Lessons From Low- and Middle-Income Countries: Alleviating the Behavioral Health Workforce Shortage in the United States

Franz F. Belz, M.P.H., Natan J. Vega Potler, M.D., Isaac N. S. Johnson, M.D., Rick P. F. Wolthusen, M.D., M.P.P.

The United States is facing a mental health workforce shortage, exacerbated by the COVID-19 pandemic. Low- and middle-income countries (LMICs) have historically grappled with even greater shortages. Therefore, LMICs have thought creatively about expanding the mental health workforce and the settings in which to deliver evidence-based and equitable mental health care. The authors introduce some mental health interventions in LMICs, describe evidence of the efficacy of these interventions gleaned from this context, and discuss the applicability of these interventions to the United States. The authors also reflect on the benefits and challenges of implementing these interventions in the U.S. mental health care system to alleviate its current workforce shortage.

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Since the COVID-19 pandemic, the prevalence of common mental health problems, including anxiety and depression, has tripled, affecting about one-third of U.S. adults (1). However, the mental health workforce has not proportionally increased to meet this heightened demand. In May 2023, about 163 million Americans lived in areas with shortages of mental health professionals, inequitably affecting communities whose members often have low socioeconomic status and are from racial-ethnic minority groups (2). Several efforts are under way to address this shortage. The U.S. government is slowly increasing the number of psychiatry residency positions. Some states are increasing reimbursement rates for psychiatric services, reducing provider administrative burden, financially incentivizing participation (e.g., implementing prompt payment policies), and increasing the psychiatric workforce with expanded roles for mid-level providers, such as physician assistants, nurse practitioners, and social workers (3). Other states are enhancing mental health care access through telehealth and interprofessional consultations. However, such efforts are unlikely to fully match the surging mental health need, particularly for common or less severe presentations that could be detected and managed in a community setting.

To that end, there is much to learn from low- and middle-income countries (LMICs) that have creatively alleviated workforce limitations to address mental health care demands. In this Open Forum, we outline task sharing and task shifting, stepped care, and collaboration with religious leaders as examples of community-based approaches used in LMIC settings that could address the mental health workforce shortage and advance mental health equity in the United States. Some of these approaches have been explored extensively in research studies. Others have been successfully translated from research to the clinical setting in LMICs.

TASK SHARING AND TASK SHIFTING

Task-sharing and task-shifting approaches have been implemented for decades in health care, particularly in LMICs to serve individuals with HIV or tuberculosis. These approaches involve the redistribution of duties such as outreach, education, screening, and treatment of common or less severe mental health conditions. Here, we focus mainly on task sharing, where the tasks are shared across diverse providers. A systematic review of 26 LMIC-based and 17 U.S.-based studies reported that community health worker–delivered interventions reduced symptoms of depression, trauma, substance use, childhood disruptive behavior disorders, and autism spectrum disorders (4). One example of task sharing in an LMIC is the Zimbabwean Friendship Bench, in which lay mental health workers, often community members supervised by a qualified mental health professional, administer several sessions of problem-solving therapy to individuals who have screened positive for common mental health symptoms (5). Of note, the intervention is associated with greater symptom

improvement than the available standard of care. The Zimbabwean Friendship Bench has been adapted to New York City, where people in recovery from mental health challenges offer coaching, support, and referrals (6). However, this task-sharing model has faced implementation challenges and lacks rigorous evaluation of its efficacy and effectiveness. Task-sharing approaches have several potential benefits. Mental health workers are more likely to come from patients' communities, which may enhance rapport and trust. Task sharing allows providers with advanced training to deliver care to persons with more complex conditions or severe symptoms.

STEPPED CARE

Stepped care is defined as a set of mental health interventions that escalate in intensity according to symptom severity or treatment failure at a lower step of care. Stepped care is often combined with task shifting, in which tasks are shifted to persons with more abbreviated training, including nonspecialized physicians, nonphysician clinicians (such as mid-level providers), nurses, and community health workers. Stepped care approaches applicable to the United States have been well validated elsewhere. For example, the PRIDE (Partnerships in Research to Implement and Disseminate Sustainable and Scalable Evidence-Based Practices in Sub-Saharan Africa) study in Mozambique is a capacity-building effort that scales up task-shifted, evidence-based psychotherapy interventions by using digital applications to integrate comprehensive mental health care into primary care settings (7). Hundreds of local lay mental health workers have been trained in evidence-based psychotherapy (8). PRIDE compares implementation outcomes for two task-shifting delivery pathways—screen and refer to a primary care provider for treatment and stepped care versus usual care in community mental health settings. The most cost-effective path will be scaled up in a region of Mozambique. Research funds intentionally cover training but not service delivery, which maximizes sustainability (9). Efforts to implement and scale up PRIDE in New York State are under way.

COLLABORATIONS WITH RELIGIOUS LEADERS

Mental health symptoms are often understood through religious and spiritual lenses. Approximately half of Americans identify as religious, so many individuals facing mental health challenges will approach religious leaders before contacting professional mental health care providers (10). For similar reasons, LMIC-based efforts have involved religious leaders in mental health care delivery. Studies from Kenya show that trained community health workers, including faith healers, can screen for mental health symptoms and appropriately refer community members to a health care facility (11). Evidence from Ghana and Nigeria has shown that the mean total Positive and Negative Syndrome Scale (PANSS) score and three subscale means (negative, positive, and general psychopathology) on the PANSS for schizophrenia were significantly lower among patients who received collaborative care (i.e., provided by traditional and faith healers and conventional health providers), compared with enhanced usual care (12). Similarly, the U.S.-based Imani Breakthrough intervention empowers persons with lived experience (or peers) and church members in Black and Latinx churches to deliver treatment for substance use (13). Intervention participants improved in all eight of Swarbrick's dimensions of wellness and all but one of Rowe's citizenship domains. Moreover, the program retained 42% and 32% of the participants at 12 and 22 weeks, respectively. These findings show that collaboration with trusted religious leaders can advance health equity by reaching and serving community members with low socioeconomic status and from racial-ethnic minority groups.

APPLICABILITY TO THE U.S. MENTAL HEALTH CARE SYSTEM

The mental health workforce gap in LMICs has led to the development of creative strategies to deliver mental health care in these countries, including task sharing and task shifting, stepped care, and collaboration with religious leaders. The United States could benefit from adopting these approaches in its own health care system to alleviate the inequitable distribution and shortage of mental health specialists. These approaches could advance mental health equity, particularly when implemented in authentic partnerships with communities that have experienced colonization, disenfranchisement, and structural racism.

Task sharing and task shifting, stepped care, and collaboration with religious leaders often overlap. Many projects in LMICs and in the United States incorporate more than one of these approaches. For example, the Zimbabwean Friendship Bench combines the ideas of task sharing (the tasks are shared across different providers) and stepped care (community members are referred "up" to specialists or "down" to lay mental health workers according to symptom severity and complexity). The Imani Breakthrough project combines the ideas of task shifting and collaboration with religious leaders who are trained as lay mental health workers. Further examples are included in an annotated bibliography in the online supplement to this Open Forum.

Although the efficacy of these strategies is well established by evidence-based research, their effectiveness in the U.S. mental health care system remains unclear. Translating and expanding these strategies present challenges related to unclear funding sources, difficulty maintaining rigor and supervision outside of grant-based research, and limited education in community-based approaches among mental health professionals and policy makers. The rigorous application of implementation science, which seeks to

understand and overcome the barriers to disseminating evidence-based research into community and clinical settings, could prove critical to overcoming these barriers.

Collaborative care may provide a paradigm for transitioning from grant-funded research to a reimbursable care model (14). After collaborative care's effectiveness was demonstrated, the guidelines of the Centers for Medicare and Medicaid Services allowed providers to be reimbursed for collaborative care services. Private insurance companies then also began reimbursing providers. In the United States, implementation science may facilitate the expansion of task sharing and task shifting, stepped care, and collaboration with religious leaders. Even though some research has been done, increased funding is needed to translate these approaches to new contexts. Medicaid reimbursement mechanisms such as state plan authority or Section 1115 Medicaid demonstration waivers could be used. As with collaborative care, accumulating evidence of the approaches' effectiveness could lead to private insurance companies funding such services.

Another challenge that needs to be addressed is the integration of these approaches into the existing U.S. health care system. The United States can learn from countries such as Kenya or India that have successfully incorporated evidence-based approaches into their health care infrastructure through mutual capacity building. Instead of just extracting the knowledge gained from experiences in LMICs, U.S. providers and policy makers could collaborate with their LMIC counterparts to address shared challenges (15). Currently, barriers to mutual capacity building include a lack of funding for joint research in LMICs and high-income countries and limited meaningful partnerships across time zones and cultures. Mutual capacity building could be strengthened by globalizing supervising structures, such as clinical and research faculty in LMICs mentoring U.S. trainees and vice versa. Additionally, organizational barriers such as funding or obtaining visas could be reduced to help LMIC clinicians, researchers, and policy makers participate in hands-on teaching and in-person conferences in the United States.

Furthermore, state laws regulating occupational licensure and legal liability for nonspecialized lay mental health care providers and licensed non–mental health care providers (such as primary care physicians) that engage in task sharing and task shifting and stepped care will need to be reviewed and amended if needed. In the United States, task-sharing and stepped care elements are already standard practice for children's mental health treatment. Extending these practices to interventions delivered by lay workers will require careful consideration and interdisciplinary collaboration. For example, mental health professionals could supervise lay mental health workers serving individuals with mild to moderate mental health symptoms rather than directly providing care. Thus, specialized providers could focus on serving persons with symptoms that are severe, treatment resistant, or both. Education about community-based approaches from LMICs, the potential of such approaches for enhancing mental health equity, and interdisciplinary discussions on mental health specialists' responsibilities will be vital to gaining the buy-in of specialized mental health providers and policy makers.

CONCLUSIONS

The United States has much to learn from LMICs in how to efficiently deliver health care. Task sharing and task shifting, stepped care, and collaboration with religious leaders are innovative strategies that could help address the mental health care workforce shortage and advance mental health equity. Expanding such services in the United States would require creatively partnering with stakeholders, implementing science research, and fostering cross-sector collaborations.

AUTHOR AND ARTICLE INFORMATION

School of Medicine (Belz) and Department of Psychiatry & Behavioral Sciences (Wolthusen), Duke University, Durham, North Carolina; Department of Child and Adolescent Psychiatry, Grossman School of Medicine, New York University, New York City (Vega Potler); Yale Child Study Center, Yale University, New Haven (Johnson). Send correspondence to Dr. Wolthusen (rick.wolthusen@duke.edu).

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