Implementation of Lay-Delivered Mental Health Interventions for Underserved Populations in the United States: A Scoping Review

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Introduction

The need for mental health services in the U.S far exceeds the availability of licensed clinicians. One in every five American adults suffer with mental illness, but according to the Substance Abuse and Mental Health Services Administration, less than 50% of those with any mental illness receive treatment[1]. Access to mental health services is not equally distributed and is particularly problematic among certain vulnerable and disadvantaged populations in the US.

Task shifting mental health services to lay providers is a popular evidence-based intervention for enhancing access to mental health care. This strategy typically involves the use of lay providers selected from a community of interest who are trained to support and augment mental health services in a variety of roles including outreach, screening, case management, and direct provision of care[2]. Lay-delivered mental health interventions in the US have resulted in statistically significant improvements in psychological outcomes and functioning[3].

There are several potential advantages to the incorporation of lay providers in mental health including the expansion of the mental health workforce, enhanced cultural competency, the ability to address sociocultural determinants of health, and cost-effectiveness. Currently, the implementation of lay-delivered mental health interventions varies greatly. To date, there have been few attempts to systematically summarize these intervention designs and the methods used to execute them. Lack of reporting on implementation measures has made it difficult for researchers to highlight best practices and replicate strategies that work.

Objectives

- Conduct descriptive analysis of recently published lay-delivered mental health interventions, delineating key target populations, provider characteristics, and core intervention components
- Assess the nature and extent of the role of the lay provider in mental health interventions
- Illustrate strategies used across interventions to recruit, train, supervise, fund, and evaluate the incorporation of lay mental health providers
- Indicate gaps and obstacles in the realization of intervention programs

Search Strategy

Database subject headings and keywords related to three major constructs were used to retrieve relevant articles:

Construct	Sample Search Terms
Community Health Workers	community health worker, community health aide, lay health worker, health mediator, lay provider, paraprofessional, lay counselor, lay volunteer, lay coach, peer navigator, navigator
Mental Health	mental health, mental health disorder, depression, anxiety, trauma
Underserved Populations* (*search terms derived from the PubMed Health Disparities and Minority Health Search Strategy[4])	J Health Care Poor Underserved [Journal], indigenous, socioeconomically disadvantaged, African Americans, African ancestry, AIAN, Alaska Natives, Asians, Black Americans, disabled, disabled persons, emigrants, immigrants, underserved, undocumented, genderqueer, LGBT, LGBTQ, homophiles homosexuals, intersex, disadvantaged populations

Table 1 Optimized Search Strategy

Study Selection

Inclusion Criteria	Exclusion Criteria
English language	Study located outside of the US
Published between 2013-2025	Scoping review, meta-analysis, systematic review, or dissertation/thesis
Study conducted in the US with lay health workers (without a health-related degree or licensing)	Study design does not explicitly address mental health or does not include mental health as a primary outcome
Randomized controlled trials, program evaluations, implementation protocols, feasibility studies	Study focuses on externalizing disorders or dementia (e.g substance abuse, developmental disorders, Alzheimer's disease)
Study population focuses on the vulnerable or underserved	
Study focuses on internalizing mental health disorders (e.g. mood, anxiety, PTSD, trauma)	

Table 2 Inclusion and Exclusion Criteria for Studies

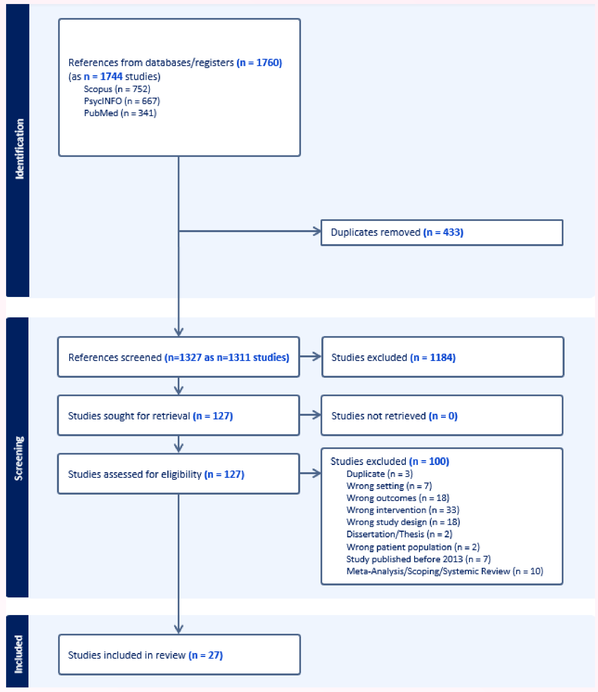

Figure 1 Scoping Review Process

Analysis

1. Researchers systemically extracted key information from each study including: study location, funding, duration, target populations, demographic characteristics of lay providers, target mental health outcomes and measures, intervention components, and key conclusions
2. Deductive codes were developed to identify emerging trends and themes in the data
3. Researchers synthesized results pertaining to study objectives in three thematic categories: implementation strengths, weaknesses, and gaps/obstacles

Results

Study Characteristics:

- Interventions were located predominantly within metropolitan areas in the mid-atlantic and southwestern united states (n=13)
- Researchers targeted a wide variety of vulnerable populations including the elderly, formerly incarcerated, immigrants, peripartum women, as well as ethnic, racial, and sexual minorities
- Women and racial/ethnic minorities accounted for the supermajority of participants in 44% and 74% of intervention studies respectively. Participants also tended to be majority low-income in up to 30% of interventions

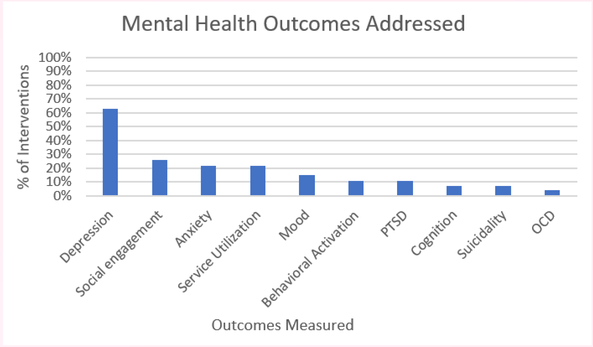

Figure 2 Mental Health Outcomes Addressed Across Interventions

Lay Health Workers in Interventions

- ***Recruitment:*** Researchers sought to recruit lay health workers who could be described as peers of the target population – matched as closely as possible in age, gender, location, etc. Lay providers were largely recruited from existing community-based organizations.
- ***Training:*** Training methods and timeline varied widely, with some lay providers receiving 4 hours of training while others received up to four months. The most popular training methods including didactics, roleplaying, and use of training manuals. Training content focused heavily on intervention-specific protocols, psychoeducation, and topics related to care-coordination (referrals, scheduling, resource navigation). A minority of interventions included training on ethics, communication, and participant safety.
- ***Supervision:*** The majority of lay providers were supervised on a weekly basis with researchers offering support and feedback either by phone or in-person throughout the course of the intervention

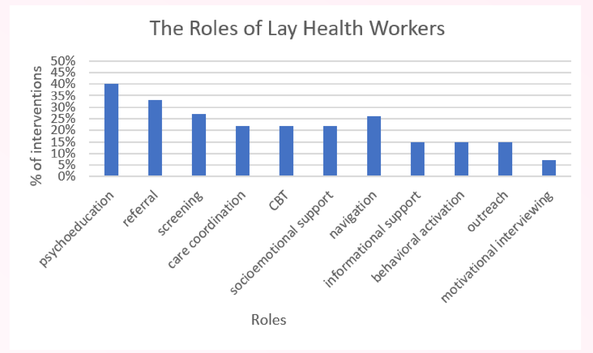

Figure 3 The Roles of Lay Health Workers Across Interventions

Conclusion

Implementation Strengths:

- Lay health workers were often embedded in the community, with cultural and linguistic proximity to target populations. Thus, paraprofessionals were able to enhance patient interactions by offering a sense of community and relatedness between patients and providers
- Flexible interventions that allowed for a variety of care settings or used technology to enhance the accessibility of interventions saw greater retention of participants
- Interventions that incorporated community-based participatory research allowed communities to adopt ownership of interventions, and provided researchers with a sustainable source of recruitment for lay health workers
- Interventions that incorporated lay health workers in stepped care models or direct patient care provided evidence for how the role of the lay health worker can be expanded beyond auxiliary support

Implementation Weaknesses:

- In intervention studies with high rates of provider drop out, lay providers disclosed that they have many competing demands and little time to devote to extra trainings or expanding responsibilities
- Researchers are often timebound by the funding period for their grant awards, and lack sustainable financing to carry out long-term interventions or lasting community partnerships

Implementation Gaps:

- Incomplete reporting about training content, duration, intervention costs, and implementation strategies limited our analyses. Practical considerations for training and funding lay-delivered interventions must be regularly reported by researchers to promote cost-benefit analyses and replicability of best practices.
- Training content was closely tied to the intervention protocol for each study with little attention paid to general competencies such as health communication, cultural competency, and approaches to acute mental health emergencies. These general competencies should be reinforced, not excluded from training, as they frequently lose salience even among seasoned lay health workers.

Acknowledgements

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