Expanding Access to Community-Based Mental Health Support:

A Review of Select Programs

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MASSACHUSETTS FOUNDATION

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INTRODUCTION

Massachusetts, like many states across the nation, is grappling with a growing mental health crisis. Psychological distress which includes, for example, depression and anxiety, is widespread, particularly among historically marginalized communities and among youth populations.[1] Experiencing psychological distress is associated with an increase in risky behaviors, like smoking and excessive alcohol use, and is a key contributor to the development and worsening of chronic conditions like cardiovascular disease and diabetes.[2]

Rates of psychological distress are not distributed equally across the population and vary by race/ethnicity and age, among other factors. In Massachusetts, nearly one in three (31.8%) adults (ages 18+) report "high" or "very high" levels of psychological distress.[3] White adults reported lower rates of high or very high levels of psychological distress (30.1%) than Multiracial (49.6%), Hispanic or Latina/o/e (42%), or Middle Eastern/North African (38%) adults.[4] Youth are also impacted. Nearly one in two (46%) youth (ages 14-17) report "high" or "very high" levels of psychological distress, and the number of children on home- and community-based behavioral health provider waitlists rose by 27 percent between 2022 and 2023.[5]

Structural problems have led to health care cost and coverage barriers (e.g., co-payments, lack of health insurance coverage for specific services or provider types), workforce shortages (which are tied, in part, to compensation challenges driven by low reimbursement for behavioral health care services), and a misalignment between the cultural and linguistic characteristics of those seeking care and those available to provide care. These challenges and others have left many residents without access to the mental health services and supports they need. The consequences are significant: One in ten Massachusetts residents report having an unmet need for mental health care, Hispanic residents were nearly twice as likely to report not receiving mental health care due to cost,[6] and the state has a documented challenge in meeting the mental health needs of communities of color and LGBTQ+ youth.[7]

Despite these challenges, the state remains a national leader in its efforts to strengthen the behavioral health system. In 2023, the state established its Roadmap for Behavioral Health Reform, which seeks to simplify access and entry to the behavioral health care system for all Massachusetts residents, regardless of health insurance coverage status.[8] In 2024, it established the Behavioral Health Workforce Center within the Health Policy Commission to examine behavioral health-related workforce shortages, licensure and certification processes, and payment rates, all of which are barriers to improving equitable access to behavioral health care.

These ongoing statewide reforms and initiatives are important, and a key focus of these activities is on supporting individuals with moderate- and high-acuity mental health needs and substance use disorders. Complementary strategies focused on individuals with low-acuity mental health needs, which are described in more detail in this brief, may serve as potential tools or approaches to increase access to mental health supports, help reduce mental health morbidity and severity, and offer another approach for augmenting the traditional mental health system.[9] The goal of this issue brief is to educate policymakers, community and health system leaders, mental health advocates, and other stakeholders on the value of these complementary interventions as a strategy to help alleviate access challenges in the traditional mental health system and as a potential approach for expanding and diversifying the mental health workforce.

KEY TERMS

Low-Intensity Community-Based Mental Health Support Programs: This term refers to programs that deliver evidence-based mental health interventions by non-clinical providers in a community-based setting. Some programs highlighted in this brief are not exclusively low-intensity nor community-based.

Non-Clinical Provider: This term describes the individuals who are trained to provide limited mental health support (i.e., the intervention) in a community-based setting, who otherwise have no license or limited-to-no expertise in mental health. Each program highlighted in this brief favors different terminology to describe the individuals delivering the intervention, including coaches, frontline workers, community health workers, and lay community members. For consistency within this brief, the term "non-clinical provider" is used unless otherwise referring to a specific type of community member (e.g., clergy) trained in the intervention being implemented.

Program: This term describes the intervention models selected for inclusion in this brief (e.g., CETA, PEARLS, etc.).

Implementation Site: This term refers to one specific location at which a program is implemented. There are hundreds of implementation sites across each of the five featured programs, and there is variation across implementation sites within each program (e.g., a single program could have implementation sites at both a church and senior center).

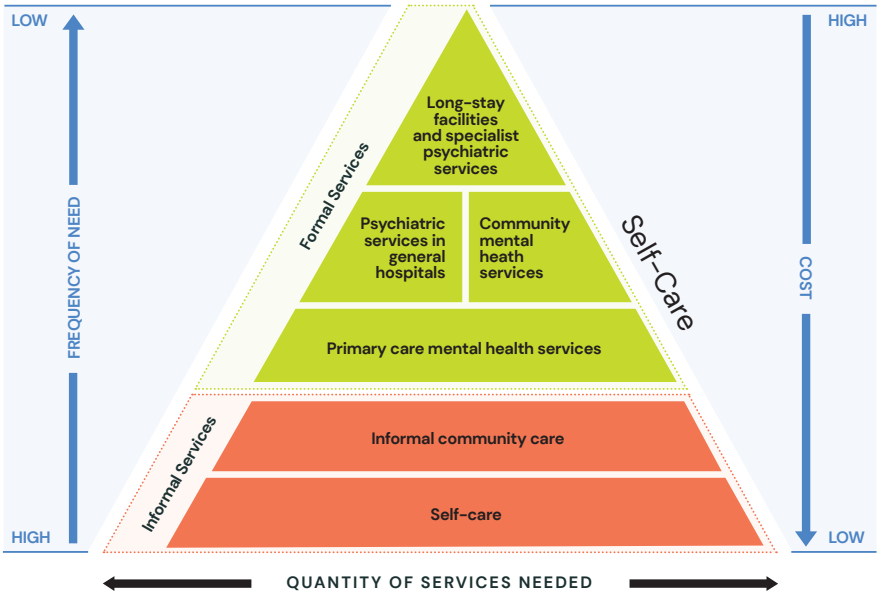
BACKGROUND

The mission of the Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) is to ensure equitable access to health care for all those in the Commonwealth who are economically, racially, culturally, or socially marginalized. Under this mission, the Foundation organizes its work into three main focus areas: coverage and care, behavioral health, and structural racism and racial inequities in health.

A key strategy of the Foundation to advance its mission and focus areas is to test and disseminate innovative care models. In line with this strategy, as part of an effort to test approaches for increasing access to behavioral health (inclusive of mental health and substance use disorder) services and potential opportunities to expand and diversify the behavioral health workforce, the Foundation launched a grant program in 2022. This program, Advancing Community Driven Mental Health (ACDMH), is a multiyear grant initiative that supports the implementation of an evidence-based low-intensity mental health program known as Problem Management Plus (PM+).[10] PM+ is a community-based strategy to train non-clinical providers to use an evidence-based protocol to deliver problem-solving behavioral techniques to individuals with low-acuity mental health concerns, like depression, anxiety, and stress.

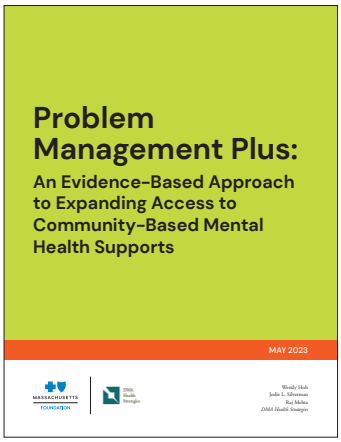
The World Health Organization (WHO) developed a pyramid framework that illustrates the ideal mix of services and how they should be organized across the mental health system. While in the United States, the mental health system is largely organized around providing services for moderate- and high-acuity patients, the WHO model supports more widespread availability and use of low-intensity community-based mental health support programs, such as PM+, which was developed by the WHO, to complement acute treatment options (see Figure 1). At present, the United States mental health system is, in many ways, the inverse of the WHO pyramid model. Moving toward a more WHO-based model of care would require the United States to support greater use of mental health services offered within communities, including programs delivered by non-clinical providers in settings such as schools, religious organizations, or other community-based social service organizations, for example. This approach to delivering mental health services is intended to optimize allocation of resources, including providers and health care dollars, and ensure the right level of services are available and accessible in the right settings for a given community.[11]

FIGURE 1. WORLD HEALTH ORGANIZATION'S PYRAMID FOR AN OPTIMAL MIX OF SERVICES FOR MENTAL HEALTH



SOURCE: World Health Organization (WHO). 2009. Improving health systems and services for mental health. https://iris.who.int/bitstream/handle/10665/44219/9789241598774_eng.pdf.

PM+ and other similar programs offer important benefits by providing basic mental health support services in an environment that may be less stigmatized than a traditional health care setting. These types of programs largely, but not exclusively, operate outside of clinical settings and are typically delivered by trained, non-clinical providers.[12] By leveraging lay personnel, or personnel without formal clinical training, low-intensity community-based programs offer evidence-based, clinically effective, and cost-effective strategies to broaden access to mental health services and supports, particularly for historically marginalized, underserved, or hard-to-reach populations, and may also help offset demand on clinical services in the health care system.



PM+ is but one low-intensity community-based mental health support program and is described in a 2023 Foundation report, *Problem Management Plus: An Evidence-Based Approach to Expanding Access to Community-Based Mental Health Supports*. Some preliminary experience implementing PM+ through the Foundation's ACDMH program is described in Appendix D of this report. This issue brief describes five other programs that can be implemented within the community and equip lay people with skills to provide low-intensity mental health services and supports. The five programs highlighted in this issue brief are: Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors), PEARLS (Program to Encourage Active, Rewarding Lives), EMPOWER, CETA (Common Elements Treatment Approach), and Project ECHO (Extension for Community Healthcare Outcomes). See the "Methodology" section below for more detail on the inclusion criteria used to determine the programs featured in this brief.

Community-based mental health support programs have the potential to improve health equity and help alleviate access challenges in the traditional mental health system by:

- Increasing cultural congruence between those seeking and those providing services by training community members representative of the population served, in multiple languages, and across multiple non-clinical settings;
- Reaching individuals who may not otherwise access the traditional health care delivery system;
- Increasing the number of individuals with low-acuity mental health conditions (e.g., anxiety, stresses of daily living) who can receive some treatment in the community, thereby potentially alleviating demand for clinically based mental health services; and
- Over time, reducing mental health morbidity and severity through the delivery of evidence-based mental health treatment techniques that can prevent low-acuity mental health needs from worsening while also teaching individuals skills to promote active participation in improving their own well-being.[13]

COMMUNITY-BASED SETTINGS

A community-based setting is a location where social or other services are provided within a specified geographic area. In this issue brief it can include settings such as: churches, social service organizations, schools, senior centers, and residential living centers.

The five programs highlighted in this issue brief have many differences, but these programs are aligned in that they offer viable solutions in a suite of broader strategies to mitigate the mental health access crisis.

METHODOLOGY

Through a landscape scan and literature review, over a dozen programs offering low-intensity mental health services in community-based settings were identified. To focus this analysis, a set of inclusion criteria was developed to determine which programs to feature in this brief. Programs included in this report have at least one intervention focused on serving individuals with low-acuity mental health concerns. However, programs that also serve individuals with higher-acuity mental, behavioral, or physical health conditions were not excluded. Included programs had to be delivered in the United States but did not need to be exclusively based in the United States or have originated here. The identified programs had to have the capability to train individuals who are not otherwise educated as mental health providers but who are required to complete a robust, structured training to deliver the intervention. This criterion eliminated one-time intervention programs, such as crisis hotlines and app-based interventions not delivered in real-time by a person. To ensure access to clinical experts for higher-acuity cases, the selected programs had to require clinical supervision of the non-clinical providers. Finally, to highlight diverse funding models, the identified programs relied on a mix of funding sources. See Appendix C for a complete list of the interviewees who contributed to this issue brief.

FEATURED PROGRAMS

The five programs that fit the criteria described above have similar core components. Importantly, the five programs use evidence-based mental health treatment techniques such as behavioral activation,[14] cognitive behavioral therapy,[15] or problem-solving therapy,[16] and all programs support individuals with depressive symptoms and/or stress and anxiety, at a minimum.[17]

Each program has distilled the fundamental skills necessary to implement certain mental health treatment techniques into accessible training modules that those delivering the intervention must complete. The training modules vary in length and intensity but generally require 8-20 hours of total training. Some training is self-directed, while other training is led by an expert or certified trainer. This relatively low training investment allows community-based organizations to implement these programs without a huge strain on staff time or the organizational budget.

Non-clinical providers participating in the five featured programs are situated in a diverse array of settings and serve in various capacities, including clergy members, individuals who are incarcerated, community health workers, frontline social services staff members, volunteers, and many others. The diversity in "type" or background of the non-clinical providers creates a virtually limitless pool of potential mental health workforce extenders; however, while most anyone can be trained, non-clinical providers must be supported by supervisors who have the clinical expertise to identify individuals who may need higher-acuity treatment from a licensed professional. For many of these featured programs, clinical supervision also provides the individuals delivering the interventions with skill-building opportunities and peer support, enabling non-clinical providers to enhance and refine their skills.

Each of the highlighted programs has community-based implementation sites. Examples include places of worship, social service organizations, schools, senior centers, and residential living centers. In some instances, the intervention can be delivered in the individual's home, over the phone, or at any location where they feel comfortable. Some of the programs have been implemented within more traditional health care settings, such as community health centers or institutional settings like correctional facilities.

Finally, each of the programs uses evidence-based tools and techniques, and the delivery of the programs has been proven effective in the United States and abroad. In general, these programs have been shown to reduce depression symptoms and severity, and hospitalizations. Regardless of the setting or type of evidence-based tools and techniques used, the training of non-clinical providers as a mechanism to expand access to mental health services and supports is a core feature of these programs. More information on program evidence and a brief description of each program are listed in the comparative table of key characteristics in Appendix A.[18]

FEATURED PROGRAMS*

Healthy IDEAS: A depression treatment program delivered through a three-to-six-month case management model.

PEARLS: A depression recognition and treatment program to treat older adults with depression and social disconnectedness delivered through a series of in-person and remote sessions.

EMPOWER: A digital platform that trained non-clinical providers can use to deliver evidence-based psychosocial interventions in various settings.

CETA: A transdiagnostic approach that combines assessment and treatment for a range of mental health issues into one single model consisting of 10 evidence-based elements of cognitive behavioral theory.

Project ECHO: A globally available learning network that connects clinical and non-clinical staff with experts who teach, mentor, and guide participants in gaining the knowledge required to treat patients locally within their community.

*Note: The research for this brief uncovered two notable programs, Friendship Bench and Rewire CBT, that merit mention, but were not fully explored in this research because they did not meet all of our specified criteria for inclusion. A brief synopsis of these two programs is included in Appendix B.

EVIDENCE-BASED MENTAL HEALTH TREATMENT TECHNIQUES

Behavioral Activation: A time-limited form of CBT for depression that "focuses on the relationship between mood and behavior to counter negative feelings of withdrawal and avoidance that often accompany mood disorders."

Cognitive Behavioral Therapy (CBT): Refers to multiple "therapeutic approaches and techniques that emphasize the interrelationships among thoughts, feelings, and behaviors."

Problem-Solving Therapy: A time-limited, strength-based intervention that "involves a step-by-step approach to constructive problem solving."

SOURCES: The Ohio State University Wexner Medical Center. "Behavioral Activation." https://wexnermedical.osu.edu/mental-behavioral/psychotherapy; and Anao Zhang, Sunyoung Park, John E. Sullivan, and Shijie Jing. 2018, January. "The Effectiveness of Problem-Solving Therapy for Primary Care Patients' Depressive and/or Anxiety Disorders: A Systematic Review and Meta Analysis." The Journal of the American Board of Family Medicine, 31*(1), 139-150. https://pubmed.ncbi.nlm.nih.gov/29330248/.*

FINDINGS

The findings below were informed by the literature review and interviews with program leaders and other subject matter experts. The findings address three major topic areas:

1. How these programs may help alleviate stress on the traditional mental health system by providing community-based mental health services and supports;
2. How these programs may help address health inequities by improving access to mental health supports for historically marginalized communities and increasing the diversity of the behavioral health workforce; and
3. How, with a sustainable and stable funding model, these programs have the potential to fulfill the important, but often overlooked, public health need to focus on low-acuity mental health concerns.

> ***"We want every person to work at their highest human potential and with the 'all teach, all learn' process, we help people move from novice to expert."***
>
> – Dr. Sanjeev Arora, former Executive Director, Project ECHO

LOW-INTENSITY COMMUNITY-BASED MENTAL HEALTH INTERVENTIONS MAY ALLEVIATE STRESS ON THE TRADITIONAL MENTAL HEALTH SYSTEM

Leveraging non-clinical providers in community-based settings to deliver low-intensity mental health services can help address two major stressors facing the traditional mental health system: workforce shortages and rising demand for care.

While not as acute as in other states, Massachusetts has an insufficient supply of mental health providers in relation to the state's needs.[19] The Health Policy Commission's newly launched Behavioral Health Workforce Center aims to tackle this issue by identifying gaps across communities and provider types, tracking disparities in cultural concordance of the workforce relative to those seeking care, and developing policy recommendations to improve the capacity of the behavioral health workforce.

One successful strategy to address system supply and demand challenges – widely used in under-resourced countries – is "task shifting" or "task sharing."[20] This approach, which is central to all programs discussed in this issue brief, reallocates specific tasks from clinical professionals to trained non-clinical providers. When properly trained and supervised, non-clinical providers are effective at providing certain mental health services and supports to individuals with low-acuity mental health conditions like depression, anxiety, and post-traumatic stress disorder.[21,22] Shifting responsibilities such as screening, education, and support for low-acuity conditions to non-clinical providers enables licensed clinicians to focus their expertise on individuals with more complex or higher-acuity needs, which can reduce problems with workforce shortages and demand for care. This is one reason some programs highlighted in this brief are also used within the clinical setting, such as many Project ECHO implementation sites.

> ***"As long as you follow a protocol, like an apprenticeship model, you can train most anyone to provide evidence-based mental health interventions."***
>
> – Laura Murray, PhD, Senior Scientist, Clinical Psychologist, Johns Hopkins Bloomberg School of Public Health, Department of Mental Health & International Health

By providing additional access points to mental health services and supports in community-based settings, these programs may help align the demand for services with the supply of providers. In some cases, these programs identify and serve individuals who would never otherwise seek mental health care in traditional clinical settings for many reasons previously mentioned and also described in more detail in the section below (e.g., stigma associated with accessing treatment), thereby potentially reducing the downstream demand that occurs when untreated conditions worsen. The reverse is also true. In some applications of Healthy IDEAS, for example, clinical mental health providers connect individuals with community-based organizations that offer the intervention as a way of "stepping down" a patient from the traditional mental health system into a community-oriented system, providing those individuals with continued access to mental health supports.

> ***"We are rethinking how we approach mental health care and reframing it, not as treatment, but as early intervention, promotion, and education."***
>
> – John Naslund, PhD, Mental Health For All Lab Co-Lead, Instructor in Global Health and Social Medicine, Harvard Medical School

TRAINING COMMUNITY-BASED INDIVIDUALS AS MENTAL HEALTH WORKFORCE EXTENDERS MAY HELP ADDRESS HEALTH INEQUITIES IN ACCESSING MENTAL HEALTH SUPPORTS

Expanding access to community-based mental health programs, delivered by non-clinical providers, can promote health equity in several ways. Individuals from marginalized communities are more likely to face structural barriers in accessing care in the traditional health care setting (e.g., more likely to lack insurance, forego care due to costs).[23] In addition, among other reasons, historic mistreatment of individuals from marginalized communities by the medical system has resulted in some mistrust of the health care system.[24,25] Given this, providing mental health supports and services outside of the traditional health care setting, and offering services where individuals frequent or live, can improve access to services for individuals who may not otherwise get needed services. In some communities, stigma surrounding mental health is also a substantial barrier to individuals in seeking care.[26] Racial and ethnic minority groups experience more public and self-stigma than non-White racial and ethnic groups.[27] This stigma, combined with a lack of cultural congruence between those seeking and those providing services in the traditional health care system, can greatly reduce access for historically underserved communities. Low-intensity mental health programs that can be integrated into community settings, such as those highlighted in this issue brief, can reduce stigma by being tailored to specific populations and incorporating culturally relevant approaches to care. Healthy IDEAS, for example, reported that individuals delivering the intervention to Latino communities avoid using the word "depression" due to well-documented cultural stigma associated with this term.[28] In the Congregational Collective's implementation of EMPOWER, staff normalize depressive symptoms, rather than medicalize them, by talking about them openly within a non-medical setting, like a church, thereby reaching individuals who otherwise may be reluctant to access services in a clinical setting. Other techniques to reduce stigma include refraining from using "clinical language" to describe non-clinical providers and their interventions. For example, PEARLS describes their non-clinical providers as "coaches," and while EMPOWER-trained individuals provide education and support through behavioral activation, they do not use language such as "therapy" or "treatment."

When program implementers consider the diversity and unique needs of the communities they serve and train local, trusted community members to deliver the interventions, cultural congruence can be enhanced between the mental health workforce and the community being served. This may lead to greater willingness to seek services and increased participation in these types of programs. Furthermore, adapting the interventions to multiple languages – for example, PEARLS can be delivered in over twenty languages – can also alleviate some health inequities by making mental health services accessible to communities that may not always have services available in their preferred language.[29]

> ***"To increase capacity and sustainability using an equity-forward approach, PEARLS built a diverse team of trainers from different backgrounds, social identities, geographies, and professional experiences."***
>
> – Lesley Steinman, PhD, Research Scientist, University of Washington

By expanding access to services outside the traditional clinical setting and implementing programs in a culturally conscious way, low-intensity, community-based mental health interventions, delivered by and for community members, may be a powerful tool in efforts to reduce health inequities.

SUSTAINABLE AND STABLE FUNDING MODELS WILL HELP ENSURE AN ADEQUATE SUPPLY OF INFORMAL MENTAL HEALTH COMMUNITY CARE PROGRAMS

Costs associated with implementing and offering these interventions, providing clinical supervision, and maintaining an adequate number of trained staff necessitate sufficient and ongoing financial support. Presently, funding to implement and continuously operate these programs is available from a patchwork of sources. As a result, there is no one-size-fits-all sustainable funding model for implementation sites to rely upon, and many implementation sites braid together various funding sources.[30]

This section describes the various sources of philanthropic, public, health plan, and health system funding that could be used to implement and sustain these programs. Since conducting research and interviews for this issue brief, sources of funding may have changed due to the current federal administration's funding priorities. This volatility in funding from the federal government further highlights the need for more stable funding sources for these programs.

PHILANTHROPY

Private foundations and other philanthropic organizations, which often serve as a source of operating and/or programmatic funds for nonprofit organizations, play a significant role in funding programs and implementation sites. Health-related foundations and charities, such as the Robert Wood Johnson Foundation and United Way, as well as senior-focused foundations like AARP Foundation, have provided both research and implementation support for specific programs featured in this brief.[31, 32] Foundations serving specific localities have also provided support for these programs, such as the H. E. Butt Foundation's support of the Congregational Collective's implementation of EMPOWER.

Philanthropy has played a crucial role as an early funder of promising community-based mental health models and may continue to do so, particularly when federal and other public funds are less stable.

PUBLIC FUNDING SOURCES

Public funding sources have included federal and state dollars administered through Medicare[33] and Medicaid[34] programs, the former Administration for Community Living (ACL) within the U.S. Department of Health and Human Services,[35] and state or municipal-specific funding streams.

Medicare/Medicaid Funding

Medicare and Medicaid fund some of these programs through capitation payments, as well as case management, depression care management, community integration services, and other billing codes. Typically, funding from Medicare and/or Medicaid is only available when the individual delivering the intervention could otherwise provide reimbursable services, which limits the type of non-clinical provider who can be reimbursed for delivering the intervention. For example, many states use various Medicaid funding models to pay for Community Health Workers (CHWs), and in those states, CHWs could be trained to implement any one of the models described in this issue brief and deliver the intervention as part of their routine reimbursable activities. In the case of Massachusetts, CHWs are not directly reimbursable by MassHealth (the state's Medicaid and Children's Health Insurance Program), but a global or capitated payment arrangement, like MassHealth's Primary Care Sub-Capitation Program could allow for accountable care organizations to support the work of CHWs trained in these models.

In some states, Medicaid waiver authority has paid for certain programs. Massachusetts funds evidence-based education programs, like Healthy IDEAS and PEARLS, through its Home- and Community-Based Services (HCBS) Frail Elder Waiver.[36] Similarly, the state of Washington reimburses for PEARLS through a Medicaid waiver program as a client education intervention.[37]

California, Colorado, New Mexico, and Oregon have all used waiver authority to support Project ECHO either implicitly or explicitly,[38] but it should be noted that not all applications of Project ECHO are focused on providing mental health support.

Federal Funding Through the Administration for Community Living (ACL)

Established in 2012, the ACL was responsible for coordinating most federally funded human service programs that assist older adults and people with disabilities. The ACL administered programs authorized by the Older Americans Act (OAA), which was the primary federal funding statute for the delivery of supportive living programs for older adults. The OAA, which provided nearly half (44%) of all funding for state-designated Area Agencies on Aging (AAAs), required part of the funds to be used on evidence-based programs and had funded AAAs to deliver and sustain evidence-based chronic disease self-management programs, like Healthy IDEAS and PEARLS. While the exact number of AAAs that have implemented Healthy IDEAS or PEARLS is unknown, there are notable examples of AAAs having used ACL funds to support the delivery of these programs. In Pennsylvania, for instance, 22 AAAs implemented Healthy IDEAS, and an AAA in North Carolina received over $600,000 in ACL grant funding to deliver PEARLS. This funding source is, however, tenuous. The ACL is scheduled to be dissolved into a new agency, the Administration for Children, Families, and Communities, as part of the restructuring of the U.S. Department of Health and Human Services,[39] and the future of its grantmaking to AAAs and other organizations is unknown. Furthermore, the reauthorization of OAA, which expired in fiscal year 2024, passed the Senate in December 2024, but as of this writing, has not been introduced to the House of Representatives.

State and Municipality-Specific Funding Streams

Some programs receive state and/or municipality-specific funding streams to operate their programs. For example, PEARLS is being funded in some California communities through the California Mental Health Services Act, or Proposition 63, a voter-approved 1 percent tax levy on individual incomes over $1,000,000.[40] Similarly, some implementations of PEARLS are being funded through the Veterans, Seniors & Human Services Levy, which is a property tax to support, in part, veterans and older adults in King County, Washington.[41]

HEALTH PLAN AND HEALTH SYSTEM FUNDING

Currently, traditional health care financing is largely unavailable to low-intensity community-based mental health programs, in part because many operate outside of formal clinical settings that payer systems are set up to reimburse.[42] However, there are some ways in which health plans and health systems could provide funding support for programs identified in this brief, without requiring a reimbursable service, because some health plans and health systems have incentives to invest in community mental health programs. For example, provider organizations that are paid under value-based payment arrangements or held to cost growth targets, like many in Massachusetts, could fund programs like PEARLS, particularly because it has demonstrated its value in reducing hospital admission rates among participants.[43] Similarly, if health plans are held accountable to population or community-centered outcomes, they could provide funding to non-clinical community-based organizations for programs – like those discussed in this brief – that help improve health plan member outcomes. Another potential health system funding source is through hospital systems in instances, where, for example, states require nonprofit hospitals to spend a minimum amount on identified community benefit needs.[44]

Currently, patchwork funding is what supports these programs, and the absence of a reliable funding model means that community-based organizations may struggle to maintain these programs. Interview sources noted challenges in making the business case to health plans and health systems to fund community-based, low-intensity mental health support programs, further highlighting the need to amplify existing research on quality and cost-effectiveness and to fund and evaluate larger-scale implementations of these programs. Ultimately, increased and stable federal, state, and health plan and system support is needed to further the reach of these programs as part of a robust mental health system.

CONCLUSION

Low-intensity community-based mental health interventions delivered by trained, non-clinical providers represent a powerful and underutilized strategy for addressing the pressing mental health needs of Massachusetts residents. These scalable, cost-effective, and culturally responsive programs can be one tool used to alleviate strain on the mental health system and increase the cultural congruence of the mental health workforce. The programs highlighted in this brief – Healthy IDEAS, PEARLS, EMPOWER, CETA, and Project ECHO – all demonstrate that mental health care can be effectively delivered by and for communities. At the same time, structural barriers, particularly around stable and adequate funding, leave these programs vulnerable to long-term sustainability. Health care stakeholders committed to expanding access to mental health services, including advocates, health care institutions, payers, and others, should explore ways to continue and expand sufficient and stable funding for these promising programs. As described here, community-based mental health support programs can serve as an important strategy to expand access to mental health services and supports, reduce inequities, and strengthen the delivery of mental health care.

APPENDIX A.

FEATURED PROGRAMS – DESCRIPTION AND CHARACTERISTICS

	PROGRAM DESCRIPTION	EVIDENCE OF EFFECTIVENESS	IMPLEMENTATION LOCATIONS	FUNDING MODEL
Healthy IDEAS (Identifying Depression & Empowering Activities for Seniors)	**Condition:** Depression **Population:** Older adults **Description:** Healthy IDEAS is a depression treatment program delivered through a 3-to-6-month case management model using behavioral activation, screening, education, and referral, when necessary, to mental health providers for higher levels of treatment.	It has been shown to reduce depression severity and reported pain.[45]	The primary application of the model uses trained case managers at community-based organizations; however, it has been delivered by community health workers, Meals on Wheels drivers, and residence service housing coordinators. It has been implemented in over 200 organizations in the United States.	Healthy IDEAS has a low-cost training model. Community organizations wishing to implement Healthy IDEAS are charged a one-time fee to cover materials and travel expenses of a certified trainer who can train up to 25 individuals at one site. The site must then pay for the time of a clinical supervisor, like a licensed clinical social worker, if one is not already on staff for ongoing clinical support, when needed.
PEARLS (Program to Encourage Active, Rewarding Lives)	**Condition:** Depression **Population:** Older adults **Description:** PEARLS is an evidence-based depression recognition and treatment program used to treat older adults with depression (whether diagnosed or not) and social disconnectedness. The intervention is delivered in 6-8 1-hour in-person sessions at home, other accessible community setting, or remotely over 4-5 months, followed by 3-6 brief telephonic sessions. The intervention includes problem-solving treatment and behavioral activation.	It has been shown to improve depression severity and remission (as measured through the PHQ-9), improve social connectedness, reduce suicidal ideation, reduce hospitalizations, and reduce nursing home stays.[46,47,48,49,50,51]	PEARLS was developed with local Area Agencies on Aging (AAAs) and continues to be implemented by AAAs and other community-based social service agencies. It has been implemented in over 200 organizations across 35 states and Washington, D.C.	PEARLS charges a per-person training fee for community organizations wishing to train existing staff to implement the program and no ongoing fee to maintain the implementation. The site must then pay for the time of a clinical supervisor as PEARLS coaches are not required to be clinicians. Clinical supervisors may include a psychiatrist, psychiatric nurse practitioner, geriatrician or other primary care provider, or a licensed clinical social worker. PEARLS recommends clinical supervision be group-based and occur regularly (weekly to monthly) depending on caseload.
EMPOWER	**Condition:** Multiple conditions **Population:** All ages **Description:** EMPOWER is a digital platform that non-clinical individuals can use to deliver evidence-based psychosocial interventions in various settings. It is primarily focused on depression and anxiety, but interventions are available for the management of individuals with serious mental illnesses, such as schizophrenia and bipolar disorder, and EMPOWER is building out training modules for additional conditions. For depression, EMPOWER uses behavioral activation over 6 sessions as the evidence-based intervention.	Data on effectiveness in U.S.-based implementations is still being gathered, but in its India-based implementation, 90% of those identified as having depression through the program have completed treatment, with over 87% of those in remission by the end of treatment.[52]	The program has a large presence in India and is also beginning to expand to more U.S.-based sites. EMPOWER is offered in the San Antonio region through a collection of faith-based organizations. It is also used in clinical settings such as the Lynn Community Health Center in Massachusetts and the Baylor, Scott, and White Health System in Texas (through a collaboration with the University of Texas Arlington).	EMPOWER implementation sites are funded through foundations such as the H. E. Butt Foundation, John Templeton Foundation, Lyda Hill Philanthropies, The Tepper Foundation, Surgo Foundation, and the Natasha Muller Impact Fund.

	PROGRAM DESCRIPTION	EVIDENCE OF EFFECTIVENESS	IMPLEMENTATION LOCATIONS	FUNDING MODEL
CETA Global (Common Elements Treatment Approach)	**Condition:** Multiple conditions **Population:** All ages **Description:** CETA is a transdiagnostic[53] approach that combines assessment and treatment for a range of mental health issues into one single model. The treatment consists of 10 evidence-based elements of cognitive behavioral therapy and motivational interviewing for substance use disorder. CETA uses an algorithm and artificial intelligence (AI)-based software solution that creates clinical pathways for individual needs – or precision-based care. The software also produces assessment results that recommend whether licensed clinical providers or non-clinical providers could treat certain individuals, allowing for task sharing. The software assists the licensed clinical or paraprofessional in delivering the interventions step-by-step, which helps increase fidelity to the intervention and allows for note-taking, supervisory coaching, and outcome tracking.	Multiple randomized clinical trials and implementation studies in the international setting have shown CETA is more effective and efficient than "treatment as usual" methods for depression and anxiety (i.e., behavioral activation and cognitive process therapy).[54]	CETA has been used in a wide range of settings in the United States and is passionate about increasing access in under-served or under-resourced areas, for example, in Native American communities, rural areas, and Medicaid-predominant settings.	Organizations wishing to implement CETA should contact CETA to discuss their needs and system challenges. CETA provides consultation on system integration (assessment, use of software, treatment, outcome use), then provides an estimate of cost, which includes implementation planning, training (2-5 days), supervision to certification, and outcome tracking. The cost includes access to the software per user.
Project ECHO (Extension for Community Healthcare Outcomes)	**Condition:** Multiple conditions **Population:** All ages **Description:** Project ECHO is an evidence-based, globally available learning network that connects clinical and non-clinical staff with experts who teach, mentor, and guide participants in gaining the knowledge required to treat patients locally within their community. While first known for providing primary care providers with specialty expertise to treat patients with hepatitis C, the Project ECHO model has expanded into a training and mentorship model for virtually any health condition. This model was included in the brief because it provides learning environments for non-clinical providers, such as community health workers and peer educators.	Project ECHO is a far-reaching model for disseminating expertise and supporting peer learning with over 700 peer-reviewed research articles consistently describing its effectiveness.[55]	It has been implemented in over 1,230 locations.[56]	Project ECHO's funding model varies by type of organization implementing the intervention, but all sites must cover the costs of the specialists providing the training.

APPENDIX B.

OTHER NOTABLE PROGRAMS

Rewire CBT

Rewire CBT is a trauma-informed, skills-based cognitive behavioral therapy program developed by the Roca Institute in collaboration with Massachusetts General Hospital. It is designed to train frontline youth and community violence prevention organization staff, as well as juvenile justice system officers, in the seven core life-saving skills necessary to support youth to heal from trauma and make healthy choices. [57] In Massachusetts, youth who have participated in this program have a 30-percent reduction in recidivism and a 50-percent reduction in homicide.[58] While this program shows the power of using lay providers to deliver a mental health intervention, we did not include it in this issue brief because its main focus was to disrupt and prevent violence by helping young people to heal from trauma.

Friendship Bench

First implemented in Zimbabwe, Friendship Bench is a depression treatment program delivered by "grandmothers" who have been trained in structured problem-solving therapy techniques but who have no other prior medical or mental health experience. These sessions are conducted on "friendship benches" located in community spaces to provide accessible and stigma-free care. Research has shown that Friendship Bench participants had a significant decrease in depression symptoms compared to a control group.[59] While there have been some adaptations of the Friendship Bench in the United States,[60] we did not include it in this brief because experience in the United States is limited.

APPENDIX C.

INTERVIEWEES

Sanjeev Arora, MD. Founder and former Executive Director of Project ECHO, Distinguished and Regents Professor of Medicine, University of New Mexico Health Sciences Center

Melissa Donegan. National Director, Healthy IDEAS Program, and Director of the Healthy Living Center of Excellence, AgeSpan

Rick Gertsema. Senior Mental Health Advisor, Miller-Dwan Foundation and ArcaMind: Global Institute for Mental Health Solutions

David Jablonski. Senior Policy Advisor, University of New Mexico Health Sciences, Project ECHO

Laura Murray, PhD. Senior Scientist, Clinical Psychologist, Johns Hopkins Bloomberg School of Public Health, Department of Mental Health and International Health

John Naslund, PhD. Co-Lead, Mental Health for All Lab, Instructor in Global Health and Social Medicine, Harvard Medical School, Department of Global Health and Social Medicine

Lesley Steinman, PhD. Research Scientist, University of Washington, Health Promotion Research Center, Department of Health Systems and Population Health

APPENDIX D.

PROBLEM MANAGEMENT PLUS: AN EVIDENCE-BASED APPROACH TO EXPANDING ACCESS TO COMMUNITY-BASED MENTAL HEALTH SUPPORTS[61]

Problem Management Plus (PM+) was first developed by the World Health Organization for use in moderate- to low-income countries with limited behavioral health services, and has since been implemented in the United States. The intervention is delivered by trained non-clinical providers for people who are experiencing common mental health symptoms, such as anxiety or depression, or stressful life problems.[62] PM+ is a strength-based approach that uses evidence-based tools to help participants set and make progress on their own goals over the course of five 90-minute face-to-face sessions.

With its Advancing Community Driven Mental Health (ACDMH) program, the Blue Cross Blue Shield of Massachusetts Foundation is funding five community-based organizations (CBO) to adapt PM+ to their settings and implement the intervention. At least three staff members at each CBO were trained to deliver PM+, and over the first implementation year, clinical supervisors observed notable growth in providers' comfort and skills with respect to delivering the PM+ intervention. By the end of the year, CBOs had enrolled a combined total of 140 clients in PM+, and more than half had completed the program. Enrolled clients were racially, ethnically, and linguistically diverse, and most had an annual household income of less than $25,000. Clients entered the program reporting problems related to families and social groups, daily activities, and physical health, among other issues. For clients who completed the program, there were statistically significant improvements in mental health outcomes, including reduced severity of depression symptoms and reduced impact of problems on their daily lives. CBOs also shared other observed impacts including improvements in providers' patience, empathy, and communication, and improvements in clients' ability to manage challenges. Overall, evaluation results show that through ACDMH, the PM+ intervention has been effectively adapted to and implemented in a range of Massachusetts community-based settings.

ENDNOTES

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9 While some of the programs featured in this brief go far beyond addressing mental health conditions, for the purposes of this work, we were specifically focused on programs that address low-acuity mental health conditions, and therefore, we use the terminology "mental health" in place of "behavioral health" (encompassing mental health and substance use disorders) throughout this brief.

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12 There are many terms used to describe the lay staff who deliver the community-based, low-intensity mental health interventions described in this brief, and they vary by program. Terms include intervenors, interventionists, facilitators, helpers, lay professionals, and non-clinical providers. Throughout this issue brief, the term non-clinical provider will be used, unless specifically referring to a non-clinical provider with another formal professional title (e.g., clergy, clinical social worker, community health worker).

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17 While some programs go far beyond mental health conditions and train more than just non-clinical providers, we were specifically focused on the non-clinical provider treatment of low-acuity mental health conditions.

18 The research for this brief uncovered two notable programs, Friendship Bench and Rewire CBT, that merit mention, but were not fully explored in this research because they did not meet all of our specified criteria for inclusion. A brief synopsis of these two programs is included in Appendix B.

19 As of May 2025, Massachusetts had a total of 52 Mental Health Professional Shortage Areas (HPSAs) as designated by the Human Resources and Services Administration (HSRA), disproportionately affecting federally qualified health centers (FQHCs) and low-income populations. *https://data.hrsa.gov/topics/health-workforce/shortage-areas*.

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