in the U.S. (6).
- A recent Wall Street Journal survey found approximately half of Americans identify as “very religious” or “moderately religious” (7). The percentage rises amongst community members identifying as Black or Hispanic.
- The more religious people are, the less likely they are to utilize professional mental health services (8).
- A Kansas City study highlights how community-based participatory research with clergy from Black churches enabled mental health prevention, screening, and linkage to higher-level-of-care, and improved mental health care access for historically underserved communities (9).

Mental Health Screening and Treatment in Harlem, New York

- Work from Dr. Hankerson and collaborators has been exploring the role of church-based mental health programs starting as early as their review of the subject matter in 2012 (10). The review concluded, “Although church-based health promotion programs have been successful in addressing racial disparities for several chronic medical conditions, the literature on such programs for mental disorders is extremely limited. More intensive research is needed to establish the feasibility and acceptability of utilizing church-based health promotion programs as a possible resource for screening and treatment to improve disparities in mental health care for African Americans.”
- Thus, in 2015, they successfully screened for depression in African-American churches, finding that 17.7% of women and 22.5% of men screened positive for depression (11). For those participants who had previously sought mental health treatment, similar percentages (53-64%) had consulted mental health professionals, primary care or

medical doctors, or a minister/priest. However, no participants screening positive for depression asked for a community mental health referral.

- Dr. Hankerson and collaborators then sought to partner with African-American churches in Harlem via community-partnered participatory research, learning valuable lessons about community engagement along the way (12).
- Moreover, they offered a persuasive editorial on why taking a church-based approach to expanding access to mental health care could prove particularly effective (13).
- They explored the possibility of training African-American clergy in interpersonal counseling and how this would be received in their church (14). Their qualitative analyses suggested a broad mistrust of medical institutions and internalized and social stigma regarding depression. Church-goers would accept clergy-delivered counseling if they were certified. The two clergy members interviewed were open to training in interpersonal counseling to aid people with depression but shared they would not counsel more people. The 2021 paper concluded that "training clergy may be insufficient to reduce racial disparities in access to evidence-based depression services" (14).
- Seemingly, an alternative model was developed where Black Americans received care from a Harlem church-affiliated mental health clinic, the Healing on Purpose and Evolving (HOPE) Center (15). A qualitative analysis of patient experiences suggested participants benefited from the services being cost-free, delivered through a trusted institution, and incorporating religious elements.

Task-Shifting & Collaborative Care

- Primary care providers prescribe the majority of stimulants to children, but children with complex psychiatric co-morbidities are more likely to receive longitudinal care from psychiatrists (16). This is an effective example of task-shifting.
- Community health workers (CHWs) have been utilized in different roles in the United States. To our knowledge, CHWs have yet to be widely used as behavioral healthcare managers in the collaborative care model. Steinman and collaborators completed some grant-funded work that examined the role of CHWs as behavioral health care managers (in a collaborative care model sense) that actively screened for depression, offered brief psychological interventions and psychoeducation, and linked community members with primary and mental health care (17). For now, Steinman's study is the exception, not the norm.
- In the United States, the CHW roles are more similar to a traditional case manager or psychoeducation role than someone trained and supervised for offering screening services and evidence-based treatments to clients (as is the case in low- and middle-income countries). For example, a review by Barnett and collaborators found a lack of evidence for CHWs delivering evidence-based treatments as the primary care provider in resource-limited settings in the US (18).

The Power of Task-Sharing/Task-Shifting, Stepped Care, & Collaboration with Faith Leaders

- When implemented in partnership with communities that have experienced disenfranchisement, structural racism, and colonization, such interventions can shift power dynamics and advance mental health equity (19).
- Global efforts have noted that the use of community-based lay workers can enhance trustworthiness, though their acceptability is not limited to being from the community (20).
- Acceptability may also be influenced by social mores and status, such as education, job title, gender, and age (21).

- Extant literature on task-sharing/task-shifting in low- and middle-income countries has highlighted limited material resources as a barrier to success (22).
- Given the potential impact of regulatory systems (e.g., state-dependent occupational licensure and legal liability) on the ability of lay workers to deliver services, the success of interventions requires buy-in from psychiatrists and other mental health professionals (23).
- Many states use Medicaid reimbursement for peer-support services in substance use disorders (24).
- Most states have an established certification process for peer workers (25).
- Though peers are commonly tasked with administrative roles (e.g., service coordination and navigation) in the U.S., community-engaged interventions exist (26).

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