Helpers in Plain Sight: A Guide to Implementing Mental Health Task Sharing in Community-Based Organizations

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We began drafting *Helpers in Plain Sight: A Guide to Implementing Mental Health Task Sharing in Community Based Organizations* in the spring of 2019. We undertook this project to help community-based organizations (CBOs) and mental health providers (MHPs) work together to bring accessible, effective mental health support to community members, when and where they need it. Now, as we prepare to release the Guide in April 2020, the world as we know it has been turned upside down by a global pandemic. The worldwide spread of a novel coronavirus and its resulting illness, COVID-19, affecting every aspect of human society – the way we move, work, learn, and especially the way we connect.

The virus poses a grave risk to physical health. At the same time, our main tools to fight its spread (i.e., staying home, closing non-essential businesses, severely limiting face-to-face interactions) might also threaten our mental health. Not only do we have to completely transform how we connect with friends and loved ones, the virus is straining healthcare systems, making it more difficult to obtain needed services, including mental health treatment. In study after study, we see that access to strong social support is a key factor in preventing or reducing mental health problems. Losing that support or making it more difficult to access is particularly concerning given the extreme social and economic stresses many people are experiencing related to COVID-19. The negative impact of lost social support is potentially even greater for people already experiencing mental health or substance use problems.

Adding to this troubling picture is the fact that the effects of this crisis, while widespread, are not evenly distributed. In New York City, for example, COVID-19 cases appear higher in neighborhoods with higher shares of Black and Hispanic residents, lower shares of residents with college degrees, lower median incomes, and higher rates of household overcrowding. Preliminary data show that the coronavirus is killing Hispanic and Black people at twice the rate it is killing White people. We might anticipate that the longstanding structural inequalities underlying disparities in COVID-19 infection and mortality will exacerbate disparities in mental health experiences and outcomes, too.

The mental health task sharing model presented in this Guide is designed to help overcome unequal access to quality care and mental health outcomes by building mental health promotion, prevention, and treatment resources in communities not well served by traditional care systems. Although we finalized the Guide before COVID-19 emerged, the present crisis has reinforced the value of task sharing in strengthening mental health delivery systems and of CBOs as especially relevant settings for task sharing.

This Guide is based largely on our experience designing, implementing, and evaluating Connections to Care (C2C), a New York City-based task sharing initiative that began in March 2016 and integrates mental health strategies into the everyday work of CBOs. In writing this Guide, we did not anticipate that these strategies would be delivered remotely. However, in the face of extreme need, C2C providers have quickly and creatively found ways to continue implementing C2C through remote means, expanding our view of what is possible. CBO staff who, through C2C, have received training and supervision to screen for mental health symptoms, deliver evidence-based psychosocial support, and refer to a clinician where appropriate, are now using those same skills in new ways. Examples include:

- CBO staff make outreach calls to maintain connections with CBO clients and other community members and use previously learned skills to proactively identify and respond to emotional distress, mental health concerns, and emerging social needs related to COVID-19.
- Trusted CBO staff are using three-way video or phone calls to make “warm handoff” referrals – introducing community members who need additional support directly to the MHP clinician receiving the referral – ensuring that referrals are completed as smoothly as possible even during the transition to telemental health.

- CBOs are continuing to deliver evidence-based mental health promotion activities, now using online platforms. For example, one workforce provider has integrated psychoeducation classes to help people manage anxiety and stress into a virtual job training program.
- CBOs and their partner MHPs are also developing new online groups to support community members through grief and loss.
- One youth-serving CBO, which developed its own internal Social Work team with weekly supervision from the MHP, now provides immediate short-term telemental health counseling to any resident of nearby public housing developments, regardless of age.
- MHPs and CBOs are leveraging virtual tools to continue and expand specialized coaching and supervision – an essential element of successful task sharing – for CBO staff. In a disaster, this support not only helps CBO staff feel they have the knowledge and skills to respond to challenging situations, but also helps them manage primary or secondary trauma, grief, and loss they may be experiencing.
- C2C providers have added new trainings and peer support strategies and made changes to organizational policies and practices to help staff deal with the immense personal and professional challenges brought on by COVID-19.

Many of these adaptations will likely prove beneficial even after the present crisis passes. For example, some C2C providers have observed that remote services have removed otherwise intractable barriers to engaging in mental health care, such as the fear of travel for people living in domestic violence shelters or the costs of travel for people in neighborhoods that are isolated from clinics. This development also calls our attention to barriers that need to be addressed with new urgency, like unequal access to computers and internet technology, and the challenge of engaging people who lack privacy or live in unsafe or unsupportive homes. Similarly, this crisis may help us learn more about effective remote training and coaching and supervision strategies, which could be used to extend task sharing to additional settings.

Now more than ever, we need new strategies to reduce disparities in mental health risk, outcomes, and access to high quality care and treatment. We believe supporting CBOs and MHPs to implement mental health task sharing can form part of a coordinated response to an unprecedented global health crisis. The action steps, recommendations, and tools in this Guide include steps that CBOs, MHPs, community leaders, policy makers, and funders can take now to respond to COVID-19 and to prepare for future challenges. For example, CBOs and MHPs can quickly develop stronger referral pathways, using strategies in this Guide. MHPs can provide, or help CBOs provide, new types of training and supervision to help CBO staff manage the personal and professional strain of this crisis as they interact with community members. Many of the expert resources listed throughout the Guide have recently been updated with additional strategies that respond to the current situation and we recognize that new resources will continue to emerge.

We hope that as community leaders, policy makers, and funders look to learn from our current crisis, they consider the strategies in this Guide as a way to proactively strengthen the mental health delivery system and ensure accessible, high quality mental health support for all who need it.

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Preface

Every year about one in five adults in the United States experiences a mental disorder like depression or anxiety.[1] Millions more have substance use disorders like drug or alcohol addiction.[2] These conditions can negatively impact many areas of peoples' lives, including their ability to find and keep a job, maintain satisfying and healthy relationships, and stay physically healthy. While risk of experiencing a mental health condition is widespread, it is not evenly distributed.[3,4] Social and economic inequalities drive disparities not only in the prevalence of mental illness but also in access to effective prevention interventions, types of diagnoses, and treatment access and quality.[5]

Addressing these layered disparities requires pairing advances in mental health treatment and promotion with strategies to remove structural barriers that limit access to effective mental health care for specific groups. Mental health professionals cannot do this work alone. Community-based organizations (CBOs) already serve and partner with people who face extreme stressors, including poverty, racism, and discrimination, and are uniquely positioned to bring timely and effective mental health care into their communities and improve equity. To date, however, CBOs have been underutilized as partners in promoting community mental health.

Task sharing is a framework that mental health providers (MHPs) and CBOs can use to take on new roles and work together in new ways to improve the mental health of community members. Task sharing uses proven methods to bring mental health support into the work that happens every day at CBOs. By equipping CBO staff with new mental health skills and bringing mental health clinicians into CBOs as capacity builders and treatment providers, task sharing allows community members to access quality mental health services in a non-stigmatized, familiar setting. It also allows clinicians to enter into more effective relationships with these organizations and their communities. Task sharing empowers CBOs and MHPs together to create new, integrated mental health care pathways that are accessible and responsive to specific communities.

This guide is an outgrowth of the RAND Corporation's independent evaluation of the Connections to Care (C2C) program, which helps CBO-MHP pairs integrate mental health strategies into the daily work of social service organizations. In tandem with that evaluation, RAND partnered with representatives from the NYC Department of Health and Mental Hygiene, the Mayor's Fund to Advance New York City, and Thrive NYC to develop a practical guide to help CBOs address mental health issues in their client population, MHPs expand the reach of their services, and funders promote mental well-being and reduce the burden of mental health challenges and related issues in the communities they support.

The Mayor's Fund to Advance New York City funded the evaluation of C2C and the development of this guide under contract MFANYC_09.01.15. RAND Health Care, a division of the RAND Corporation, conducted the evaluation and led development of this guide. A profile of RAND Health Care, abstracts of its publications, and ordering information can be found at www.rand.org/health-care.

**Throughout this guide we use the term* mental health strategies *to mean any one of the specific skills and activities CBO staff will learn and implement to address the mental health of their client population.*

Community-based organizations already serve and partner with communities that face extreme hardships, and are uniquely positioned to promote community mental health.

Acknowledgments

This guide would not have been possible without contributions from the staff and leadership at each of the New York City-based CBOs and MHPs involved in implementation of the C2C initiative. We are grateful to the following organizations for their commitment and dedication to improving community mental health through C2C:

Arab American Association of New York; Bedford Stuyvesant Restoration Corporation; Brookdale Hospital Center; Brooklyn Community Services; CAMBA; CASES; Catholic Charities of Brooklyn and Queens; Center for Employment Opportunities; Comunilife; Dean Hope Center at Teacher's College, Columbia University; Hetrick-Martin Institute; Hetrick-Martin Institute Counseling Center; Hudson Guild; Hudson Guild Counseling Center; Hunter Silberman School of Social Work; Institute for Family Health; Jewish Board of Family and Children's Services; New York University Langone Hospital - Brooklyn; Northern Manhattan Improvement Corporation; Red Hook Initiative; Safe Horizon; Safe Horizon Counseling Center; Safe Space; Sheltering Arms Children and Family Services; STRIVE; The Committee for Hispanic Children and Families; The Door: A Center of Alternatives; The Family Center - Brooklyn; The HOPE Program; Union Settlement; University Settlement; Urban Health Plan; and Voces Latinas.

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Finally, we would like to acknowledge that funding for C2C has been supported by private and federal funders through grants to the Mayor's Fund to Advance New York City and the NYC Department of Health and Mental Hygiene. The C2C evaluation and the development of this guide have primarily been supported by private funds and a federal grant from the Social Innovation Fund of the Corporation for National and Community Service.

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Chapter 1

Introduction

Strong and effective mental health systems depend on having enough people, with the right skills, in the right place.[6] Unmet need for mental health care is widespread, and licensed mental health clinicians alone cannot meet that need. Improving mental health, especially for communities who face structural disadvantages like poverty and discrimination, means rethinking who delivers care, how, and where. Efforts to improve mental health can, do, and should happen outside of traditional clinical care settings, and people without prior mental health training have an important role to play.

Task sharing initiatives across the world have demonstrated that people without prior mental health training – from community health workers, to family members of people with mental illness, to primary care doctors and nurses, and more – can learn and use new mental health skills successfully, with the right supports.[6,8-10] When they do, they can significantly expand the reach and effectiveness of the mental health delivery system.

Introduction continued

People who are well positioned to promote mental health by learning and using new skills are often hidden in plain sight. In this guide, we focus specifically on **community-based organizations** (CBOs) as uniquely capable but underutilized partners in promoting mental health. Every day, CBOs address a wide range of social needs and serve people seeking to advance important personal goals, overcome obstacles, and improve their quality of life. People who work at CBOs often come from the very communities they serve. Through trusted relationships, CBOs engage community members to improve individual and community outcomes across issues that span education, employment, housing, health, criminal justice, child and youth development, immigration, and more.[7]

At the same time, staff at CBOs may witness a wide range of mental health issues that prevent the individuals they serve (hereafter referred to as *CBO clients* or, simply, *clients*) from reaching their goals or engaging in services. For example, a job counselor may work with a job seeker who misses multiple job interviews. A paralegal working to prevent an eviction may learn that a client is experiencing intimate partner violence. Someone seeking food assistance may tell a benefits navigator they don't want to go on living. A young person may turn to a peer counselor at a youth services organization to grieve a friend's death. In each of these examples, CBO staff would not typically have the tools to understand and address the underlying mental health issues. A **mental health task sharing approach,** however, puts mental health promotion, care, and prevention skills into the hands of CBO staff.

This guide is intended to help CBOs and licensed **mental health providers** (MHPs) act on opportunities to improve mental health in their communities. The guide describes the process of setting up a task sharing arrangement between CBOs and MHPs, so they can work together to lower barriers to effective mental health care. While MHPs engaging in partnerships with CBOs may be individual clinicians, throughout this guide we use the term to refer to provider organizations. The text box below provides a snapshot of what task sharing means in a CBO setting.

The terms *task shifting* and *task sharing* are often used interchangeably. In this guide we use *task sharing*, as it provides additional emphasis on the collaborative, team-based approach to mental health promotion and treatment.

Task Sharing Overview

What are the *tasks*? Tasks are activities or strategies that improve individual mental health and promote well-being. They might include screening to identify mental health needs, education to help individuals understand mental health issues, and/or activities that help individuals strengthen social or emotional skills, overcome barriers, and directly manage and improve distress and symptoms of mental health disorders.

Who shares them? Licensed mental health clinicians, like psychologists or social workers, collaborate with CBOs to identify mental health skills CBOs can implement and integrate into CBO work. Clinicians provide ongoing support and coaching to CBO staff to implement the skills.

Why CBOs? CBOs are located in the community, where individuals already seek other services. CBOs are often seen as trusted partners that are invested in the well-being of individuals and communities.

How do CBOs and MHPs implement task sharing? CBO staff receive skill-based trainings in mental health education, promotion, and counseling for use with CBO clients. Licensed mental health providers, in close coordination with CBOs, provide advice, ensure high quality implementation, and when necessary, provide individual treatment.

How the Guide Was Developed

We developed this guide based largely on our experiences in developing, monitoring, and evaluating the Connections to Care (C2C) initiative in New York City. The Mayor's Office for Economic Opportunity (NYC Opportunity), New York City Department of Health and Mental Hygiene (NYC DOHMH), and Mayor's Fund to Advance New York City (Mayor's Fund) launched C2C in March 2015 as part of ThriveNYC, New York City's program to tackle critical gaps in mental health care and promote mental health for all New Yorkers. These cross-sector partners shared an expectation that integrating mental health supports into CBOs can help both CBOs and MHPs more effectively fulfill their missions and improve mental health and social outcomes. C2C tests one approach to task sharing by supporting 14 diverse CBOs to contract with and fund one or more MHP partners (see next page for C2C model overview). Together, these CBOs and MHPs empower CBO staff to learn and use new mental health skills and reduce client barriers to accessing clinical mental health care and promotion, when needed. New York City is further investing in this model by replicating C2C at ten sites delivering Jobs-Plus, a workforce program for residents of New York City Housing Authority developments in 2020.

C2C is a five-year pilot initiative; implementation began in March 2016. Interim evaluation findings show that, in its first two years of implementation, C2C exceeded its target in terms of number of C2C staff trained to deliver the four core strategies, and that C2C was on track to meet its target of reaching 40,000 New Yorkers in five years. We will report on the findings of C2C's impact, implementation, and cost by late 2020. For a brief primer on the C2C model, see: Connections to Care (C2C): Evaluating an Initiative Integrating Mental Health Supports into Social Service Settings. For more information on interim findings from the C2C evaluation, see: Evaluation of the Connections to Care (C2C) Initiative: Interim Report.

In addition to drawing on the C2C experience, we reviewed the literature on mental health task sharing, both globally and in the United States, and implementation science. We cite some of this literature in the guide and in the additional resources sections throughout. To complement published literature and resources, we incorporated input from experts with experience implementing and evaluating mental health task sharing programs, as well as CBOs with experience carrying out task sharing. Based on C2C and related research, this guide offers one path to planning and executing a mental health task sharing initiative with CBOs, which may be adapted or improved on by additional implementers and researchers.

How the Guide Was Developed continued

C2C Model Overview: Mental Health Care Begins at the CBO

Implementers

Competitively selected CBOs who choose MHP partners and together apply for funding

CBOs have expertise in a range of social services:

Workforce development

Youth services

Emergency shelter/housing

Immigrant services

Adult education

Domestic violence and others

New Mental Health Strategies at the CBO

MHPs provide consultation, training, and supervision to equip CBOs to deliver four core strategies:

Mental Health First Aid to identify and respond to signs of mental health problems or crises

Motivational Interviewing to promote positive behavior change

Screening to identify symptoms

Psychoeducation to help understand and manage symptoms and illness

These four core strategies were selected as a starting point for C2C based on evidence of their effectiveness, feasibility, and perceived usefulness. There is no one standard set of strategies implementers must use. As detailed in Chapter 3, implementers should carefully select strategies that best fit population needs and implementation resources and goals.

Clinical care in communities

CBOs and MHPs match timely, appropriate mental health supports to individual and community needs. Strategies include:

Task-shared mental health support at the CBO

Specialized clinical care on-site at the CBO, which may happen through:

- MHP clinicians working on-site at the CBO
- MHPs providing supervision to enhance care CBO clinicians deliver
- Graduate student clinicians in training

Strengthening referral pathways to external MHP clinics

Coordinating care between the CBO and MHP

Intended Audience

This guide is primarily designed for use by CBOs and MHPs working together to improve mental health for a shared target population. This guide will also help those who design, fund, or otherwise support community mental health initiatives to understand the scope of task sharing and needed resources. Such organizations include city, state, and federal agencies; foundations; and other health or human services funders and providers.

Guide Goals and Aims

The overall goal of this guide is to provide CBOs and MHPs with the information and resources needed to design and implement a task sharing approach. To accomplish that goal, this guide:

1. **Describes the value and core components** of a mental health task sharing approach
2. **Explains the new roles** both CBOs and MHPs should be prepared to take on
3. **Offers considerations** for designing a task sharing approach based on community-specific priorities and resources
4. **Describes specific mental health strategies** that can be implemented in a task sharing approach and the types of support needed to ensure high quality implementation
5. **Provides guidance on key content and structures** that need to be in place to successfully implement a task sharing approach
6. **Provides a tool for assessing implementation** of mental health task sharing

Navigating the Guide

The following chapters provide comprehensive, in-depth guidance for anyone involved in the process of planning, designing, implementing, monitoring, or improving a task sharing approach. Although the activities are presented in a particular sequence, they can be completed in any order. Decision points may need to be revisited multiple times during planning and monitoring. Some design considerations mentioned early on will be informed by content in later chapters. For this reason, readers may find value in reading the entire guide before launching planning or design activities. The guide contains several features to support implementer efforts, which are marked with the corresponding signposts.

Worksheets
key questions and activities designed to help CBOs and MHPs form a partnership and then design and implement a mental health task sharing approach

Additional resources
brief descriptions and links to resources CBOs and MHPs may wish to consult in designing a task sharing approach

C2C examples
illustrations of real-world examples of task sharing implementation as it occurred in the C2C initiative

Checklists
summaries of required and recommended components of task sharing activities described in detail in Chapters 5; can be used to prepare for implementation as a readiness check

Task Sharing Self-Assessment Tool
included in Appendix C; can be used by task sharing implementers to assess what is working well and what needs improvement

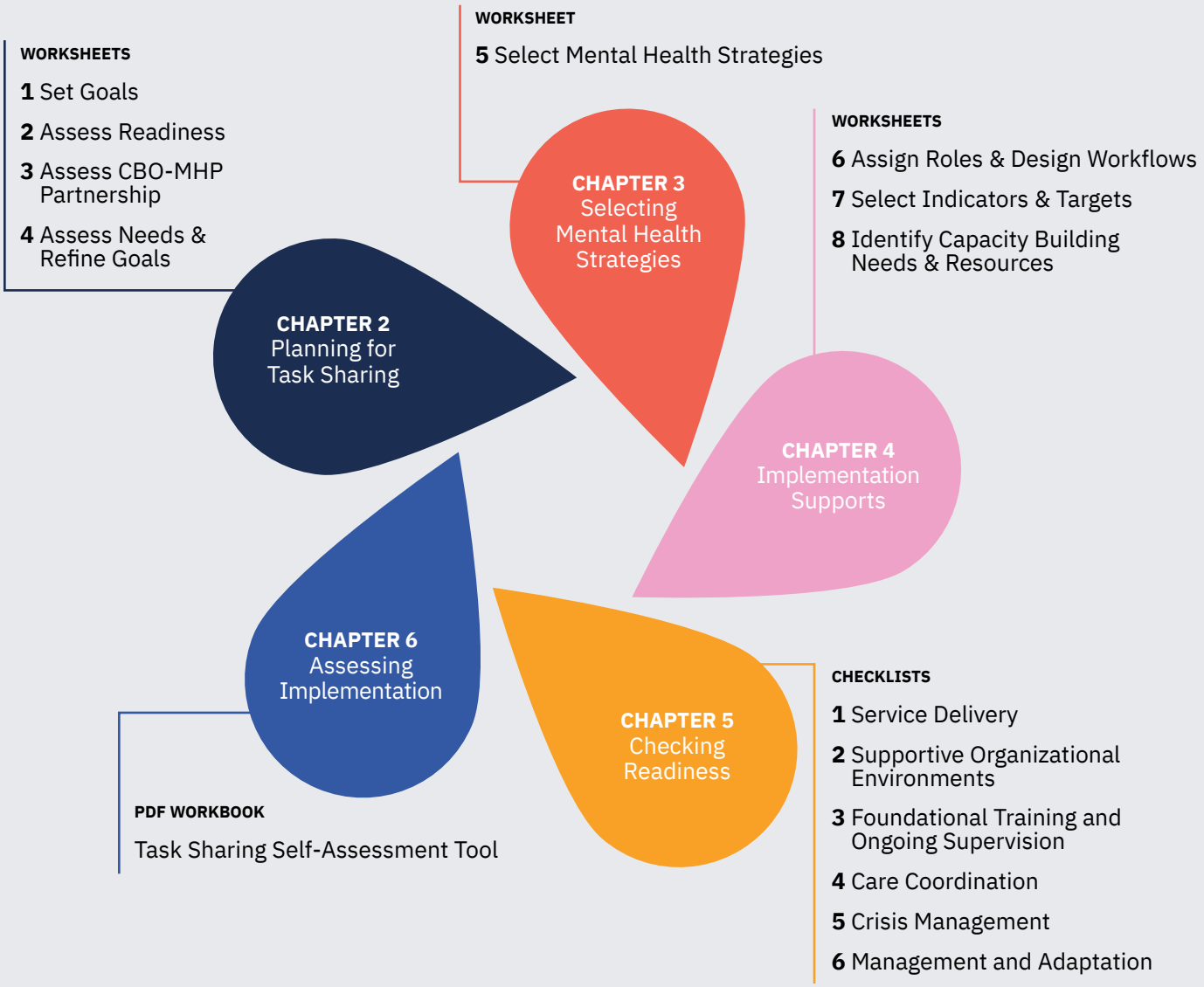
Glossary
includes definitions of important key terms introduced in the guide

Navigating the Guide

The roadmap below helps readers navigate the different phases and corresponding resources and activities included in the guide.

In addition to using this guide, implementers and funders should seek ongoing input and participation from community members and other experts while building a task sharing approach. This additional input will strengthen the selection and adaptation of strategies to fit local needs. Throughout the guide, we provide recommendations on identifying and using such relevant expertise.

Roadmap to the Guide: Task Sharing Phases and Corresponding Chapters and Activities



A Final Word

Everyone who experiences mental illness, trauma, distress, and other adversities deserves healing and growth. However, mental health care is too often developed without meaningful input from users and communities. No community should face extreme barriers to accessing prevention and treatment resources. We need new strategies, including new relationships between clinicians and communities, to reduce persistent disparities in risk for mental illness, and in mental health care access and outcomes. This is especially true if we want to address disparities linked to structural racism and other historically and socially structured sources of distress and trauma. C2C and other task sharing programs demonstrate how shifting traditional roles and power, and rethinking who is a part of mental health care delivery, can have positive effects. This guide can help CBOs and MHPs harness their respective strengths through task sharing to support the mental well-being of the communities they serve.

Task sharing can help us relocate the power to name, understand, and address mental health within communities.

Advancing CBO Missions

For CBOs, effectively addressing mental health can be a fundamental step toward fulfilling their mission. An executive director at one C2C CBO described how leadership and staff routinely saw situations where mental health needs exacerbated families' hardships. For some, it meant the inability to maintain a job. For others, it meant loss of stable housing. "Unless we get to the root of the problem, on top of everything else that the families are facing, they're not going to move forward," the executive director reported. "We want long-term outcomes. We want resilience." Task sharing at this CBO became about enhancing, not changing, its underlying goals and services. Addressing mental health challenges through task sharing has contributed to successful client outcomes across the CBO's programs.

Chapter 2

Planning for Task Sharing

Task sharing allows CBOs and MHPs to work together to improve mental health care access, experiences, and outcomes within a particular community. Such gains require long-term investment and commitment. In this chapter, we describe the value and key components of task sharing as well as pre-implementation planning activities for CBOs and MHPs.

Task Sharing Value and Key Components

Mental health task sharing can be especially valuable to CBOs and MHPs because it has the potential to:

Reduce mental health stigma. CBOs can play a powerful role in normalizing and de-stigmatizing conversations about mental health and the act of seeking help for emotional distress. Through specialized training and supervision, task sharing reduces stigma among CBO staff and equips them with the confidence and skills to initiate compassionate and accurate conversations about mental health with CBO clients. In the process, CBO staff and clients develop a new shared language around mental health that makes sense for their community.

Minimize suffering caused by distress and treatable mental health conditions. Task sharing gives CBO staff the tools to prevent, identify, and respond to signs of distress or mental illness proactively. In removing barriers to mental health care, CBOs and MHPs can also reduce the amount of time people suffer alone and the social and economic costs that often accompany that suffering.

Promote positive mental health and social outcomes. CBOs and MHPs serve individuals who have mental health and social needs that can reduce quality of life. Mental health and social needs are often interconnected. Task sharing strengthens the capacity of CBOs and MHPs to address these needs in a timely and coordinated way by integrating mental health support into the underlying social services of the CBO and enabling CBOs and MHPs to share their expertise and resources with each other. This integrated approach can help CBOs better engage people experiencing mental illness or distress in CBO services and provide both social support and mental health support to help them achieve important life goals.

Improve the mental health care delivery system. Task sharing brings the mental health care delivery system into the everyday lives of people who might otherwise face significant access barriers or choose not to engage with traditional mental health clinics. The trusted relationships CBOs have with community members can increase the acceptability of mental health care delivered by both CBO and MHP staff. In addition, changing where clinicians deliver care can also improve how they deliver it. Partnering with CBOs allows MHPs to learn about the challenging circumstances of individuals' lives in ways that may not be possible in a clinical setting. It also creates opportunities for CBOs and community members to share their wisdom and perspectives with clinicians, helping MHPs look beyond traditional approaches and tailor engagement and treatment approaches to maximize impact.

Incorporating Mental Health into Everyday CBO Activities

One C2C CBO has spent decades developing culturally responsive services for LGBTQ young people, many of whom are people of color. Though this CBO already housed a mental health clinic specializing in LGBTQ mental health care before C2C, it recognized a need to extend this care beyond clinic walls, partly because so many young people reported prior negative experiences with the mental health delivery system. After three years of implementing task sharing through C2C, a leader at this CBO noted, "There has been a cultural shift, where we now feel that everyone needs a certain level of knowledge and conversation skills around mental health, in the same way that everyone in every role in the organization needed to be able to talk about HIV ten years ago." This CBO has now built mental health knowledge and skills into its everyday interactions with young people, from intake to high school equivalency classes, and from HIV prevention services to career training programs.

Task Sharing Value and Key Components continued

CBOs can be important partners in reducing health care costs and improving health care quality, not just because of the social services they provide, but because of their capacity to act early to prevent or respond to mental health conditions in their communities, when they receive the right supports. Across the United States, for example, health systems and payers are working to reduce avoidable hospitalizations and emergency room visits. CBOs have an important role to play in this work. Through C2C, clinicians provide ongoing coaching and supervision to CBO staff so they can integrate skills related to identifying and responding to mental health issues into the frequent and meaningful conversations they have with CBO clients. This ongoing clinical support helps CBOs grow their capacity to act quickly and effectively when they see signs of distress, maximizing opportunities to prevent the onset or worsening of symptoms, improve well-being, and reduce the burden of mental health crises for individuals and communities.

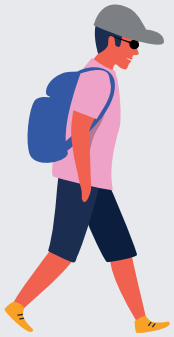
To achieve the value of task sharing, several **core components** must be in place, including:

- **Collaboration** between one or more CBOs and one or more MHPs with a shared target population
- An **integrated care** pathway that extends across the CBO and MHP
- **MHP support** for CBO staff to take on new mental health skills and roles
- **Organizational support** at both the CBO and MHP to provide staff with the time and resources they need to use new skills and fulfill new roles

Through task sharing, CBOs can help strengthen mental health care delivery systems.

Improving System-Wide Responses to Crises

One C2C CBO described how, before C2C, calling 911 was its only option when a client appeared to be in crisis. Managing these crises often meant hours of time from multiple staff and, when emergency services weren't the right fit for the client's needs, left clients and staff feeling drained and dissatisfied. By training CBO staff in mental health knowledge and skills and embedding an MHP clinician on-site to consult in challenging cases, the CBO has transformed how it responds to potential crises. One staff person said, "I wouldn't necessarily say distress is a crisis. Sometimes a person is just venting… They're talking about these things for the first time, and that's a good thing. These situations provide a great opportunity to use what we've learned from our C2C trainings." When CBO staff are unsure what to do or a person expresses severe distress, the CBO can immediately consult with the MHP, reducing the time and stress involved in managing crises. The CBO and MHP also debrief crises immediately after they happen; this helps CBO staff manage their emotional reactions and plan for appropriate follow-up.



Shifting Roles

For task sharing to succeed, CBOs and MHPs will need to draw on their current capabilities and also commit to building new ones. The figure below describes the kind of capabilities that can be leveraged to meet the goals of mental health task sharing. While not every CBO and MHP will have all the capabilities below, they can work together with community members and CBO clients to draw on their collective strengths and make task sharing successful.

Task sharing builds on the expertise of CBOs, MHPs, and community members.

Capabilities Leveraged in a Task Sharing Approach

CBO

Engage community members in trusted relationships

Address various types of life challenges and social determinants (e.g., housing, employment, education)

Help clients navigate social service or legal systems

Strengthen community ties and networks

Gather data and promote local voice to identify social needs, goals, and strategies

Develop and deliver culturally responsive approaches to improve social outcomes, which may include trauma-informed approaches

MHP

Identify and help people understand specific mental health issues

Provide specialized clinical care, including therapy and/or medication

Provide specialized training and supervision in mental health skills

Apply clinical expertise to design, test, implement, or improve approaches to clinical care

Gather data about mental health needs and goals and develop strategies to improve mental health outcomes

CBO Clients & Community

Identify community needs and priorities related to mental health and social outcomes

Identify trusted community resources

Provide input to design and improve services and support

Help generate responsive solutions to community history and culture

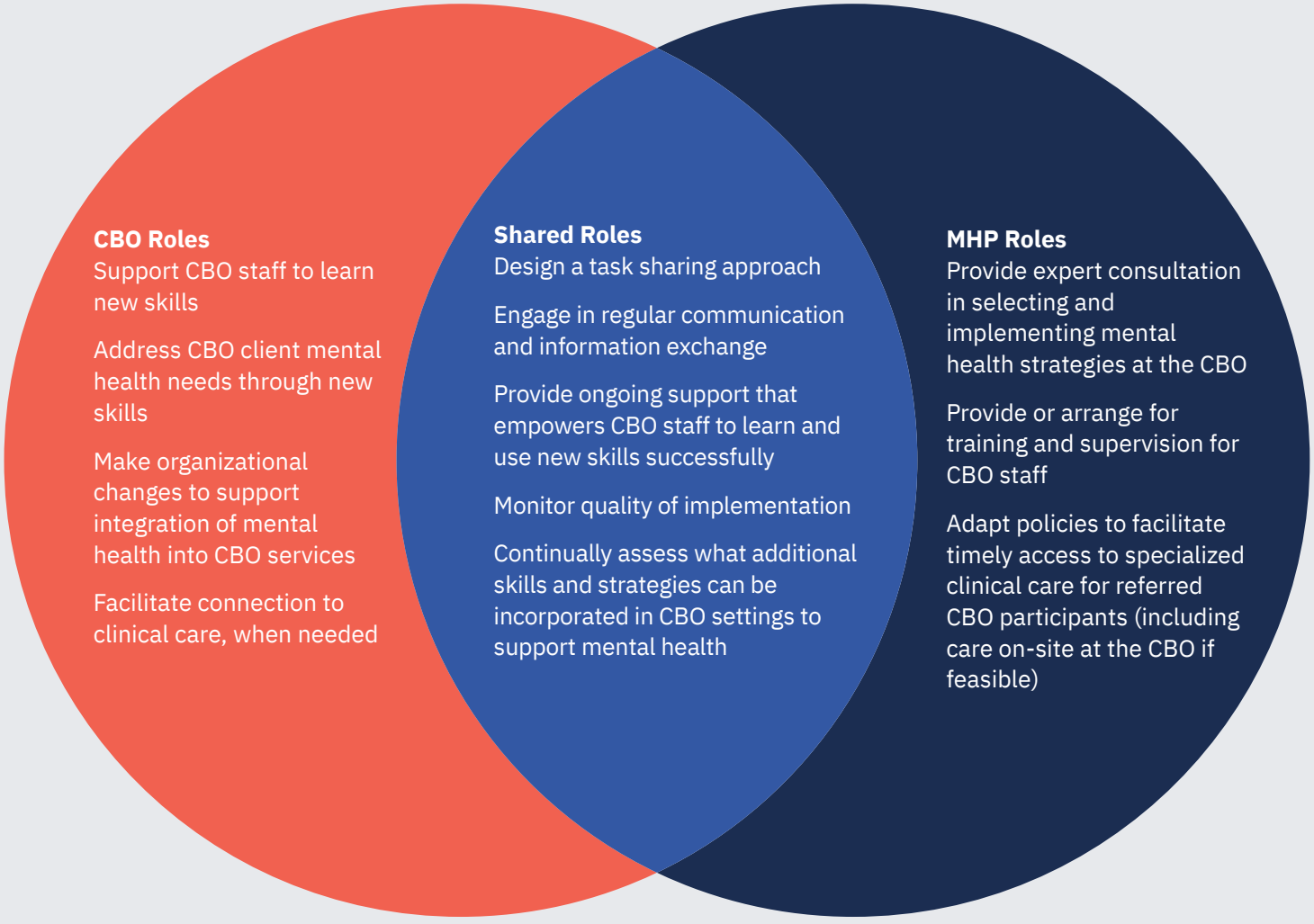
Offer social support

Take action to improve individual or community mental health and well-being

Shifting Roles continued

Using these capabilities as a strong foundation for task sharing, CBOs and MHPs will also take on new roles to integrate the critical but often disconnected capabilities of each partner. The figure below describes new individual and shared roles both types of organizations should expect to take on during the task sharing process.

CBO and MHP Roles for Successful Task Sharing



Setting Overall Goals

Early in the process of designing a task sharing approach, CBOs and MHPs will need to determine why they want to engage in task sharing and their overarching goal(s). Clarifying these two points will help organizations shape their partnerships. Worksheet 1: Set Goals for Task Sharing includes a series of questions designed to help CBOs and MHPs brainstorm what overall needs they hope to address and document high-level goals for the partnership. We recommend that organizational leaders from potential CBO-MHP partners complete Worksheet 1 together. Completing this high-level needs assessment and goal setting will establish a shared vision, identify some of the challenges ahead, and determine what might be accomplished. After CBOs and MHPs have established their partnership, we provide guidance for completing a more in-depth needs assessment (see Worksheet 4) to inform mental health strategy selection and other important implementation decisions.

Assessing CBO and MHP Readiness

After setting high-level goals, CBOs and MHPs will need to determine organizational readiness to take on new roles and develop or adapt programs and policies to meet those goals. Worksheet 2: Assess CBO and MHP Readiness and Resources is designed to help each organization gauge its readiness for task sharing implementation. Worksheet 2 contains separate sections for CBO and MHP organizational leaders to fill out independently, with input from other staff, as needed. Worksheet 2 allows each organization to reflect on its own experience and expectations, gain a clearer understanding of the commitment needed to successfully engage in task sharing, and begin to understand what additional external support, training, and resources may be needed to make task sharing successful. Worksheets 2 and 3 can be used by CBOs and MHPs considering a new partnership or by organizations considering expanding an existing relationship.

Establishing a CBO-MHP Partnership

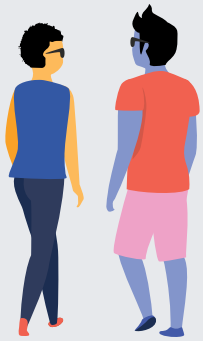
Once the CBO and MHP have assessed their own capabilities through Worksheet 2, we recommend CBO and MHP organizational leaders come together to share summaries of those assessments with one another. Worksheet 3: Assess Partnership Fit is designed to facilitate a conversation about the completed readiness assessments. It can help potential partners determine whether they have sufficient joint resources to resolve identified challenges and move forward with the partnership, or if the partnership is not a good fit for one or both organizations. If, after completing Worksheets 2 and 3, either the CBO or the MHP does not feel ready to engage in a task sharing partnership, one or both organizations may decide to pause the planning process to address identified challenges. For example, one or both organizations may need to obtain more staff or leadership buy-in before proceeding. However, if organizations find that they disagree about more foundational issues (e.g., fundamental differences in what each hopes to accomplish, or how best to train CBO staff), the partnership may never be a good fit. In such situations, we recommend the CBO and/or MHP seek out a different partner organization and complete Worksheets 2 and 3 again with that new organization.

While assessing readiness and establishing a partnership take time, the success of task sharing depends heavily on the training, supervision, and support that the CBO-MHP partnership will provide to CBO staff. Both organizations must take time early on to assess the partnership's ability to facilitate these kinds of high quality supports. Such joint planning exercises can also provide a strong foundation for the ongoing, close collaboration that will take place during task sharing implementation. We strongly recommend CBO and MHP implementers who decide to work together develop a formal Memorandum of Understanding (MOU) that describes each organization's roles and the services each will provide. The additional resources at the end of this section include a link to a sample MOU that can be used as a starting point.

The success of task sharing depends heavily on the training, supervision, and support that the CBO-MHP partnership will provide to CBO staff.

Leveraging CBO and MHP Expertise

Task sharing involves mutual capacity building across CBOs and MHPs, both of which have critical expertise to share. One C2C CBO that provides HIV and domestic violence services to a primarily immigrant community has years of experience testing trauma-informed service delivery strategies. Based on this experience, the CBO funded its MHP to adopt a more flexible, individualized approach to delivering mental health services by working with clients on-site at the CBO. The CBO helped the on-site MHP clinician meet with clients immediately after or within a few days of when they expressed a mental health need. Initial appointments focused on building rapport and exploring client needs, rather than completing intake forms. The MHP helped CBO staff implement routine screening for common mental health conditions to better identify people who may need a referral. The MHP also trained CBO staff to deliver group-based psychoeducation focused on reducing harms related to substance use and forming new relationships after experiences of trauma.



Establishing a CBO-MHP Partnership continued

Sharing Information and Protecting Privacy

One important aspect of the CBO-MHP relationship is care coordination, discussed in more detail in Chapter 4. When done well, care coordination facilitates the appropriate delivery of mental health strategies to those who need them and ensures that CBO and MHP staff find complementary ways to work together and avoid redundancy. Effective care coordination requires regular communication and information sharing. At a minimum, CBOs and MHPs will want to communicate regularly about the progress of training, supervision, and task sharing implementation at the CBO.

CBO-MHP partners will also find it critical to exchange information about individual CBO clients. While organizations cannot share many types of protected information, some types can be shared with the appropriate protections and consent in place. For example, CBOs may wish to share case notes with MHPs, and MHPs can inform CBOs about client appointments kept or missed. This type of client-level information exchange greatly enhances partners' ability to serve clients but must be done securely and legally. Before engaging in client-level information sharing, CBOs and MHPs will need to understand the Health Insurance Portability and Accountability Act (HIPAA) and other laws and policies governing the sharing of personally identifiable information (PII), which can be very specific (see the Additional Resources box for more detail). PII can include health information as well as data on receipt of public services or other sensitive information. We recommend developing a data sharing agreement early on in the task sharing design process, as it may affect subsequent decisions. For more resources on how to securely exchange client-level information, we recommend consulting the resources in the box below, discussing options with MHP leadership (who may have procedures in place that could be adapted), and/or seeking additional outside legal support, as needed.

CBO-MHP partners will also find it critical to exchange information about individual CBO clients.

Additional Resources
Forming Partnerships and Sharing Data

The Center for Health Care Strategies Partnership Assessment Tool helps CBOs and health care organizations partner more effectively to maximize impact on health outcomes.

The Robert Wood Johnson Foundation's Data Across Sectors for Health (DASH) initiative has a resource sheet with links to multiple sources to help navigate consent and data sharing.

The U.S. Department of Health and Human Services (HHS) has an easy-to-read summary of the key elements of HIPAA as well as guidance for protecting different types of health data.

SAMHSA has compiled resources related to individual confidentiality and data sharing. While the resources are primarily geared toward data sharing between primary care and mental health care entities, much of the information will still be applicable to CBO-MHP data sharing.

The Dual Diagnosis Capability in Addiction Treatment (DDCAT) toolkit has a good example of a Memorandum of Understanding (MOU) in Appendix F that could be adapted for use by CBOs and MHPs.

Assessing Needs and Refining Goals

During initial goal setting, Worksheet 1 required CBOs and MHPs to perform a high-level assessment of CBO client needs. However, to understand where to focus task sharing efforts, which specific mental health strategies the CBO needs, and how those strategies will be implemented, CBO-MHP partnerships will need to conduct a more thorough needs and resources assessment. The extent of this assessment will depend on time and staff capacity. However, this step is invaluable for designing task sharing. Soliciting perspectives from even a small group of diverse stakeholders can help CBOs and MHPs pick the strategies and structures that will position their task sharing approach for success.

As part of a needs assessment, we recommend talking to different kinds of stakeholders (e.g., CBO clients, CBO staff, community members) to understand how they think about mental health and what challenges and opportunities they see for addressing mental health needs. If feasible, we also recommend examining CBO and MHP data, and/or local health data, to better understand what common needs might exist in the CBO client population or in the community served by the CBO. Worksheet 4: Assess Needs and Resources and Refine Goals guides CBOs and MHPs through these processes. It provides a list of suggested stakeholders to consult and sample questions to ask. It also provides space to record findings from these conversations. The final section of Worksheet 4 prompts the partnership to summarize the specific mental health needs of the CBO client population and refine initial goals based on the information gathered. Carrying out the activities outlined in Worksheet 4 will likely require a mix of CBO and MHP leadership, program staff, and data management staff.

Additional Resources
Conducting a Needs Assessment

MentalHealth.gov has developed a comprehensive guide for conducting community conversations about mental health and provides resources in Spanish.

The Institute for Healthcare Improvement (IHI) and the Center for Health Care Strategies (CHCS) led the development of a quick guide to conducting a data review to better understand the needs and assets of people with complex needs.

The Community Toolbox – a service of the Center for Community Health and Development at the University of Kansas – compiled a toolkit and related resources for conducting a community needs and resources assessment.

The CDC compiled resources and lessons learned from incorporating a health equity lens into assessing community needs and implementing strategies to address these needs.

Chapter 3

Selecting Mental Health Strategies for Task Sharing

Many CBOs and MHPs already focus on strategies to improve community emotional resilience and well-being in creative, place-based ways. In this chapter we provide information about mental health strategies CBOs and MHPs can implement in a task sharing approach to advance the work of helping communities achieve mental health. This information will help CBOs and MHPs select the strategies that will work best in their settings. Successful implementation of these strategies requires not only training and support, but also a foundation of trusting, respectful, and compassionate relationships between CBO staff and clients. Beyond the scope of this guide, CBOs and MHPs may determine that other foundational strategies are needed to support task sharing in their settings, such as trauma-informed principles and skills.

Considerations for Selecting Mental Health Strategies

Evidence of effectiveness. We chose the strategies described in this chapter because they have shown promise in other task sharing approaches and research has demonstrated that they can be implemented effectively by non-mental health professionals.[8-15] Throughout this guide we emphasize the importance of selecting evidence-based or evidence-informed mental health strategies. An evidence-based strategy has been researched scientifically, proven effective, and demonstrated similar results across more than one study or program. An evidence-informed strategy is also grounded in research but may not yet be proven effective through rigorous studies. As CBO-MHP partners consult additional resources and select strategies, we recommend choosing evidence-based or -informed strategies, as they provide partnerships the best chance to achieve desired outcomes. CBOs and MHPs can also play an important role in adapting strategies to improve community mental health.

Alignment with target outcomes. In the descriptions below, we indicate outcomes that can be achieved based on the evidence associated with each strategy. These target outcomes include:

- Reducing mental health stigma
- Identifying individual mental health needs and symptoms
- Providing accurate information and resources about mental health
- Promoting engagement in CBO or MHP services
- Strengthening an individual's ability to cope with emotional distress
- Strengthening an individual's ability to effectively manage and reduce existing mental health symptoms

Working together, CBOs and MHPs can select strategies that best match the outcomes they hope to achieve, based on the needs and resources identified in Chapter 2.

Target population and type of mental health strategy. CBOs and MHPs can maximize task sharing impact by determining a target population to work with and the type of strategy needed to achieve intended outcomes. For some CBO-MHP partnerships, it might be critical to reach a wide audience with broadly applicable strategies to promote well-being and prevent mental health problems. Others will want to implement more narrowly focused strategies with a specific group of individuals who have known mental health risks or needs. When making these decisions, CBO-MHP partnerships can think of strategies as falling into the following categories along a spectrum:

Promotion: can be offered to anyone to achieve a positive sense of self-esteem, promote mental well-being, and strengthen ability for self-care, coping with adversity, and other strategies to enhance and protect mental health.

Prevention: intended to stop the onset or worsening of mental health symptoms. These may be:

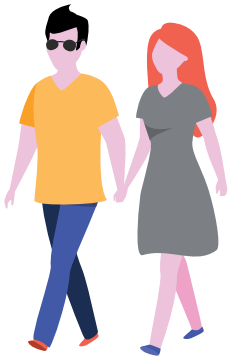
Universal · targeted to a whole population regardless of individual risk for any mental health disorder.

Selective · targeted to where there is heightened risk of developing mental disorders or distress that can impair functioning. The risk may be imminent, or it may be a lifetime risk. Risk groups may be identified on the basis of different risk factors known to be associated with the onset of a mental disorder (e.g., family history, exposure to violence/trauma, extreme stress, or prior mental illness).

Indicated · targeted to individuals identified as having detectable signs or symptoms of a mental disorder.

Treatment: diagnose a specific mental health disorder and provide therapy, medication, or other targeted care intended to cure the disorder or reduce the symptoms

Maintenance: support individuals previously diagnosed with mental health disorders or specific needs to maintain improved well-being and/or recovery, such as through continued engagement in recommended treatment or care, social supports, and/or self-help strategies that have helped the individual achieve improved well-being.



Considerations for Selecting Mental Health Strategies continued

Many of the strategies described in this chapter can be flexibly applied to multiple phases of the spectrum described on the previous page. When determining how to apply strategies, CBOs and MHPs should consider not only the mental health needs of their shared population but also how to maximize the benefit of their partnership. For example, CBOs might already be carrying out promotion activities successfully without added MHP support. Similarly, some aspects of MHP-provided treatment may not change significantly by partnering with a CBO. We recommend selecting and applying strategies in ways that draw on expertise and strengths of both CBOs and MHPs.

Feasibility and fit. When determining what strategies can feasibly be implemented, CBOs and MHPs will want to consider: capacity of the MHP to provide adequate training and ongoing support; ability of CBO staff to learn and use a new skill; whether implementation of the strategy will work with CBO workflows and administrative structures; and whether and how current workflows and administrative structures can be altered. Fit considerations include how closely a given strategy matches the mission and values of the CBO and MHP and how a strategy can help CBO staff succeed in their existing jobs and add value/address challenges to their work with CBO clients.

Mental Health Strategy Descriptions

CBOs and MHPs have many options to choose from when determining which mental health strategies they will implement. The following pages describe several of these options in more detail. All can be successfully implemented with a diverse range of individuals. All can also be layered on top of trauma-informed approaches to service delivery. For more on working with individuals with trauma histories, see the resource box on pg. 31.

First, we provide detailed descriptions of psychoeducation and screening. Task sharing can be implemented without these strategies, but we consider them to have an important role and thus recommend including them in a task sharing approach. Following psychoeducation and screening descriptions, we include a table that briefly describes other mental health strategies CBO-MHP partners can consider implementing, all of which have been used successfully in task sharing. Finally, we describe referral to specialized, clinical care for clients whose needs warrant more intensive mental health services.

After reviewing the descriptions below and any additional resources, CBOs and MHPs can work together to complete Worksheet 5: Selecting Mental Health Strategies. It includes a series of questions to aid decision-making and provides space to document the selection of the specific strategies to be implemented. In completing the worksheet, CBO and MHP leaders will want to ensure that selected strategies match shared priorities and available resources. We also recommend leadership staff consult with client-facing staff at both the CBO and MHP before finalizing selections. Chapter 5 of the guide includes pre-implementation checklists for each of the strategies described here. Once CBO-MHP partnerships have selected the strategies to implement, they can use the corresponding checklists in Chapter 5 to determine whether all the critical components are in place.

Mental Health Strategy Descriptions · Screening

TARGET OUTCOMES

Identifying individual mental health needs

Providing accurate information and resources about mental health

Strengthening an individual's ability to manage and reduce mental health symptoms

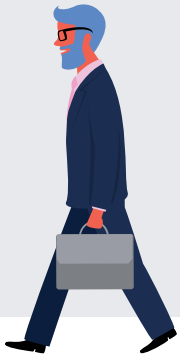
SAMPLE APPLICATIONS

Universal prevention: All clients (either across entire organization or within a particular CBO program) screened for symptoms of one or more mental health conditions

Selective prevention: Clients at risk for certain conditions screened for those conditions (e.g., clients with trauma history screened for PTSD, homeless clients screened for depression, etc.)

Indicated prevention: Clients with identified symptoms of a specific condition screened for that condition

Treatment: Clients can be re-screened at regular intervals to determine if symptoms are improving. CBOs and MHPs can use this information to deliver more responsive care, as needed, until an individual achieves and sustains improvement



Often, the only way to know if someone is suffering is to ask them. Screening is an evidence-based way to ask individuals about symptoms and identify mental health needs. Screening involves asking a series of questions about an individual's mental health symptoms (e.g., thoughts, feelings, behaviors, and physical symptoms like loss of appetite or trouble sleeping). **Importantly, screening is not time consuming.** Screening is often delivered as a brief intervention and can be integrated into other meetings or conversations that already happen at the CBO.

Screenings can be administered by trained CBO staff, or CBO clients can self-administer screenings using paper and pencil or tablet-based screening tools. In either scenario, CBO staff will need to be trained in the process of introducing and administering screenings, as well as discussing screening results and next steps with clients.

Often, the only way to know if someone is suffering is to ask them.

Mental Health Strategy Descriptions · Screening continued

Screening as a Tool to Engage Clients

For a C2C CBO that provides early childhood education services, the primary value of screening is in starting a productive conversation with parents and caregivers about their mental health. During orientation and registration, CBO staff introduce mental health and well-being as a part of the comprehensive services they provide. CBO staff conduct mental health screens with parents and caregivers several weeks after orientation, once they have developed rapport. When parents and caregivers screen positive or request a referral to a clinician, CBO staff connect the individual directly with the MHP. Even when parents and caregivers decline to answer screening questions, the CBO has noted that offering the screens in a nonjudgmental way opens a door to revisit these conversations at a later time. Frequently, parents or caregivers will disclose symptoms or ask for help accessing care in the weeks or months after the initial screening.

When done well, screening serves three critical functions. First, it provides a way for CBO staff to initiate and normalize compassionate conversations about mental health with CBO clients, regardless of whether that person is currently experiencing symptoms. The formal, tested questions on screening tools can help CBO staff structure their conversations with CBO clients, empowering CBO staff and clients to explore mental health in a productive way. Second, it provides CBO staff with information about client mental health needs that can guide appropriate follow-up. Third, it offers a way to monitor changes in an individual's symptoms over time and make decisions about adjusting care, when needed.

Screening is most effective when CBO staff can help CBO clients understand the screening results, consider what the results mean to them and what action they might want to take, and decide on the right next step. Having a timely, accurate, and nonjudgmental conversation about screening results with CBO clients is a critical component of the screening process. For all individuals – and especially those who indicate experiencing mental health symptoms – part of this conversation should include psychoeducation (the provision of accurate, up-to-date information about mental health symptoms and potential ways to manage them; see next section). It should also include helping the individual explore next steps they may want to take, such as by using Motivational Interviewing strategies (see pg. 34). In addition, CBOs implementing screening will also need to ensure they have protocols in place for dealing with screening-related crises/emergencies (e.g., client admits to having suicidal thoughts as part of a depression screening). For more on crisis management, see pg. 51.

Screening is a tool CBO staff can use to have helpful, compassionate conversations about mental health.

Mental Health Strategy Descriptions · Screening continued

Integrating Screening into CBO Workflows

One C2C CBO with a high volume of new clients each month looked for ways to streamline its screening process and make sure clients with the greatest mental health needs were connected to resources. As a way to triage client needs, staff first implement a brief, two-question screen for depression, the PHQ-2, during CBO intake. When CBO clients screen positive on the PHQ-2, CBO staff continue the conversation by using the PHQ-9. The PHQ-9 is a 9-question depression screen, which can also be administered in a matter of minutes. Implementing the PHQ-2 first helps the CBO to tailor its intake conversations based on client priorities and needs, focusing follow-up conversations about depression symptoms on people who are more likely to be affected.

Screening is NOT meant to establish the definitive presence (or absence) of a mental health condition (e.g., a depression diagnosis). Diagnosis of any disorder can only happen through a clinician's assessment. We recommend that screening by CBO staff only occur when the CBO has an established protocol for referral to a licensed mental health provider who can perform such an assessment. Licensed providers can also facilitate treatment (including medication), should it be needed or requested by the CBO client. In sum, **any CBO implementing screening should also be prepared to provide crisis management, psychoeducation, and timely referrals for further evaluation and care, as needed.**

Screening is most useful when it is systematic, though ad hoc screenings can be used as a complement. Systematic screening is implemented at predetermined time points in order to reach an entire target group of CBO clients, regardless of whether they are already suspected of experiencing symptoms (e.g., during intake, or within 6 weeks of being assigned a case manager). Systematic screening is implemented in a consistent manner regardless of who is asking the questions, and with validated screening tools. Validated tools are those that have been shown through research to detect specific mental health conditions. Systematic translation into the native language of the recipient (i.e., translation is not done "on the fly" by the screener) greatly enhances the accuracy of the question. Initially, individuals may decline to participate in screening or may not fully disclose symptoms. In some cases, however, they will start a conversation about mental health symptoms with a CBO staff person in the following days, weeks, or months, at which point screening questions can be asked again.

CBO and MHP staff can use screening results to determine next steps to best meet an individual's needs. For example, individuals with severe symptoms may be offered some mental health strategies at the CBO in addition to a referral for clinical assessment and treatment. Other individuals with mild symptoms may just receive CBO-provided strategies with a plan to monitor through rescreening. For clients who engage in CBO programming for multiple weeks or months, rescreening can provide valuable information about ongoing client symptoms, an additional opportunity to talk to clients about how they are doing and actions to take, and an important data point for measuring the impact of task sharing. To review the pre-implementation checklist for screening, see pg. 63 in Chapter 5.

Mental Health Strategy Descriptions · Screening continued

Additional Resources
Screening

The Agency for Healthcare Research and Quality (AHRQ) has compiled a list of validated screening tools for a variety of mental health and substance use conditions.

The National Center for Post-Traumatic Stress Disorder (NCPTSD) – an initiative of the Department of Veterans Affairs – includes information about validated screeners for trauma and PTSD.

The United States Preventive Service Task Force has established evidence-based guidelines for depression screening in adults, including links to additional resources.

The National Institute on Drug Abuse (NIDA) provides a list of common screeners for alcohol and drug abuse, as well as commonly co-occurring problems like depression.

The Center on Addiction offers a practitioner manual to implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) to screen and deliver early intervention services for risky substance use.

NCTSN's screening and assessment tools are a good resource for partnerships interested in screening for trauma and PTSD among children and adolescents.

Mental Health Strategy Descriptions · Psychoeducation

TARGET OUTCOMES

Reducing mental health stigma

Providing accurate information and resources about mental health

Strengthening an individual's ability to cope with emotional distress

Strengthening an individual's ability to manage and reduce mental health symptoms

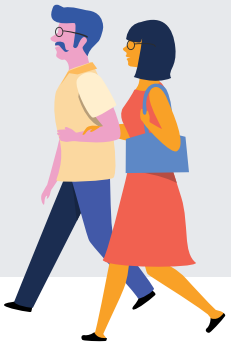
SAMPLE APPLICATIONS

Universal prevention: All clients (either across entire organization or within a particular CBO program) are provided general information about mental health conditions

Selective prevention: Clients at risk for certain conditions are provided information about that condition

Indicated prevention: Clients with identified symptoms of a specific condition are provided information about that condition

Treatment: Clients diagnosed with a specific condition receive psychoeducation to improve their ability to understand and manage that condition



Psychoeducation involves the sharing of accurate information about mental health symptoms, their origins, and options for managing them, including treatment. Psychoeducation strategies can also combine information sharing with individual or group conversations to help people manage a specific condition. For example, a structured psychoeducation program for depression may include print or digital information to help clients understand depression, as well as group sessions to help them learn and use positive thinking and problem-solving skills. Whether psychoeducation focuses on information sharing alone or information sharing combined with health promotion activities, it can significantly increase understanding of mental health and reduce feelings of isolation associated with experiencing a mental health disorder. It also creates an opportunity for individuals to consider and articulate their own mental health experiences and what mental health means to them. As a result, delivering psychoeducation at a CBO provides one meaningful opportunity for CBOs and MHPs to invite and apply community insights into defining and addressing mental health issues.

Psychoeducation can help people better understand and manage mental health symptoms, and feel less alone in the process.

Mental Health Strategy Descriptions · Psychoeducation continued

Using Psychoeducation to Address CBO Client Priorities

One C2C CBO focused on workforce services uses psychoeducation not only to normalize conversations about mental health, but also to address how the stress of finding and keeping a job relates to mental health. Through psychoeducation, CBO staff work with clients to identify and strengthen concrete strategies for managing that stress. Another C2C CBO that serves a primarily immigrant population uses psychoeducation to normalize the experience of mental health symptoms specifically related to the everyday realities of being a new immigrant. This psychoeducation also helps clients develop a culturally relevant, non-stigmatizing vocabulary to talk about mental health.

Some of the most common mental health disorders, including depression, anxiety, PTSD, and alcohol and drug use disorders, are well-suited to being addressed through a task sharing approach. Psychoeducation on some or all of these conditions provides a good starting point from which to build. We have included links to psychoeducation examples related to these conditions in the resource box on pg. 31. MHPs can help CBOs select these or other relevant psychoeducation materials to share with clients.

MHPs and CBOs should work together to develop a strategy for training staff in how and when to share that information with clients and monitor implementation of the approach. Whenever possible, we recommend psychoeducation materials be made available not just to the individual affected by the condition but also to family members and/or caregivers so that they can understand the effects of mental health symptoms, and what they can do to support their loved one(s).

Of note, some partnerships may wish to focus their psychoeducation efforts on other types of problems that may be rare in the general population but relatively common for their clients (e.g., psychosis, antisocial behavior). We do not cover such problems in depth in this guide, but task sharing has an important place in managing these as well. We encourage partnerships to consult with local (e.g., departments of mental health) and national experts (e.g., NIMH, SAMHSA, NAMI) for additional information and resources. To review the pre-implementation checklist for psychoeducation, see pg. 64 in Chapter 5.

CBOs can use psychoeducation to address a range of mental health disorders that may be relevant for their communities.

Mental Health Strategy Descriptions · Psychoeducation continued

Additional Psychoeducation Resources
Common Mental Health Problems

Anxiety and Depression
The Anxiety and Depression Association of America (ADAA) is a national organization whose website includes information and videos that explain symptoms of anxiety and depression and introduce strategies for managing such symptoms.

Generalized Anxiety Disorder: when worry gets out of control is a brochure developed by the National Institute of Mental Health (NIMH) to describe generalized anxiety disorder signs, causes, and possible treatments

The Depression Toolkit was developed at the University of Michigan, this toolkit includes sections for individuals who are experiencing symptoms of depression, strategies for managing depressive moods and staying healthy, and tips for family members and friends on how to support loved ones with depression.

Suicide
The Suicide Prevention Resource Center has materials useful for understanding and identifying suicide risk, warning signs, prevention, and intervention.

Trauma and PTSD
The National Center for PTSD, part of the Department of Veterans Affairs, provides helpful information about trauma and PTSD symptoms and treatment that is relevant for both veterans and civilians.

NIMH's handout on Post-Traumatic Stress Disorder (PTSD) describes causes of PTSD as well as symptoms and treatment options.

The National Child Traumatic Stress Network (NCTSN) website contains information about child trauma, related symptoms, and treatments and practices.

Drug and Alcohol Abuse and Dependence
The National Institute on Alcohol Abuse and Alcoholism (NIAAA) website includes information about alcohol's effects on the brain and body as well as where to find support and treatment.

The National Institute on Drug Abuse's Easy to Read Drug Facts includes a What Is an Addiction? section that describes drug addiction, risk factors, and treatment options, and includes short informational videos.

Mental Health Strategy Descriptions · Additional Common Mental Health Strategies

Task sharing often uses strategies that build and strengthen coping, communication, problem solving, and similar skills for preventing and treating mental health symptoms, as well as helping individuals achieve CBO programmatic goals. The table below provides examples of some of these types of strategies. As noted earlier in this chapter, many of the strategies below can be implemented as forms of mental health promotion, prevention, or treatment, depending on their application. All can be implemented by CBO staff with appropriate training and support. To review the pre-implementation checklist for additional common mental health strategies, see pg. 65 in Chapter 5.

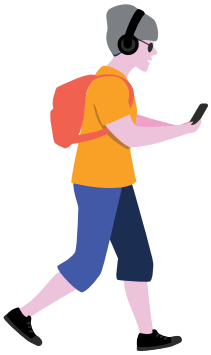
Common Mental Health Strategies for Task Sharing

Strategy + Resources	Description	Target Outcomes	Sample Applications
Behavioral activation			
Resources: a. Society of Clinical Psychology's Behavioral Activation information page. Includes training and treatment resources, including mobile apps, worksheets, and manuals. b. Lejuez CW, Hopko DR, Acierno R, Daughters SB, Pagoto, SL. Ten Year Revision of the Brief Behavioral Activation Treatment for Depression: Revised Treatment Manual. 2011. *Behav Modif;* 35: 111.	Behavioral activation aims to improve an individual's mood by encouraging them to get involved in pleasant and task-oriented activities. It is most often used to address depression or grief. The goal is to reduce depressive symptoms and increase individuals' involvement in activities that make them feel rewarded and satisfied.	Promoting engagement in CBO or MHP services Strengthening ability to cope with emotional distress Strengthening ability to manage and reduce mental health symptoms	*Selective prevention:* with clients who might be at risk for depression or are having trouble engaging in everyday activities. For example, those who have suffered loss of a loved one or experienced a stressful life event such as loss of a job or loss of housing could benefit from this strategy. *Indicated prevention:* with clients who display some symptoms of depression such as noting that they have little interest in doing things or are having trouble getting out of bed in the morning.

Mental Health Strategy Descriptions · Additional Common Mental Health Strategies continued

Common Mental Health Strategies for Task Sharing

Strategy + Resources	Description	Target Outcomes	Sample Applications
Mental Health First Aid (MHFA)			
Resources: a. Mental Health First Aid USA's listing of resources and training opportunities	Individuals attend an in-person workshop designed to equip them with knowledge and skills to identify, understand, and respond to signs of mental health and substance use problems or crises—in others and in themselves. Workshops can be offered to CBO clients, staff, and community members as a way to increase mental health literacy and reduce mental health stigma.	Reducing mental health stigma Providing accurate information and resources about mental health	*Universal prevention:* with all clients to reduce mental health stigma and increase mental health literacy.



Mental Health Strategy Descriptions · Additional Common Mental Health Strategies continued

Common Mental Health Strategies for Task Sharing

Strategy + Resources	Description	Target Outcomes	Sample Applications
Motivational Interviewing (MI)/Motivational Enhancement			
Resources: a. Motivational Interviewing Network of Trainers (MINT) guidance documents b. Rosengren DB. Building Motivational Interviewing Skills (2nd Edition): A Practitioner Workbook. 2017. Guilford Press. c. National Institute on Alcohol Abuse and Alcoholism Motivational Enhancement Therapy Manual	Motivational interviewing is a collaborative counseling strategy that uses conversation skills to help individuals commit to, carry out, and sustain positive behavior changes. MI has been demonstrated to help people make improvements across a range of health and mental health conditions, including but not limited to reducing unhealthy alcohol or drug use, engaging in treatment, and promoting physical activity. Mastery of MI requires substantial training and time commitment. Motivational Enhancement uses similar principles but refers to a narrower set of conversation skills that can be learned with less time commitment, and which are well suited to brief and focused conversations.	Promoting engagement with CBO or MHP services Strengthening ability to cope with mental distress Strengthening ability to manage and reduce mental health symptoms	*Promotion*: to create trusting relationships with people who have experienced trauma or discrimination, and promote self-determination *Indicated prevention:* clients who mention or screen positive for or display some symptoms of alcohol or drug misuse (e.g., neglecting responsibilities with family or work due to drug/alcohol use, drinking in situations that are dangerous) *Treatment and Maintenance:* to promote engagement in ongoing treatment services and healthy decision-making

Mental Health Strategy Descriptions · Additional Common Mental Health Strategies continued

Common Mental Health Strategies for Task Sharing

Strategy + Resources	Description	Target Outcomes	Sample Applications
Parent Skills Trainings			
Resources: a. National Center for Parent, Family and Community Engagement. (2015). *Compendium of parenting interventions.* Washington, D.C.: National Center on Parent, Family, and Community Engagement, Office of Head Start, U.S. Department of Health & Human Services. *(See table on pgs. 16-19 for program descriptions)* b. Examples of evidence-based programs include (but are not limited to): Triple P 123 Magic Parenting the Strong-Willed Child The Incredible Years	Wide range of programs that aims to strengthen parent-child relationships and confidence in use of effective parenting strategies. Typically involves teaching parents communication and positive parent-child interaction skills and positive reinforcement methods to improve children/adolescent's behavior and functioning.	Strengthening ability to cope with mental distress Strengthening ability to manage and reduce mental health symptoms	*Selective prevention:* to equip any client who is also a parent with important skills and to improve parent-child interactions *Indicated prevention:* with parents who have identified/been observed to have difficulty communicating and interacting with their children or for parents of children with difficult behavior.

Mental Health Strategy Descriptions · Additional Common Mental Health Strategies continued

Common Mental Health Strategies for Task Sharing

Strategy + Resources	Description	Target Outcomes	Sample Applications
Problem solving therapy			
Resources: a. Nezu AM, Nezu CM, D'Zurilla TJ. (2013). Problem-solving therapy: A treatment manual. New York: Springer. b. National Network of Problem Solving Therapy Clinicians, Trainers, and Researchers	Individuals learn how to identify problems, choose goals, and come up with and implement realistic solutions so they can effectively overcome problems. Can be used to prevent problems before they produce mental or emotional difficulty or to address existing problems such as depression, anxiety, relationship problems, and emotional distress	Strengthening ability to cope with mental distress Strengthening ability to manage and reduce mental health symptoms	*Universal prevention:* with all clients to equip them with effective problem-solving skills and potentially prevent mental health problems before they arise *Selective prevention:* with clients who are facing particularly difficult problems or life stressors *Indicated prevention:* with clients who show symptoms of a mental health problem to help them develop effective, healthy ways of coping with stressful situations or challenges
Relaxation and meditation training			
Resources: a. Helpguide.org review of relaxation exercises b. Kaiser Health review of meditation and relaxation apps	Relaxation training typically includes muscle relaxation and/or breathing exercises to reduce the effects of stress, anxiety, and tension. It is meant to improve coping skills and overall well-being. Through meditation, individuals learn techniques to improve concentration and reduce stress.	Strengthening ability to cope with mental distress Strengthening ability to manage and reduce mental health symptoms	*Universal prevention:* with all clients to help them cope with and reduce stress *Selective prevention:* with clients are facing particularly difficult problems or life stressors *Indicated prevention:* with clients who show symptoms of a mental health problem to help them develop effective, healthy ways of coping and reducing distress

Mental Health Strategy Descriptions · Additional Common Mental Health Strategies continued

Common Mental Health Strategies for Task Sharing

Strategy + Resources	Description	Target Outcomes	Sample Applications
Suicide prevention			
Resources: a. The Zero Suicide toolkit provides tools for identifying and preventing suicide risk b. The Suicide Prevention Resource Center has a comprehensive search function for finding suicide prevention programs and toolkits for different populations and settings.	Wide range of programs or interventions that aim to help individuals and communities with one or more of the following: understanding suicide, reducing stigma, recognizing suicide risk and protective factors, providing social support to vulnerable individuals, and/or connecting individuals at risk for suicide with follow-up care.	Reducing mental health stigma Providing accurate information and resources about mental health Strengthening ability to cope with mental distress	*Universal prevention:* with all clients to help them understand suicide, recognize warning signs, and know where to get help for themselves or others *Indicated prevention:* with clients who show immediate or serious risk for suicide to connect them to help immediately

C2C

Matching Mental Health Strategies to Community Priorities

Through C2C, one CBO that serves immigrants integrated problem solving therapy and psychoeducation about common mental health conditions into an existing inter-generational support group designed to help young women overcome discrimination and develop leadership skills.

A youth-serving CBO adapted an HIV prevention program where young people who provide street outreach use personal stories to engage peers in HIV prevention and treatment services. Now, outreach workers also develop and share their own personal stories of experiencing mental health conditions and taking steps to manage them, and, through Youth Mental Health First Aid (YMHFA), have the skills to support or refer peers who might disclose mental health concerns or symptoms.

Mental Health Strategy Descriptions · Additional Common Mental Health Strategies continued

Additional Resources
Common Mental Health Strategies for Task Sharing

WHO's mhGAP Intervention Guide Version 2.0 details evidence-informed interventions for prevention and management of several common mental health conditions

WHO's Problem Management Plus manual describes the use of behavioral activation, relaxation training, problem solving therapy, and strengthening social supports

SAHMSA's Evidence-Based Practice Resource Center is a clearinghouse for evidence-based tools and resources. You can search for information by topic area (including mental health) and target audience (including community organizations)

Where There is No Psychiatrist is a comprehensive implementation manual that provides a practical approach to addressing mental health in community-based settings

Center for Health Care Strategies and the Robert Wood Johnson Foundation developed Key Ingredients for Successful Trauma-Informed Care Implementation that provides a succinct description of best practices for working with individuals with trauma histories

SAHMSA has a dedicated resource page for trauma-related resources and trauma-informed approaches to social service delivery

Mental Health Strategy Descriptions · Referral to Specialized Care

TARGET OUTCOMES

Providing accurate information and resources about mental health

Promoting engagement with CBO staff

Strengthening ability to cope with mental distress and improve mental health

SAMPLE APPLICATIONS

Indicated prevention: With clients who have identified symptoms of a specific condition (often identified through screening for that condition) or who have specifically requested a referral for treatment.

Referral consists of connecting clients to licensed mental health clinicians who can formally assess a person's mental health status and, when needed, provide treatment in the form of therapy (e.g., cognitive behavioral therapy) and/or medication (e.g., antidepressants). Whenever feasible, we recommend CBOs arrange to have a clinician (from the MHP or other organization) on-site at the CBO for at least part of the week to accept referrals and ease appointment follow-through for CBO clients. C2C CBOs have found that they often identify clear episodes of mental illness or severe distress that would benefit from more formal care, but with clients who face significant barriers to accessing that care, including not knowing where to go, mistrust of clinical providers, and limited time and financial resources. C2C providers have found that making clinicians available at the CBO is a powerful way to overcome these barriers. This role could also be filled by graduate student interns from local schools of social work or counseling. If no on-site provider is available, CBOs may make referrals to a clinician at an offsite clinic or office. Referral may be to the MHP or another provider depending on client needs and preferences. Referral sources should be able to provide appropriate care that matches clients' identified needs (e.g., if a client has symptoms of alcohol misuse, the referral should provide treatment for alcohol use disorder).

C2C providers have found that making clinicians available at the CBO is a powerful way to overcome barriers to care.

Mental Health Strategy Descriptions · Referral to Specialized Care continued

C2C

Offering On-Site Referrals

A multiservice C2C CBO hired a full-time mental health clinician to provide on-site clinical care. This clinician receives supervision from a senior clinician at the MHP and, in turn, supervises five graduate student therapists who provide clients with counseling at the CBO (at no additional cost to the CBO). CBO staff who want to refer clients directly to the CBO's on-site clinician introduce clients in person, often immediately after offering a referral. This clinician assesses the individual's needs and either provides services directly, assigns the client to a graduate student therapist in training for counseling, or, if therapy is not needed at that time, refers the client to CBO staff for support and monitoring.

Every CBO and MHP can strengthen referral pathways by using a "warm handoff" approach in which the CBO staff, MHP staff, and CBO client all actively participate in the process of initiating clinical care. Warm handoffs encourage engagement and trust because a familiar CBO staff person introduces the CBO client to the mental health provider and, when sharing information about the client, does so with the client present. A warm handoff would ideally involve initiating a face-to-face connection between the CBO client and mental health provider, if time and resources allow. Warm handoffs can also be made via phone calls by CBO staff on behalf of the CBO client, as opposed to merely giving the individual contact information with which to initiate contact themselves. In a warm handoff, a CBO or MHP staff person is accountable for follow-up at every step of the referral, engagement, and treatment process. For example, with client consent, a CBO staff person directly connects with an MHP clinician to ensure the client can be seen at the clinic before making a referral. The MHP reaches out to the client if they miss an appointment, or, with consent, notifies the CBO so it can perform outreach and follow-up, too. This type of warm handoff referral promotes successful engagement between the client and the provider, whether that provider is located down the hall or across town. Warm handoffs are most effective when they can happen immediately when someone wants or needs a referral, or as soon after as possible.

Warm handoffs encourage engagement and trust.

Mental Health Strategy Descriptions · Referral to Specialized Care continued

Improving External Referral Pathways with Warm Handoffs

One C2C CBO that provides families with emergency shelter could not offer clinical care to clients on-site. The CBO's MHP partner helped the CBO develop and implement a warm handoff protocol to improve engagement in clinical care at the MHP's off-site clinic. As part of this protocol, CBO staff offer to complete an MHP phone screening with clients, who can then visit the MHP during flexible drop-in hours. The CBO also offers transportation assistance for clients traveling to the MHP. With client consent, the MHP notifies the CBO when clients do or do not complete a referral, so the CBO can provide continued support and follow-up.

In addition to a warm hand-off, CBOs and MHPs can take steps to make the referral process more seamless and increase the likelihood of client follow-through. For example, the client may be able to fill out MHP intake forms on-site at the CBO, and CBO staff can then facilitate the secure transmittal of this information to the MHP. CBO staff can also help clients prepare copies of whatever documents will be needed at the MHP, so clients arrive at the MHP with everything they need. In some cases, CBO clients may not be ready to accept a referral at first. We recommend partnerships continue to support clients who initially decline or are unable to complete a referral, including by having ongoing conversations about clients' understanding of their needs and proposed solutions, and by leaving the door open to revisiting the referral offer at a later date.

Gathering information for referral

As part of the referral-making process, **we recommend CBO staff ask clients about current and previous involvement in mental health services as well as current medication use** for a mental health issue. Knowing a client's past experiences with mental health services can help staff offer the most appropriate referral (e.g., if a client had a previous negative experience with a particular provider organization, CBO staff can avoid referrals to that organization). We would not expect CBO staff to make judgments about the appropriateness of client medications, but gathering this information and sharing it with the referral source (if the client consents) allows the mental health provider to have more informed conversations with the CBO client about what treatment(s) might be most appropriate. For more information on safely sharing client information, including information about medications and engagement in mental health treatment, see the additional resources box on pg. 20.

To review the pre-implementation checklist for referrals, see pg. 66 in Chapter 5.

We recommend partnerships continue to support clients who initially decline or are unable to complete a referral.

Chapter 4

Setting Up Implementation Support

In this chapter we describe the implementation support structures and expertise that can be crucial for establishing and monitoring high quality task sharing: supportive organizational environments; foundational training and ongoing supervision; care coordination; crisis management protocols; and ongoing management and adaptation. These supports help CBOs and MHPs ensure that task sharing implementation goes as planned and has the intended effects, and that staff communicate effectively and feel adequately supported in their new roles.

Supportive Organizational Environments

Creating a climate that leads to effective task sharing requires a collective effort at multiple layers within an organization and a strong commitment from leadership. Most organizations will find they need to make changes to policies and practices to align with task sharing values. Below, we recommend actions CBO leaders can take – in close collaboration with MHPs – to create organizational environments that support CBO staff in learning and using new skills successfully.

Consistently reinforce the value of task sharing and new skills. CBO leaders can convey the importance of task sharing by having program leaders and/or senior team members complete foundational trainings in mental health strategies along with CBO staff. Leaders can then relate the use of new skills to organizational mission and program-specific goals. They can also assess the alignment between the new skills and other organizational norms or mandates and reconcile conflicts. Finally, organizational leaders can incorporate key principles and skills of mental health task sharing into organization-wide policies, routine meetings, and/or service delivery practices (e.g., establishing regular times for staff self-care activities, incorporating mental health well-being into all lines of service delivery, funding on-site mental health support for clients and staff).

Most organizations will find they need to make changes to policies and practices to align with task sharing values.

Creating a Supportive Culture

At a CBO that provides workforce services, a client expressed extreme anger toward staff. Before C2C, the CBO would have responded by discharging this client. As a CBO leader put it, "The message would have been, 'we don't think you're ready [for our services] now, but we invite you to come back when you are.'" Through C2C, though, staff have been equipped to diffuse anger and open productive conversations with clients. In this case, staff learned that the client was grieving the recent loss of his wife, and they made a same-day referral to an MHP clinician working on-site at the CBO. Now, the CBO is revising its policies and practices to shift away from a focus on discipline and toward a culture of engagement. One CBO staff member described this culture change as, "Now, we attend to the whole person."

Supportive Organizational Environments

continued

Ensure access to training and ongoing coaching and supervision in new mental health skills. To ensure high quality implementation, CBO leadership must protect staff time for initial and refresher trainings, as well as routine, ongoing supportive coaching and supervision (hereafter referred to simply as supervision; see next section) to grow and strengthen CBO staff skills. CBO leaders can designate these activities as high priority and make every attempt to guard against competing demands or interruptions.

Establish and share clear, realistic expectations. We recommend CBOs and MHPs adjust job descriptions and performance targets to reflect capabilities and activities related to delivering mental health strategies, and to make sure staff understand these new performance goals. We also recommend updating new job postings to include relevant task sharing responsibilities and skills. Organizations may need to update training processes for new hires, ensuring all receive some introduction to task sharing. Staff who will be directly involved in the delivery of mental health strategies should receive specific training in these strategies shortly after being hired.

Invite feedback and make improvements. We recommend building in routine mechanisms for asking staff, managers, and trainers and supervisors what works and what remains challenging, and then using this feedback to address concerns and make improvements (for more on quality improvement, see pg. 57).

To review the pre-implementation checklist for supportive organizational environments, see pg. 67 in Chapter 5.

Protect staff time for initial and refresher trainings, as well as routine, ongoing supportive coaching and supervision.

C2C

Leadership Matters in Building Staff Buy-In

One C2C CBO knew that implementing new skills would take time, effort, and buy-in from CBO staff who would be asked to use new strategies in their everyday tasks. Some staff questioned whether the CBO was the right place to address mental health; others worried taking on new strategies would further complicate their efforts to address clients' already complex problems. The CBO's executive director knew that making an institutional commitment would motivate her team to work through implementation challenges. To support staff, the CBO hired a designated Mental Health Counseling Program Coordinator, who served as a resource for staff across programs. Staff buy-in grew stronger when they began using new skills and saw a reduction in client outbursts, dropouts, and other negative incidents, both in the classroom and throughout the organization. Now, conversations about how mental health affect CBO staff and clients are part of the everyday work of this CBO.

Foundational Training and Ongoing Supervision

Together, foundational training and ongoing supervision form a cohesive learning strategy to help CBO staff develop the knowledge, confidence, skills, and good judgment they need to apply new mental health strategies effectively. Foundational training includes initial and refresher trainings designed to expose CBO staff to new knowledge, ideas, and behaviors. However, training alone cannot ensure CBO staff reach or maintain the skills needed to achieve positive outcomes. Ongoing supervision provides CBO staff with expert guidance, emotional support, and structured opportunities to try out and sharpen their skills and judgment. This type of supervision mirrors the support and coaching provided to mental health clinicians during their training and should **not** be confused with job performance or accountability monitoring, or other types of administrative supervision. In fact, we strongly recommend separating supervision sessions for task sharing skills from administrative supervision, to give CBO staff the freedom to engage in questioning, try out new skills and make mistakes, accept and process supportive feedback that can improve their skills, and reflect candidly on their experiences of using new skills with CBO clients.

Later in this chapter, we introduce Worksheet 6: Assign Roles and Design Workflows, which includes space to document training and supervision decisions, including who will provide training and supervision, and how, when, and where both will be delivered. To inform those decisions, we recommend several actions below, all based on best practices in training and supervision for mental health skills. We also recommend consulting relevant literature, practice guides, and/or subject matter experts to determine the specific content and duration of training and supervision, which will vary according to the skill being learned. At minimum, we believe supervision should begin within one month of initial training and occur for at least two hours per month in the following six months. After this initial period, CBOs and MHPs can work together to determine what level of ongoing support is needed.

Ongoing supervision provides CBO staff with expert guidance, emotional support, and structured opportunities to try out and sharpen their skills and judgment.

Foundational Training and Ongoing Supervision continued

Supervision Recommendations

Establish appropriate expert oversight. Designate one or more expert CBO or MHP staff to oversee the design, implementation, and ongoing improvement of training and supervision. At a minimum, these experts should demonstrate mastery in the relevant strategies being taught and should have demonstrated success achieving positive training or supervision outcomes. They can also help design a strategy for monitoring training and supervision quality and effectiveness. This strategy should include ways to ensure consistency across trainers and supervisors, so CBO staff receive training and supervision of similar depth and quality, regardless of who provides it. It should also include regular solicitation of input from CBO staff and clients to adapt training and supervision strategies as needed and regular review of task sharing quality monitoring results (see pg. 57 for more on quality monitoring strategies).

Select qualified trainers and supervisors. Training and supervision are specialized skills. We recommend individuals selected for these roles:

- Demonstrate high levels of proficiency in the strategies they are helping others learn.
- Be trained in specific techniques to help adult learners master new skills.
- Be knowledgeable in and apply current evidence-based best-practices of effective training or supervision.

In cases where neither the CBO nor MHP has the resources to provide training and supervision in a particular skill, they may choose to work with an external consultant or technical assistance provider. In such cases, CBO and MHP staff may develop new mental health skills at the same time. Partnerships may also choose to implement peer-led supervision sessions as an alternative or complement to supervisor-led sessions. We recommend that a training and supervision expert assist the peer group in developing structured group learning processes, monitoring the effectiveness of supervision, and troubleshooting supervision challenges or complex cases.

CBOs and MHPs can also consider developing new trainers or supervisors within the CBO or MHP. We recommend that CBOs and MHPs notice staff who are energized about using new mental health skills and who demonstrate high skill levels. With specialized training and support from an experienced trainer or supervisor, these staff – from either the CBO or the MHP – may be well positioned to take on new roles as trainers or supervisors, enhancing the reach and sustainability of training and ongoing supervision activities for task sharing.

Experiential Learning for Skill Building

One C2C MHP found that shadowing helped build CBO staff confidence and skills. The on-site MHP clinician would shadow CBO staff to learn about their jobs and the expertise they already have, and CBO staff would shadow the MHP clinician to see how she applied mental health skills. The clinician continued shadowing CBO staff as they began using their new skills, so she could provide real-time, supportive feedback and step in if CBO staff needed her help. The MHP clinician observed that shadowing opened her eyes to the complex challenges that CBO staff and clients encountered every day. It also helped her build rapport with CBO staff which in turn encouraged them to take risks in trying out their new skills.

Foundational Training and Ongoing Supervision continued

Focus training and supervision activities on strengthening and maintaining skills, including significant opportunities for experiential learning (i.e., "learning by doing"). We recommend that initial training sessions dedicate at least 50% time to experiential learning activities, and that the proportion of time devoted to experiential learning in ongoing supervision sessions be increased over time. Skill-focused training and supervision also includes incremental learning goals to build confidence and provide frequent opportunities for supportive, accurate progress checks. We recommend that trainers and supervisors structure feedback sessions as a collaborative activity, where CBO staff self-reflect on learning progress and both learners and supervisors have valuable perspectives to offer.

Adapt training and supervision activities to the CBO setting. By becoming familiar with the CBO mission, services, workflows, and staff roles, trainers and supervisors can adapt activities to better fit the CBO setting. This adaptation may include integrating terms and phrases relevant to CBO staff and clients and using CBO case examples and real plays (i.e., working through a real problem CBO staff have encountered). Adaptation also allows trainers and supervisors to build on the existing knowledge and expertise of CBO staff and help them connect new skills to their professional roles, the priorities and needs of CBO clients, and the goals of their program or organization. As with any new practice, CBOs and MHPs may want to consider testing adaptations by piloting new training or supervision strategies at a small scale before spreading within the organization (e.g., starting in a program or unit where there is high buy-in, or where there is a particularly good fit between the new skills and programmatic needs).

Incorporate fidelity monitoring and decision supports into ongoing supervision. Fidelity monitoring includes tools or processes to monitor skill levels across CBO staff. It allows supervisors to:

- Use a consistent set of standards when assessing skills
- Help learners identify the strengths in their practice
- Help learners identify specific areas for improvement and concrete strategies to improve their skills

Fidelity monitoring may take a range of formats, such as:

- Verbal or written prompts that supervisors use to guide CBO staff in reflecting on how they would use specific skills in a particular situation
- Feedback from the supervisor based on direct observation of CBO staff using new skills
- Use of a validated coding tool to identify strengths and areas for improvement in an audio recording of a CBO staff member applying their skills

Supervision Helps CBO Staff Manage the Emotional Demands of Their Work

Some C2C CBOs routinely witness violence, family separations, and other traumas in their work. Ongoing coaching and supervision can play a critical role in supporting CBO staff as they encounter and help their communities address extreme hardships. At one CBO, staff who work with young people experiencing homelessness described how ongoing supervision in Motivational Interviewing helped them redefine success and manage their emotional reactions to seeing young people suffer. As one staff member put it, "We used to say, 'we need to save them.' Now I know I can't save people, but I can effectively engage people who have already experienced a lot of let down and betrayal and help them find their own motivation and strength. I no longer have the same fear of failure."

Foundational Training and Ongoing Supervision continued

In addition to fidelity monitoring, decision supports help CBO staff develop the judgment and skills to effectively respond to specific situations. Such supports may include:

- Access to real-time consultation with a supervisor when challenging situations arise
- Shadowing strategies, where CBO staff can first observe an expert implementing a skill, and be accompanied by an expert when they begin implementing it themselves
- Written protocols that help staff understand what to do and when, and that provide guidance for selecting best next steps when there are multiple options
- Automated prompts or reminders in electronic data systems to help CBO staff follow protocols, apply best practices, or follow up based on client needs

Support staff to manage the emotional demands of the work. Trainers and supervisors can play an important role in providing CBO staff with strategies to manage the emotional impacts of their work. This includes, but is not limited to, addressing fears or concerns related to implementing new mental health skills or having conversations with clients about specific mental health symptoms. CBO leaders can also promote CBO staff well-being by providing access to wellness activities (e.g., mindfulness, yoga, running groups, or other peer-led activities), flexible work schedules, or improved mental health insurance benefits.

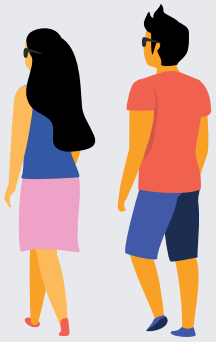
Though this guide focuses specifically on training and supervision to help CBO staff build mental health skills, we recognize that important opportunities exist for CBOs to be the expert in training and capacity building for MHPs. We encourage CBO-MHP partners to explore such opportunities for mutual learning and organizational strengthening.

To review the pre-implementation checklist for foundational trainings and ongoing supervision, see pg. 68 in Chapter 5.

C2C

Emotional Support for Staff

Beyond routine coaching and supervision, C2C MHPs also offer ad hoc support in difficult and stressful situations. One C2C MHP introduced training for CBO staff in how to manage grief and loss after a tragic client death. Another C2C MHP facilitated listening circles for staff and clients at a CBO serving immigrants after they learned of extreme violence in their home country.



Foundational Training and Ongoing Supervision continued

Additional Resources
Training and Supervision

National Implementation Resource Network has compiled a coaching practices profile that synthesizes research on supervision and coaching best practices to guide development of training supports and infrastructure for effective and efficient supervision.

Zero to Three, a non-profit focused on early development and well-being, has developed a helpful description of reflective supervision principles and links to additional resources.

The World Health Organization has a series of training manuals including train-the-trainer and supervisor training manuals designed to build mental health service delivery capacity among non-specialist providers in low-resource settings.

Care Coordination

Care coordination entails regular communication and information exchange among a multi-disciplinary team of CBO and MHP staff. When managed effectively, care coordination can:

- Improve access to appropriate mental health care (e.g., by determining the mental health strategies being delivered at the CBO, the treatment choices being offered by the MHP, and the effect of these on desired outcomes for individual clients)
- Make navigation of the health care system easier (e.g., by discussing improvements to MHP referral procedures)
- Address CBO and MHP staff needs (e.g., by reviewing training and supervision strategies, discussing what works, and updating as needed)
- Promote shared responsibility for the overall success of the task sharing approach

The specific content and frequency of care coordination meetings will likely evolve over time. We recommend meeting at least monthly as task sharing is launched, although many CBO-MHP partnerships may find the need for even more frequent meetings at first. CBOs and MHPs may also wish to set up different kinds of care coordination meetings with different attendees. For example, some care coordination meetings can be used to discuss individual client cases, whereas others may include broader discussions about task sharing implementation, what is working well, and what needs improvement. We recommend CBOs and MHPs also meet regularly to review data related to task sharing implementation and outcomes (for more, see tracking implementation processes and outcomes on pg. 56). In addition to regularly scheduled meetings, CBOs and MHPs should set up mechanisms and points of contact to facilitate ad hoc communication for urgent matters, as needed.

To review the pre-implementation checklist for care coordination, see pg. 70 in Chapter 5.

Care coordination brings together CBOs and MHPs to improve experiences and outcomes for CBO clients.

Using Multiple Perspectives to Better Coordinate Care

A C2C CBO that provides early childhood education services began holding weekly care coordination meetings between CBO family workers and MHP clinicians to better coordinate services. CBO staff reported being initially intimidated by the clinical language that MHP staff used in these meetings. Recognizing this, the C2C program manager structured the meetings so that both family workers and clinicians were invited to contribute. Family workers shared their insight into clients' self-reported priorities and life experiences, and how clinicians could improve engagement strategies. Clinicians shared their perspectives on how to recognize mental health issues and specific strategies for supporting clients experiencing these issues. A CBO leader commented, "I believe the family workers' feelings of self-worth and confidence in their knowledge and skills have improved as a result of these meetings."

Crisis Management

Any CBO implementing a task sharing approach will need to develop or update its existing protocols for crisis management. As part of talking about mental health conditions and symptoms, CBO clients may share thoughts of self-harm or suicide or experience a crisis reaction. CBOs should be prepared for these kinds of emergencies and have a plan in place to address them. Effective responses to mental health crises can improve an individual's recovery experience, and even decrease the potential for future crisis situations. For CBOs that choose to implement screening, crisis management should be integrated into the screening protocols and follow-up guidance (for more on developing screening and other implementation protocols, see pg. 56).

Crisis management protocols provide explicit guidance for CBO staff members. They describe how to:

- Evaluate the severity of the crisis (e.g., potential for immediate harm to the individual or others)
- Provide support and reassurance to the person in crisis
- Determine appropriate next steps (e.g., enlisting immediate support from friends or family, immediate referral and connection to clinical care)
- Follow up with the individual and staff involved in the incident to process the situation and explore options for dealing with similar situations in the future

MHPs can provide guidance on and resources for each of these steps. We also recommend CBOs have a designated contact at the MHP who can be reached at any time for consultation on mental health crises.

In addition to emergency MHP contacts, we recommend CBO staff have these crisis lines readily available:

Suicide Prevention Lifeline: 1-800-273-8255

Suicide Prevention Lifeline chat: https://suicidepreventionlifeline.org/chat/

National Domestic Violence Hotline: 1-800-799-7233

Organizations may also want to provide CBO staff with local crisis resources. For example, New York City residents can connect to free, confidential mental health support through the local crisis line NYC Well (1-888-NYC-WELL).

To review the pre-implementation checklist for crisis management, see pg. 71 in Chapter 5.

Responding to Potential Crises More Effectively

At one C2C CBO, a case manager who provides workforce and education services noticed that a young person had stopped attending his internship program. The young person's mother had expressed concern that her son was spending his days in bed. In group-based supervision, the case manager, his peers, and the clinician facilitating the group discussed the young person's symptoms, which could indicate a mental illness, and strategized around how to reach out to him. When the case manager next spoke with the young person, he described thoughts of self-harm. The case manager used the new counseling skills to keep the young person engaged, develop a safety plan, and connect him to an MHP clinician on-site at the CBO. The clinician assessed the young person and successfully connected him to more specialized outpatient clinical care in the community.

Crisis Management continued

Additional Resources
Crisis Management

The National Alliance on Mental Illness (NAMI) published Navigating a Mental Health Crisis, a resource guide for how to deal with mental health emergencies.

The Substance Abuse and Mental Health Services Administration (SAMHSA) hosts the Suicide Prevention Resource Center, a comprehensive resource for effective prevention efforts.

The Suicide Prevention Resource Center developed a guide for creating crisis protocols that could be adapted to the CBO setting.

Management and Adaptation

Preparing for implementation of task sharing involves assigning roles and workflows, creating protocols, and setting up structures to monitor and adapt the selected approach. In the sections below we provide guidance for each of these activities.

C2C providers have identified the key roles listed below as helpful for implementing and managing a task sharing initiative. The amount of time each of these roles will need to dedicate to task sharing will depend on the size of the CBO and the scope of task sharing activities.

Key Management Roles for Implementing Task Sharing

CBO Roles

Experienced manager to oversee and coordinate task sharing implementation

Senior team member to support the manager, facilitate program design decisions and organizational change, and provide overall project oversight

Staff support with data collection and reporting

MHP Roles

Experienced clinician to oversee and coordinate task sharing implementation and supervise interns, if applicable

One or more clinicians to receive referrals from the CBO and/or provide clinical care on-site at the CBO (can be the same clinician mentioned above)

Senior clinician to support the experienced clinician and the CBO in design and implementation decisions and provide overall project oversight

Staff support with data collection and reporting, as applicable

Management and Adaptation continued

Assigning Roles and Workflows

Developing workflows for implementation involves deciding which CBO staff will deliver mental health strategies, and therefore receive training and supervision; who will provide training and supervision; and which strategies will be offered to clients. Combined, these decisions can be used to create an initial workflow for the task sharing approach. Sharing workflows with CBO and MHP staff reduces uncertainty about roles, ensures a systematic approach, and helps to maximize the reach of selected mental health strategies. During workflow creation and role selection, consider:

- How to capitalize on the strengths and expertise of different types of staff to support implementation, training, and supervision
- Which CBO and MHP staff can participate, given current workloads (and what changes might need to be made to accommodate new work)
- How to involve CBO and MHP staff involvement in the decision-making process
- What current CBO client flow looks like, and how that might change
- How to integrate supervision and support

Worksheet 6 walks through specific questions related to each of the bulleted points above and provides a structure to help assign and document roles and workflows. We recommend that the CBO and MHP staff who will be responsible for task sharing coordination at each organization fill out this worksheet together.

Sharing workflows with CBO and MHP staff reduces uncertainty about roles, ensures a systematic approach, and helps to maximize the reach of selected mental health strategies.

Adapting Staff Roles

For one C2C CBO, many clients disclosed experiences of sexual and domestic violence to CBO staff. The CBO saw this as an opportunity to implement a psychoeducation curriculum to promote safety and healing for survivors of sexual violence. In deciding when and where to integrate this curriculum into its services, the CBO considered which staff already had strong engagement and facilitation skills, and where staff had frequent opportunities for ongoing, meaningful conversations with clients. The CBO decided to train teachers of its English as a Second Language (ESL) classes to implement the psychoeducation. The CBO helped teachers grow into this role by pairing them with a CBO social worker, who co-facilitated initial sessions and provided weekly coaching and supervision. When piloting psycho-education, the CBO noticed that the curriculum sometimes naturally led to conversations about mental health symptoms, which prompted the CBO to adapt its workflow to add screening at set points in the ESL program.

Management and Adaptation continued

Revisiting Roles and Workflows

We recommend regularly revisiting CBO and MHP staff roles throughout the course of task sharing implementation. Implementation might start with a small cadre of CBO staff that may be expanded over time as resources and staff skills increase. CBO staff may take on additional roles (e.g., as trainers or supervisors) as they demonstrate competency in their originally assigned set of tasks. Similarly, initial workflows may not prove ideal for service delivery. For example, workflows may have client screenings occurring during CBO program enrollment, but a CBO may find that individuals need more time to feel comfortable sharing sensitive information with CBO staff. Soliciting feedback from staff and clients can help make these kinds of adjustments.

Creating Implementation Protocols

After making decisions about training, supervision, and service delivery, consider documenting these decisions into written implementation protocols. These protocols can be used along with decision supports (see pg. 48) to help staff understand what to do, when, and provide guidance to staff for selecting best next steps. When followed as intended, implementation protocols help ensure reliable, consistent implementation of selected strategies and workflows. Below we provide examples of suggested information for implementation protocols for a sampling of strategies:

Screening: when to offer and to whom, process for introducing initial and follow-up screens, process for conducting initial and follow-up screens, how to score and interpret results, how to share results back with clients, how to share results with the clinical provider (for a referral), and how to securely document and store results.

Referral pathways: when/under what circumstances to offer, who should offer, how to decide where to refer, step-by-step process for connecting client to referred provider, process for documenting referrals and following up afterward.

Crisis management: how to recognize a crisis or emergency, who CBO staff should notify for help or consultation, when they should do so, what supports are available in aftermath of a crisis, how and when staff will debrief emergencies and difficult situations.

Expanding CBO and MHP Capabilities

One C2C MHP adjusted the referral protocol it developed with its CBO partner based on the progress CBO staff were making in learning and using new mental health skills. “In just one year, we saw significant changes in what CBO staff are capable of doing. Now, we can confidently refer people who are experiencing mild or moderate mental health symptoms to a CBO staff person, who we know can deliver evidence-based support with monitoring and coaching. And we save our clinicians’ time for people with more serious mental health needs.”

Management and Adaptation continued

Tracking Implementation Processes and Outcomes

Successful management of task sharing involves consistently documenting and reviewing a set of data points, or indicators. Indicators help gauge progress on implementation and the impact of task sharing strategies. We recommend tracking a combination of indicators:

Process indicators measure activities completed and quality of implementation

Short-term outcome indicators measure client and staff knowledge, attitudes, and skills related to individual client well-being

Long-term outcome indicators measure client well-being

For each indicator, CBO-MHP partnerships will also want to establish targets or goals and measure progress against those targets. Selecting indicators early—before actual task sharing implementation begins—allows CBOs and MHPs to (1) update current data tracking/data management systems to incorporate new data points; (2) provide clear guidance to staff on data collection processes; and (3) track changes over time.

Worksheet 7: Select Indicators and Targets is designed to help CBOs and MHPs select and record indicators for monitoring task sharing. It also includes task sharing specific examples of process, short-term outcome, and long-term outcome indicators and targets. We recommend task sharing coordinators at both the CBO and MHP work together and with their respective data managers to fill out Worksheet 7. CBO and MHP organizational leadership may also have input on what task sharing outcomes need to be tracked.

In selecting indicators and targets, it may be helpful for CBO-MHP partners to sketch out a logic model for their task sharing approach. A logic model creates a visual representation of how task sharing is supposed to work by describing the activities to be implemented and their intended effects. Logic models also provide a coherent picture of how all the individual pieces of an approach fit together and contribute toward larger goals. Information from completed Worksheets 4-6 can be used to develop a logic model. Additional resources for developing a logic model are included in the box below; the logic model for the C2C program is also included in Appendix E.

CBOs and MHPs need data on the activities they complete and the impacts they have to learn from, improve, and document the value of task sharing.

Additional Resources
Selecting Indicators and Targets

Centers for Disease Control and Prevention's Office of Performance Evaluation has developed multiple resources related to indicator development and program monitoring.

The United States Agency for International Development's (USAID) Knowledge for Health (K4Health) project has a how-to guide with step by step instructions for creating indicators and using them as part of program monitoring and evaluation. It also includes links for developing a logic model.

The Community Tool Box has a comprehensive guide for developing a logic model that can be accessed here.

Management and Adaptation continued

Continuous Quality Monitoring and Improvement

The process of systematically documenting data, using it to understand impact and outcomes, implementing changes to improve those outcomes, and tracking results is referred to as continuous quality improvement (CQI). CQI uses simple methods to test adjustments or innovations to the work to see if they improve things or help reach goals better. Incorporating CQI activities into the routine flow of task sharing work can also demonstrate to staff and clients that they play an important role in identifying and overcoming barriers to improved mental health. Adopting a CQI approach to task sharing implementation means regularly assessing processes and activities to answer these key questions:

- To what extent are task sharing strategies being carrying out as planned (including both delivery of mental health strategies and training/supervision support)?
- What is working well?
- What barriers are in the way of task sharing goals?
- What activities have been attempted to overcome barriers, and have they worked?
- To what extent is the chosen approach having the intended effect on CBO clients?
- What additional resources or changes are needed to continue to improve individual mental health and programmatic outcomes?

To answer these questions, we recommend regularly reviewing process and outcome indicators, described above; revisiting information from training and supervision (e.g., fidelity monitoring); and soliciting regular feedback from CBO clients and CBO and MHP staff. CBOs can collect client feedback through short surveys given to individuals as they exit CBO programming or at the end of workshops or other activities. Such feedback can also be gathered through focus groups or individual conversations. Staff feedback can be collected similarly through conversations or in written form; it can also be incorporated into supervision sessions or staff meetings or approached as a stand-alone activity. One way to get staff buy in and simultaneously collect feedback is to share results from quality monitoring and ask staff to share their reactions and provide suggestions for improvements.

To review the pre-implementation checklist for management and adaptation, see pg. 72 in Chapter 5.

Using CQI to Improve Client Engagement in Care

A CBO focused on job readiness and placement for formerly incarcerated people found that less than half of its clients who completed an initial referral to the on-site MHP ended up attending their second appointment. The CBO tested two changes aimed at improving follow-up rates. It reconfigured scheduling so that a client's MHP appointment would fall on the same day they were already on-site at the CBO for a job training session. It also provided a short training and resource guide to help its Job Coaches and Job Development staff apply best practices in engagement and referral. As a result, 90% of targeted participants accepted and participated in a second MHP session on-site at the CBO after their initial meeting with the clinician.

Management and Adaptation continued

Additional Resources
Quality Improvement

National Implementation Research Network's Active Implementation Hub (AI Hub) is a learning environment for practitioners, coaches, and trainers and Includes web-based tools on using data to inform program decisions and how to implement a quality improvement approach, among others.

Promoting Success: Getting to Outcomes Guide to Implementing Continuous Quality Improvement for Community Service Organizations offers practical steps for conducting CQI in community service organizations (CSOs) and provides tools that are of specific relevance to CSOs.

The Agency for Healthcare Research and Quality (AHRQ) has developed directions, examples, and worksheets for how to implement the Plan-Do-Study-Act (PDSA) approach to quality improvement.

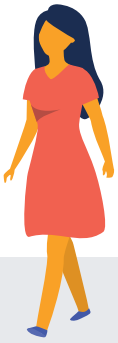
Additional Considerations

Identifying capacity-building needs and resources. Many of the resources needed for implementing task sharing will be found at either the CBO or MHP. However, CBOs and MHPs may need additional technical assistance or training to build their capacity, whether in the delivery of a specific mental health strategy or more broadly on topics such as managing organizational change or assessing implementation effectiveness. Worksheet 8: Identify Capacity Building Needs and Resources includes several questions to help organizations think through what additional support may be needed, as well as space to document what resources can be made available to meet those needs. We recommend task sharing coordinators at both the CBO and MHP work together with organizational leadership to fill out Worksheet 8.

Cost considerations. As with any new program or initiative, overall costs of task sharing require using a mix of current resources and funding new expenses. For example, some amount of current staff time will need to be reallocated at the CBO and MHP to take on task sharing roles. Potential new costs might include funding for an on-site clinician at the CBO, external trainings, part or all of a staff position to manage and monitor task sharing, and/or make database improvements. Each partnership's costs will be different depending on the scope of task sharing and how current staff resources can be reallocated. The additional resources box for cost includes tools to help CBOs and MHPs begin to estimate these expenses.

Some cost and sustainability considerations for task sharing are unique. For example, unlike some programs a CBO might implement, task sharing requires continual training and supervision to grow CBO staff skills in delivery of mental health strategies and make adaptations/ implement new strategies to better meet CBO client needs. One potential way to address the continual cost of training and supervision is to build in a training of trainers (ToT) model in which one or more CBO staff acquire the skills necessary to train and/or supervise fellow CBO staff in task sharing strategies. While the MHP will likely always be needed in some expert advisor capacity, a ToT model can offset some of the cost and provides an opportunity for professional development for CBO staff.

CBOs and MHPs may need additional technical assistance or training to build their capacity for task sharing.



Leveraging CBO Trainers and Supervisors

Beyond providing training and ongoing supervision to CBO staff, MHPs can help CBOs develop their own training and supervision capabilities. One C2C CBO/MHP partnership noticed that some CBO staff were energized about learning Motivational Interviewing (MI) and were demonstrating high skill levels. The CBO and MHP invested time and resources in supporting these CBO staff to complete specialized training so that they could deliver MI training and supervision. Now, the CBO has two dedicated MI trainers who not only quickly train new staff, but who have also extended training to neighboring community organizations the CBO often refers clients to. Additional CBO staff provide ongoing MI supervision, allowing the CBO to promote continued, high quality MI delivery.

Additional Considerations continued

Task sharing provides other unique opportunities to leverage CBO staff resources. For example, if a CBO already has a licensed clinical social worker (LCSW) on staff, it may consider partnering with a local college or university to host social work interns. The LCSW can supervise the interns, who in turn, provide free or low-cost counseling to clients. CBOs can also explore participation in innovative payment models (e.g., value-based payment) to offset costs. Under these types of arrangements, CBOs typically partner with a health care system to provide certain services and receive payment in return. For example, a local health care system may determine that many of the individuals who frequently use expensive emergency department (ED) services also experience depression or PTSD. In order to reduce costs associated with ED use, they may be interested in partnering with a local CBO that is perceived as a trusted and safe place to talk about these mental health issues, offering payment to a CBO-MHP partnership that can document improved mental health outcomes for their shared client/patient population.

No matter the funding source being pursued, we recommend CBOs and MHPs create a value proposition for task sharing that can be used to solicit funding. A value proposition answers the question of "why" funders should support your efforts. As task sharing implementers are first securing funds for implementation, the "why" may be aspirational. But with time, data from implementation efforts can be used to demonstrate how task sharing affects both staff and clients. A task sharing value proposition may incorporate some or all of the following domains: increased access to care, reduced burden of mental disorders in the community, improved social determinants of health (e.g., education attainment, housing, job placement, economic stability), and return on investment/potential for cost savings. The box below contains additional resources for estimating task sharing costs, creating a value proposition, and understanding value-based payment arrangements.

A value proposition answers the question of "why" funders should support your efforts.

Additional Resources
Cost

Center for Health Care Strategies has an Excel-based tool for CBOs and health care organizations to estimate their total cost of partnering on an initiative.

The AIMS Center at the University of Washington created the Financial Modeling Workbook to help organizations understand costs and revenues associated with integrating mental health strategies into other forms of service delivery. Although originally designed for organizations providing primary health care, the Workbook can also help CBOs accurately estimate revenues and expenses for providing integrated mental health services.

The Center for Health Care Strategies authored a fact sheet on how CBOs and health care organizations can partner to improve individual outcomes, including lessons learned from four specific initiatives. They also developed a Value Proposition Tool to help CBOs articulate the value that they can provide to health care organizations.

Additional Considerations continued

Weaving Task Sharing into the Fabric of CBO Work

One organizational leader at a C2C CBO reflected on the benefits she has seen from the time and energy spent building the infrastructure and capacity to integrate C2C into the CBO. This meant updating data systems, implementing new coaching and supervision structures, figuring out how to strengthen referral pathways, and integrating psychoeducation into the CBO's everyday work. She described that the benefits include "more informed and capable CBO staff who demonstrate improved ability to communicate with parents and caregivers, address crises, recognize potential mental health signs and symptoms, and use helpful language when talking about mental health. You will no longer hear staff say, 'This person is crazy.'" She also observed that staff are more open to discussing their own mental health and use C2C coaching and supervision to reflect on how their emotional reactions to a situation can impact the work they do. She noted, "Using C2C skills has become so much a part of the way we work now that we can't imagine going back to the way it was before."

Chapter 5

Checking Implementation Readiness

The previous chapters of this guide describe how to design a successful task sharing approach. In this chapter, we summarize key components from those chapters into a series of pre-implementation checklists. These lists are meant to serve as a way to verify that the task sharing approach CBO-MHP partners have designed has the content and structures in place to achieve desired outcomes.

The checklists are organized according to the following structure:

Services

- Screening
- Psychoeducation
- Common Mental Health Strategies
- Referral

Implementation Support

- Supportive Organizational Environments
- Foundational Training and Ongoing Supervision
- Care Coordination
- Crisis Management
- Management and Adaptation

The checklists are meant to be a quick reference that can be consulted during preparation for launching task sharing implementation. They summarize both the required and recommended components of each of the activities bulleted in the list above.

Content from the checklists is also repeated in the Task Sharing Assessment Tool that accompanies this guide (explained in more detail in Chapter 6), which can be used for ongoing assessment of efforts once implementation is underway.

Services · Screening Checklist

For each of the strategies CBOs and MHPs will use in task sharing, we recommend consulting the corresponding checklist prior to beginning implementation. We recognize not all partnerships will implement all the strategies listed here. CBOs and MHPs need only use those that are relevant to their approach. CBOs and MHPs can place a check next to each component (in black bold text) to indicate whether it is in place/completed. If one of the required components is NOT in place, we recommend revisiting guidance in Chapter 3 for this component and delaying implementation until all required components are in place.

Required

Screening instruments:

- ☐ **Have been validated**
  Instruments you plan to use have been shown through research to detect the specific mental health issue you are targeting
- ☐ **Are available in the native language(s) of CBO clients**
  As relevant, instruments are translated into the language clients feel most comfortable using (including any variation in dialect), and do not, therefore, require that staff translate the materials on a case-by-case basis

Screening is:

- ☐ **Only offered for conditions you are able to address through task sharing and established referral sources.**
  Only screen for conditions for which you have a plan to follow up with strategies offered at the CBO and an established pathway to appropriate clinical care, if needed.

Plan for screening includes:

- ☐ **Systematic approach CBO staff will use for offering and administering screenings**
  (e.g., how the screening will be introduced, when screenings will be offered, to whom screenings will be offered, how results will be shared with clients) at specific time points to all clients or to all CBO clients in a specific program or to clients exhibiting certain characteristics).
- ☐ **Follow up with timely psychoeducation**
  CBO staff consistently provide clients with timely psychoeducation to help them understand screening results and resources available.
- ☐ **How screening results will be used to guide decisions about follow-up services**
  For example, what screening score thresholds trigger strategies offered by CBO staff and/or referrals for clinical mental health treatment or therapy.

Recommended

- ☐ **Plan in place to offer screenings more than once to clients who initially decline**
  Plan to systematically identify clients who initially decline screening and offer these clients subsequent screening opportunities, as time engaged in CBO services allows.
- ☐ **Plan in place for rescreening**
  As feasible given CBO workflow and program length, plan incorporates protocols for CBO client rescreening to monitor progress and inform services offered

Services · Psychoeducation Checklist

Required

Psychoeducation materials and resources:

- ☐ **Match the needs of the client population**
  Materials match client needs identified and noted as priority for addressing through task sharing. Needs could be condition specific (e.g., depression, anxiety) and/or could encompass broader overview of mental health issues and conditions.
- ☐ **Are evidence-informed**
  Materials are grounded in proven research and provide accurate information about the specific condition being addressed
- ☐ **Include specific, up-to-date information on mental health condition(s)**
  Including: what the mental health condition(s) is; how to recognize and manage symptoms; and what resources are available to support symptom management and improvement (including treatment options, as relevant)
- ☐ **Are accompanied by plan to distribute according to client needs**
  CBO staff demonstrate knowledge of which materials to offer to which clients, and when.

Recommended

- ☐ **Plan in place to provide materials and resources to family and caregivers.**
- ☐ **Materials are customized to match specific community resources and treatment options available.**

Services · Additional Common Mental Health Strategies Checklist

Note: *specific guidance on implementation of each strategy will vary; consult implementation manuals and other guidance documents to supplement the general guidance below and check readiness.*

Required

Selected strategies:

- ☐ **Are evidence-based or evidence-informed**
- ☐ **Match the mental health conditions/outcomes you are targeting**
  Strategies match the priority mental health need(s) you decided to address during needs assessment and goal setting.
- ☐ **Are supported by implementation protocols or decisions supports**
  Protocols and supports are in place to help staff make decisions about which strategies to offer to which clients and under what circumstances.

Services · Referral Checklist

Required

Plan for referral includes:

- ☐ **Use of a warm handoff approach**
  CBO staff provide clients with information about the referral source, what to expect at intake, how long they might need to wait for an appointment, and engage the client in the process of connecting to the referral source (via phone call or in person)
- ☐ **Information that will be shared with referral source**
  CBO staff provide referral source with reason for referral, point of contact at CBO for questions, and (with client permission) information such as client screening scores, current medications, etc.
- ☐ **Incorporation of client needs when selecting referral sources**
  For example, client ability to pay out-of-pocket costs, availability of culturally/ linguistically competent clinicians at referral site, distance from CBO/client home or work, and/or reputation of referral source within the client's community.
- ☐ **Strategies to minimize the time from referral intake to treatment delivery**
  CBO and referral source work together to reduce delays to access in care, which can have negative effects on mental health outcomes and client satisfaction.
- ☐ **Mechanism for confirming appointments kept**
  Referral provider notifies CBO of appointments kept and missed so CBO can follow up with clients who miss appointments.

Referral sources:

- ☐ **Are established for all mental health conditions for which CBO clients are screened**
  Not all clinical mental health providers treat all mental health conditions (e.g., some mental health provider organizations do not offer treatment for substance use). Establish referral sources for all conditions for which you screen.

Recommended

- ☐ **Plan in place for following up with clients who do not initially engage with referred services**
- ☐ **Establish referral sources for needs that cannot be met by CBO or an MHP**
  For example, medical services, housing support, job training, or additional social support services.

Implementation Support · Supportive Organizational Environments

We consider each of the following components to be essential to implementing a task sharing approach. CBOs and MHPs can place a check next to each component to indicate it is in place/completed. If one of the required components is NOT in place, we strongly recommend revisiting guidance from Chapter 4 and delaying implementation until it is.

Required

CBO and MHP organizational leaders have a plan for:

- ☐ **Training CBO program leaders and/or senior team members**
  Plan includes leadership participation in foundational training in order to consistently convey the value of task sharing and to ensure leaders can relate the use of new CBO staff skills to the organizational mission and specific program goals.
- ☐ **Protecting staff time for training and supervision**
  Training and supervision are high priority activities that are protected from other interruptions, ensuring adequate opportunities to learn and practice new skills.
- ☐ **Ensuring CBO and MHP staff understand performance expectations related to task sharing**
  Expectations are shared with staff and job descriptions for relevant CBO and MHP staff include task sharing-related responsibilities and skills.
- ☐ **Training new staff in task sharing**
  Newly hired staff who will be involved in delivery of mental health strategies receive initial training in these skills as soon as possible and are incorporated into the ongoing supervision schedule.
- ☐ **Soliciting staff feedback on task sharing implementation**
  For example, through discussion sessions, surveys, etc., to understand what is working, what additional support is needed, and to solicit suggestions for improvement.

Recommended

- ☐ **Plan to separate supervision for task sharing skills from other types of supervision.**
  To help CBO staff engage in learning behaviors like questioning, trying out new skills, making mistakes, and reflecting on their experiences.

Implementation Support · Foundational Training and Ongoing Supervision

Required

CBO and MHP have selected:

- ☐ **One or more experts to oversee training and supervision**
  Including design, implementation, and ongoing improvement activities; experts demonstrate mastery in the relevant strategies being taught and demonstrated success achieving positive training or supervision outcomes.
- ☐ **Qualified trainers and supervisors**
  At minimum, appropriately qualified trainers or supervisors:
  - Demonstrate high levels of skill in the strategies they help others learn
  - Have received specialized training in how to train or supervise others in the relevant skill(s)/strategies
  - Are knowledgeable in and apply best practices for training/supervision.

Training and supervision plans include:

- ☐ **Opportunities for experiential learning**
  Including activities that allow CBO staff to demonstrate new knowledge and skills through role plays, direct observation of service delivery with feedback, and other learning-by-doing strategies.
- ☐ **Incremental learning goals**
  Learning goals build upon the skills and knowledge CBO staff already have and are smaller and more frequent, providing frequent opportunity for progress checks.
- ☐ **Mechanism for providing regular, supportive, accurate feedback**
  Including the involvement of CBO staff in self-reflecting on learning progress as part of the feedback process.
- ☐ **Adaptations for the CBO setting**
  Examples include: integrating terms and phrases that are relevant to CBO staff and clients; explicitly connecting use of strategies to CBO goals; integrating case examples from CBO work; and using client data and ongoing client feedback and input to shape plans and curriculum.
- ☐ **Mechanism for monitoring quality and effectiveness of training and supervision**
  Including monitoring consistency across trainers and supervisors and regularly soliciting CBO staff experiences.

Plans for task sharing supervision include:

- ☐ **Beginning supervision shortly after training and continuing regularly thereafter**
  We recommend beginning within one month of initial training and occurring for at least two hours a month in the first 6 months of implementation.
- ☐ **Fidelity monitoring**
  Supervisors use direct observation, role plays, and other strategies to understand how trained staff are implementing newly acquired skills and help them build on their existing expertise to achieve high quality implementation.
- ☐ **Decision supports**
  To help CBO staff develop the judgment and skills to effectively respond to situations and help staff understand best next steps when there are multiple possible options.
- ☐ **Strategies to help staff manage emotionally demanding work**
  Examples of support strategies include: conversations to help staff process situations they encounter, opportunities for staff to co-deliver new skills with more experienced MHP or CBO staff before implementing on their own, and activities specifically designed for staff self-care (yoga, relaxation, running groups, peer support, etc.).

Implementation Support · Foundational Training and Ongoing Supervision continued

Recommended

- ☐ **Piloting new training or supervision strategies before implementing on a larger scale**
- ☐ **Plan to incorporate a training-of-trainers model**
  With adequate training and tools, CBO staff can successfully fulfill some training and supervisory roles. As CBO staff gain confidence and experience in the delivery of a particular skill, we recommend providing a clear path for them to utilize this expertise in your training and supervisions structure.

Implementation Support · Care Coordination

Required

Plan for care coordination includes:

- ☐ **Schedule for regular meetings and process for ad-hoc communication**
- ☐ **Involving a multi-disciplinary team of CBO and MHP staff**
  Including both management and direct service staff from CBO and MHP, whenever possible.
- ☐ **Sharing progress and outcome indicators**
  Including indicators related to the implementation of strategies as well as training and supervision.
- ☐ **Exchanging information about client engagement in CBO and MHP services**
  As allowed under data sharing agreements, share information about client engagement in clinical services at the MHP and client engagement in CBO-based services.
- ☐ **Mechanism for documenting programmatic challenges and potential solutions**
  Care coordination meetings are used not just to discuss individual cases but also broader aspects of task sharing implementation. Document implementation challenges discussed in care coordination meetings and potential solutions.

Implementation Support · Crisis Management

Required

Crisis management protocol describes how to:

- ☐ **Evaluate the severity of the crisis**
- ☐ **Provide support and reassurance to the person in crisis**
- ☐ **Determine appropriate next steps**
- ☐ **Follow up with the individual and staff involved in the incident**
  To process the situation and explore options for dealing with similar situations in the future.
- ☐ **Reach MHP or other designated resource in case additional consultation is needed**

Implementation Support · Management and Adaptation

Required

CBO and MHP management have established:

- ☐ **Implementation protocols**
  To effectively convey workflows, decision points, and resources for staff.
- ☐ **Process for collecting and reviewing indicators**
  Including data collection and review procedures to track who is delivering and receiving services, whether your task sharing approach is being implemented as planned, and if your approach is having the desired impact on staff and clients
- ☐ **Changes to current data collection processes and system**
  New indicators are incorporated into current CBO data collection processes and data management systems, where possible; separate tools established if current systems are not in place/not able to be adapted.
- ☐ **Process for sharing progress updates with staff**
  Create opportunities for sharing process and outcome indicators with staff (e.g., through staff meetings, during supervision sessions) so they understand the effect their efforts are having and where improvement is needed.
- ☐ **Mechanism to regularly assess CBO and MHP roles and responsibilities**
  To look for ways to both expand the skills of CBO and MHP staff who are implementing task sharing strategies effectively and determine where additional support/training may be needed.
- ☐ **Ways to solicit staff feedback on task sharing implementation**
  And incorporate feedback into task sharing improvement and adaptation efforts.
- ☐ **Ways to solicit client feedback on services received**
  And incorporate feedback into task sharing improvement and adaptation efforts.
- ☐ **Continuous quality improvement approaches**
  Fully integrate the process of collecting and assessing indicators related to task sharing service delivery, service quality, and client and staff outcomes into established CBO data systems and processes. Assess data regularly and use it to make organizational-level decisions about funding priorities and staffing.

Chapter 6

Assessing and Improving Implementation

In this chapter we provide guidance for using the Task Sharing Self-Assessment Tool in Appendix C. The Tool is meant to help task sharing implementers and/or funders understand what is working well and where improvement is needed. It draws directly from the checklists in **Chapter 5** and related content in previous chapters.

Neither the Tool nor ongoing process and outcome indicator tracking and quality monitoring is meant to serve as a formal evaluation. While evaluation by an objective, outside organization serves as a rigorous method for quantifying impact, we recognize that CBOs and MHPs may not have the financial resources available to fund such an effort. However, CBOs and MHPs can use continuous quality improvement (CQI) methods to test, improve, and document learning and outcomes from a structured implementation process. We provide the Task Sharing Assessment Tool as one resource to guide these learning and improvement efforts.

Instructions for Using the Tool

Below we describe a step-by-step process for using the self-assessment tool.

Step 1: Understand the tool structure. The tool is made up of eight tables that correspond to the key components from Chapters 3 and 4. For each table:

- The first column,"Question," includes a check on the content and quality of specific implementation components.
- The second column, "Response," provides space to rate how consistently the component is being implemented.
- The final column, "How do you know?" provides space to explain the rating selected.

Step 2: Identify appropriate staff to complete the tool. To ensure a more complete picture, we recommend more than one person complete the tool. Someone from both the CBO and MHP could complete the tool independently, or the tool could be completed as a group. It may make sense to have different staff complete different tables, depending on their knowledge of task sharing implementation.

Step 3: Rate your approach. CBO-MHP partners should only fill out tables relevant to their approach (e.g., do not fill out screening if it is not being implemented). Raters can use information from quality monitoring, feedback from staff and clients, direct observations, and review of task sharing protocols and decision supports to answer the questions in the tool. For each component, use the space in the "Response" column to indicate the quality of this component during current implementation (Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done). Below we provide guidance for how to select a response option:

Excellent · you have strong implementation of this activity. You can continue to establish new strategies to reinforce the principles of this activity, as needed. Continue to periodically measure your performance for this activity and use your progress to inform best practices. Identify opportunities to share best practices with other organizations.

Good · you are implementing some parts of this activity well but there are challenges with consistency. Learn from what you are doing well and incorporate those best practices universally to foster consistency. Continue to measure your performance for this activity to determine if you are able to make improvements.

Needs some improvement · you have the foundational elements in place for this activity but there are areas for improvement. Clearly articulate which areas for improvement you will target and Identify resources you can leverage in your improvement process. Continue to measure performance and establish accountability across your team for strengthening the activity in question.

Needs a lot of improvement · you may have knowledge of this activity and be executing a few key principles well for this activity, but you have not yet been able to transfer knowledge fully into practice. Design an action plan that builds on your current knowledge and describes concrete steps you will take to improve your performance in this activity. Continue to monitor this activity frequently.

Not done · you have not done this or have not achieved any degree of competency and need to establish additional capacity in this area.

After selecting a response, fill in a justification for this selection in the last column. To maximize the utility of the tool and to facilitate sharing the results with others, it is important to always include information about your response selection.

Step 4: Review and share your results. Once completed, CBOs and MHPs can share results with staff and leadership at both organizations to determine priority areas for improvement.

Step 5: Revisit the Tool periodically. We recommend revisiting the tool and re-assessing performance throughout implementation. At a minimum, we recommend using the tool soon after training has been conducted and service delivery and supervision are underway, and then once or twice a year as a check on quality and progress.

Interpreting Results

Looking across responses in each table will give CBO-MHP partners a sense of which areas need improvement. For example, if multiple raters select “Excellent” for most components within a table, this is likely a strength for the task sharing approach, and processes may only need small tweaks to continue improving. This would likely not be an area to prioritize for immediate improvement. Conversely, if raters have selected “Needs some improvement,” “Needs a lot of improvement,” or “Not done” for most components within a table, there are likely several weak spots in implementation and activities that should be prioritized as areas for improvement and/or additional capacity building assistance. If answers are highly variable within a tab, it likely means that implementation is inconsistent and could benefit from further investigation to understand where specific improvements are needed.

Appendix A

Glossary of Terms

Glossary of Terms

Community-based organization (CBO): Community-based entities that provide non-medical social services to meet community needs.

Connections to Care (C2C): A mental health task sharing initiative based in New York City involving partners from community-based organizations and mental health providers.

Continuous Quality Improvement (CQI): A planned, systematic, and ongoing process of reviewing data and using information to initiate, monitor, and evaluate changes intended to improve individual and programmatic outcomes.

Crisis management: Protocols help ensure that an organization responds to a mental health crisis in an organized, timely, and compassionate way.

Decision supports: Tools, resources, and protocols that help CBO staff develop the judgment and skills to effectively implement task sharing and provide guidance for selecting best next steps when there are multiple possible options.

Evidence-based mental health strategies: Activities, practices, and principles that have been demonstrated through research to achieve the desired impact on mental health outcomes.

Evidence-informed mental health strategies: Adaptations of evidence-based mental health strategies that may not yet have been tested through rigorous research studies.

Fidelity monitoring: Tools or processes to monitor skill levels across CBO staff and check to see if mental health strategies are being implemented as intended.

Implementation protocols: Step-by-step guidance and workflows for implementing mental health strategies.

Indicators: Data points such as a number or proportion that measure (or "indicate") the extent to which planned task sharing activities have been conducted (i.e., process indicators) and program achievements have been made (i.e., outcome indicators).

Mental health: Encompasses conditions with cognitive, emotional and behavioral symptoms (e.g., depression, anxiety, alcohol and drug abuse).

Mental health provider (MHP): Licensed mental health clinicians such as psychologists, social workers, and psychiatrists. In this guide MHP can refer to both the provider organization and the individual licensed provider.

Psychoeducation: Provision of accurate information about mental health; information may be about a range of mental health concerns or specific information about a particular mental health condition.

Screening: Process of answering a series of questions aimed at identifying the presence of mental health symptoms (e.g., depression, trauma, substance misuse

Appendix B

Worksheets

CBO & MHP Name Date

Worksheet 1: Set Goals for Task Sharing

Early in the process of developing and implementing a task sharing approach, it is helpful to think about why you want to do so. What challenges are you trying to overcome? What do you hope to accomplish and for whom? This worksheet includes a series of questions related to these topics and space to document your answers. Answers to the questions below will help you develop your overarching goals for task sharing. While this worksheet can be completed by a CBO alone, we recommend that organizational leaders from potential CBO-MHP partners fill the worksheet out together. Doing so will establish a shared understanding of some of the challenges ahead as well as a vision for what might be accomplished.

When setting task sharing goals, we have found that it helps to start by thinking about the overarching programmatic goals of your CBO, the *challenge(s)* you face in meeting those goals, and how mental health plays a role. Answering questions 1 and 2 below will allow you to think through these issues and document your responses.

1a. **What is the overall goal of your CBO?**
(Examples: to assist formerly incarcerated people in finding employment; to provide early childhood education for low income families)

1b. **What outcomes do you track related to this goal (if any)?**
(Examples: % of clients who are employed full time after 6 months in the program; % of children who are kindergarten-ready by the end of the program)

Worksheet 1: Set Goals for Task Sharing

2a. Consider the mental health of your clients. Have you noticed any mental health symptoms that concern you in your client population? Potential symptoms might include feeling sad or down, excessive fears or worries, extreme mood changes, withdrawal from friends or activities, significant tiredness or low energy, trouble sleeping, trouble coping with daily problems or stress, excessive anger or hostility, or problems with alcohol or drug use, among others.
How might clients' mental health symptoms affect their motivation or ability to participate in CBO programming?

Example 1: some clients seem to feel very anxious in social situations – this is a problem because most of our job training programs are group-based and require interacting with others.

Example 2: many of my clients have trouble getting out of bed in the morning or taking care of their personal hygiene. I sometimes wonder if they are depressed. This makes it harder for them to engage in programming and attend job interviews.

Example 3: some students' parents struggle with drug and alcohol addiction. Often this makes it hard for them to get children to school, provide a safe and supportive home environment, and meet the child's basic needs.

2b. **What (if anything) are CBO staff currently doing to address these issues?**
(Examples: providing clients with a list of mental health resources, making referrals to other organizations)

Worksheet 1: Set Goals for Task Sharing

3. **Task Sharing Goals.** Now take the information from questions 1 and 2 on the previous two pages to identify 1-3 key goals for your task sharing approach. You may have some goals related to general mental health promotion and others that specifically address some of the symptoms you identified in question 2.

   Example Task Sharing Goal 1: To improve client engagement in job training sessions by teaching them skills to cope with stress and anxiety.

   Example Task Sharing Goal 2: To promote general mental health of clients by educating them on signs and symptoms of mental health problems and what to do if they are experiencing symptoms.

   Task Sharing Goal 1

   Task Sharing Goal 2

   Task Sharing Goal 3

Worksheet 2: Assess CBO and MHP Readiness and Resources

This worksheet includes separate sections to be completed by organizational leaders from the CBO and the MHP considering a partnership to implement task sharing. Both CBOs and MHPs will take on new roles and dedicate substantial resources to make task sharing successful. Before doing so, we recommend each organization assess its own readiness and preparation.

The following pages include readiness self-assessments for both CBOs and MHPs as well as space for each organization to make notes about the resources they could contribute to a task sharing partnership. After each organization has completed its respective assessment, we recommend sharing the results with each other. Worksheet 3 *is designed to facilitate that conversation and provides additional questions and activities related to forming a partnership.*

CBO & MHP Name Date

Worksheet 2: Assess CBO and MHP Readiness and Resources

Assess CBO Readiness and Resources

This page is to be completed by representative(s) from the CBO. To fill out the table below, review each readiness feature in the left column and determine if your organization already has this feature, has it but could use some additional support to strengthen/bolster it, or does not yet have it. Indicate which description fits best by placing an "X" in the corresponding column to the right.

We consider the features in the table below critical for launching task sharing. While you can work on strengthening the features during the planning phase, if you are lacking more than two, we recommend pausing planning until they are at least preliminarily in place. Similarly, if you need additional support on many of the features below, you may want to consider prioritizing that strengthening before moving forward with other parts of planning. We include space on the following page for you to note next steps in strengthening readiness.

Does my organization have.....?	Yes, have this feature	Yes, but could use support	No, do not have this feature
Ability to effectively partner with other organizations	☐	☐	☐
Organizational buy-in for supporting new CBO staff roles and the cultural change inherent in a task sharing approach	☐	☐	☐
Support of key senior leadership to dedicate financial, staff time, and space resources to implement mental health strategies and to meet regularly with MHP partner	☐	☐	☐
Dedicated, private space to hold sensitive conversations with CBO clients	☐	☐	☐
Stable, ongoing CBO programming (e.g., meets programmatic requirements from funders/others, has relatively stable staffing)	☐	☐	☐
Experience collecting and tracking program performance data or institutional commitment to start tracking this kind of data	☐	☐	☐
Plan in place to finance activities involved in task sharing approach	☐	☐	☐

Worksheet 2: Assess CBO and MHP Readiness and Resources

Next Steps

Review which key features in the table are not in place or need strengthening and use the space below to note next steps for shoring up these features.

Use the space below to describe what experience and resources your CBO already has that it can bring to the task sharing approach. If the CBO does not have any experience or resources in this area, write N/A in the notes section.

Designing an Approach

Does the CBO have previous experience implementing any services related to mental health education or promotion, specifically? If yes, please describe. If not, describe relevant experience designing and implementing other programs that could be relevant to task sharing (e.g., important lessons learned, etc.)

Training/Supervision

Is the CBO able to offer resources for training and supervision (e.g., space on-site at CBO for training and supervision to take place, projectors, dry erase boards, printing of materials, etc.?)

Worksheet 2: Assess CBO and MHP Readiness and Resources

Referrals

Does the CBO have previous experience making mental health referrals? If yes, to whom and describe what the process looks like?

Information Sharing

Does the CBO anticipate any challenges sharing information about task sharing activities and/or specific CBO clients with the MHP? If yes, please describe.

Organizational Resources

For what kind of services/resources might the MHP be able to refer its clients to the CBO? Does the CBO have relationships with the community, funders, and other professional networks that might help advance the MHP's mission/goals?

Worksheet 2: Assess CBO and MHP Readiness and Resources

Assess MHP Readiness and Resources

This page is to be completed by representative(s) from the MHP. To fill out the table below, review each readiness feature in the left column and determine if your organization already has this feature, has it but could use some additional support to strengthen/bolster it, or does not yet have it. Indicate which description fits best by placing an "X" in the corresponding column to the right.

We consider the features in the table below critical for launching task sharing. While you can work on strengthening the features during the planning phase, if you are lacking more than two, we recommend pausing planning until they are at least preliminarily in place. Similarly, if you need additional support on many of the features below, you may want to consider prioritizing that strengthening before moving forward with other parts of planning. We include space on the following page for you to note next steps in strengthening readiness.

Does my organization have.....?	Yes, have this feature	Yes, but could use support	No, do not have this feature
Licensure to provide clinical mental health services (e.g., counseling/ psychotherapy, psychiatric medication management)	☐	☐	☐
Experience delivering high quality clinical services to individuals similar to the proposed CBO client population(s)	☐	☐	☐
Experience training individuals or groups without formal clinical training or any background in mental health	☐	☐	☐
Capacity and institutional commitment to effectively partner with other organizations	☐	☐	☐
Support of key senior leadership to dedicate financial and staff-time resources toward provision of training, clinical supervision, and regular meetings with CBO partner	☐	☐	☐
Capacity to serve new clients referred from CBO (consider wait-lists, clients without insurance, etc.)	☐	☐	☐

Worksheet 2: Assess CBO and MHP Readiness and Resources

Next Steps

Review which key features in the table are not in place or need strengthening and use the space below to note next steps for shoring up these features.

Use the space below to describe what experience and resources the MHP already has that can be used in task sharing. If the MHP does not have any experience or resources in the area, write N/A in the notes section.

Designing an Approach

What mental health screening tools and clinical assessments is the MHP familiar with/using in practice?

What types of psychoeducation materials does the MHP use? What experience does the MHP have in reviewing and selecting psychoeducation materials?

Worksheet 2: Assess CBO and MHP Readiness and Resources

What other evidence-based or evidence-informed treatment, prevention, or promotion skills that could be considered for task sharing does the MHP have expertise in?

Training and Supervision

How willing/able is the MHP to dedicate resources to adapting training and supervision to better fit the CBO context/needs (e.g., inviting input from CBO staff and adapting training materials and techniques to fit CBO staff needs and the CBO workflow and context)?

Does the MHP have experience facilitating training and supervision in evidence-based mental health strategies (e.g., screening, psychoeducation, behavioral activation, etc.)? If yes, how does the MHP typically provide training and supervision and give feedback?

NOTE: we recommend a combination of experiential learning opportunities, direct observation of implementation, and reflective supervision so learners can discuss reactions to challenging situations and determine how to address them in the future.

Does the MHP have the capacity (e.g., qualified staff with availability) to train CBO staff and provide coaching and supervision on-site at the CBO?

NOTE: There is growing evidence to support the use of some forms of technology for supervision (e.g., video teleconference) as a supplement to face-to-face contact. If a CBO and MHP have the capacity for such an option and feel it would be a good fit, it can be explored in lieu of or in addition to on-site support.

Worksheet 2: Assess CBO and MHP Readiness and Resources

If the MHP is not able to provide training and/or supervision, does it have partnerships or connections to organizations that could provide training? If yes, describe.

Referrals

Does the MHP have experience working with populations similar to the CBO clients (e.g., youth, trauma survivors, immigrant populations, etc.)? If yes, briefly describe.

Could the MHP facilitate access to specialized care for CBO clients who need it? How? (e.g., could the MHP give CBO clients priority in scheduling? Provide intakes or other services on-site at the CBO? Could there be a sliding scale payment system or reduced fees for CBO clients?)

Are there certain mental health conditions that the MHP is not equipped to address (e.g., substance use) and therefore might require additional referral sources? If yes, please describe.

Worksheet 2: Assess CBO and MHP Readiness and Resources

(For CBOs with large populations of non-English speakers)
What MHP resources are available to provide services in languages other than English?

Information Sharing

Does the MHP anticipate challenges sharing information for CBO clients referred to the MHP (e.g., appointments kept)? If yes, please describe.

Organizational Resources

Does the MHP have relationships with the community, funders, and other professional networks that might help advance the partnership's goals? If yes, please describe.

CBO & MHP Name Date

Worksheet 3: Assess Partnership Fit

The purpose of this worksheet is to help organizational leaders from potential CBO and MHP partners decide if their combined readiness and resources are sufficient to support implementation of a mental health task sharing approach.

We strongly recommend CBO and MHP organizational leaders have completed responses from Worksheet 2 (self-assessment of readiness and resources) at hand. Then, each organization can share results from its self-assessment and use the additional questions below to guide a discussion about potential partnership strengths and challenges. As you share results, please use the space below to take notes. You can then decide if there are sufficient joint resources to resolve any challenges and move forward with the partnership or if the partnership is not a good value proposition for one or both organizations.

Additional questions to facilitate partnering discussion:

- *What does each organization hope to accomplish through task sharing?*
- *What are the most important resources each organization can bring to the partnership?*
- *What potential challenges does each organization see in partnering?*
- *How does each organization envision the delivery of new mental health supports and services fitting into its organizational culture and workflows?*
- *How and how often does each organization envision that information sharing between CBO and MHP will happen?*

Worksheet 3: Assess Partnership Fit

Summary of Findings

Use the space below to pull relevant information from Worksheet 2 and CBO-MHP discussion of the questions on the previous page to summarize strengths of a potential partnership as well as challenges that will have to be overcome in order to partner in a task sharing approach.

Summary of strengths and resources of the CBO-MHP partnership

Summary of challenges that will need to be addressed for a successful partnership

Worksheet 3: Assess Partnership Fit

Partnership Decisions

After discussing strengths and challenges and the overall fit of the partnership, use the space below to indicate your decision about moving forward with the partnership and next steps.

☐ **Yes, we are ready to move forward. Our immediate next steps to formalize the partnership are**
(use the space below to describe next steps, such as developing a Memorandum of Understanding (MOU)):

☐ **We would like to move forward, but we need to work on some things before we continue the process**
(use the space below to list what each organization will work on and a timeframe for these activities)

☐ **We have decided this partnership is not a good fit for the following reasons**
(use the space below to describe these reasons, which may help both organizations understand what they need to look for if they want to pursue this effort with a different partner organization)

CBO & MHP Name Date

Worksheet 4: Assess Needs and Resources and Refine Goals

The purpose of this worksheet is to gather and record important information about CBO client needs as well as existing community resources to inform the design of your task sharing approach. In particular, this worksheet is designed to answer the following questions:

1. *Who does the CBO serve (i.e., characteristics of CBO clients?);*
2. *What potential mental health needs do CBO clients have?;*
3. *How do CBO clients, CBO and MHP staff, and community members perceive mental health issues?;*
4. *What barriers to task sharing might exist?; and*
5. *What community resources exist to support task sharing? Gathering this information can help you describe the needs of the CBO client population and decide which of those needs you'd like to address through task sharing. To gather this kind of information, we recommend soliciting input from CBO staff, clients, community members, and other stakeholders and reviewing CBO data.*

By soliciting information from stakeholders, you can:

- *Gain an understanding of how mental health-related issues are currently understood*
- *Understand what challenges and supports related to addressing mental health exist in your community*
- *Understand how resources used in task sharing might need to be customized to your specific context*
- *Get buy-in for task sharing and build credibility*

Examining existing CBO data allows you to:

- *Identify characteristics of the CBO clients who will be served by task sharing*
- *Identify patterns in CBO client service use or referrals*
- *Identify areas of mental health need*

Worksheet 4: Assess Needs and Resources and Refine Goals

Invite Stakeholder Input

Below, we provide suggestions about which stakeholders you might want to consult and questions you might want to ask. We also provide space to record with whom you ultimately speak. Because some of your stakeholder groups may not be familiar with language used to describe mental health or comfortable talking about it, we include tips for how to set the stage for these conversations.

Selecting stakeholders. We recommend including a diversity of individuals to ensure you are not just hearing one perspective. Consider talking to:

- CBO Clients
- CBO Staff/Leadership
- MHP Leadership
- Community leaders/other community members
- Individuals (e.g., CBO clients and other community members) who have used mental health services
- Experts in community mental health design and implementation
- Other CBOs that have adopted this approach

Tips for talking to stakeholders about mental health. Not all stakeholders will be familiar with the language used to describe mental health or comfortable talking about it. When starting conversations, keep the following tips in mind:

- It may be helpful to start the conversation by describing what you hope to achieve (e.g., learn more about needs and resources) and defining some of the terms you will use (e.g., mental health, mental health, substance use, health promotion, etc.).
- It might help to provide some basic facts up front about mental health issues and who is impacted by these issues.
- Set expectations by recognizing that everyone comes to the conversation with their own views. The point of the exercise is not to determine who is right or wrong but to better understand how mental health is impacting individuals and the community.
- It may be helpful to open the conversation by asking stakeholders to share their perspectives on the needs of the community in general (not just specifically related to mental health)

Sample stakeholder questions:

- What challenges do CBO clients face meeting life goals and/or participating in or benefitting from CBO programming?
- What or who supports CBO clients in attaining goals? (e.g., family support, peer support, CBO staff, specific programmatic resources, etc.)
- How do you think mental health issues (e.g., stress, feeling anxious, feeling down/discouraged) or substance use affect program clients?
- Are program clients willing to talk about mental health issues? Substance use issues? Why or why not?
- What concerns about or proposed alternatives to conventional mental health care or terminology do you have?
- Are there specific issues (e.g., trauma, depression, drug use) that you think pose the greatest challenge for CBO clients? For the community at large?
- What mental health/substance abuse resources do clients already access? What have you heard about resources that worked well/did not work well?
- What are views on how mental health/substance use services are currently delivered in the community? How might this be improved?
- Are there specific populations/ programs within the CBO that might benefit most from mental health services/supports?
- What are the obstacles to realizing mental health and well-being in your community?
- How do CBO staff currently support mental health needs of community? Which CBO staff (names or type of staff) do clients currently reach out to in times of stress and/or crisis?
- *(for CBO and MHP staff)* What resources/training could support staff like you to address mental health issues within the CBO client population?
- *(for CBO and MHP staff and leadership)* What barriers or challenges do you see in trying to provide mental health services/ supports at the CBO?

Worksheet 4: Assess Needs and Resources and Refine Goals

Summary Notes: Stakeholder conversations
List groups consulted

Summarize findings from conversations
In particular, list any information you were able to gather about mental health needs of CBO client population, barriers to addressing mental health with CBO clients, and any existing community resources you could access to support your task sharing approach.

Worksheet 4: Assess Needs and Resources and Refine Goals

Conduct a Data Review

Although you may not collect specific mental health information on CBO clients, CBO data can still provide some helpful reference points for shaping your task sharing approach. Below, we describe the types of information that can be helpful to gather and provide space to record your findings. You may not collect every type of information listed below and/or you may find it helpful to use the space on this page to record other relevant CBO or MHP information.

Review data to describe:

- Number of CBO clients (e.g., by year, by quarter, by CBO program)
- Typical amount of time clients are involved in CBO programming and whether it varies by type of services delivered/type of CBO programming
- CBO attrition rates and reasons for attrition (if known)
- Client demographics (e.g., gender, age, languages spoken, income, etc.)
- Referrals to other organizations (what kinds of referrals do you make most frequently? To which organizations do you most frequently refer?)
- Mental health referrals (for what kinds of issues do you make mental health referrals? To which organizations do you refer? Are clients in specific CBO programs or with certain demographic characteristics more likely to receive referrals?)

Summary Notes: Data review

Worksheet 4: Assess Needs and Resources and Refine Goals

Use Information Collected to Refine Goals

You can use the information gathered from stakeholder input and data reviews to refine the goals set in Worksheet 1 *and start to articulate which CBO clients you want to serve through task sharing and what sorts of issues you want to address. The Refining Goals Table on the next page asks you to answer the following questions:*

- **Who do we want to serve through task sharing?**
  You may decide you want to target all CBO clients with some strategies and specific subpopulations with other strategies.
- **What kinds of issues do we want to target?**
  Some common issues that can be addressed through task sharing are reducing mental health stigma, identifying individual mental health needs, providing accurate information about mental health (either generally or about specific conditions), promoting engagement with CBO staff, and strengthening an individual's ability to cope with mental distress and improve their mental health. You can choose to target these or other issues in your approach.
- **What barriers/challenges do we anticipate?**
- **What resources at the CBO, MHP, or in the community could support our efforts?**

Worksheet 4: Assess Needs and Resources and Refine Goals

We recommend you have the overarching goals you described in Worksheet 1 with you as you fill out the table below. Start with the leftmost column and list one CBO group you'd like to serve through task sharing. In the next column, list the issue that you'd like to address with that population. In the middle column, note why you want to target that issue and population (i.e., how did you decide this was a priority?). Finally, use the last two columns to document anticipated challenges and resources. On the next page, we include an example of a completed table that may be helpful as you refine your own goals.

Refining Goals				
Who do we want to serve through task sharing?	What issues do we want to target?	Why do we want to target these issues?	What barriers/ challenges do we anticipate?	What resources could support our efforts?

Worksheet 4: Assess Needs and Resources and Refine Goals

EXAMPLE: Refining Goals

Who do we want to serve through task sharing?	What issues do we want to target?	Why do we want to target these issues?	What barriers/ challenges do we anticipate?	What resources could support our efforts?
All CBO clients	Reduce stigma around mental health and increase knowledge about what mental health is	Stakeholder conversations revealed that many CBO clients don't fully understand mental health issues or how they might impact their life goals and participation in CBO services	Not all clients will be open to hearing about/talking about these issues	MHP has developed great mental health overview information that could be adapted and offered at CBO
All CBO clients	Identify which clients might be experiencing depression so we can provide resources	Data review showed we have made lots of referrals for suspected client depression	Not all clients will want to talk about their own specific mental health issues	Trusted relationships that CBO staff have with clients may provide an "in" for us to talk about these issues
Clients in domestic violence support group	Something to help deal with effects of trauma	It is clear that many clients in this group are struggling to cope with effects of trauma	We're not sure what resources are the best fit	We have a relationship with a trauma-focused organization that might be able to help us

CBO & MHP Name Date

Worksheet 5: Select Mental Health Strategies

The purpose of this worksheet is to select and document the specific mental health strategies you will implement in your task sharing approach. It draws heavily from the goals documented in Worksheet 4. *We recommend CBO and MHP leaders and lead task sharing staff at each organization review Worksheet 4 and use it as well as Chapter 3 of the guide and any related resources to develop answers to these questions:*

- **Are there specific mental health conditions we want to target?** Which strategies are best suited to addressing those specific conditions (e.g., problem solving therapy for depression, Motivational Interviewing for substance misuse)?
- **Are there specific community conditions we want to target?** Which strategies are best suited to addressing broader sources of emotional distress or trauma in our community, or their effects?
- **Do we want to implement screening for symptoms of specific mental health conditions?** If yes, you will want to make sure you also have related psychoeducational materials and referral pathways.
- **What is the strength of evidence for the strategies we are considering?** Have they been shown to improve outcomes for the conditions or issues we are targeting?
- **Are the strategies likely to be seen as acceptable to CBO clients, CBO staff implementers, and community members?** If no, could they be adapted to make them so?
- **Do any of the strategies under consideration require adaptation to better fit our setting?** For example, will any translations be needed, or do we want to adapt a one-on-one strategy so that it could be offered in a group setting?
- **Do we have the CBO and MHP workforce capacity to adequately train, implement, and supervise for this strategy?** If not, you may want to scale back implementation to a smaller group of CBO clients or select a different strategy.

Notes

Worksheet 5: Select Mental Health Strategies page 2 of 3

As you review answers to the questions on the previous page , use the table below – Select Mental Health Strategies for Task Sharing – to document your strategy selection. For the two left columns, revisit what you wrote in Worksheet 4. You can either transfer that information directly or use the notes on pg. 101 to slightly modify your original answers before entering them into the table below (see example on the next page). Then use the two right columns to list the specific strategy, tool(s), and materials you will use and what adaptations may be needed before you begin to implement

Select Mental Health Strategies for Task Sharing			
Who do we want to serve through a specific strategy?	What kind of specific issue(s) do we want to target?	What specific strategy will we use?	What adaptation is needed (if any)?

Worksheet 5: Select Mental Health Strategies

EXAMPLE: Select Mental Health Strategies for Task Sharing

Who do we want to serve through a specific strategy?	What kind of specific issue(s) do we want to target?	What specific strategy will we use?	What adaptation is needed (if any)?
Wanted to serve all CBO clients but don't currently have resources. Will start with all CBO clients in adult education program	Identify which clients might be experiencing depression so we can provide resources	Screen all clients for depression using PHQ-9 screening tool	Will need to develop introduction script for CBO staff so they can explain to clients what screening is and why it is being offered to them
Will start with all CBO clients in adult education program	Provide resources to clients who might be experiencing depression	1. Psychoeducation 2. Referral to specialized clinical care when screenings reveal moderate or severe symptoms of depression	1. Adapt MHP psychoeducation materials on depression 2. Develop referral protocol so CBO staff know exactly how to engage client in referral process and how to document and follow up on referrals made
Will start with all CBO clients in adult education program	Provide resources to clients who might be experiencing depression	Problem Solving Therapy	N/A
Clients in domestic violence support group	Something to help clients deal with effects of trauma	Implement Risking Connection workshop	N/A
Clients in domestic violence support group	Something to help clients deal with effects of trauma	Referral to specialized clinical care for PTSD if clients request it	Need to develop referral protocol so CBO staff know exactly how to engage client in referral process and how to document and follow up on referrals made

CBO & MHP Name Date

Worksheet 6: Assign Roles and Design Workflows

*The purpose of this worksheet is to clearly define roles for task sharing and create a workflow to meet client and staff needs. The **Task Sharing Workflow Planner** on the next page provides space to indicate which CBO and MHP staff will implement various task sharing activities, how, when, and where. We recommend that staff who will be in charge of overseeing task sharing activities at both the CBO and MHP work together to complete the Workflow Planner.*

The Workflow Planner is broken up into the following groups of activities: Training and Supervision; Engage CBO Clients in Mental Health Strategies; and Provide Oversight/Quality Monitoring. To help you fill in the Planner, and as a way to generate staff buy-in and ensure the best possible integration of task sharing strategies into current workflows, we recommend involving CBO and MHP direct service staff in answering the following questions:

CBO and MHP staff workload and characteristics

- *Which staff roles can be modified to incorporate sufficient time for delivery of mental health strategies/ training/supervision?*
- *Which staff roles entail interactions with CBO clients that lend themselves most naturally to the strategies you are planning to implement?*
- *Which staff have the necessary interpersonal skills to implement your selected strategies (or which staff can be trained to master these skills)?*
- *Is fluency in a language other than English important for implementing the strategy? Which staff have the necessary language skills?*

CBO client flow

- *How do clients typically engage in CBO services or activities and do any of the strategies lend themselves to incorporation in those existing activities and workflows?*
- *How much time does a client typically spend engaged in CBO services and which strategies can be delivered during that amount of time?*
- *Can strategies be integrated into current programming or will they need to be planned and implemented separately?*

Integration of supervision

- *How will supervision and other supports be incorporated into current CBO and MHP staff schedules?*

Available resources

- *Do you have enough capacity/ resources to offer all selected mental health strategies to all clients or just a subset? If you cannot offer all strategies to all clients, which clients might benefit most from receiving each strategy?*

Task Sharing Workflow Planner adapted from:
https://aims.uw.edu/resource-library/clinical-workflow-plan

Worksheet 6: Assign Roles and Design Workflows

Task Sharing Workflow Planner

In the tables below, the left-most column lists task sharing activities. As you move to the right, use the table to document who will complete the activity, how it will be completed, when, and where. Some activities may not be relevant to your task sharing approach – feel free to leave those blank or fill in with "N/A." Each table also provides space for you to document additional activities not already listed, what kind of organizational resources will be needed, and any additional notes.

Training and Supervision

	Who *Name or staff role*	How *Brief description of how activity will happen*	When *In terms of client flow or staff routine*	Where
Provide expert oversight into training design and implementation				
Provide initial trainings				
Provide refresher trainings				
Provide trainings for newly hired staff				
Provide supervision in delivery of mental health strategies				
Other:				
Other:				

Needed Resources/ Additional Notes:

Worksheet 6: Assign Roles and Design Workflows

Engage CBO Clients in Mental Health Strategies	Who *Name or staff role*	How *Brief description of how activity will happen*	When *In terms of client flow or staff routine*	Where
Identify client needs/ conduct screening *(if relevant)*				
Provide psychoeducation in conjunction with needs identification				
Deliver other strategy *(name strategy here):*				
Deliver other strategy *(name strategy here):*				
Deliver other strategy *(name strategy here):*				
Conduct referral to MHP or external provider, as needed				
Participate in regular CBO-MHP care coordination meetings				

Needed Resources/ Additional Notes:

Worksheet 6: Assign Roles and Design Workflows

Provide Oversight/Quality Monitoring	Who *Name or staff role*	How *Brief description of how activity will happen*	When *In terms of client flow or staff routine*	Where
Provide overall coordination and oversight of task sharing implementation				
Oversee development of crisis management and implementation protocols				
Ensure task sharing data are being entered into data management systems				
Regularly review process and outcome indicators				
Share indicators and other quality monitoring data with CBO and MHP staff				
Collect feedback on implementation from CBO clients and CBO/ MHP staff				
Other:				

Needed Resources/ Additional Notes:

CBO & MHP Name Date

Worksheet 7: Select Indicators and Set Targets

The purpose of this worksheet is to document what indicators you will use to monitor task sharing implementation. We recommend that CBO and MHP staff in charge of coordinating/overseeing task sharing work with CBO and MHP leadership and data management staff to complete this worksheet.

This worksheet provides space to document process, short-term, and long-term indicators. Process indicators track whether services are delivered as planned. Short-term outcome indicators measure the interim effects that you hope will lead to longer-term changes. Long-term outcome indicators measure the overall impact of your approach and logically follow from short-term indicators (but won't necessarily take many months to achieve). Below we provide questions that may help you identify relevant indicators for each stage of implementation.

Process Indicators

- How many and which CBO staff are receiving training and supervision?
- How many and which CBO staff are implementing each mental health strategy?
- How many and which clients are engaged in each of the mental health strategies you offer? (e.g., how many clients are screened? How many receive psychoeducation? How many referrals are made and accepted?)
- How satisfied are clients with the services offered?
- How often does a multi-disciplinary team of CBO and MHP staff meet for care coordination meetings to discuss service delivery, training, and supervision, as well as individual client needs, as relevant?
- How satisfied are staff with support they receive through training and supervision?
- Are quality improvement tools and data useful and used?

Short-Term Indicators

- How has staff knowledge and practice changed?
- How proficient are staff in the new skills in which they have been trained (i.e., what is the quality of service delivery)?
- How have client symptoms, knowledge, and/or behavior changed?
- What changes have been made as a result of care coordination meetings and data monitoring strategies?
- How many clients identified as having mental health needs have received services at CBO and/or MHP to address this need?

Long-Term Indicators

- How has client well-being or functioning changed?
- Are clients meeting CBO program outcomes and/or goals?

For each indicator, you will also want to establish targets or goals and measure your progress against those targets. On the next page, we provide an example of each type of indicator and a corresponding target.

Example Process and Outcome Indicators with Targets

Process indicator

- Indicator: # staff participated in training
- Target: 7 staff participate in training by [DATE]

Short-term indicator

- Indicator: Staff mental health knowledge/attitudes
- Target: 80% trained exhibit improved knowledge as measured by training pre/post test

Long-term indicator

- Indicator: Client well-being
- Target: 75% of clients of clients who indicated moderate or severe depression symptoms on initial screening showed improvement in symptoms after eight weeks

CBO & MHP Name Date

Worksheet 7: Select Indicators and Set Targets

*In the **Indicators and Targets** table below, we provide space for you to record what type of indicator you will track (process, short-term, or long-term outcome), what will be measured, the data source you will use, how frequently you plan to review the indicator, and what your target or goal for the indicator is. We also provide a table with some completed examples.*

Task Sharing Indicators and Targets

Type of Indicator	What will be measured	Data source	Frequency of review	Target or goal

CBO & MHP Name Date

Worksheet 7: Select Indicators and Set Targets

EXAMPLE: Task Sharing Indicators and Targets

Type of Indicator	What will be measured	Data source	Frequency of review	Target or goal
Process	Number of staff trained in PHQ-9 depression screening	Training logs	Monthly for the first 4 months, quarterly thereafter	Train all current intake coordinators (4), train new intake coordinators as hired
Short-term outcome	Staff proficiency implementing depression screening and follow-up	Direct observation of staff administering screening & follow-up	Observe all staff once per quarter	All staff implement screening and follow-up according to protocol
Long-term outcome	Client symptoms	Screening scores entered into data tracking system	Monthly	75% of participants who reported moderate or severe symptoms show improvement upon re-screen

CBO & MHP Name Date

Worksheet 8: Identify Capacity Building Needs and Resources

The purpose of this worksheet is to document what additional capacity building support you may need to implement your task sharing approach. We recommend task sharing coordinators at both the CBO and MHP work together with organizational leaders to answer the series of questions below. These questions are designed to document needs related to training, supervision, adapting strategies to your setting, and overall implementation management. For each section, we also include space to identify potential resources to fill those needs. As you think through answers to the questions, it may help to look back at previously completed worksheets, especially Worksheet 4: Assess Needs and Resources and Refine Goals *and* Worksheet 6: Assign Roles and Design Workflows.

Training

Does the MHP have the capacity and sufficiently qualified personnel to train CBO staff in all of the strategies you selected for implementation?

☐ Yes ☐ No

If no, list which strategies need additional training support:

List resources that may be available to supplement MHP training capacity:

Worksheet 8: Identify Capacity Building Needs and Resources

Supervision

Does the MHP have capacity and qualifications to supervise CBO staff in all strategies you selected for implementation?

☐ Yes ☐ No

If no, list which strategies need additional supervision support:

Are there current CBO staff who have qualifications and capacity to supervise for the strategies listed above or could be trained to do so?

☐ Yes ☐ No

If yes, list which strategies CBO staff could supervise, with appropriate training and support:

List additional resources that may be available to supplement MHP supervision capacity:

Worksheet 8: Identify Capacity Building Needs and Resources

Adapting Strategies

Do any of your selected strategies need further adaptation in order to implement in your setting?

☐ Yes ☐ No

If yes, list which strategies and what adaptations are needed:

List resources that may be available to support adaptation:

Worksheet 8: Identify Capacity Building Needs and Resources

Implementation Management

Do you need additional capacity building or resources for any of the following aspects of implementation management:

- Managing organizational change (e.g., getting buy-in from stakeholders, aligning existing CBO/MHP policies to task sharing approach)
- Inviting routine feedback from staff, managers, trainers, and supervisors
- Indicator selection, collection, and tracking processes
- Using feedback and data to assess the success/effectiveness of your approach
- Managing care coordination/communication between CBO and MHP
- Extra help on QI/QA practice, aims setting, measure dashboards
- Others?

☐ Yes ☐ No

If yes, list for which aspects you need additional resources/capacity building:

List resources that may be available to support your management needs:

Appendix C

Task Sharing Self-Assessment Tool

Task Sharing Self-Assessment Tool · Instructions for Use and Interpretation

Instructions for Using the Tool

Step 1: Understand the tool structure. The tool is made up of eight tables that correspond to the key components from Chapters 3 and 4. For each table:

- The first column,"Question," includes a check on the content and quality of specific implementation components.
- The second column, "Response," provides space to rate how consistently the component is being implemented.
- The final column, "How do you know?" provides space to explain the answer provided in Column Crating selected.

Step 2: Identify appropriate staff to complete the tool. To ensure a more complete picture, we recommend more than one person complete the tool. Someone from both the CBO and MHP could complete the tool independently, or the tool could be completed as a group. It may make sense to have different staff complete different tables, depending on their knowledge of task sharing implementation.

Step 3: Rate your approach. CBO-MHP partners should only fill out tables relevant to their approach (e.g., do not fill out screening if it is not being implemented). Raters can use information from quality monitoring, feedback from staff and clients, direct observations, and review of task sharing protocols and decision supports to answer the questions in the tool. For each component, use the space in the "Response" column to indicate the quality of this component during current implementation (Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done). Below we provide guidance for how to select a response option:

Excellent · you have strong implementation of this activity. You can continue to establish new strategies to reinforce the principles of this activity, as needed. Continue to periodically measure your performance for this activity and use your progress to inform best practices. Identify opportunities to share best practices with other organizations.

Good · you are implementing some parts of this activity well but there are challenges with consistency. Learn from what you are doing well and incorporate those best practices universally to foster consistency. Continue to measure your performance for this activity to determine if you are able to make improvements.

Needs some improvement · you have the foundational elements in place for this activity but there are areas for improvement. Clearly articulate which areas for improvement you will target and Identify resources you can leverage in your improvement process. Continue to measure performance and establish accountability across your team for strengthening the activity in question.

Needs a lot of improvement · you may have knowledge of this activity and be executing a few key principles well for this activity, but you have not yet been able to transfer knowledge fully into practice. Design an action plan that builds on your current knowledge and describes concrete steps you will take to improve your performance in this activity. Continue to monitor this activity frequently.

Not done · you have not done this or have not achieved any degree of competency and need to establish additional capacity in this area.

After selecting a response, fill in a justification for this selection in the last column. To maximize the utility of the tool and to facilitate sharing the results with others, it is important to always include information about your response selection.

Step 4: Review and share your results. Once completed, CBOs and MHPs can share results with staff and leadership at both organizations to determine priority areas for improvement.

Step 5: Revisit the Tool periodically. We recommend revisiting the tool and re-assessing performance throughout implementation. At a minimum, we recommend using the tool soon after training has been conducted and service delivery and supervision are underway, and then once or twice a year as a check on quality and progress.

Task Sharing Self-Assessment Tool · Instructions for Use and Interpretation

Interpreting Results

Looking across responses in each table will give CBO-MHP partners a sense of which areas need improvement. For example, if multiple raters select "Excellent" for most components within a table, this is likely a strength for the task sharing approach, and processes may only need small tweaks to continue improving. This would likely not be an area to prioritize for immediate improvement. Conversely, if raters have selected "Needs some improvement" "Needs a lot of improvement" or "Not done" for most components within a table, there are likely several weak spots in implementation and activities that should be prioritized as areas for improvement and/or additional capacity building assistance. If answers are highly variable within a tab, it likely means that implementation is inconsistent and could benefit from further investigation to understand where specific improvements are needed.

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Screening and Identification

Question	Response	How do you know?
Do CBO staff consistently offer/ administer screening instruments that have been validated through prior research? *CBO staff only screen using instruments that have been shown through published research to detect the specific mental health issue you are targeting.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are screening instruments available in the native language(s) of your client population? *As relevant for your CBO population, all screening instruments are translated into the language clients feel most comfortable using, and do not, therefore, require that staff translate the materials on a case-by-case basis (which could lead to inconsistencies).*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Is screening only offered for conditions for which you have an established referral source? *Screening is most effective when it is followed by appropriate follow-up, including referrals to specialized clinical care where needed. Only screen for conditions for which you have an established pathway to appropriate connection to care. For example, screening for alcohol or drug use should not be implemented if there is no established referral relationship with substance use treatment providers.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Screening and Identification

Question	Response	How do you know?
Do trained CBO staff implement a systematic approach to screening administration? *CBO staff consistently follow a systematic process for offering and administering screenings according to the screening approach you have selected (universal, selective, indicated).*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do trained CBO staff deliver timely psychoeducation in conjunction with screening? *CBO staff consistently provide clients with timely explanation of their screening results and psychoeducation to help them understand screening results and resources available.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do trained CBO staff use screening results as one source of information to guide decisions about follow-up services? *CBO staff use screening results as part of a consistently followed process to decide which mental health strategies the client should be offered and the process for engaging clients in these additional strategies. CBOs and MHPs work together to determine what screening scoring thresholds trigger referrals for clinical mental health treatment or therapy.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Screening and Identification

Question	Response	How do you know?
Recommended: Do trained CBO staff use a standardized process to offer screening more than once to clients who do not initially engage with screening? *CBO staff use a consistent process to:* *1. identify clients who initially decline screening and* *2. offer these clients subsequent screening opportunities, as client engagement in CBO services allow.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Recommended: Do trained CBO staff use a standardized process to offer rescreening to clients? *As time in CBO programming allows, CBO staff use a consistent process to offer rescreening to clients. Rescreening results are used to monitor progress and adjust services and care provided if needed. Rescreening results are also used in quality monitoring and improvement efforts.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Psychoeducation

Question	Response	How do you know?
Do selected materials and resources match the identified needs of the participant population? *Original materials were selected to match client needs identified as part of the task sharing design phase; do materials still meet needs - including any new needs - that may have surfaced through ongoing solicitation of client feedback and data review?*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are selected materials and resources evidence-informed? *Regardless of the specific topic covered, materials used in delivery of psychoeducation are grounded in proven research and provide accurate information about the specific condition being addressed.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do selected materials and resources include up-to-date descriptions of mental health condition(s)?	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Psychoeducation

Question	Response	How do you know?
Do selected materials and resources include up-to-date and accurate information about symptom recognition and management?	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do selected materials and resources include up-to-date and accurate information about resources to support well-being (including treatment options, as relevant)?	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do materials distributed by trained CBO staff match client needs? *CBO staff demonstrate knowledge of which psychoeducation materials to offer to which clients, and when.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Psychoeducation

Question	Response	How do you know?
Recommended: Are materials and resources provided to family and caregivers (as well as clients)?	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Recommended: Are materials customized to match specific community resources and treatment options available?	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Additional Common Mental Health Strategies

Question	Response	How do you know?
Are additional mental health strategies being implemented evidence-based or evidence-informed? *Strategies are supported by published research and/or other evidence demonstrating they can be expected to lead to positive outcomes when implemented effectively.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do selected strategies match the mental health conditions/outcomes you are targeting? (overall) *Initial strategies were selected to match priority mental health need(s) identified during task sharing design phase; do the strategies you are implementing still address the mental health conditions/ outcomes you are targeting?*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do trained CBO staff implement strategies according to specific client needs? *CBO staff demonstrate knowledge of which strategies to offer to which clients, and when based on individual client need.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Additional Common Mental Health Strategies

Question	Response	How do you know?
Do trained CBO staff consistently use a systematic approach to deliver mental health strategies? *Trained CBO staff follow implementation guides/use decision support tools when delivering strategies. Though delivery will vary according to individual clients and the strategy being used, the guiding principles/core components of evidence-based strategies should be delivered by CBO staff in a way that maintains fidelity to implementation instructions.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Referral

Question	Response	How do you know?
Do trained CBO staff use a consistent process to determine when to offer clients referral to more specialized, clinical mental health care? *CBO staff take into account identified client needs (surfaced through screening or other interactions with clients) when deciding when to offer clients a referral.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are there established referral sources for all mental health conditions for which clients are screened/have demonstrated need? *Not all clinical mental health providers treat all mental health issues (e.g., some mental health provider organizations do not offer treatment for substance use). Are there referral sources for all issues for which you screen?*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do trained CBO staff consider client needs and potential barriers when selecting referral sources? *CBO staff consider a range of client needs when offering referrals, to potentially include: client ability to pay out-of-pocket costs, availability of culturally/linguistically competent clinicians at referral site, distance of referral site from CBO/client home or work, and reputation of referral source within the client's community.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Referral

Question	Response	How do you know?
Do trained CBO staff collect and deliver relevant client information to the referral provider? *CBO staff provide referral source with reason for referral, point of contact at CBO for questions, and (with client permission) information such as client screening scores, current medications, previous history with mental health treatment, etc.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do CBOs receive information from referral source about appointments kept? *Referral provider notifies CBO of appointments kept and missed so CBO can follow up with clients who miss appointments.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do trained CBO staff use a warm handoff approach to facilitate referrals to specialized clinical care? *CBO staff consistently use a process in which they provide the client with information about the referral source (e.g., what services will be offered, what to expect at intake, how long they might need to wait for an appointment) and engage the client in the process of connecting to the referral source (e.g., making a phone call for an appointment with the client present, initiating a face-to-face introduction of the client to the on-site clinician, etc.); a warm handoff process is used for ALL mental health providers to whom CBO staff refer clients.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Referral

Question	Response	How do you know?
Is there more than one trained CBO staff member who can facilitate a warm hand off referral to specialized clinical care? *To ensure that client referrals can be made in a timely fashion, ensure there are trained staff for every shift/day of the week who can facilitate referrals to specialized providers. Ideally, any staff member delivering task sharing services can also facilitate warm handoff referrals.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are clients who accept referrals to specialized clinical care able to get timely services? *Ensure individuals referred for specialized clinical care are seen as soon as possible. While there is no established standard for what constitutes "timely care" for a mental health care referral, delays to access in care can have negative effects on mental health outcomes and client satisfaction. CBOs and MHPs should work together to minimize the time from referral to intake and treatment delivery.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Recommended: Are there are established referral sources for needs that cannot be met by CBO or a mental health provider? *Clients may need additional resources that cannot be provided by either the CBO or a mental health specialist (e.g., medical services, housing support, job training, or additional social support services). To ensure your task sharing approach is as holistic as possible, develop referral relationships with relevant service providers.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Referral

Question	Response	How do you know?
Recommended: Do trained CBO staff use a standardized process to follow up with clients who do not initially engage with referred services? *Not all clients referred to specialized care will accept the referral. For those clients, CBO staff offer subsequent referral opportunities.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Supportive Organizational Environments

Question	Response	How do you know?
Does CBO leadership participate in foundational trainings? *CBO program leaders/senior team members consistently participate in foundational training in order to convey the value of task sharing and to ensure leaders can relate the use of new CBO staff skills to the organizational mission and specific program goals.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do CBO and MHP staff have protected time to participate in training and supervision? *Training and supervision are high priority activities that are protected from other interruptions, ensuring CBO staff have adequate opportunities to learn and practice new skills.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do CBO and MHP staff understand performance expectations related to task sharing? *Expectations are shared with staff and job descriptions for relevant CBO and MHP staff include task sharing-related responsibilities and skills. Staff are made aware of any changes in expectations as the task sharing approach evolves and is adapted.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Supportive Organizational Environments

Question	Response	How do you know?
Are newly hired staff consistently trained in task sharing responsibilities in a timely fashion? *Newly hired staff who will be involved in delivery of mental health strategies receive initial training in these skills as soon as possible and are incorporated into the ongoing supervision schedule.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Is staff feedback regularly solicited and incorporated into overall monitoring and improvement processes? *For example, through discussion sessions, surveys, etc., to understand what is working, what additional support is needed, and to solicit suggestions for improvement.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Supportive Organizational Environments

Question	Response	How do you know?
Recommended: Is task sharing supervision separated from other types of supervision that occur for CBO staff? *To help CBO staff engage in learning behaviors like questioning, trying out new skills, making mistakes, and reflecting on their experiences, task sharing supervision occurs separately from administrative or other task-based supervision*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Foundational Training and Ongoing Supervision

Question	Response	How do you know?
Are one or more expert CBO and/ or MHP staff overseeing design, implementation, and ongoing monitoring of training and supervision activities? *Experts should demonstrate mastery in the relevant strategies being taught and should be able to achieve demonstrated success achieving positive training or supervision outcomes (i.e., most staff are consistently meeting learning goals and reporting satisfaction with training and supervision). Experts consistently monitor quality of training and supervision and make improvements to training and supervision processes as necessary to enhance quality*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are CBO staff consistently offered opportunities for experiential learning? *Both training and supervision offer opportunities for CBO staff to learn by doing and include activities that allow CBO staff to demonstrate new knowledge and skills through role plays, direct observation of service delivery with feedback, and similar strategies*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Foundational Training and Ongoing Supervision

Question	Response	How do you know?
Are CBO staff provided with incremental learning goals? *Learning goals build upon the skills and knowledge CBO staff already have and are smaller and more frequent, providing frequent opportunity for progress checks*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do CBO staff receive regular, supportive, accurate feedback on their implementation of task sharing?	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are training and supervision adapted to the CBO setting? *Approaches and materials are tailored to the CBO setting. Examples of how to tailor include: becoming familiar with CBO staff roles and workflow before planning supervision; explicitly connecting use of strategies to CBO goals; integrating relevant case examples from CBO work; and using data on client experiences and needs to shape training plans and curriculum.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Foundational Training and Ongoing Supervision

Question	Response	How do you know?
Does supervision include strategies/ activities to help CBO staff manage emotionally demanding work? *Examples of support strategies include: conversations to help CBO staff process the situations they encounter, opportunities for CBO staff to co-deliver new skills with more experienced MHP or CBO staff before implementing on their own, and activities specifically designed for staff self-care (yoga, relaxation, running groups, peer support, etc.)*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Does supervision begin shortly after training and continuing regularly thereafter? *We recommend beginning within one month of initial training, and occurring for at least two hours a month in the first 6 months of implementation.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Do CBO staff have access to decision supports? *To help CBO staff develop the judgment and skills to effectively respond to situations and help staff understand best next steps when there are multiple possible options*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Foundational Training and Ongoing Supervision

Question	Response	How do you know?
Recommended: Are new training or supervision strategies piloted before implementing? *To test content and strategies on a small scale, determine what works, and make adaptations/improvements before implementing on a larger scale.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Is training and supervision consistently led by qualified trainers and supervisors? *At minimum, appropriately qualified trainers or supervisors: demonstrate high levels of skill in the strategies they help others learn; have received specialized training in how to train or supervise others in the relevant skill(s)/ strategies; are knowledgeable in and apply best-practices for training/ supervision.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Is the quality and effectiveness of training and supervision consistently monitored? *Activities include monitoring consistency across trainers and supervisors as well as monitoring CBO staff satisfaction with training/supervision and attainment of learning goals. Information from this monitoring is used to improve training and supervision as needed.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Foundational Training and Ongoing Supervision

Question	Response	How do you know?
Does supervision include mechanism for regular fidelity monitoring? *Supervisors use direct observation, role plays, and other strategies to understand how trained staff are implementing newly acquired skills, help them build on their existing expertise to achieve high quality implementation*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Recommended: Is a train the trainer model implemented in which select CBO staff gain skills to supervise other CBO staff in task sharing approaches (i.e., MHP does not have to provide all supervision)?	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Care Coordination

Question	Response	How do you know?
Are care coordination meetings held regularly with a multi-disciplinary team of both CBO staff and MHP staff? *To facilitate the most productive conversation possible, engage both management and direct service staff from CBO and MHP in care coordination meetings, whenever possible.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are progress and outcome indicators routinely shared between CBO and MHP? *CBO and MHP share process and outcome indicators related to the implementation of strategies as well as training and supervision.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Care Coordination

Question	Response	How do you know?
Is information about client engagement in CBO and MHP services routinely shared between CBO and MHP and discussed in care coordination meetings? *As allowed under data sharing agreements, information is provided to the CBO from the MHP about client engagement in clinical services and to the MHP from the CBO about client engagement in CBO-based services. This information can inform conversations that both MHP and CBO staff have with clients.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are there established processes and protocols for addressing emergency/ crisis situations? *CBO staff have access to and follow established protocols for emergencies including how to get appropriate support to the individual in crisis and how to provide appropriate follow-up once the crisis is resolved.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Care Coordination

Question	Response	How do you know?
Is information from care coordination meetings documented and used to inform programmatic changes? *Care coordination meetings are used not just to discuss individual cases but also broader aspects of task sharing implementation. Document implementation challenges discussed in care coordination meetings and potential solutions.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Task Sharing Self-Assessment Tool continued

Instructions: *Use information from quality monitoring, feedback from staff and clients, direct observations, review of task sharing protocols and decisions supports, and any other helpful documentation to answer the questions below. In the "Response" column, rate how well you are implementing each component by selecting one of these options: Excellent, Good, Needs some improvement, Needs a lot of improvement, Not done. Use the column "How do you know?" to describe why you selected the response and what information you used to make that selection.*

Managing Implementation

Question	Response	How do you know?
Do all staff implementing task sharing activities have access to protocols and decision making tools to help guide their work? (e.g., screening protocols, referral protocols, referral decision-making guides) *CBO and MHP work together to develop protocols and guides that effectively convey work flows, decision points, and resources for staff; CBO and MHP ensure all staff have easy access to this material to promote shared understanding.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are process and outcome indicators tracked and regularly reviewed? *Implement data collection and data review procedures to track who is delivering and receiving services, whether your task sharing approach is being implemented as planned, and if your approach is having the desired impact on staff and clients*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Managing Implementation

Question	Response	How do you know?
Are staff using data systems and/or new tools established to track task sharing data collection and is data being entered in a timely fashion? *Ensure new task sharing indicators are incorporated into CBO data collection processes and data management systems, where possible. Separate tools to track task sharing outcomes are set up if current systems are not in place/ not able to be adapted. Staff regularly enter task sharing data in a timely fashion so that decisions about task sharing can be made based on complete and current information.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Is staff feedback on task sharing implementation regularly solicited? *Regularly ask staff to give feedback (e.g., through discussion sessions, surveys, etc.) to understand what is working from their perspective, where they need additional support, and ask for concrete suggestions to improve the approach.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Managing Implementation

Question	Response	How do you know?
Are CBO and MHP roles and responsibilities regularly assessed? *Use process and outcome indicators, information collected during training/ supervision sessions and care coordination meetings, and feedback from CBO and MHP staff to look for ways to both expand the skills of CBO staff who are implementing task sharing strategies effectively and determine where additional support/training may be needed.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Is CBO client feedback on service delivery, including task sharing strategies, regularly solicited? *Regularly solicit feedback from clients (e.g., through exit interviews, brief surveys, etc.) to understand client outcomes, what services clients perceive to be effective, and where there are gaps.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
Are task sharing process and outcomes indicators regularly shared with staff? *Create opportunities for sharing process and outcome indicators with CBO and MHP staff implementing the task sharing approach (e.g., through staff meetings, during supervision sessions) so they understand the effect their efforts are having and where improvement is needed.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	

Task Sharing Self-Assessment Tool continued

Managing Implementation

Question	Response	How do you know?
Is a continuous quality improvement approach used (i.e., is data systematically used to adapt program implementation)? *Use process and outcomes indicators, information from care coordination meetings and supervision, and feedback collected from staff and clients to make improvements and continually adapt program to ensure high quality service delivery.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	
OVERALL RATING FOR THIS COMPONENT: *Look across ratings above and select the category that best summarized how your partnership is doing on this component.*	☐ Excellent ☐ Good ☐ Needs some improvement ☐ Needs a lot of improvement ☐ Not done	**NEXT STEPS:** *Use the space below to describe how you will resolve challenges identified in this component.*

Appendix D

Works Cited

Works Cited

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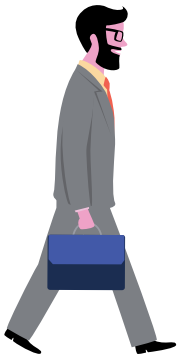

Appendix E

C2C Logic Model

C2C Logic Model

Inputs

FUNDERS

Federal funds

Matching funds raised by CBO/MHP

TECHNICAL ASSISTANCE

Local University School of Social Work

Additional subject matter experts

IMPLEMENTERS

15 competitively selected CBO-MHP partnerships

COMMUNITY ASSETS & RESOURCES

Free, city sponsored training in MHFA

New healthcare payment policies (e.g., Medicaid redesign)

Local MH programs (e.g., additional mental health services)

C2C Program Strategies

Screening

Motivational interviewing

Psychoeducation

Mental health first aid

Mechanism for referral to mental health services

Care coordination between the CBO and MHP

Outputs

C2C training and ongoing coaching and supervision for CBO staff

CBO workforce **achieve competency** in C2C program strategies

High quality delivery of C2C program strategies

C2C program continually improved through use of **CQI approach**

Outcomes/Impact

CBO/PROGRAM LEVEL

Increased **identification** of mental health issues

Reduced **barriers** to accessing and utilizing mental health services

Increased **referrals** to mental health services

Improved **knowledge, attitudes, and behaviors** of program staff toward mental health issues and services

Improved CBO and MHP capacity to promote community mental health

Reduced stigma

INDIVIDUAL CBO CLIENT LEVEL

Decreased **symptoms** (e.g., depression, trauma, anxiety)

Improved **functioning**/quality of life

Improved **knowledge, attitudes, and behavior** around mental health issues

Improved social outcomes linked to CBO services (e.g., employment status)

Increased **access** to mental health services

Increased **utilization** of mental health services

SYSTEMS LEVEL OUTCOMES

Improved access to high quality mental health care in community settings for people with low incomes

More efficient and effective use of the CBO and MHP workforce

Shift toward mental health promotion and prevention activities

Reduced health and social services spending

Reduced disparities in mental health and social outcomes