



Community Initiated Care: Building Skills to Improve Mental Health

Frequently Asked Questions

What is Community Initiated Care (CIC)?

Community Initiated Care (CIC) is based on a concept commonly cited as “task-sharing” or “task-shifting” – a model of intervention that is not dependent on licensed clinicians and has been successfully used internationally to provide care through non-specialized, trained healthcare workers, and even “lay” members of the community.

CIC should be understood as a broadly inclusive concept of democratizing and empowering individuals to learn how to respond to mental health and addiction issues and take helpful action in the moment. Specifically, effective CIC efforts involve training and supporting community members to ensure that they acquire the knowledge, skills, and competencies necessary to deliver high quality evidence-informed programs for prevention and early intervention of mental health concerns. Though each of the following layers of care have distinct components, certain knowledge and skills overlap all three:

1. Self-care, with or without guidance, entails offering skills to everyone in the community, with a particular emphasis on settings like educational institutions and work places;
2. Mental health promotion and prevention interventions which can be delivered by persons who are already engaged in activities within community-based settings and therefore place them in a unique position to provide these interventions;
3. Low-intensity psychosocial interventions delivered to people with mental health distress/disorders, by those specifically employed as community-based health care providers.

Through the task-sharing approach, mental health promotion, prevention, and low-intensity interventions can be delivered by a range of both “lay” members of the community and professionals, including but not limited to: barbers and beauticians, teachers, faith-based and spiritual leaders, community health workers, peer support specialists, first responders, safety net providers, and many others regularly engaged in community settings.

While the emphasis of CIC is focused on leveraging existing place-based relationships and increasing capacity in the wider community to deliver mental health promotion and prevention interventions, its application will be complementary to self-care and low-intensity psychosocial interventions outlined above.

We anticipate our approach will not only reduce the incidence of mental health and substance use concerns but also prevent their escalation, reducing the overall unmet need for care as well as the associated inequities. It will significantly reduce demand on the specialized clinical workforce, offering a multitude of entry points to a coordinated system of care, with the capacity to address the full spectrum of mental health needs.¹

Eventually, this will lead to healthier communities and a need-based utilization of specialist mental health resources.

How is CIC different from or similar to other training models?

There are a variety of resources, information, and formal training opportunities to address mental health needs within a community context. While all of these models are anchored in place-based collaborations and relevance to communities, the structure and application of each is unique and there are different mechanisms which govern financing, delivery, supervision, and evaluation. Examples of existing models include:

- **Mental Health First Aid:** a one-time, 8-hour training initially developed to provide a basic set of skills to respond to an emergent need in crisis situations. While it includes tangible intervention strategies like learning to administer naloxone, it differs from CIC in the way that it is typically applied as a short-term transaction to recognize and triage those in need to other services.
- **Peer Support Services:** a process in which people with common experiences or challenges unite as equals to give and receive help based on the knowledge from these shared experiences. A key characteristic of this type of support that differs from CIC is that peers are typically individuals with a similar background, demographic, or commonality of lived experience. Payment structures that fund peer support services, particularly those linked with clinical services, may also be contingent on a diagnosis prior to engagement in this type of care.
- **Community Health Workers (CHWs):** frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. Though CHWs are based in the community to help address a variety of needs, this service differs from CIC in the way that CHWs are trained and specifically employed to fulfill the role of promoting health or nutrition in their community - as opposed to the emphasis of CIC in expanding mental health intervention skills among those already engaged in other roles within community-based settings.

The goals of these non-clinical services are focused on providing needed mental health support, but each has a different approach. It is important to note that the intent of CIC is not to supplant or create a program that is in competition with these other vital programs but augment the community-based mental health delivery system by embedding care in any place that people are likely to present with need through broadly distributing the knowledge and transferable skills to those best positioned to provide meaningful support.

¹ https://www.scattergoodfoundation.org/publication-series-pdf/?series_id=22&post_id=5465&previous=1294

What are models of intervention or examples of Community Initiated Care?

There are models of CIC both abroad and in the United States. Many of the models are straightforward with their goal: encourage people to open up about mental health issues and struggles while supporting them.

In a recent article, [“Making It Easy to Get Mental Health Care: Examples from Abroad,”](#) the Commonwealth Fund, highlighted examples such as [“The Friendship Bench”](#) in Zimbabwe. This model trained grandmothers with Problem Solving Therapy skills to treat anxiety and depression. It has been scaled and adapted to several countries, including the Netherlands and across school campuses throughout the world.

[“Enhancing the Capacity of the Mental Health and Addiction Workforce: A Framework,”](#) a report from Well Being Trust and the Bipartisan Policy Center, lifts up [The Confess Project](#) as a model in the United States. The Confess Project is an organization that partners with barbers in Black communities around the country to provide training in identifying common mental health conditions, such as anxiety and depression, particularly in boys and men of color, as well as their families. Barbers are trained in active listening, non-triggering language use, and healthy coping skills.