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RESEARCH ARTICLE

Visibility Beyond Fidelity: Well-timed and Well-situated Community Health Worker Support for Mental Health

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ABSTRACT

We here present the implementation of three instructional modules developed by and for community health workers (CHWs) to support mental health groups as a component of broader resource and support activities in their communities. The innovative conceptual framing is presented in an extended introduction, with a focus on the distinction between academic and community perspectives and a ground for visibility into community dynamics that comes from providing and tracking responsive support. CHWs have drawn considerable academic attention as potential agents of change, but we believe they are limited by top-down insistence on fidelity to expert opinion. We highlight the specific framing of their activities in terms of engaged support that generates its own type of visibility beyond compliance and fidelity. Section 2 details the development of the modules and the methods that were applied to drive the design of the encompassing interventions. The modules were used to help form 10 mental health support groups, within the larger context of individual resource navigation support, and we report some of the responses to those activities in section 3. The CHWs were embedded in their communities as part of a long-term research project designed to describe the capacity and impact of self-directed and empowered CHWs. The final discussion in section 4 ties the evidence of the stories back to the conceptual framing and proposes a responsive framing of expertise within the community setting that would allow creative engagement with individuals to guide the emerging understanding of the social dynamics. Section 5 concludes our presentation.

1. Introduction

1.1. Strengths, Equity, and Crisis

COVID 19 revealed underlying health disparities in outcomes for low income and minority populations.[1] The necessity of working together to respond to the pandemic also drew attention to long-standing systemic inequalities in health care emerging from racial and social injustices.[2] Many groups turned to CHWs to address those issues.[3] The issue of data gaps, and the invisibility of the problems in those populations that had less data reported, was relevant to our interdisciplinary team of researchers, which includes both humanities and data science researchers.[4] As the pandemic continued, communities faced accentuated issues around unemployment, food insecurity, housing insecurity, and lack of childcare.

As emergency funding flowed to the responsible healthcare and social service institutions from a series of government and non-profit sources, CHWs were recruited to be "trusted health messengers" of the same system that had long failed "hard to reach" populations of low income and minority communities.[5] The CHW interventions met with varying success, as we can report informally from our own experiences and the reports of others in our professional networks, but they also faced structural barriers in deployment due to limitations in the roles the CHWs were allowed to play by the funders.[6] The long-term and encompassing research the present authors lead was designed to describe barriers to empowering embedded CHWs and to assess their capacity to support community strengths when given a larger and more creative role; the present research represents an early finding concerning how to frame interactions between CHWs and experts more effectively. The CHWs most directly involved in the mental health modules were working in Spanish-speaking communities in a large urban setting (Houston, Texas), but the research team includes Black and Asian CHWs embedded in other communities around the area. The modules were tailored for their specific use case in the Spanish-speaking community, and not meant to be deployed in other spaces. The research is meant to be holistic *for the specific context*, not to be *universal and generally applicable* as a rule for CHW deployment. We hope to draw out important lessons from the process of engagement and are not trying to prove a claim *about* CHWs as such.

As we noted in terms of the COVID epidemic, the strengths of the CHWs emerged in response to the crisis, but they emerged within structural limits that prevented local insight into the dynamics of the situation from being brought to bear at higher levels of the organizations. The visibility the CHWs had into the dynamics were not shared up the chain. The present paper represents an early outcome of our continuing research into how well-situated agents of change such as embedded community health workers[7] can be allowed to operate independently, with appropriate and responsive support, to create better understanding. This is a step beyond the call for CHWs to have more voice in existing structures – although it is in the same direction. The attentive response to the situation implies transformation of the existing structures and calls for new ways of approaching the provision of services, not just recognition or awareness of excluded voices. Increasing the presence and power of the CHW voice only matters if it's paired with engagement from the system-level actors in a shared effort to fix the system. For several decades, in recognition of the need

for a new paradigm for healthcare provision in general, there have been calls to think of the intersecting institutions as part of a complex adaptive system.[8] We suggest, following a slightly different metaphor, understanding the CHWs as the best-situated translational interface between systems that are constantly adapting from both sides and don't share a common frame. To achieve progress in the absence of an already shared language, the interfacing systems need a mutually reinforcing commitment to finding a new and open space of dialogue. The shared visibility into the dynamics that precedes being able and willing to engage in this transformational dialogue is what we hope to secure as a function of the CHWs' expanded role.[9]

1.2 Falling Outside the Frame

In the U.S., the default definition of CHWs remains that they are trusted by community members because of a shared identity. At the same time, they are trusted by health experts to faithfully help disseminate health information only to the extent of their fidelity to a training program. Both assumptions are a problem. The conception of their role as faithful messengers who carry the same identity doesn't contest the built-in hierarchies and implicit privileges of the expert knowledge economy or reflect the capacity of CHWs to advocate for people in the community or work for systemic change; it optimizes the existing system by identifying CHWs as well-situated to convey a message, like a bridge, except it's only a bridge to the existing (and broken) healthcare system. Other publications have noted the difference between employer perspectives and CHW perspectives and have given prominence to CHW experience and voice.[10,11] Our programs did not seek to create change by training CHWs to recognize and contest power, but to ask whether they can act immediately and effectively as grounded and creative agents of health. We agree with the widespread idea that CHWs can be effective policy advocates and can provide a voice for social justice.[12] However, this must include a recognition that community voice is not monolithic; after all, there is no pre-existing definition of social justice that CHWs uniformly embrace. As a practical matter, the CHWs do not embody a shared ideological framework or vision of political transformation; they reflect the diversity of their own spaces and work toward local and sustainable health outcomes which create the conditions for more equitable outcomes. The change they make possible is grounded in the work they do, where (ideally) they are 6 oriented by helping individuals and families to find their own strengths, in all the diversity and complexity that implies, and improve their shared capacity for working toward better health.

There is a great deal of recent literature on the potential economic advantage of having CHWs on clinical and community outreach and education teams.[13] Randomized trials and evaluations are less common, and have less clear results.[14] The target is often the portions of the population that have not been utilizing the system as designed, either because they failed to engage properly with the bureaucracy or because they actively refused to participate, either from distrust or antipathy. Homeless people, for example, can cost the system more money if they refuse shelter and clinical care, and CHWs with lived and local experience of homelessness can leverage their trusted relationships to coordinate better care and less expensive outcomes. More broadly, CHWs are thought to be cost-effective for the non-

compliant and the non-cooperative, as well as for the simply excluded or ill-informed, across the spectrum of chronic disease management, resource utilization, and help with long-term life goals; it has already been reported by others that CHWs achieve these goals by providing social support and personal engagement, beyond shared identities.[15]

Many people have noted the effects of the pandemic on mental health, including detailed analyses of the overall mechanisms.[16] The team of CHWs found anecdotally, as confirmed nationally by surveys and widely covered news stories, that the pandemic had led to significant increases in self-identified need for mental health services, but that there was significant awareness that much of the marketing around mental health was directed exclusively toward rich and privileged audiences and that no accessible options were responsive to their specific needs. The CHWs worked with the current authors to understand the limitations and opportunities and developed specifically tailored modules in consultation with content experts and focus on strengths-based framings for the encounters. Our role as researchers was to understand the capacity of the CHWs to do self-directed work. As also part of the management team, we encouraged them to trust their insights into community dynamics and to make barriers and strategies visible to both the participants and the researchers. Some of the CHWs initially preferred the idea of expert presenters, but they were easily convinced that the more practical and immediate response was to develop their own approach to presenting modules and materials. They resisted the idea of branding the interventions locally, however, and embraced the association with the university and the expertise of the academics who had been involved. We note this disjunction with respect to the role of the experts in passing and emphasize that we do not believe that any particular expert content in the modules was determinative, nor that the expertise in the modules was particularly innovative. In fact, the content was very deliberately moderate, uncontested, and unsurprising. The branding helped the CHWs pitch the groups to potential participants but cutting-edge expertise did not play a large part in the implementation.

The extent to which the problem of mental health is self-identified in the community is an important clue to our driving question about visibility and the work of CHWs. When we put question marks around the phrase "hard to reach," above, it signaled our hesitancy around naming groups of people that are not well-integrated into the systemic offerings for mental health (and related social) services. We do not want to use names that implicitly place the fault with the excluded, as if they chose not to have access to expensive and specialized services that are in short supply, but we also wanted to emphasize how much the "hard to reach" designation reflects the perspective of the system. After all, the distance attributable to non-compliance and the distance due to lack of resources appears to be the same problem for the system – the population is simply "hard to reach" or "resistant." In the same vein, the CHWs are said to be "well-situated" because they identify with or live in proximity to the "hard to reach" community. From the perspective of the community, to be well-timed and well-situated is to be in a position to respond effectively and intelligently at the appropriate level, regardless of what the system wants. It is not simply to be aware of the system and its shortfalls, but to see the interface between the

many dynamics of individuals and institutions at play and to provide a strategy for improving the outcomes. It requires visibility into the system and creative engagement with the individuals. The CHWs must provide the interface between complex and adaptive systems, beyond being representatives of any particular point of view.

A number of philosophers have seen the need to approach the distinctions between systemic description and individual experience more carefully, without abandoning the use of evidence and argument in the decision-making framework. [17] Even more acutely from the community perspective, the embedded CHWs see the lived experience of individuals with concrete goals facing the intersecting barriers, bureaucracies, and institutions that control access to the resources and pathways to success; the CHWs have the immediate visibility into the intersections and complexities. The task of the current research is to map the visible structures of facing and navigating these barriers to an appropriately humble and capacious but still academic framing. The replication crisis in the social sciences, which was especially pointed within the psychology community, had put the difficulties with purely quantitative approaches in a new light, since it seemed impossible to reach the idealized solutions.[18] We take inspiration from the practice of grounded theory,[19] but we want to emphasize the transformative power of the CHWs and the more general framework of advocacy for the individuals facing the barriers – the research does not simply observe the problems but seeks to understand how to make a better approach visible to everyone involved.

1.3 Making the Frame Visible

In the work of the Community Health Worker Training Center discussed here, the goal is to create trainings that help CHWs find an independent voice that emerges from their specific and grounded work and not from abstract ideological commitments or adherence to a script for the interaction. The encompassing research seeks to identify components that have some modularity, focused on strengths-based framing of health strategies and the types of support that university level expertise can provide as responsive to community needs.

The work to destigmatize mental health treatment and the support individuals need to seek out help when facing a mental health challenge requires the kind of individualized work that embraces strength – both individual and shared capacity – as the individual's own definition of doing well and being healthy. The trainings emerge from the belief that the best destigmatizing approaches are not the ones that successfully market a lifestyle of participation in the expert-driven and medicalized approach to mental health, but ones that shows how structured group work in mental health can rest in strengths-based approaches that allow each individual to embrace their own sense of having the proper capacity to engage with the world. This approach allows the CHWs to engage in mental health work without either lionizing rebellion against the system or insisting that non-expert communities should be compliant in the face of expertise. Our experience as authors reflects the same dynamic, as our way of explaining the process frames the work for an academic audience in sharper terms than the CHWs would use; we would note differences and encourage distance from expert opinion, but the CHWs did not want to represent a divergent or contesting perspective. They kept the framing on the individuals they worked with and used the developed modules as part

of the strategy for helping people succeed in their specific situations. The problematic framing from the system's perspective was minimized (not erased) without drawing attention to the academic critique of the frame. The CHWs saw themselves as best-situated to respond at the right time because they could take ownership of the engagement without (falsely) assuming the mantle of expertise. The standard academic tools for distinguishing moments of impact and efficacy, it should be emphasized, elevate that expert perspective and erase the work of the engaged individual CHW that condition and precede the efficacious intervention.

Part of the lessons learned for the current authors is that CHWs, especially after the deeply politicized experience of the pandemic, should not be too closely identified with faithfully carrying messages about public health to "hard to reach" communities. They should be credited with making it possible to better understand why "hard to reach" was the system's limited perspective on the problem to begin with, and that a better approach to creating health equity requires a more consistent understanding of the perspective of individuals in the community. The desire for better mental health services, in that view, is grounded in the understanding that people need help that is attuned to their strengths and their goals for a better life, not a treatment that simply makes it easier to accept their individual situation as a necessity over which they have no control.[20]

1.4 The Invisibility of Reflected Fidelity

The metaphor of "perspective" comes from the idea that different ways of seeing a problem determine what people will see as appropriate solutions. The experience of mental health crises during the pandemic points to the ways in which both the medical expert and the critical social activist were partaking in the system's perspective on the problems of health equity and access. The turn to visibility, in the place of perspective, is meant to focus attention on the tools required to see the problem at the right place and the right time for an appropriate response, as opposed to doubling down on the question of whether one occupies the right position (universal and expert) from which to say authoritatively that a diagnosis (about the individual or the society) is true or false.

Concretely, this requires abandoning the insistence on tracking whether CHWs teach a course with fidelity to the original design and turning to the question of whether CHWs can be trusted to address the diverse contours of the lived experience through the tools provided by the modules. The framing in terms of fidelity drives blindness to any dynamics that fall outside the frame. Project-based learning has different issues with course design and the limitations of content-driven assessment of the teachers, but it explicitly locates the value of the education in the learners' ownership of their different perspective.[21] The goal of centering "visibility" in the work on mental health is to show how the turn to strengths, as embodied in project-based curriculum and strengths-based engagement, avoids the trap of taking fidelity to the perspective of the original design as the final and appropriate object of assessment. Instead, the goal of the assessment should be how well it provides support to the work that needs to be done, which is in its turn dependent on being able to gain visibility into the underlying processes as individuals work to create personally meaningful and resilient appropriations of what is offered.

This paper suggests that visibility is a structure that is "beyond" fidelity. We are searching for a way of approaching the shared space under the banner of understanding the barriers that prevent successful "visibility" into that process but more importantly by understanding what strategies do succeed (and what success looks like to the different participants).

1.5 Mental Health Support Emerging from CHWs Embedded in Communities

For the Community Health Worker Training Center at our institution, this has meant embracing non-expert ways of talking, with a deliberate incorporation of expert opinion within the less formal, and more community-oriented, framing. Expert ways of categorizing and naming (making visible scientific phenomenon) are brought in only as required by the community members leading the development of the training, and only insofar as that expertise serves the immediate goals of the CHW presenting the material to the community. This results in the current paper not being itself a co-production with the CHWs, as it consciously moves within an academic framing to point explicitly to the limits of that framing independently of the CHWs concerns with the effectiveness of their own work for the sake of the individual community members. The authors are not experts in mental health or medicine more generally. We are deeply engaged in the academic enterprise and in the management of the programs that employ the CHWs; we admittedly do not occupy an objective place outside the process. The CHWs have varied experience with academic training but are encouraged to retain a community-based and strengths-based framing for all their activities. The shared visibility of the problems and potential strategies for achieving better health come from tracking and understanding the specific activities of the CHWs. The current paper does not pretend to capture a universal description nor to speak in the voice of a more authentic community. The claim is that the visibility is prioritized by insisting on the difference in the perspectives and allowing that difference to ground the strategies and work of the CHWs, as reported in the current and deliberately separated academic writing, which emerged from the shared process of trying to understand how the community strengths can be supported.

From the academic perspective, we see that our existing healthcare industry and broader economic system creates inequalities that exacerbate health issues, such as mental health, by limiting access to appropriate expertise. Community health workers are trained to immediately address issues faced by community members while looking for strategies to deal with long-term barriers. They may or may not have an academically grounded theory of the system, but they share the visibility into what has failed in specific cases. The CHWs are typically individuals from low-income communities, mostly women, and mostly minorities that work to be advocates, educators, and resource navigators of their communities. The professionalization of CHWs in Texas arose because of the inequitable healthcare system around them, but the role as individuals working together to address concrete health concerns preceded the paid role and still guides much of the development of the CHW community.[22]

In August 2022, as part of both a long-term research project into CHW efficacy and a short-term funding opportunity stemming from

COVID relief funds, the University of Houston Community Health Workers Initiative at the Honors College hired embedded community health workers from communities within the city of Houston, Texas and surrounding areas of Pasadena and Galena Park, Texas. These communities are culturally and linguistically rich but faced with disparities in education and resources including mental health providers. CHWs conducted outreach and collected stories from individual community members. These stories were collected in an open text format and in a nonlinear manner, many times through organic and unplanned conversations between community members and CHWs.

The stories were collected to help the CHWs start conversations with community members around the values and challenges facing their community. The CHWs were asked to listen closely for needs and strengths and to feel comfortable advocating for specific needs they saw in their story collection. We chose to do story collection in an open text format to allow the CHWsto have the flexibility needed to enter details regarding the conversation.

This paper seeks to understand how the CHWs responded to the increased needs around mental health that community members described through their stories. Three modules were created for CHWs to use as themes for support groups that they could form within the communities they were serving. The staff and faculty team reviewed them with the CHWs, the CHWs then usedthese modules to structure support group activities in their communities. During the group activities the CHWs collected additional stories and anecdotal feedback regarding their impact. Part of the academic framing that is too often taken for granted is that a curriculum is developed as a vehicle for information. The idea of the modules is that they structure the delivery of appropriate and responsive information within the broader approach to supporting strengths and self-advocacy within a community through sustained and developing dialogue about the theme facilitated by the CHWs. The underlying claim of the current work is that CHWs oriented by dialogue and not pedagogy can positively impact the struggle for equity in communities that donot see themselves fitting into the dominant representations of good health. With this idea, the CHWs focused on creating support groups with community members to facilitate this dialogue about the theme.

2. Methods

2.1 Background

There were three modules – "Destigmatizing Mental Health," "Taking Care of Your Emotional Well Being," and "Mental Health Resources for Crises" – created to guide the CHWs in facilitating support groups in their communities. The focus was primarily on support groups because in strategy discussions with the CHWs it was decided that the CHWs could offer the most effective help while also maintaining a clear distinction between their scope of practice and the scope of a licensed professional that can legally and expertly provide counseling and therapy. The CHWs hired had also trained with the university team through the state-approved 160-hour community health worker certification training, which is project-based and strengths-based. The training team regards Community Health Workers (CHWs) as effective agents in fostering mental and general well-being, as opposed to perceiving them merely as a conduit to achieving compliance with expert

diagnosis and treatment. Through their training, they are encouraged to engage in sustained dialogues, comprehend the nuanced structural and environmental factors contributing to an individuals' suffering, and discern the intricacies and culturally specific facets of healing from trauma, scarcity, anxiety, and mourning. Each of these dialogues is understood to be a lasting commitment to a situated process and not the application of a solution to a problem or of a diagnosis and treatment to a disease. In addition to training in how to have empathetic conversations, they also received training on motivational interviewing and resource navigation. An additional module was used that one of the CHWs had created under separate funding in the summer of 2022 named "Duelo", (Spanish for Grief) which was focused on providing support to people that had experienced a loss; it was developed by the CHW in response to COVID 19 but when implemented it was made available to anyone that had experienced a loss.

The three modules we present here ("Destigmatizing Mental Health," "Taking Care of Your Emotional Well Being," and "Mental Health Resources for Crises") were created by a Masters student in Psychological Counseling with the feedback of CHWs from Pasadena and Galena Park. The creation of these modules was overseen by two professors experienced in mental health, public health, and community engagement in addition to a staff member experienced in public and community health. We recognize the significant intellectual contributions of that work but are not focusing on any specific elements from that production. CHWs are beginning to receive recognition for their success in reducing stigma associated with mental health care and facilitating access for individuals.[23] We applaud this work, but we believe it is grounded in the commitment to a strengths-based dialogue facilitated around the theme and not in a content-based pedagogy that increases awareness of a fact about human psychology.

"Destigmatizing Mental Health" was focused on initiating a conversation around mental health and overcoming the stigma associated with mental health. The team felt this theme was the culturally appropriate opening gesture for the dialogues. These modules were implemented in a Spanish-speaking population where conversations around mental and emotional health were relatively uncommon. The next module – "Taking Care of Your Emotional Well Being" – focused on coping techniques built from the base of being aware of different emotional states such as anger, anxiety, and depression. It also allowed the dialogues to further destigmatize discussion of mental health. "Mental Health Resources for Crises" went over the resources available to people with mental health needs, which included national resources such as the 988 hotline and local resources within the Greater Houston area. "Duelo" was created by a CHW after having attended various trainings around the process of grief and support from her native country of Mexico. In the summer of 2022, her project won a CHW competition that was held with COVID 19 related funding, which allowed her to implement the project within her community. The project was later integrated into the rest of the mental health modules.

The full cadre of community health workers were responsible for providing feedback throughout the development of the mental health modules. It was imperative that the

implementation of these workshops be grounded in the activities of the CHWs within their communities and be supportive to the community members receiving the information.

2.2 Participants

There were 4 CHWs that implemented the mental health modules throughout the Galena Park and Pasadena communities, located adjacent to each other in the Houston area. This team included the CHW who had created "Duelo." The mental health modules were typically delivered within 3-5 sessions but the CHWs were provided with the flexibility to take their time in implementing the workshops to be responsive to the needs of their participants. "Duelo" was implemented separately because it consisted of 4 separate sessions and was oriented toward the process of grieving while the other mental health modules were oriented toward general mental health needs and support. The modules were delivered between January 10, 2023 and July 6, 2023 with a total of 172 individual going through 10 distinct workshops.

The CHWs and staff developed these mental health modules with no presupposition concerning data or research. The current authors were interested in hearing from the CHWs about what they encountered in their communities and insisted on data collection for the overarching study of CHW effectiveness. There were no formal metrics established in advance and instead we drew from auto-ethnographic observations from the CHWs through their story collection. As part of an overall commitment to evidence generating practices, the stories were systematically examined and reported back to the research team. As part of the commitment to dialogue as a means of support in dynamic and difficult situations, there had been feedback loops established between the 4 CHWs who implemented the modules and their work supervisor, a UH staff member experienced in public and community health. These workshops were delivered for free and delivered at partnerships the CHWs established themselves when they began their work in August 2022. Attendance was taken at every session and no other information was collected besides names and phone numbers for each individual participant. The attendees received no incentive to join the workshops.

3. Intervention

The modules were delivered from January-July 2023 throughout Galena Park and Pasadena. A total of 172 individuals attended the workshops. Anecdotally, the CHWs reported during their feedback loops with their supervisor that they saw improvements in the individuals attending and shared stories through an open text format and in a nonlinear manner. The CHWs had no incentive to emphasize positive outcomes, besides the general desire to be seen as participating in successful work. No employment or career benefits were tied to success, and the CHWs were told specifically that both negative and positive stories were helpful. Still, the stories uniformly described feelings of hope after joining the workshops and many individuals described feeling less socially isolated after the workshops. The participants may have been saying what they believed the CHWs wanted to hear, but the CHWs felt that the feedback was authentic. The workshops were delivered in churches and community centers. The 2 workshops that were virtual were delivered through a church. The community health workers found settings

that were accessible to the community and had existing relationships and open doors for broad participation. The removal of barriers is crucial to creating better access around resources such as the health education that CHWs are offering[24] and trust can be seen as a moderator of these relationships.[25] CHWs have been found to be effective in addressing mental health needs,[26] especially in communities that face disparities to access like Pasadena and Galena Park. In addition to lack of access, these communities face the additional barrier of very limited support in Spanish. More research is needed to find an effective model that does not cross professional boundaries but creates equitable access to mental health services for individuals within their own context.

4. A sampling of CHW accounts of participant stories

Where the CHWs recorded the stories in English, we have made small changes for clarity and grammar. We have also removed any identifiable information. In other cases, we have translated the Spanish into English, with the smallest possible modifications for clarity. CHWs collected these stories after delivering mental health workshops and talking to community members through their outreach activities.

"She shared during our last DPP [Diabetes Prevention Program] class that her son passed away 18 years ago during the night. She signed up for our upcoming Duelo workshop. She said during the years she took different workshops and spoke to therapists, and they helped, but sometimes she feels like she needs to talk to people that have had a loss too. She said a loss like that is a lifetime struggle that you never get over, you just learn to live with it and on occasion share your story with others. It amazed me how strong she is, and I hope our Duelo sessions are what she needs now."

Galena Park CHW

In doing outreach, the community health workers had a heightened visibility to the needs of the community and thus were positioned to better to respond to them. The training in mental health that they had received had allowed them to feel comfortable opening these dialogues into mental health and creating visibility into the topic while being responsive in a way that best accommodated the community member. Access is an issue within mental health, especially with low income communities, in the story below, the community member struggles with accessing a mental health facility that can be financially feasible and needs the help of a CHW in finding a place that best fit her financial needs.

"The woman came to the mental health class because she's been struggling with depression. We had been able to help her go to a clinic, but she stopped because they were charging her too much. I then helped her find three other clinics, and she found one of them to be helpful. This week, I spoke to her over the phone. She's feeling much better, undergoing treatment, and we agreed to speak again soon and I offered my services and assistance in case she needed anything else."

Pasadena CHW

Through this creation of visibility, individuals also feel more comfortable to confront their symptoms. In the story below, the community member is unsure if she is going through depression prompting her and the CHW to have a conversation in which the CHW shares resources that may be helpful to the community member.

"This couple has a family business; they sell vegetables to several restaurants in the Houston area. It is a very demanding job that takes up most of their time and causes a lot of stress. She thinks that she is going through depression since she feels like crying for no reason. She also believes that this could have been caused by her mother's illness. It was a very stressful situation for her. She has 2 teenage children. I was able to share with her some mental health information and gave her information about the Harris County mental health clinic."

Pasadena CHW

Through each of the stories below, CHWs detail strengths of the individuals that they come across during their workshops. Through the collection of these stories, CHWs create visibility into the real complexities community members confront within their own health context and how they work to overcome those complexities.

"I met this lady at the community center during a Mental Health Workshop. She asked me if I could sit next to her to translate since she does not understand Spanish 100%. She was extremely interested in the session, and she told me that she wants to work on herself since she feels that she has always been controlled in her life, as a child by her mother and now by her grown children. She wonders if she can still change at her age. She also mentioned she suffers from Anxiety; she says in public she must wear a mask to cover up her mouth because she gets so anxious, she cannot breathe well so she must breathe through her nose, and she feels uncomfortable. I shared with her about my experiences with anxiety and she felt relieved. I told her I will attend every Friday so I can help her by translating and continue to share our mental health experiences."

Galena Park CHW

"I met her for the first time during our Mental Health workshop in Galena Park. She had never attended one of our workshops. She has anxiety and panic attacks and hardly leaves her house but when she heard about our Mental Health workshop she decided to get up and out of the house to get to our class. She needs a walker to move around and that did not stop her. It was wonderful to see the change in her from the first session to the last. At the beginning you could tell she was barely able to get out of bed and by the last session she was all dressed up. She said our workshop helped her to get out of the house and socialize with people and get some sun. We shared resources with her in case she needed them. She said she was going to try to join us during our next workshops."

Galena Park CHW

"She has attended our Duelo and Mental Health workshops in Galena Park. She is a strong, hard-working single mom. She lost her son in an accident, and she went through a strong episode of depression, in which she would drink too much alcohol and she had a fight with her sister whom she has not had a relationship with since. She says she was able to overcome her depression on her own, but she continues to show signs of mental health problems. She says she struggles with her mind every day to not go back to that depression. We have shared several resources with her."

Galena Park CHW

5. Discussion

We see these as very human accounts of what the CHWs immediately experience as successful

in their interactions with the individual participants, even though they are second-hand accounts and the CHWs are clearly motivated to hear and relay good feedback. The accounts have a surface plausibility, for example, that an anxious person comes out feeling less isolated and therefore more at ease. They also include details that support the overall positive interpretation or that provide a sense of why the narrative feels trustworthy, for example, the details about other family members impacted by their struggles with mental health. The stories also speak to the importance of the relationship between the individuals and the *CHW, where the content of the* class is of less importance. This fact may point to the ways that the replication of results in interventions often depend on externalities around the context and delivery of the content. Given that they are honestly responding to the CHWs about their feelings, the participants would be likely to engage in whatever is presented to them and score well on whatever metrics were used to assess the intervention, no matter the content. Having a control group with a different curriculum might sort out the questions about competing hypotheses concerning the curriculum content, but one would have to ensure that the control group was not seen as automatically less engaging because it is not the new project that the CHW is excited about.

The more important conclusion, from the perspective of the current paper, is the responsive framing of expertise. The purpose of the group support remains framed by the CHWs owning the project and asking for responsive and appropriate expertise within the context of a community relationship that they are driving. The assessment of what works can remain within the community perspective, as framed by the CHW as interfacing with the complexities of the system and working with the community members toward creative, timely, and appropriate responses.

The fundamental activity of the CHWs is resource matching and care coordination. They are embedded in their communities as the ones who can help individuals navigate through a difficult situation. They respond to the lived experience of barriers people encounter on the paths to their own best outcomes, but they respond as well-situated to understand the complexity and as respecting the agency of the person in the situation. This same framing also puts people in the right space for success in mental health group work, where the key is the provision of support and help in navigating pathways without taking over or providing a readymade solution. The participants come expecting a dialogue and a place of responsive engagement with the individual, in whatever place that person is starting from. They are prepared to see the interaction with the CHW as well-situated and well-timed because they initiate the contact without giving up their sense of self-determination and agency. If they are directed toward more expert resources by the CHW, it should remain in the framework of the participant's perspective on what counts as the right path.

Engaging the creative intelligence of the CHWs in the original formulation of the groups, and the decisions about what expertise to include in the curriculum, provides the extra step where innovation and expertise can be grounded in the lived experience of community members intersecting with the system. As that intersection is better mediated by CHWs, the visibility of the underlying dynamics emerges as explicitly

precedent to the restricted and reflected visibility of looking for confirmation or refutation of a theory framed by expert perspective (or the expert practices of defining problems in certain ways). The humble outcomes from these small groups –no doubt replicated countless times in countless situations where CHWs have managed to expand their roles and lead individual and group interactions with appropriate concern for framing the engagement as about the participants' own capacity for transformation – points to an ambitious but attainable model for CHW deployment, across both service provision and research into the effectiveness of CHWs. If the managers and employers can more effectively and consistently support that creative and appropriate framing, the outcomes of the other education and behavioral interventions that depend on engaged participation from the community can be improved across the board.

6. Conclusions

CHWs – like many front line social service and healthcare workers – often complain of the difference between what they feel is valuable in their work and the metrics they report to their employers. The current paper traces that problem, at least in part, to the dominance of expert perspective in assessment of CHW interventions, which precedes and conditions the financial incentives often blamed for the misfit metrics. The proper humility in the expert response respects the process of CHW engagement but does not pretend to be merely recording the community's voice or to be subservient to community members' opinions about how to solve medical problems. The dialogue is an open-ended process and requires respect for alternative voices and commitment to long-term transformation. Mental health challenges face the community at a place where the expert system has failed to provide enough access points to individualized care. CHWs can provide a framing for the first steps – for destigmatization, willingness to change behavior, openness to dialogue – without excluding expert knowledge or foreclosing other pathways to improved health. The process is simple and intuitive, but the assessment and understanding require allowing creative CHW engagement to enhance mutual visibility at the interface between knowledge production systems. Fidelity to expert opinion is given within the frame of engaged, well-situated, and well-timed activities that are meaningful to the community and provide the trust that lets individuals engage in transformative activities.

Conflict of Interest Statement:

The authors have no conflicts of interest to report.

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