Capacity and Non-Compliance: Mental Wellness Modules in a Community Health Worker Certification Course

Erica Hua Fletcher*, Daniel M. Price

University of Houston, The Honors College, 212 M.D. Anderson Library, Houston, TX 77004, United States

Abstract

Purpose: To train Community Health Workers to see themselves as contesting the diagnostic imperatives to treat "mental illness," while recognizing and addressing structural barriers to community mental wellbeing.

Method: Drawing from an analysis of course material, auto-ethnographic observations of class dynamics, and social theory from Critical Public Health and Mad Studies, this paper describes three new mental wellness modules integrated into a semester-long Community Health Worker certification course in a public housing jobs program. The class met in a public housing community center in Houston, TX and consisted of a group of 15 students, both pre-health undergraduate students and local residents, who worked in teams to discuss local definitions of mental wellness and design site-specific community mental wellness programs.

Results: The modules reframe bio-psychiatric epistemology and hierarchical ideals of medical compliance in terms of political, social, and economic struggles familiar to the residents as local community health concerns. Project-based learning encouraged students to recognize personal capacity to navigate current public mental health services and to foster collective strategies promoting peer-based approaches to community wellness.

Discussion: We note limits of our own pedagogical approach and indicate neoliberal pressures that preclude local definitions of mental wellness in favor of standardized learning and employment outcomes.

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1. Introduction

Community Health Workers (CHWs) are traditionally members of the community they serve, and their success in improving health outcomes is often attributed to the ways that they are embedded in social and cultural contexts that expert medical staff may not know firsthand. In recent years, CHWs have won legitimacy as an effective interface between public health initiatives and community education throughout the U.S., although doubts about general efficacy abound and only fairly restricted use cases have been validated in randomized control trials. As policymakers at all levels and political inclinations have become convinced by the arguments for cost-saving

preventive care, CHWs have been called into action as the frontline for public health messaging, programming, and health services navigation with the expectation that they can better deliver culturally sensitive framing of preventive health messages.[1]

The temptation in neoliberal health policy reform is to treat the CHWs as the lowest paid workers, faithfully following instructions from their supervisors, and presumed to use their local expertise to more effectively deliver the approved messaging from the professional staff. Our still evolving hypothesis is that the power relations between traditional mental health professionals and resistant community members condition all the claims to expertise and the meaning of *complianc*e at both expert and local levels; consequently, we do not propose to invert the epistemic power relations, with private or anti-science truth claims suddenly taken more seriously than the hierarchical messaging. Rather, the encompassing attitude toward the expert knowledge claim as a tool of power must be changed: instead of authoritative diagnoses and medication adherence as an instrument that compels compliance, the struggle to find a path toward mental well-being should be seen as a shared project of striving to respond appropriately. The CHWs should not play the role of contesting expertise within the same framework of power relations, but should reframe the search for wellness in terms of the specific context and the human struggles at stake. Following that intuition, we developed a class that seeks to engage CHWs in shaping power dynamics around shared projects that can deliver improved health outcomes as appropriate self-management and community supported mental wellbeing. The traditional hierarchical approaches have declared the hardest-to-reach individuals to be non-compliant and uninterested in their own health. In contrast, the CHW approach emphasizes a community based on shared relations, in shared projects oriented by community well-being, and seeks to render the question of compliance secondary. The hardest to reach individuals are not simply better encouraged to become compliant, but are actively engaged in the question of what sort of compliance is acceptable and necessary.

This paper describes the three modules we developed on mental wellness, which combined information about traditional avenues to access Houston's public mental health care system with critiques of the system's limits and strategies to advocate for local residents and build projects supporting mental wellness. Houston, as the fourth largest city in the United States, has long experienced health inequities within its sprawling patchwork of ethnic enclaves; and it serves as an important site to model innovative approaches to site-specific interventions. Through insisting on local definitions of mental wellness and course assignments drawing from urban resources, we encouraged the CHWs to see themselves as contesting the diagnostic imperatives to treat "mental illness," while recognizing and addressing structural barriers to community well-being. In the same vein, by insisting on our role as facilitators of local CHW leadership—instead of purveyors of university expertise, we encouraged the students to see the presence of the university as enabling productive individual difference from existing power structures instead of imposing a binary choice between compliance and resistance.

2. Methods

2.1. Participants

As certified CHW instructors, we co-taught 14 day-long workshops covering eight mandatory competencies, and including three community mental wellness modules developed under the flexible category of "specific health knowledge" within the free CHW certification course.[2] We modularized the course into 14 discrete sessions to enable students to attend the weekly sessions nonconsecutively, as their varied schedules and responsibilities permitted (for a total of 95 face-to-face hours). We also provided homework assignments to earn additional hours towards the 160 h for training certification through the Texas Department of Health and Human Services.[3] The diverse class of 15 students—consisting of pre-health undergraduate students and local residents—met on a weekly basis over a single semester (January-May 2017). The course was housed within a community center at a large public housing complex near campus and within an historically black, low-income area.[4]

2.2. Community engagement

In many ways, this course mimics aspects of community-based participatory research (CBPR); however, throughout the process of establishing community partnerships and building the framework for this course, we struggled against the existing CPBR models, since they too easily slip into reified conceptions of voice as incontestable and already existing local expertise.[5] The kinds of questions that can be asked, what the social researcher can offer the community, and what community representatives can imagine as a benefit or compensation for participating in the study

are often limited by a single research grant's breadth and scope, as well as the isolated capacity of the social researcher. The encompassing financial and conceptual structure of university participation enforces the priority of generalizable findings, in research that is not muddied by advocacy or personal engagement, and all but precludes the shared project approach championed here.

Due to our desire to seek deep community partnerships instead of pursuing our own pre-existing research initiatives, no research proposals were submitted to our university's Institute Review Board for this class (as no formal data metrics were collected), and participating students were not required to sign informed consent forms or research waivers to engage with this class. Instead, our qualitative approach to community partnerships draws from auto-ethnographic observations of class dynamics, an analysis of our course material, and selected literature from Critical Public Health, post-critical social theory, and Mad Studies. Through informal conversations with each other, students in our CHW course, staff members from public housing, and colleagues on campus, we came to see several dynamics within and outside of the class as crucial to the ongoing development of the CHW course's structure and content.[6] We, as course facilitators and social researchers, compared our field notes from the class sessions, triangulated our findings, and made changes to the course structure as deemed necessary. In playing a dual role, we acknowledge that our study findings are limited by our own biases in interpreting the class's engagement with the mental wellness modules, our blind spots within fieldwork to the perceived efficacy of such pedagogical interventions among students, and the inherent power dynamics of the student/instructor relationship. Nevertheless, by providing a free training with both residents and university students, we sought to allow community-engaged research projects, service learning, and service delivery to emerge within the framework of the community in a way that would have traction, sustainability, and scalability not accessible to typical CBPR single grant projects.

2.3. Background

CHW certification through the State of Texas Department of Health and Human Services became formalized in 2009, after decades of grassroots health organizations training health promoters (*promotoras*) to advocate for migrant farmworkers living in South Texas. These advocates quickly became national leaders, and encouraged Texas to set robust standards for certification. A 160 hour training requirement emerged, and several thousand CHWs are now certified under those standards in the state. However, the initial group of health activists—largely bilingual, middle-aged Chicanas committed to health care as a human right—found themselves in a strained partnership with legislators who quickly pushed for a quantification of health outcomes that justified CHWs as instruments of cost saving interventions . Practical cost-saving imperatives, occasioned by Texas' refusal to expand Medicaid, induced stop-gap measures (such as Article 1115 Waivers and Delivery System Reform Incentive Payment (DSRIP) Programs) to provide narrow funding mechanisms for CHWs to be paid through state resources, but limited the CHW mandate through insisting on evidence-based interventions with centralized control of messaging.[7]

Our pedagogical approaches to collective action in support of mental wellbeing draws from both Critical Public Health that takes a structural approach to contextualizing mental suffering and from Mad Studies, an emerging, contentious field of health scholarship that seeks to destabilize and/or transcend the mental health professions which reify liberal notions of mental health recovery as a linear, objective, and universal production of rationality.[8] We also draw lessons from peer support movements, which began as grassroots movements in the mid-1970s against psychiatric establishments in the United States and beyond. [9–11] With the failure to sufficiently fund community mental health centers in lieu of the closure of state asylums, clinicians and peers struggled to provide adequate services for those experiencing mental distress (much less create true community mental wellness plans). As the role of peer support specialists became codified in the early 2000s and the field professionalized, critiques formed that the original impetus of disrupting and dismantling psychiatric institutions became co-opted as former patients began to serve as handmaidens to professionals in the disciplines of psychiatry and psychology. As low-wage workers themselves, certified peer specialists were often the most expendable and lacked the same (sanist) credibility as other mental health care providers on their team; and within the hierarchical power dynamics of biopsychiatric expertise, the peers often serve as models of patient compliance and are called to encourage their clients to adhere to medical regimes of governance. The peer support model of mental illness intervention, because of its entrenchment within hierarchical governance and set funding mechanisms, cannot provide the same kind of preventive, project-based, subversive and

holistic work as CHWs who are tasked with shaping shared projects of mental wellbeing.[12]

Accordingly, our hope in creating these modules was that the return to CHWs as a source of innovative strategies in collective action and mental well-being could serve as a means to reinterpret the initial impetus behind the grassroots activism of peer-led movements in mental health and reinvigorate discussions within consumer/survivor/ex-patient movements of the 1990s, recent Mad studies scholarship, and Critical Disabilities activism. Although CHWs have a more varied scope of service provision than peer support specialists, our fears that their labor will become relegated to constrained roles within neoliberal models of accountability are very real. Within our constrained roles as academics, we advocate for more access to mental health services and for public funding mechanisms for peer support specialists, but we also recognize such services have their limits and that they can do violence to the patients they attempt to serve. The modules on community mental wellness that we piloted in our CHW class, along with our efforts to cultivate an employment network of CHWs, serve as first steps in envisioning models against static definitions of mental wellness and rigid roles of health care professionals.

2.4. Theoretical Framework

In our context, the idea that individuals and communities use language as a tool of mastery is embodied in the diagnostic imperative of both neoliberalism and critical positionality, that is, in the idea that a privileged person internalizes a correct name for what is wrong (with an individual or a system) and then convinces other people to use the same name and to organize their activities by reference to that name. The approach to mental well-being is based on the idea that healthy consciousness provides names for the objects of the world, and compliance is the power relation where those names originate with an external authority but are internalized by the patient as the correct path forward. The political response that asserts the privilege of local knowledge against scientific authority remains within that frame, and just inverts the claim about who has best access to knowing the true names. To change that framing is not to engage in the critical practice of unmasking ideology, or providing better names for the conditions of the current errors, but to insist on a more fluid and adaptive process of wellbeing as capacity to engage the world. That the capacity to engage precedes the activity of naming is both obvious and profoundly disruptive, since that sense of engagement points to a

practice of academic inquiry and mental wellness based on shared projects in a shared world in place of the biomedical model based on private projects, justified by individual possession of correct knowledge.

We take this disruption of the privilege of theory to be embodied in the CHW modules around the problem of expertise, and the mistake involved in merely valorizing local expertise against professional expertise: In very broad terms, the Hegelian struggle for recognition (and after him, through Marx and most critical social theory) means that power serves the interests of an abstraction—individual selves or an embodied class of people who, for example, possess a belief that they feel deserves to be valued by others and that justifies the use of power to enforce the adoption of that belief.[13,14] Any response that merely defends a different belief ends up imposing an abstraction. Instead, the Foucauldian articulation of power—in which power is enacted, upheld within everyday health decisions, and is productive of smaller forms of truth that cannot be abstracted—allows for a non-dialectic unfolding of actually embodied capacities. These capacities can use different moments of struggle with and against a powerful expertise to enhance engagement with health as a process—not an abstract ideal.

More simply, our suggestion is that the process of struggling with a diagnosis, or contesting the diagnostic imperative more broadly, is itself a way to embody the open-ended search for a healthy mental (and communal) life. The ethical imperative is not to name in accordance with what is true, but to be oriented by the needs of the community; not to recognize commonality, or to see the other person as having contractual rights and obligations, but to see the opportunity for new and more robust shared projects and engagements through the cultivation of a non-confrontational difference.

2.5. Process

Our pedagogical approach to community mental wellness is a search for knowledge without mastery, an attempt to convey capacity in working together toward an end not conquered through knowledge, but through engagement and the deliberate alignment of the varied lenses through which we engage the world instead of any specific vocabulary or consensus grounded in truth claims. The fact that this also embodies a very old and fairly intuitive sense of health need not return us to a simpler time without access to any of the technologies of modern science. Rather, it points to a new compromise between the scientist and the community,[15] and a sense that the

project of searching for knowledge is separable from the mastery of Science.

Our training also draws from popular education models that recognize the local knowledge of CHW students as those who have lived experience with mental struggles or have served as caregivers for those who have navigated the public mental health care system. We view CHWs as force for mental wellbeing —not a stepping stone towards compliance. Peers or embedded community members have a different knowledge of someone suffering from mental duress —they have the time and capacity to listen deeply to their concerns, to understand the structural and environmental factors contributing to their suffering, and to recognize the nonlinear, culturally specific aspects of healing from trauma, scarcity, anxiety, and mourning. Nevertheless, we also seek to convey the practical utility of the diagnostic moment, which can serve as a tool to enable access to the public mental health care system, educational and occupational accommodations, and Social Security benefits for disability. We understand that psychotropic medication can be very useful for many patients, even while such medication remains contested and disputed amongst mental health scholars in terms of its potential iatrogenic effects associated with longterm use,[16] and vested interests in the co-evolution of the American Psychiatric Association alongside Big Pharma.[17] Our approach, therefore, is not trying to convince our students of any particular ideology. Rather, we are adamant about bringing people into shared health projects that incorporate community mental wellness as integral facets against which mental illness diagnosis (and its prescriptive nature) operates.

3. Intervention

3.1. Module 1: Access to public mental health care & alternative approaches

We provided information on common methods to access the local public mental health care system. We discussed the application process, financial requirements, and other necessary paperwork and elicited stories of lived experiences with the system. We indicated instances in which Crisis Intervention Trained police officers or Mobile Crisis Units could be called out to homes, Mental Health Warrants filed, free or sliding-scale mental health crisis clinics could be utilized for drop-in visits, hotlines and helplines to be called, and emergency treatment received through the local public hospital system and the public psychiatric

hospital. We discussed traditional peer and family-based discussion groups, like the National Alliance for Mental Illness and Depression and Bipolar Support Alliance. Our CHW students shared some of their experiences, and we talked about gaps in public mental health care, the long waitlist to get an appointment with a counselor or psychiatrist, and the ethical dilemmas associated with involuntary commitment to psychiatric wards or incarceration in the local criminal justice system.

On the same day, we also contextualized mental stressors as products of oppressive structures in our society and economy. We discussed the effects of trauma and poverty at an individual and communal level. We sought to normalize the experiences of non-consensus reality and described similar efforts led by peers throughout the world: For example, Hearing Voices Network has established support groups to explore and make meaning from sensory (including auditory) variations. Over the last three decades, Open Dialogue has gained traction as a method for engaging with those in extreme mental states that brings clinicians, family, and friends into conversations to engage authentically with each other and to improve social dynamics. The Soteria House model has been replicated throughout the world and offers guests experiencing non-consensus reality a number of non-psychiatric interventions for coping with their mental states. In addition, we utilized sections from The Icarus Project's publication *Madness and Oppression: Paths to Personal Transformation and Collective Liberation* [18] to discuss steps to address oppression, deescalate crisis situations, encourage harm reduction strategies, and transform communities. We did this through an open conversation over several hours framed by the question of how to engage systematically and effectively, and not by classifying different movements or defending or denouncing any particular approach.

Moreover, we sought to facilitate historically-informed perspectives on mental wellness/community wellness. To do so, this often meant allowing time in our class to listen to residents discuss the effects of forced integration of public schools, the economic effects of Jim Crow laws (which prevented black small business owners for receiving loans from local banks), countless public health surveys in more recent years that did not result in systemic change in the area, the public outrage against the closure of several public schools in the area for charter schools which replaced them, the threat of eviction due to surprise inspections, the fear of Child Protective Services taking children away from their mothers or grandmothers, and police

apathy to calls from the public housing center. We talked about the sense of alienation and separation many residents feel in public housing, and we elicited counter-narratives about the rich local history and human capacity of the neighborhood.

3.2. Module 2: Advocacy

In our second community mental wellness session, we trained students to become mental health advocates and discussed strategies to advocate for community wellbeing at the local and state level. We gave a brief overview of legislative processes and mechanisms to pass laws, along with the roles local community organizations, think tanks, and lobbyists play in influencing politicians' support and public sentiment. We then discussed students' experiences talking with staffers and state representatives, and residents from public housing discussed the intimate relationship that many local politicians had with the housing center and with the nearby high school. They talked about their working relationships and friendships with politicians and past initiatives to advocate for community interests (to varied degrees of success).

The local political dynamics that residents described centered on the cultural and historical significance the particular place held for many prominent African American leaders, who grew up in and around the housing project, which had long been celebrated for its close-knit community and local advocacy work.[19] It had weathered the erosion of social services over the last several decades, along with a diminished sense of community support and cohesion. The stories emerged as directed dialogue, oriented by the possibility of collective action and recognition of the limits and risks of political engagement at the individual level.

At the end of the workshop, we asked the CHW students to create an elevator pitch of their project with fellow students and practice it with the class in preparation for their final presentations. As a follow-up activity, one of our students lead a training to discuss strategies to identify their local state representatives and contact them to advocate for a policy that was up for a vote in the Texas legislature. Our students made calls to their state representatives and read off a short script in support of a bill which provides funding mechanisms for peer support specialists who provide mental health support in low-income areas. These exercises allowed students to imagine potential roles as CHWs and community leader, to build capacity, and add value to problem-based learning.

3.3. Module 3: Self care as a political act

On our final session devoted to mental wellbeing, we facilitated a discussion on compassion fatigue and emotional burnout that CHWs and other health care providers often experience in their jobs as a product of poor infrastructure, rather than personal failing. We shared stories of students' experiences with poor work environments as a cause of poor mental health, and traced its effects on personal wellbeing, familial relations, and community ties. We talked about adequate work conditions as a form of community mental wellness, as a matter of economic justice and basic respect. Noting the limits of popular discourses on self-care, which all-too-frequently posit consumerism as an antidote for mental distress, we sought to situate mental wellness within social, political, and economic factors. We indicated the outreach that we had done on campus to create partnerships with research centers to hire our students for a living wage ($15 an hour), along with community partnerships we have established through the City Health Department and other health organizations to create part time jobs for our CHW students as well.[20]

We concluded the afternoon session by inviting an undergraduate student who was taking our class to lead a workshop on art as a form of mindfulness. She, along with a team of students engaged in a service learning project from outside our class, provided a brief overview of creative expression as a way to care for oneself and as strategic activities to solicit community feedback and participation. Together, they guided students through an art-making session, a short meditation, and a drawing exercises that asked them to illustrate their social networks and sense of community. They ended the workshop by creating a vision board which enabled students to illustrate shared leadership of their health project, along with listing future plans to scale project implementation. Such engaging activities allowed students to think in visual and structural terms about community wellness and translate such creativity to their own initiatives.

4. Discussion

4.1. Curricular limitations

In our analysis of structural barriers to addressing community mental wellness, we found that some of the immediate challenges to project-based learning included the complexities of working with a diverse group of students in which issues of digital literacy,

age, class, and race influenced their engagement within the course. With our pre-health undergraduate students, a lack of experience in public health care systems proved to be the greatest barrier to their full participation. Most of them came from middle class incomes, held coverage under their parents' health insurance plans, and knew little about the bureaucratic hurdles to access free or sliding scale health care in Houston. Others lacked exposure to the limits of top-down health care provision, which made our critique of traditional health models less pointed and relevant to their imagined futures as health care professions. Meanwhile, public housing residents' caregiving responsibilities for family members with chronic health issues, their own inadequate access to health care, and scheduling conflicts with work would often interfere with their class attendance and participation in group activities. As single mothers or grandmothers raising their grandchildren, many of them also provided great insight into reasons there was a lack of trust between community members and health care providers. Here, we must also recognize our own limits as course instructors in providing the time-intensive mentorship needed to ensure adequate support for all students. In the months following this course, we have created several part-time employment opportunities for some of our former students; and we are continuing to work with them as they implement projects they developed during the course. Together, we advocate for local solutions to local problems and improve social and economic conditions in the Third Ward through solidarity and collective action.

4.2. Toward a culture of health

The CHW Initiative at our university consists of a community based approach to CHW training and the creation of a dynamic network of CHWs—modeled on demand economy businesses where training, quality-control, and governance are all distributed and enforced through open protocols. A sustainable network can provide the university with infrastructure for future community interventions and research, create jobs for community members, and enhance learning opportunities for students. The critical engagement with local data means that faculty, students, community organizations, and CHWs are all oriented toward the open questions of actually achieving healthier communities and can work together toward innovative solutions grounded in community experience. Combined, the CHW training and our network embody an integrated culture of health.

In our plan to develop a local CHW network in conjunction with our certification class, we aim to advocate for living wages, change employment structures to adapt to the needs of local residents, and promote a robust community. Our challenge is to resist some aspects of neoliberal demands for limited, often exploitative job roles within which CHWs currently operate. As facilitators, we often asked ourselves what strategies we could take to ensure the CHW class could develop through leadership from the middle, in the sense that we did not know what projects would take shape in advance. We did not want the class to mold our students into mental health experts, white-collar bureaucrats, or philanthropists with upper middle-class values. We do not seek to quantify their work through grade point averages as a metric of success. Rather, we asked ourselves and local stakeholders how we could create jobs that allowed for the creativity, flexibility, and dynamism needed for CHWs embedded in communities to thrive personally and through their projects?

Our approach is not revolutionary, but subversive. Cautiously, we code-switch with various stakeholders when pitching the types of flexible, project-based jobs we seek to establish. We must work around our university's $1 billion fundraising campaign, its Third Ward Initiative, the Quality Enhancement Plan to promote Community and Co-Curricular Engagement, and the initiative to building a medical school for primary care and preventative health—all of which to varying degrees still assume an approach that affirms the role of the expert in "solving" community problems. To potential funders, we argue that such cost-saving measures to support embedded community members as CHWs, rather than provide additional financial incentives for clinicians at community health clinics who are not from the communities they serve, could have real traction among those seeking community-engaged models for preventative mental health care. We operate on the margins to critique the limits of what prescriptive, diagnostic categories for mental illness can provide and the limits of what top-down community building can offer in terms of sustainable development. Nevertheless, in furthering problematic employment models that do not offer the benefits of full time employment (such as health insurance, life insurance, and retirement), we may very well perpetuate the patchwork fixes that expect CHWs to take up Herculean challenges, which public health experts and mental health professionals cannot adequately address.

4.3. Analysis

Structural, economic, societal barriers—these are the many ways that CHWs and peer support specialists are kept from being mental health experts, yet asked to do something on the front lines that experts cannot do—i.e., both navigating health care systems and ensuring sufficient compliance as legitimate roles.[21] For many who suffer within (and because of) mental health care systems—including CHWs as well as peer support specialists, a mental illness diagnosis guides their treatment and affirms the role of the psychiatrist as expert, in this case the one who prescribes compliance and upon whose prescriptions should be acted.[22,23] Such top-down approaches to mental health can be crippling to those who struggle within biopsychiatric and epidemiological models of mental illness diagnosis and treatment in the United States; and this structure depends on something illegitimate in their insistence on the struggle to get things done at the front line. Thus, in including mental health modules into the CHW class, we found ourselves charged with this problem of struggling against the model of expert diagnosis.

Our contestation of mental health expertise lies within an embodied approach in liminal places where struggle can happen against the categories, not through social theory abstracted from or projected upon the lives of those living at the margins. Our challenges with teaching in public housing are similar, in some ways, to our struggle against psychiatry and antipsychiatry movements—against models that seek to define themselves from the center or from one particular set of identity politics.[24] As the anti-psychiatry movement of the 1980s fell on deaf ears to those who felt as though they were helped by traditional mental health services, we do not want to posit a singular model of mental health or a simplistic critique of capitalism as schizophrenic itself. For us, the space between resistance and compliance lies within the careful cultivation of community engagement that allows for flexibility and nuance—for everyday solutions to local issues.

5. Conclusion

Facing such dire cuts to public health care and a lack of mental health care parity and access, communities must find survival strategies to organize in addressing local needs. Through creating spaces for local definitions of mental wellness to unfold, we seek to cultivate our students' capacity to promote mental wellness at a community level. Moments of pause, of reflection—the ability to stall a mental illness diagnosis, to utilize the benefits a diagnosis affords without succumbing to the weight of chronicity and stigma also associated with it—these are the strengths CHWs can bring to community-engaged initiatives. The ability to move beyond clinical settings, to bring "experts" into a greater recognition about what is at stake in community initiatives, to invite local residents and other stakeholders into conversations before the terms of engagement are agreed upon—such are the strengths of CHWs that we seek to amplify.

As CHW instructors, we encourage our students to resist neoliberal systems of diagnosis and psychiatric compliance that all-too-quickly assume top-down assumptions of health as a liberal singularity, even as we struggle against co-optation and complicity in developing educational and employment opportunities for our students. We recognize that we as scholars are not liberators, in any heroic sense. Rather, we too are engaged within the struggle to promote leadership from the middle. Within our university and beyond, we must operate against systems of diagnosis and prescriptive action to subvert imperatives which would further marginalize, displace, or oppress those who stall against the public mental health care system. Within the margins, through nonlinear, collective approaches, we find a small, but powerful place to embrace mental diversity and embody important interventions over and against the mental health professions.

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Disclosure

Not applicable.

Ethics statement

This paper details a qualitative approach to course development. Because no formal data metrics were collected from students in the course, no research

proposals were submitted to our university's Institute Review Board for this class, and participating students were not required to sign informed consent forms or research waivers to engage with this class.

Conflicts of interest

None.

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None.

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Erica Hua Fletcher is a visiting assistant professor at the Honors College, University of Houston, USA.

Daniel M. Price is a clinical assistant professor at the Honors College, University of Houston, USA.