https://doi.org/10.1038/s44184-024-00094-7

Advancing community health worker models to support youth and families' mental health

Erika L. Gustafson & Stephanie A. Torres

Check for updates

Community health workers (CHWs) have demonstrated effectiveness in delivering EBTs; however, the integration of CHWs in the U.S. mental health system remains limited. This Comment presents key recommendations for optimizing CHW integration into the mental health spectrum of care to better meet the needs of youth. We discuss necessary advancements across domains of practice, research, and policy to support the sustainability of these models.

> It was clear in many parts of the world that the dominant medical and public health models were not meeting the most urgent needs of poor and disadvantaged populations […] Out of necessity, local communities and health care workers searched for alternatives to vertical disease campaigns […] [I]t was thought that locally recruited community health workers could, with limited training, assist their neighbors in confronting the majority of common health problems[1].

Community-based health approaches of the 1960's and 1970's emerged in response to dominant medical models that, although effective, were largely inaccessible. Today, the U.S. is facing a similar crisis in youth mental health wherein dominant service models are insufficient. The field has developed many evidence-based treatments (EBTs), the gold standard for addressing mental health disorders, and meta-analyses show similar EBT outcomes across racial and ethnic groups[2,3]. However, only 20% of youth with mental health needs receive care[4], and when in treatment, 28%-75% prematurely drop out[5]. The treatment gap is even more pronounced for systemically minoritized youth, with 8% of Black and Brown youth receiving services compared to 18% of White youth[6]. Disparities also exist for adults[5], meaning the family unit is doubly impacted by inequities as both children and their caregivers face challenges to treatment access. Therefore, we have mental health treatments that are effective but inaccessible, resulting in a mental health system failing to meet the needs of our most marginalized children and families. This necessitates a turn toward innovative, community-driven approaches for delivering mental health supports[7].

One such approach is integrating community health workers (CHWs) in mental health services. CHWs are known by a variety of terms, including paraprofessionals, lay health workers (LHW), peer support specialists (PSS), and *promotores de salud*, amongst others. We use the CHW term to refer to trusted individuals *from the community served* who have no formal mental health training, and who act as a bridge between the community and health and services[8]. CHWs can occupy a range of roles in mental health services, including: direct interventionist, stepped-care (i.e., CHWs treat lower acuity cases while licensed providers treat higher acuity cases), auxiliary care (i.e., CHWs provide psychoeducation and address barriers to care), and outreach/navigation. As interventionists[9], CHWs have demonstrated effectiveness and feasibility in delivering mental health interventions[8]. Primarily studied in low-and middle-income countries[8], there is growing interest in integrating CHWs into mental healthcare in the U.S. The near-peer aspect of CHWs' positionality facilitates engagement in ways that traditional mental health providers cannot. As community members, CHWs share key social identities with the families they serve, which can allow them to provide more culturally and linguistically relevant services, promote trust and treatment buy-in[9,10]. As described by Mehta et al., CHWs' social positionality is a key strength that promotes engagement via social network processes[11]. Trusting a trained community member may lead to increased adherence to treatment and better health outcomes[12], chipping away at the disparities in access to care for minoritized populations. Thus, CHWs increase both the accessibility and cultural relevance of services.

For the purpose of this Comment, we focus on models in which adult CHWs take on a direct interventionist role. It is important to note that CHW models offer an *extension* to the spectrum of care; they are *not* meant to supplant specialty mental health services. These CHW models should *not* act as a substitute for advanced services and licensed providers given the risk of over-extending the CHW role and perpetuating existing inequities for marginalized communities. Though beyond the scope of this paper, we strongly assert that advances still must be made in specialty treatment access, particularly for populations impacted by systemic inequities.

CHW mental health models: what will it take? While CHWs have demonstrated effectiveness in their ability to deliver EBTs, CHW models have not achieved mainstream integration into mental health services. The reasons for this sit at the nexus of practice, research, and policy considerations.

Practice. To advance CHW models into clinical practice, we must determine where and how to integrate CHWs into the spectrum of care, and specifically examine (1) in what settings do youth and families most stand to benefit from CHW integration, (2) what level of support is necessary for CHW models, and (3) what cases are appropriate for CHW services. Because youth are situated at the center of intersecting family, school, and community systems, leveraging CHW models in support of youth mental health becomes a question of how to support the integration of CHWs into systems that are most relevant to youth. This is critical given that youth engagement in treatment may be largely dependent on other systems, such as parents or schools.

Schools are the most common access point for youth mental health services[13], and youth from low-income households and minoritized racial/ethnic groups are most likely to *only* receive services in educational settings[14]. Integrating CHW mental health models into schools would both increase access to mental health services while also supporting overburdened school systems. This aligns well with the multi-tiered systems of support (MTSS) that embeds interventions of varying degrees of intensity to match the ranging needs of students in schools[15]. In MTSS, supports range from universal mental health promotion and prevention efforts such as improving school climate (Tier 1), to early-intervention initiatives such as small group-based programs to improve emotional awareness (Tier 2), to targeted interventions such as individual counseling for those students with higher levels of need (Tier 3). A breadth of research has demonstrated the success of these prevention services, particularly for promoting mental health among minoritized youth[16]. Having a spectrum of interventions ultimately increases the capacity of the service system; this similarly applies CHW models in mental health. For example, the Parents Achieving Student Success (PASS) program embedded CHWs in schools to support Latine and Black children's social, emotional, and behavioral functioning in school, and their parents' use of positive parenting strategies; integrating CHWs into the school setting allowed them to more easily access both children and parents, and engage parents in their child's schooling and mental health promotion.[17]

Outpatient settings are the second most common treatment setting for youth[13]; thus, similar to school integration, adding CHW mental health interventions to these settings promises to reach a large portion of youth. Additionally, home visiting and telehealth services play an important role in increasing treatment options for families for whom traditional clinic-based services may be inaccessible, e.g., those in rural communities and other mental health service shortage areas. CHW home visiting and telehealth models can be implemented as stand-alone services (e.g., refs. 18,19), or as a flexible extension of services based in clinics or community-based settings (e.g., ref. 20). Across these settings, CHW integration will require training and support at the staff and organizational levels, as well as sustainable funding mechanisms to support their work.

A second consideration is around supervision and support for these CHW models. Even for advanced licensed providers, uptake from training in new EBTs is low unless followed by ongoing practice and supervision, and often adherence is not maintained at follow-up[21]. Therefore, it is all the more necessary that CHWs receive both training in EBTs[22,23] *as well as* robust ongoing supervision to support their implementation of EBTs. Indeed, supervision from licensed mental health providers is a common feature of CHW mental health models[15], and we assert that this is a critical component for their feasibility, as it supports the provision of quality care and provides an in-built safety net for triaging higher acuity cases. For example, CHWs may encounter clients with presentations beyond the scope of their abilities, and supervision from a licensed clinician provides a mechanism through which to ensure cases are staffed with the appropriate provider. Given the severe mental health provider shortage[24], supervision by licensed providers is particularly impactful as it expands the reach of mental health providers who are able to serve more clients through supervising CHWs than they could by seeing clients individually. For licensed mental health providers, their role may already include the provision of supervision to trainees. Thus, training in the supervision of CHWs would be a natural extension of their role that would prepare licensed providers to meet any unique needs of CHWs. It is also important to acknowledge that because CHWs are members of the community served, they likely face similar systemic stressors as their clients, and as such, CHWs may face additional burden during EBT delivery. Therefore, beyond clinical supervision, CHWs may benefit from additional supports, including from those who have a shared understanding of the CHW role (i.e., peer consultation from fellow CHWs and supervision from advanced CHWs)[22], to prevent vicarious trauma and burnout.

Lastly, we propose that CHWs are optimally positioned to provide prevention and early intervention services with lower acuity cases, and serve as a bridge while patients await specialty care. Long wait times for mental health services are consistently cited as a barrier to care by both youth[25] and their parents[26], which presents an opportunity for CHWs to intervene during a period in which patients typically go without care. Mobilizing CHWs during this time capitalizes on their ability to effectively deliver EBTs, as well as serving as a bridge between the community and health services. In turn, this potentially increases access for lower acuity cases, preventing youth from needing a higher level of care, while also allowing higher-need cases to be triaged to providers with more advanced training, ultimately making for more judicious use of limited provider resources (for an example of this type of auxiliary care model in adults, see ref. 27). Consistent with serving lower acuity cases, the EBTs that are best suited for CHW delivery will likely be time-limited and follow a structured, manualized format to facilitate ease of delivery. Indeed, a systematic review of CHW-delivered EBTs found that interventions had a mean duration of approximately 10 weeks, and the majority used manualized protocols[28].

Research. Addressing these practice considerations requires strong academic-community partnerships that center the voices of CHWs and other key community partners, including youth, parents and other important youth-facing community members (e.g., school and after school staff). Academic researchers and community partners should work together not only for the purpose of program evaluation, but throughout the process of development, implementation, and sustainment. Dissemination and implementation science (DIS) is well suited to examine how to optimize the implementation process. DIS seeks to understand how to effectively translate evidence-based practices and policies into real-world settings, closing the evidence-practice gap. DIS can be used to understand the necessary steps to adopt, implement, and sustain practices (process models); pinpoint the underlying mechanisms of successful dissemination and implementation (explanatory models); and examine implementation outcomes (outcome models)[29]. For example, these models can be used to understand what factors impact the implementation of CHW interventions across different contexts, what level and mode of supervision is necessary for CHWs, and best practices for how CHWs can triage clients. Barnett and colleagues[30] specifically used RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance), an outcome model, to describe ways CHWs can expand reach of services while contributing to the effectiveness, uptake, implementation, and maintenance of EBTs.

To optimize the fit of an EBT within specific settings and populations, DIS work must engage community partners. Community-engaged research (CEnR) is the process of engaging key community partners throughout the research process from the conceptualization of the project to the dissemination and translation of the research to practice[31]. When determining where and how to integrate CHWs into the spectrum of clinical care, it is imperative that CHWs are co-leading these efforts. This will not only optimize implementation, but ensure that these practices are sustainable. It is also important that youth have a seat at the table to inform the development of CHW mental health models. Youth participatory approaches, such as youth participatory action research (YPAR), empowers youth to use research and evidence to improve conditions in their lives and communities[31]. Like CHWs, youth partners can serve as co-researchers,

becoming actively involved in research and decision making regarding how CHWs are integrated into mental health services.

One specific framework that integrates both DIS and participatory methods is community-engaged dissemination and implementation (CEDI) research. CEDI centers community voice by engaging stakeholders in determining barriers and facilitators to dissemination and implementation[32]. The combination of DIS and CEnR will promote the advancement in CHW models in clinical practice.

Policy. A major impediment to mainstream integration of CHW mental health models is the lack of reliable funding mechanisms. In 2022, only 7 states covered CHW services under the state Medicaid plan. The specific services covered varied across states, but the common factor was a limited scope of coverage[33]. Only one state covered CHW counseling, and this was only for smoking cessation and substance use screening. Thus, coverage for CHW mental health services is virtually nonexistent despite evidence demonstrating CHWs' efficacy in this domain. However, more states are moving to include coverage of CHW services, which presents an opportunity for developing reimbursement models for CHW mental health services. For example, in 2021 and 2022, Illinois[34] and California[35] respectively passed legislation creating pathways for Medicaid coverage of CHW services. As states work through delineating the implementation of this legislation, it is critical that (1) CHWs be included so that their expertise informs policy implementation, and (2) coverage for mental health services be included in these policies.

It is also necessary to center the needs of youth mental health to inform policy considerations. This entails supporting the systems most important and accessible to youth. Therefore, insurance policies should include coverage for CHWs to work within schools, homes, and community-based organization settings, in addition to traditional outpatient clinic settings. Coverage should encompass delivery of EBTs *as well as* the other components of the CHW role that promote youth mental health, such as addressing barriers to treatment (e.g., case management to address social determinants of health), mental health education (e.g., psychoeducation provided via community outreach and family engagement), and navigation (e.g., facilitating connections to other mental health services). From a systems-level perspective, such policies not only increase the accessibility of mental health supports for youth, but they also strengthen communities via increasing community capacity to care for its community members. Investing in these CHW models through insurance coverage is ultimately an investment in community mental health infrastructure.

Conclusion

Longstanding inequities in access to mental healthcare for youth, particularly youth from systemically minoritized communities[6], requires a turn toward community-driven solutions. Embedding CHWs into the mental health spectrum of care offers a promising means through which to address these inequities[9]. Advancing CHW mental health service models will require careful consideration of the supports needed for optimal integration across home, school, and community settings, as well as delineating the types of cases most appropriate for the CHW role (i.e., low acuity presentations). DIS and participatory methods are critical to advance evidence on *how* to best implement CHW-led mental health interventions. Finally, changes on the policy level are necessary in order to ensure that CHW services are billable, contributing to increased access and long-term sustainability. Of note, responding to the practice, research, and policy needs of CHW mental health models will require engaging with a range of ethical considerations. For example, it will be necessary to grapple with questions of role boundaries for CHWs as an interventionist and near-peer; supporting CHW wellbeing while in an interventionist role; maintaining quality of care for clients; power sharing in intervention development, implementation, and evaluation; and ensuring fair, living wages for a workforce whose credentials differ from those in traditional health and mental health service systems. Beyond the scope of this Comment, these ethical questions merit thorough examination in future scholarly works. Ultimately, practice, research, and policy considerations *must* center the lived experiences of CHWs, parents, and youth partners. This will ensure that these services are equitable, shrinking the evidence-practice gap and addressing the multifaceted nature of youth mental health.

Data availability

No datasets were generated or analyzed during the current study.

Erika L. Gustafson [1] ✉ **& Stephanie A. Torres** [2]

[1]Institute for Juvenile Research, Department of Psychiatry, College of Medicine, University of Illinois Chicago, Chicago, IL, USA. [2]Department of Educational Psychology, College of Education, University of Illinois Chicago, Chicago, IL, USA. ✉e-mail: gustafs6@uic.edu

Received: 19 December 2023; Accepted: 10 October 2024;
Published online: 29 October 2024

References

1. Irwin, A. & Scali, E. Action on the social determinants of health: Learning from previous experiences (Social Determinants of Health Discussion Paper 1 (Debates)). (World Health Organization, 2010). https://www.who.int/publications/i/item/9789241500876.
2. Cougle, J. R. & Grubaugh, A. L. Do psychosocial treatment outcomes vary by race or ethnicity? A review of meta-analyses. *Clin. Psychol. Rev.* **96**, 102192 (2022).
3. Huey, S. J. & Polo, A. J. Evidence-based psychosocial treatments for ethnic minority youth. *J. Clin. Child Adolesc. Psychol.* **37**, 262–301 (2008).
4. CDC. *Improving Access to Children's Mental Health Care* (Centers for Disease Control and Prevention, 2023).
5. Modi, H., Orgera, K. & Grover, A. *Exploring Barriers to Mental Health Care in the US* (AAMC, 2022).
6. Rodgers, C. R. R., Flores, M. W., Bassey, O., Augenblick, J. M. & Cook, B. L. Racial/ethnic disparity trends in children's mental health care access and expenditures from 2010-2017: disparities remain despite sweeping policy reform. *J. Am. Acad. Child Adolesc. Psychiatry* **61**, 915–925 (2022).
7. World Health Organization. *World Mental Health Report: Transforming Mental Health For All—Executive Summary* (Geneva, 2022) Licence: CC BY-NC-SA 3.0 IGO.
8. Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A. & Lau, A. S. Mobilizing community health workers to address mental health disparities for underserved populations: a systematic review. *Adm. Policy Ment. Health* **45**, 195–211 (2018).
9. Barnett, M. L., Lau, A. S. & Miranda, J. Lay health worker involvement in evidence-based treatment delivery: a conceptual model to address disparities in care. *Annu. Rev. Clin. Psychol.* **14**, 185–208 (2018).
10. Gustafson, E. L., Atkins, M. & Rusch, D. Community health workers and social proximity: implementation of a parenting program in urban poverty. *Am. J. Community Psychol.* **62**, 449–463 (2018).
11. Mehta, T. G., Atkins, M. S., Gustafson, E. L., Rusch, D. & Watling Neal, J. A crisis too valuable to waste: lessons learned during Covid-19 to improve behavioral health care for children and youth. [Manuscript Submitted for Review] (2023).
12. Rafizadeh, E. B., Rice, E., Smith, J., Bell, J. & Harvath, T. A. Understanding how community health workers build trust with low-income women of color at-risk for maternal child health disparities: a grounded theory study. *J. Community Health Nurs.* **40**, 219–231 (2023).
13. Duong, M. T. et al. Rates of mental health service utilization by children and adolescents in schools and other common service settings: a systematic review and meta-analysis. *Adm. Policy Ment. Health* **48**, 420–439 (2021).
14. Ali, M. M., Teich, J., Lynch, S. & Mutter, R. Utilization of mental health services by preschool-aged children with private insurance coverage. *Adm. Policy Ment. Health* **45**, 731–740 (2018).
15. Hoover, S. et al. *Advancing Comprehensive School Mental Health Systems: Guidance From the Field* (National Center for School Mental Health: University of Maryland School of Medicine, 2019).
16. Malone, C. M., Wycoff, K. & Turner, E. A. Applying a MTSS framework to address racism and promote mental health for racial/ethnic minoritized youth. *Psychol. Sch.* **59**, 2438–2452 (2022).
17. Lakind, D., Bradley, W. J., Patel, A., Chorpita, B. F. & Becker, K. D. A multidimensional examination of the measurement of treatment engagement: implications for children's mental health services and research. *J. Clin. Child Adolesc. Psychol.* **51**, 453–468 (2022).
18. Williamson, A. A., Knox, L., Guerra, N. G. & Williams, K. R. A pilot randomized trial of community-based parent training for immigrant latina mothers. *Am. J. Community Psychol.* **53**, 47–59 (2014).

19. Magaña, S. et al. A randomized waitlist-control group study of a culturally tailored parent education intervention for latino parents of children with ASD. *J. Autism Dev. Disord.* **50**, 250–262 (2020).
20. Knox, L., Guerra, N. G., Williams, K. R. & Toro, R. Preventing children's aggression in immigrant Latino families: a mixed methods evaluation of the Families and Schools Together program. *Am. J. Community Psychol.* **48**, 65–76 (2011).
21. Beidas, R. S. & Kendall, P. C. Training therapists in evidence-based practice: a critical review of studies from a systems-contextual perspective. *Clin. Psychol. Sci. Pract.* **17**, 1–30 (2010).
22. Garcini, L. M. et al. Mind the gap: identifying training needs of community health workers to address mental health in U.S. Latino communities during and beyond the COVID-19 pandemic. *Front. Public Health* **10**, 928575 (2022).
23. Barnett, M. L., Puffer, E. S., Ng, L. C. & Jaguga, F. Effective training practices for non-specialist providers to promote high-quality mental health intervention delivery: A narrative review with four case studies from Kenya, Ethiopia, and the United States. *Camb. Prisms Glob. Ment. Health* **10**, e26 (2023).
24. Butryn, T., Bryant, L., Marchionni, C. & Sholevar, F. The shortage of psychiatrists and other mental health providers: causes, current state, and potential solutions. *Int. J. Acad. Med.* **3**, 5 (2017).
25. Radez, J. et al. Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *Eur. Child Adolesc. Psychiatry* **30**, 183–211 (2021).
26. Reardon, T. et al. What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies. *Eur. Child Adolesc. Psychiatry* **26**, 623–647 (2017).
27. Patel, V. et al. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. *Lancet* **376**, 2086–2095 (2010).
28. Singla, D. R. et al. Psychological treatments for the world: lessons from low- and middle-income countries. *Annu. Rev. Clin. Psychol.* **13**, 149–181 (2017).
29. Estabrooks, P. A., Brownson, R. C. & Pronk, N. P. Dissemination and implementation science for public health professionals: an overview and call to action. *Prev. Chronic Dis.* **15**, E162 (2018).
30. Barnett, M. L., Luis Sanchez, B. E., Green Rosas, Y. & Broder-Fingert, S. Future directions in lay health worker involvement in children's mental health services in the U.S. *J. Clin. Child Adolesc. Psychol.* **50**, 966–978 (2021).
31. Ozer, E. J. et al. Youth participatory approaches and health equity: conceptualization and integrative review. *Am. J. Community Psychol.* **66**, 267–278 (2020).
32. Holt, C. L. & Chambers, D. A. Opportunities and challenges in conducting community-engaged dissemination/implementation research. *Transl. Behav. Med.* **7**, 389–392 (2017).
33. Medicaid and CHIP Payment and Access Commission. *Medicaid Coverage of Community Health Worker Services* (2022). https://www.macpac.gov/wp-content/uploads/2022/04/Medicaid-coverage-of-community-health-workerservices-1.pdf.
34. *410 ILCS 67: Community Health Worker Certification and Reimbursement Act* (2021). https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=4090.
35. Department of Health Care. *Community Health Workers*. https://www.dhcs.ca.gov/community-health-workers, (2022).

Author contributions

E.L.G. devised the project and outline. E.L.G. and S.A.T. contributed to writing the manuscript and critically revising it.

Competing interests

The authors declare no competing interests.

Additional information

Correspondence and requests for materials should be addressed to Erika L. Gustafson.

Reprints and permissions information is available at http://www.nature.com/reprints

Publisher's note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Open Access This article is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License, which permits any non-commercial use, sharing, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if you modified the licensed material. You do not have permission under this licence to share adapted material derived from this article or parts of it. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by-nc-nd/4.0/.

© The Author(s) 2024