Amid Mental Health Workforce Shortages, How Can We Creatively Expand Who Can Deliver Care?

Adolescent Health & Well-Being

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*Editor's Note: This post is part of our **Blind Spots series**, exploring how current and potential future policy changes will affect children, families, and communities, and what can be done to mitigate harm.*

The need for youth mental health services significantly outpaces the services available. Adolescence in particular represents a period of increased risk for the development of mental health problems, including depression. Yet many youth do not receive treatment at all, let alone evidence-based treatment.

Federal cuts to longstanding funding streams for mental health programs, changes to Medicaid coverage, and decreases in research funding risk further limiting access to mental health care. These cuts come on top of a shortage in the mental health workforce, therefore compounding the issue of insufficient mental health care providers to meet the needs of children and adolescents.

In this environment, it will be even more important to think creatively about *who* can deliver mental health services. This has sparked increased interest in the field in various task-shifting models, which offer training for providers without a specialization in mental health care (e.g., school counselors, community health workers, mentors) to implement mental health interventions.

Task-shifting has shown promise with a number of mental health interventions. As a researcher focused on adolescent depression prevention, I'm especially interested in how task-shifting can be used to expand access to evidence-based depression prevention programs, including Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST), to promote teen well-being.

Preparing Different Types of Providers to Implement a Depression Prevention Program

IPT-AST is a group-based program that focuses on teaching adolescents communication and interpersonal-problem solving strategies to help them improve their mood and prevent depression. Our hope is that task-shifting can expand access to prevention programs like IPT-AST, which can reduce the chance that youth go on to experience more significant mental health problems.

The goal is to expand access to depression prevention to meet adolescents where they are. Additionally, the hope is that by training individuals who adolescents have established, trusting relationships with (e.g., school counselors, mentors), this can build comfort in participating in prevention programs like IPT-AST. Below, I'll share examples of how my colleagues and I have begun exploring the possibility of task-shifting to deliver IPT-AST.

Mentors in the community

Mentors are highly valued members of their communities who can often connect with youth who may not otherwise be inclined to seek mental health services. I am collaborating with colleagues at the University of Minnesota to train mentors from a mentoring organization in IPT-AST in the hopes of expanding access to mental health care in rural communities.

Mentors participating in this study are 18 or older and have completed the typical mentor or mentor supervisor screening and selection process through a mentoring organization. This study is specifically testing different models for training mentors in IPT-AST to determine how online, asynchronous training materials compare to typical IPT-AST training procedures (i.e., initial 1-2 day training).

Counselors and school staff

Teens spend the majority of their waking hours at school, making this a key mental health access point. We have collaborated extensively with schools to train and supervise school counselors and other school personnel to implement IPT-AST, including through the Children's Hospital of Philadelphia (CHOP) Tri-County School Mental Health Consortium. We have worked closely with our school partners to make modifications to IPT-AST to fit their training backgrounds and the structure of their school day, including shortening sessions.

Health care providers in primary care clinics

Given that most youth visit primary care clinics annually for well-visits, this is another critical setting for the delivery of mental health care. We have adapted IPT-AST to increase its feasibility in this setting and are currently partnering with two CHOP primary care practices on a pilot study to test the adapted version of IPT-AST, called Brief IPT-AST (B-IPT-AST). While the program is currently being led by research team members, the goal is for clinicians embedded in primary care settings with varying levels of mental health training to be able to lead this program in the future.

Peer providers

Finally, we are working with colleagues at Columbia University to integrate IPT-AST into HIV support groups in Mozambique, led by peer providers who are 18-24 years old and are part of a peer mentoring program within HIV services. Peer delivery models have the potential to drastically extend the mental health workforce globally. We are in the early stages of this work but anticipate modifying program materials so peer providers have examples of ways to apply IPT-AST skills to HIV-related content like treatment adherence and disclosure.

Flexibility in Delivery of Mental Health Care: Policy & Practice Opportunities

Through these collaborations, we are looking for ways to engage multiple new provider types to increase access to IPT-AST in different contexts. This approach recognizes the critical need to engage a range of individuals in the mental health care workforce who have not traditionally provided mental health services.

It also highlights the policy opportunity to ensure that insurance reimbursement for evidence-based mental health care includes non-specialty providers. At a time when funding cuts and workforce shortages are key concerns, task-shifting models are a bright spot in the mental health care landscape.

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