CoLab
Community & Behavioral Health Policy

Non-Specialist Mental Health Service Models for Youth: A Scoping Review

Purpose

This scoping review explored the literature on therapeutic interventions currently being delivered globally via non-specialist providers in community or home-based settings to support child and adolescent mental health. This review addressed the following questions to inform the CARE project approach to designing non-specialist models in Washington state: 1) Who has played the role of non-specialist providers to deliver services? 2) What service delivery models have non-specialists adopted? 3) What intervention models have non-specialists delivered and to what extent have those required adaptation? 4) What models of training and ongoing supervision have been used to support non-specialists? and 5) What strategies have been used to support non-specialist providers' maintenance of learned skills and to assess treatment fidelity?

Approach

The approach to this scoping review was based on the guidance of the Joanna Briggs Institute method (Khalil et al., 2016; Peters et al., 2015) with the goal of identifying characteristics of non-specialist workforce service models for child and youth mental health. The process includes: (1) identifying the research question, (2) systematically searching for relevant studies, (3) screening and selecting studies, (4) charting the data, and (5) collating the results. Findings are grouped into key concepts and used to inform a best practice model of child and adolescent mental health services delivered via non-specialist providers. A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis was conducted and no current or underway systematic reviews or scoping reviews on the topic were identified.

A systematic search of the literature yielded 799 articles, 21 of which were deemed relevant when assessed by the inclusion and exclusion criteria. The first phase involved removing duplicates (226), resulting in 573 papers remaining. Titles were then reviewed, with 465 papers eliminated, leaving 108 papers for review. Abstracts were reviewed next, eliminating 65 papers and leaving 43 for full text review. Following full text review, 22 papers were eliminated, resulting in 21 papers for final review. These full-text articles are included at the end of the report.

Findings

The articles obtained were randomized controlled trials (RCT) 9 (42.9%), quasi-experimental studies 2 (9.5%), feasibility/acceptability studies 9 (42.9%), or readiness assessments 1 (4.8%). The majority of studies were conducted in LMIC (12; 57.1%), including Thailand, South Africa, Rwanda, Pakistan, Uganda, Zambia, Tanzania, Liberia with four (19%) conducted in the United

States, as well as one in Canada (4.8%), two in Sweden (9.5%), one in the United Kingdom (4.8%), and one in China (4.8%). A mix of quantitative (11; 52.4%), qualitative (4; 19.0%), and mixed methods (6; 28.6%) approaches were seen.

Intervention models

Who has played the role of non-specialist providers to deliver services?

The majority of studies (76.2%) described a community health workers/lay counselor model, referring to members of the same community as those who are seeking services who do not have background or training in mental health. There was variation regarding the extent to which these workers had at minimum high school education versus college education, with some studies not providing details on education level. Two studies (9.5%) described a model in which youth peers with lived experience served as youth workers or peer mentors to young people, while another study described "youth workers" who had experience working with young people and families but no prior formal mental health training. Youth worker models typically supported adolescent and young adult mental health without family involvement. One study (4.8%) involved a model of adult mentors who were nominated by youth who served as heads of household and other community members. The remaining studies (9.5%) described peer caregiver models in which caregivers with lived experience of supporting a child with mental health needs were trained to deliver services. These services often supported caregivers of young children (3 to 7 years of age), or caregivers of neurodivergent children.

What service delivery models have non-specialists adopted?

Regarding how services were delivered, 13 studies (61.9%) described a group-based model, with varying degrees of group structures. For example, six studies (28.6%) referenced a model in which caregivers and youth meet in separate groups, and then come together for a joint session, while one study held only family sessions. The other six studies (28.6%) were either caregiver-only or youth-only groups. A smaller number of studies (23.8%) described individual sessions, with four involving only caregivers or only youth, and one study involving caregiver-focused sessions with their child present. Three studies (14.3%) referred to hybrid-models, in which group-based sessions with youth and caregivers were held as well as individual sessions for youth. There was significant variation in length and frequency of sessions. Session length ranged from one session to 23 sessions, with a little more than half of the studies (52.4%) indicating weekly sessions. In terms of intervention settings, 12 studies (57.1%) conducted care in community settings, while three studies (14.3%) described home-based care, and four studies (19.0%) referenced some combination of home-based, clinic-based, and/or community-based care. One study (4.7%) involved delivery of services virtually.

What intervention models have non-specialists delivered and to what extent have those required adaptation?

Interventions differed in terms of mental health target conditions. Nine of the studies (42.9%) identified both post-traumatic stress symptoms and depression as mental health targets, and were informed by cognitive behavioral and trauma-focused evidence-based approaches (e.g., trauma-focused cognitive behavioral therapy, trauma-focused narrative exposure therapy). For studies with depression and anxiety as primary mental health targets (14.3%), but without focus on post-traumatic stress symptoms, intervention models followed interpersonal psychotherapy protocols. Two studies (9.5%) adapted parenting skills interventions (e.g., Parent-Child Interaction Therapy, Incredible Years, Nurturing Parenting Program) for younger children (under age seven) with child behavior and parenting skills as primary targets of intervention, while one intervention for children two to nine years old was specific to Autism following the Preschool Autism Communication Treatment approach. Two studies (9.5%) described using the WHO Mental Health Gap Action Program (mhGAP), one for children with developmental disabilities, and the other combining mhGAP with other manuals specific to supporting youth and families with serious mental illness (e.g., Care for People with Schizophrenia in India). Three studies (14.3%) described specific programs focused on family strengthening that were delivered to youth and families presenting with a range of internalizing and externalizing symptoms, while one study described a general approach for training mentors in supporting youth mental health but did not describe a specific evidence-based model or protocol. Twelve studies (57.1%) explicitly described a process of adaptation for evidence-based models to meet the specific needs of the community being served, with four studies (19.0%) referencing a community-based participatory research approach that informed intervention adaptation. Notably, all interventions assessing effectiveness demonstrated some benefit on youth mental health and behavioral symptoms, and caregiver-child relationship outcomes.

What models of training and ongoing supervision have been used to support non-specialists?

There were a variety of approaches to training and supervision. While four studies (19.0%) did not describe length of training, across the remaining studies (80.9%), training length ranged from one day of didactics and classroom instruction to one week of didactics plus three months of field training, shadowing, and lectures. Training models included a mix of in-person meetings, didactics, coaching and feedback, role-plays, supervised observation of skills practice with case studies, apprenticeship models, and reading books and manuals. One study (4.7%) described two refresher sessions following training, but very few studies described approaches for supporting non-specialist providers' maintenance of learned skills aside from ongoing supervision. Regarding supervision models, six studies (28.6%) did not provide specific information on supervision. Nine of the studies (42.9%) described weekly supervision meetings, with variation as to whether meetings were in person or virtual. Four studies (19.0%) referenced

using a cascade model, in which local specialists who were trained and supervised by licensed professionals then served as trainers and supervisors to non-specialist providers.

What strategies have been used to support non-specialist providers' maintenance of learned skills and to assess treatment fidelity?

While the majority of studies (61.9%) did not describe a specific process for monitoring treatment fidelity, there was variability in approach for those that did. Two studies (9.5%) described fidelity and therapeutic competence being monitored through several activities including case discussions in supervision, observation and evaluation of sessions, and review of case notes. Another study (4.7%) indicated that group facilitators completed a form that documented activities and objectives for each session, omissions or changes, participant reactions, and facilitator reflections. Two other studies (9.5%) described a combination of the first two approaches, using both a fidelity monitoring system and a fidelity checklist. One study (4.7%) reported that trainers were required to demonstrate competence using a live competency rating tool and fidelity of program delivery by facilitators was then rated by the trainers using an adapted version of the competency rating tool. Similarly, another study (4.7%) described evaluation of fidelity by experts who rated a certain percentage of treatment session videos.

Summary

Three models of care were identified, including community health workers (trusted members of the community identified to deliver care), youth workers (young adults with lived experience of mental health challenges), and peer caregivers (caregivers with lived experience of caring for a child with mental health needs). The majority of interventions were adapted from evidence-based models and delivered in community settings. One key takeaway from this review is how heterogeneity in community needs must be taken into account when designing models of care. All of the models described in the research literature were implemented in different community contexts, responding to diverse needs, including family structures, mental health target conditions, ages, and physical locations. It is critical that academic and research partners allow for models to be designed from the ground up, taking into account that even within communities there is variability regarding what support is needed, what would be acceptable to different community members, and what types of models could work.

Sample of References Accessed During Review

Bhana, A., Mellins, C. A., Petersen, I., Alicea, S., Myeza, N., Holst, H., ... & McKay, M. (2014). The VUKA family program: piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. AIDS care, 26(1), 1-11.

Brown, L., Thurman, T. R., Rice, J., Boris, N. W., Ntaganira, J., Nyirazinyoye, L., ... & Snider, L. (2009). Impact of a mentoring program on psychosocial wellbeing of youth in Rwanda: Results of a quasi-experimental study. Vulnerable Children and Youth Studies, 4(4), 288-299.

Ertl, V., Pfeiffer, A., Schauer, E., Elbert, T., & Neuner, F. (2011). Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial. Jama, 306(5), 503-512.

Goodkind, J., LaNoue, M., Lee, C., Freeland, L., & Freund, R. (2012). Feasibility, Acceptability, and Initial Findings from a Community-Based Cultural Mental Health Intervention for American Indian Youth and Their Families. Journal of community psychology, 40(4), 381–405. https://doi.org/10.1002/jcop.20517

Kahan, D., Lamanna, D., Rajakulendran, T., Noble, A., & Stergiopoulos, V. (2020). Implementing a trauma-informed intervention for homeless female survivors of gender-based violence: Lessons learned in a large Canadian urban centre. Health & social care in the community, 28(3), 823–832. https://doi.org/10.1111/hsc.12913

Puffer, E. S., Johnson, S. L., Quick, K. N., Rieder, A. D., Mansoor, M., Proeschold-Bell, R. J., ... & Boone, W. J. (2022). Family Strengthening in the Context of COVID-19: Adapting a Community-Based Intervention from Kenya to the United States. Prevention Science, 1-12.

Williamson, A. A., Knox, L., Guerra, N. G., & Williams, K. R. (2014). A pilot randomized trial of community-based parent training for immigrant Latina mothers. American Journal of Community Psychology, 53(1), 47-59.