

Community Health Workers: Bridge to Pediatric Mental Health Equity

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We currently face a national crisis¹ in youth mental health and well-being and significant child behavioral health inequities. There is a growing recognition among health care institutions, policymakers, researchers, and communities that major health problems of our time, including this crisis, must be confronted by addressing the underlying “causes of the causes,”² or social determinants of health. Social determinants of health³ are defined by the US Centers for Disease Control and Prevention as the conditions in which people live, learn, work, play, worship, and age and highlight the role that power and privilege occupy in shaping societal access to these resources. Social determinants of mental health (SDoMH) encompass the same conditions of social determinants of health, with the addition of the stigma often associated with mental health and substance use disorders. SDoMH focus on the social/environmental factors that place certain groups at increased risk for mental health concerns and worsening outcomes for individuals who already have mental health concerns.⁴ Addressing SDoMH is a key strategy to toward Healthy People 2030 goals and “the attainment of the highest level of health for all people.”⁵

An increase in isolation and loneliness due to the COVID-19 public health emergency and associated community and family stressors have worsened these social conditions. Youth exposed to higher rates of discrimination, trauma, violence, dislocation, and disenfranchisement have

been especially impacted. Recovery from the COVID-19 public health emergency has been difficult across health, mental health, and education, with these youth continuing to report higher rates of harassment in tandem with persistent feelings of fear, sadness, isolation, anxiety, depression, and hopelessness.^{1,6}

Community-driven innovations are critical to meet SDoMH needs and equity goals, giving every child the “opportunity to attain their full health potential.”⁷ The following section summarizes SDoMH for children and families, followed by presentation of 2 complementary models to better meet these needs: the clinician-led model⁸ and the community team model.⁹

SOCIAL DETERMINANTS OF MENTAL HEALTH FOR CHILDREN AND FAMILIES

Social determinants impact every child across the mental health services continuum including assessment; psychotherapy; medication management; inpatient psychiatric services; residential-, home-, and community-based treatment; and prevention services.¹⁰ Beginning prenatally and extending through childhood, differential access to any behavioral health intervention, let alone evidence-based interventions, is based on SDoMH and especially impacts children due to their dependence on adults for healthy environments,⁸ as well as risks associated with parenting

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practices and maternal/caregiver mental health.¹⁰ In addition, childhood represents a critical time across socioemotional, psychological, physical, and cognitive development, which significantly influences future mental health and well-being into adulthood.

The recent AACAP Clinical Care Update¹¹ reiterates the need for culturally relevant, cross-system innovations to expand access and improve the quality of services across the public health pyramid. Cotton and Shim⁸ provide a compelling rationale for meeting SDoMH needs to address mental health inequities. Moreover, Shim and Compton⁴ highlight the role of Western systemic issues in conjunction with power, privilege, and racism driving an unfair and unjust distribution of opportunity. Complementing the call to action from Cotton and Shim⁸ and the rural health equity framework introduced by Braverman *et al.*,¹² we share here community innovations within our rural pediatric mental health work around SDoMH and equity.

Compton and Shim¹³ provide an explanatory model of pathways by which SDoMH and inequity impact children. In their model, public policies and social norms drive unfair and unjust distribution of opportunity, encompassing the full range of social determinants. These decreased opportunities for children and their families lead to 4 proposed mechanisms associated with adverse mental health outcomes:

1. Reduced options and poor choices associated with limited mental health literacy and limited/no access to culturally relevant, evidence-supported interventions across the mental health services continuum
2. Increased behavioral health risk factors
3. Increased physiologic stress responses driven by increased, unremitting levels of chronic stress as well as emergent crises
4. Increased psychological stress and maladaptive coping responses

TWO MODELS TO MEET SOCIAL DETERMINANTS OF MENTAL HEALTH

We describe 2 models/approaches designed to meet child and family SDoMH needs—the traditional clinician-led model, which is most common in mental health service settings, and the community team model, which is based on clinician and community collaboration.

Clinician-Led Model

The clinician-led model focuses on child and adolescent mental health professionals addressing patient SDoMH needs in clinical settings.⁸ Clinician examples span

implementing clinical best practices (eg, using the *DSM-5* cultural formulation interview); sharing resources with patients and families (eg, compiling a list of local food banks); and advocating at the organization, state, and national levels (eg, advocating for access to early childhood education programs for all children).

The model provides many benefits, including leveraging the clinician–patient relationship to support families in talking about these important needs and linking with resources. Moreover, the respected role of child and adolescent mental health professionals in communities provides a unique window of opportunity to advocate around SDoMH and mental health equity. The clinician-led model faces barriers, including often little or no clinician training in SDoMH conversations or approaches to meet needs, overwhelming clinical loads and responsibilities with little time to build community relationships, workflows and clinical space that does not accommodate SDoMH discussions, lack of institutional leadership buy-in/support, limited reimbursement options for the SDoMH discussion, workforce shortages, and lack of support staff with bandwidth and expertise in local systems of care.¹⁴

Community Team Model

The community team model moves the focus of addressing SDoMH needs to the community. This model builds upon a historical foundation of mental health services for serious mental illnesses moving from institutions to community settings. For example, assertive community treatment provides behavioral health and SDoMH services to youth with serious mental illnesses in their communities, using team members trained in the areas of psychiatry, social work, nursing, substance use disorders, and supported employment. Moreover, assertive community treatment strives to achieve equity among youth with serious mental illnesses by engaging youth who are more challenging to become involved in treatment and accessing resources. This approach considers their lived experiences and contexts, thereby enabling the provision of culturally responsive care.¹⁵

Community-related initiatives (eg, assertive community treatment, wraparound services, intensive care coordination, integrated care) have included a range of roles, including community-based mental health professionals, case managers, paraprofessionals, peer mentors, and others. Our focus is adding the community health worker (CHW) role, an approach that is used extensively in low- and middle-income countries and under many names (eg, lay health workers, promotores, outreach health workers), but is less used in child mental health initiatives in the United

States.¹⁶ Dedicated to meeting child SDoMH needs and advancing equity, CHWs are “frontline public health workers who are trusted members of the community.”¹⁷ Driven by the COVID-19 public health emergency, CHW programs across varied health purposes and age groups have reached a tipping point in which their contribution is increasingly being recognized as integral to health and health care.¹⁸ Used for decades in low- and middle-income countries,¹⁹ but new to the U.S., CHWs have been used more with adults with chronic medical conditions than with children and families. Because of high unmet needs, communities and child-serving systems are piloting CHWs to address child mental health inequities.

The community team model also draws from comprehensive school mental health system approaches and teams, including administrators, educators, specialized instructional support personnel (eg, school psychologists, school social workers, school counselors, school nurses, other school health professionals and paraprofessionals), working in partnership with students and families as well as community health and mental health partners. These teams advance student mental health initiatives to meet universal, selective, and indicative needs, with growing efforts to address “social influencers of health and education,”^{20(p1)} which align with SDoMH.

The CHW role does not replace the paramount roles of other team members. CHWs focus on SDoMH, allowing greater capacity for other team members to focus on their areas of child expertise. While similar, peer and family workers give support based on their personal experiences with mental health and/or substance use conditions and support community members in navigating systems associated with the same condition. CHWs also promote mental health and draw from overall life experiences, with greater focus on overall health and health promotion in overall communities.

A combination of 3 functions set the CHW apart from other important workforce roles that may also address SDoMH.^{16,21} First, they are service extenders that bring services to people and people to the health care system. Second, they are also culture brokers who share similar cultural backgrounds and experiences, which in turn helps engage children and families. Their role is to actively interpret and mediate family needs and bidirectionally communicate with health care teams and other child-serving systems of care, rather than serve as passive conduits to implement health care recommendations. Third, they serve as social change agents addressing SDoMH needs within the family’s lived environment. CHWs assist families with navigating often confusing and complex clinical systems surrounding paperwork, costs, and mental health literacy, as well as support difficult conversations about experiences of

marginalization and racism.⁹ Barnett *et al.*^{16(p195)} summarize CHW roles within mental health services, including bridging entry into clinical services, supporting patient adherence, providing lower levels of care to patients with less intensive needs within stepped care models, disseminating prevention and intervention strategies, and reducing stigma associated with receiving mental health care. A growing number of states have established CHW standards and certification processes (www.astho.org), including scope of practice, competencies, training, supervision, and professionalization (www.nachw.org); these processes may be tailored for work of CHWs with children and families.

Building on the clinician-led SDoMH examples of Cotton and Shim,⁸ Table 1 illustrates child-relevant CHW examples across a variety of settings, including schools, primary care, and other community settings. These examples are drawn from the pediatric CHW literature as well as deidentified composites of the authors’ current CHW work through the school-based Telehealth ROCKS program.⁹ While the community team model has many benefits, challenges include slow societal adoption of population health approaches, lack of knowledge about the CHW role and misperceptions in relation to other roles, siloed services and misalignments of incentives to support CHW, varied reimbursement for CHWs, and limited CHW training and supervision supports specific to working with children and families.

CONCLUSION

The clinician-led and the community team models both answer the call to action to meet child and family SDoMH needs as part of approaches to address child mental health inequities. In clinics and across the variety of community settings presented in Table 1, including school, public health, primary care, and church- or faith-affiliated settings, the models are complementary and reinforcing approaches to support families in meeting SDoMH needs wherever they present (eg, clinic and community) and across focus (eg, clinical health care and population health). Future work needs to address how the people and processes across models may work together to advance coordinated care and maximize impact as well as align with mental health equity initiatives to confront and eradicate structural racism.⁸ There are indications that states will expand CHW reimbursement,²⁹ opening doors toward CHW sustainability and expansion of the community team model as well as opportunities to work more closely with clinician-led efforts. With their unique community expertise and trust-building skills, CHWs are a promising workforce to meet SDoMH needs in partnership with mental health clinicians, whole family systems of care, and communities.

TABLE 1 Social Determinants of Mental Health (SDoMH) and Examples of How Community Health Workers (CHWs) Can Support Children and Families

SDOH/SDoMH domains	Setting	CHW composite examples drawn from the literature and from program experiences
Food insecurity	School	CHWs established and maintained community resources to address food insecurity and address barriers to use for K-12 grades and college-age individuals. ⁴
Housing insecurity, housing discrimination, housing condition	School-based health center	CHWs observed families struggling with transient living situations, assisted with legal aid regarding predatory housing and segregation as well as set up housing condition remediation plans. ⁸ CHWs have also assisted with crisis housing situations, including a number of house fires.
Parental/guardian unemployment, mental health, health literacy, and social isolation	Urban clinic	CHWs helped guardians prepare for a job fair, practiced mock interviews, and subsequently increased the guardians' openness to their depression treatment by locating culturally relevant resources.
Household income	Community mental health center	Parent peer support specialist/CHW led the implementation of a poverty simulation as a springboard for community mental health center staff engagement and discussion around supporting clients and families.
Educational inequality, access to transportation, health care transition	Federally Qualified Health Center	CHWs volunteered for the local Area Health Education Center health careers advisory board and brought a community voice to setting up health careers activities that have scholarships, provide transportation and food, and include health care professional mentors from marginalized backgrounds.
Language and literacy; immigration status	Rural school	CHW liaised with educators, school-based mental health, family, and community leaders to support a young student who came unaccompanied from Guatemala (speaking a Mayan dialect) and identified culturally sensitive community support for coping with trauma. ²²
Parental education, healthy lifestyle interventions	Urban home visiting	Trained and supervised natural helpers/CHWs address oppositional behaviors by delivering parent-child interaction therapy in homes of families from low-income, predominantly Latinx and Black neighborhoods with children. ^{23,24}
Access to health care, stigma, digital literacy/access, community violence	Primary care	Promotora/CHW helped Latinx transgender youth and parents navigate digital literacy/access needs to connect with a telebehavioral health therapist who specializes in supporting Latinx LGBTQ youth. ^{25,26}
Quality of health care	Specialty clinic, academic medical center	Family navigators/CHWs supported marginalized families for several months between a positive ASD screening result and specialty team assessment. CHWs identified barriers to engagement as well as additional contacts based on the needs of families. ²⁷
Lack of child care; education; interpersonal violence; suicide prevention	School	A CHW joins a truancy meeting to address student barriers to attendance, as an older sibling has missed school because she is staying home to babysit younger siblings so that parent can attend work. ⁹
Stigma, access to mental health services	Faith network	A lay health worker/CHW embedded in a faith-based network listens to a Black/African American parent's concerns about their child's increasing difficulties at school as well as stigma. The CHW helped the family access a list of child behavioral health providers with experience/expertise in working with families from the faith community. ²⁸

Note: See Cotton and Shim SDoMH framework.⁸ ASD = autism spectrum disorder; SDOH = social determinants of health.

More broadly, opportunities to advance these SDoMH models align with the current mandate of the US Department of Health and Human Services (HHS) to advance a comprehensive federal approach addressing social determinants of health.³⁰ Across HHS federal programs (eg, Medicare, Medicaid, Temporary Assistance for Needy Families, Head Start), a central priority is integrating health services with human services. The 3-pronged strategies of HHS inform ways to continue to improve the SDoMH models described in this article, including a 2-generation focus, addressing the needs of the whole family.³¹ First, better data are needed to inform the impact of SDoMH approaches on meeting SDoMH needs and decreasing SDoMH crisis needs as well as better data on the longer-term impact of SDoMH on child and family outcomes and related population/community outcomes. Better data are also needed to drive continuous quality improvement processes in implementing the SDoMH models. Second, the SDoMH models are aimed at improving mental health and social services connections. Third, the SDoMH models lend to strategies associated with whole-of-government collaborations around the numerous agencies/groups impacted by SDoMH needs in children, including agencies representing mental health, public health, health care, education, social welfare, among others, and cross-cutting governmental initiatives advancing equity.

The magnitude of the child behavioral health crisis requires an unprecedented, sustained multisystem response, hand in hand with families and communities, to advance health equity. The complementary clinician-led and community team SDoMH models are important parts of this response. Drawing from Maslow's hierarchy of needs, meeting SDoMH needs is an essential foundation to support additional universal, selected, and indicated clinical mental health interventions. Given the scope of unmet whole family SDoMH needs and resulting health inequities across marginalized groups and communities with low resources, an all-hands-on-deck approach is needed to systematically ask all families about SDoMH needs and listen to their priorities; to share culturally relevant and community-relevant, up-to-date resources; to navigate access to these resources and jointly problem solve barriers; and to follow-up about worsening or new needs. Importantly,

innovation paired with dissemination and implementation of science best practices is needed to scale these models to meet SDoMH needs, including strategically recruiting and retaining workforces with SDoMH competencies and offering opportunities for supervision, training, and advancement.¹⁶

By widely meeting SDoMH needs over time, the 2 models have the potential not only to improve mental health and overall health for the child and family, but also to improve these outcomes for the broader community. Through meeting SDoMH needs upstream, the models have great potential to decrease needs for downstream clinical services for some children, and, it is hoped, to open quicker access to such services for children in need.

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