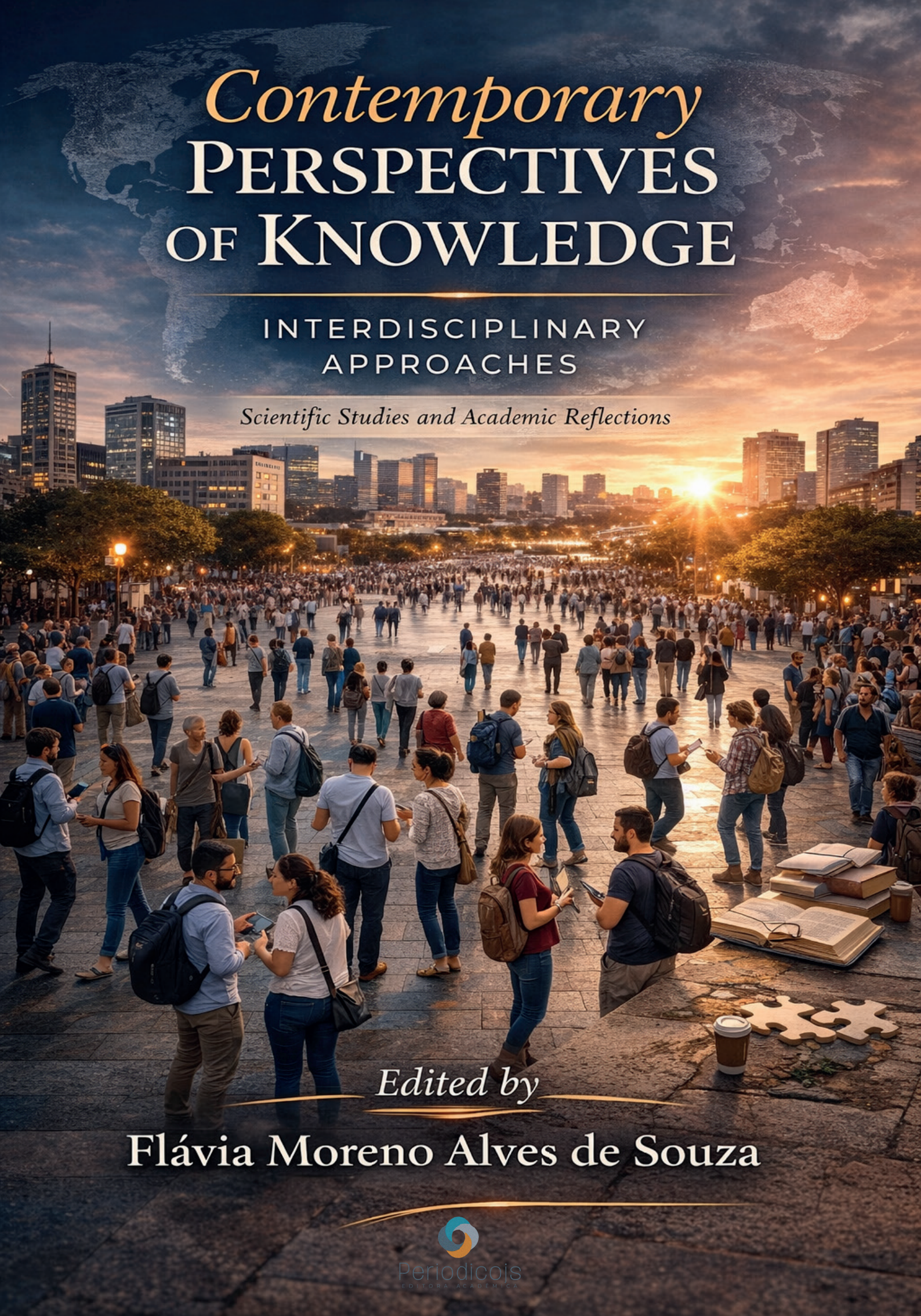




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INTERDISCIPLINARY
APPROACHES

Scientific Studies and Academic Reflections

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Chapter 32

BEYOND THE CLINIC: ADDRESSING THE BEHAVIORAL HEALTH WORKFORCE SHORTAGE



BEYOND THE CLINIC: ADDRESSING THE BEHAVIORAL HEALTH WORKFORCE SHORTAGE

Thayse Sopper Boti Cei¹

Abstract: Objective: To systematically synthesize the scientific evidence on the role of non-clinical facilitators (lay workers, community health workers, peer support workers, low-intensity practitioners, and health coaches) in expanding access to behavioral health care, given the projected shortage of licensed clinical professionals. Data sources: PubMed/MEDLINE, PMC, Cambridge Core, ScienceDirect, Wiley Online Library, SpringerLink, and medRxiv/BioMed Central, plus primary institutional sources (HRSA, WHO, and Brazil's Federal Council of Psychology, CFP), searched between July and August 2026. Eligibility criteria: Studies published mostly between 2013 and 2026, in English or Portuguese, including official workforce projection reports, systematic and scoping reviews, meta-analyses, randomized controlled trials, and large-scale observational studies ($n > 1,000$, where applicable) on mental health interventions delivered by non-clinical facilitators. Data extraction and synthesis: Single-reviewer extraction using a structured form. Narrative synthesis was used because heterogeneity in designs, populations, and outcomes precluded quantitative meta-analysis. Certainty of evidence was rated using a simplified adaptation of the GRADE domains. Results: Of 82 raw records identified, 37 studies and sources were included in the final synthesis. The evidence indicates a projected shortage of 136,350 psychologists in the United States by 2038 (HRSA); a global treatment gap of approximately 50%, reaching 90% in low-income countries (WHO); and marked territorial inequality in Brazil. Randomized controlled trials show the effectiveness of interpersonal counseling delivered by community health workers for depression in Brazil ($n = 86$) and Cameroon ($n = 400$). Psychological Wellbeing Practitioners show consistent effectiveness within the UK stepped-care model. Evidence for health coaching is of low-to-moderate certainty for behavioral

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outcomes and of low certainty for specific psychiatric outcomes. Limitations: Single reviewer, no prospective protocol registration, no quantitative meta-analysis, and a simplified (non-formal) risk-of-bias assessment. Conclusion: Non-clinical facilitators, integrated into stepped-care models with active clinical supervision, can expand access to behavioral health care without replacing licensed clinicians.

Keywords: behavioral health; workforce shortage; task-shifting; non-clinical facilitators; health coaching; stepped care; peer support; systematic review; PRISMA; mental health in Brazil.

Introduction

Rationale

Access to mental health care is increasingly a matter of structural capacity, not merely individual will or financial means. The World Health Organization's (WHO) Mental Health Atlas 2024, built on data from 144 countries, shows that more than one billion people live with a mental disorder, that global resources for mental health remain stagnant at around 2% of health budgets, and that the global median is just one specialist per 10,000 inhabitants (WORLD HEALTH ORGANIZATION, 2024). According to the Pan American Health Organization, fewer than 10% of people with psychosis in low-income countries receive any kind of care, compared with just over 50% in higher-income countries (PAHO/WHO, 2025). A systematic review with Bayesian meta-regression covering 84 countries between 2000 and 2019 found that treatment coverage for major depressive disorder ranged from 51% in high-income settings to only 20% in low- and lower-middle-income settings (GLOBAL GAP IN TREATMENT COVERAGE FOR MAJOR DEPRESSIVE DISORDER, 2022).

In the United States, more than 122 million people live in designated Mental Health Professional Shortage Areas, and 6,202 additional practitioners would be needed just to remove those designations (BUREAU OF HEALTH WORKFORCE, 2025a). The projection anchoring this article



is even more severe: 136,350 additional psychologists would be needed by 2038 to meet all unmet demand, compared with 99,840 needed simply to maintain current utilization patterns (BUREAU OF HEALTH WORKFORCE, 2025b). In Brazil, although the country has about 439,000 registered psychologists (CFP), nine out of ten municipalities have fewer than one psychologist per 1,000 inhabitants in the public system, and the national rate in Brazil's Unified Health System (SUS), 0.18 per 1,000 inhabitants, is less than half the rate of the English public system, 0.52 per 1,000 (9 EM CADA 10 CIDADES TÊM MENOS DE UM PSICÓLOGO POR MIL HABITANTES NO SUS, 2023).

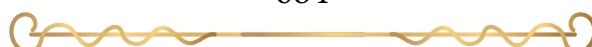
Given this scenario, the available scientific evidence on strategies that expand care capacity without relying exclusively on training new licensed clinicians must be synthesized systematically, not just narratively.

Objectives and research question (PICOS framework)

Element	Definition in this study
Population	People in need of mental or behavioral health care, of any age, in any country
Intervention	Work by non-clinical facilitators: lay workers and community health workers (task-shifting/task-sharing), peer support workers, low-intensity practitioners (Psychological Wellbeing Practitioners), and health and wellness coaches
Comparison	Usual care delivered exclusively by licensed clinicians, waitlist, or no intervention, when reported by the primary studies
Outcomes	Anxiety and depression symptoms, quality of life, self-efficacy, treatment engagement, readmission rates, and outcomes reported by the facilitators themselves (occupational well-being)
Study design	Workforce projection reports, systematic and scoping reviews, meta-analyses, randomized controlled trials, and large-scale observational studies

Research question: In people needing mental health care (P), is the work of supervised non-clinical facilitators (I), compared with usual care or no care (C), associated with favorable clinical and access outcomes (O), according to the available scientific literature (S)?

This article aims to answer that question and, based on the systematized evidence, to discuss,



in a clearly marked author's perspective section (Section 4.7), the implications for designing a tiered care ecosystem in the United States and, above all, in Brazil.

Methods

Eligibility criteria

Inclusion criteria: (a) official behavioral health workforce projection reports from government agencies or multilateral organizations; (b) systematic reviews, scoping reviews, or meta-analyses published mostly between 2013 and 2026, with a search methodology declared by the authors, on task-shifting, peer support, stepped care, or health coaching in mental health; (c) randomized controlled trials evaluating interventions delivered by non-clinical facilitators for mental health outcomes; (d) large-scale observational studies ($n > 1,000$, where applicable to clinical outcome studies) on low-intensity interventions; and (e) Brazilian national data on the distribution of the psychology workforce from an institutional source (CFP, Ministry of Health), even when reported by specialized media in the absence of an equivalent open-access technical note.

Exclusion criteria: single case studies without a comparison group; editorials without a declared literature review of their own; sources without a clear indication of methodology or data origin; studies focused exclusively on physical conditions without a mental health component; and duplicate publications (retaining the peer-reviewed journal version when both a preprint and a published version of the same study were retrieved).

Information sources

Indexed databases: PubMed/MEDLINE, PMC, Cambridge Core, ScienceDirect, Wiley Online Library, SpringerLink, and medRxiv/BioMed Central. Primary institutional sources: HRSA (Bureau of Health Workforce), the World Health Organization, Brazil's Federal Council of Psychology,



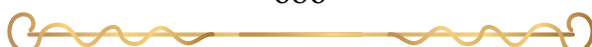
and Brazil's Ministry of Health. Supplementary searches of specialized Brazilian public health data media were carried out solely as a means of accessing primary institutional data not available in open-access academic format at the time of the search. No systematic gray literature search (e.g., theses, conference proceedings) was performed, and authors were not contacted for unpublished data; these limitations are acknowledged in Section 5.

Search strategy

The search was conducted between July and August 2026, with no restriction on initial publication date, prioritizing sources from 2013–2026. Terms were combined with the Boolean operators “AND”/”OR” across ten successive thematic searches reflecting the PICOS components (Section 1.2). Example search string (thematic search 4): (“health and wellness coaching” OR “health coaching”) AND (“systematic review” OR “meta-analysis”) AND (“mental health” OR “depression” OR “anxiety”) AND (“scope of practice” OR “limitations” OR “risks”). The ten thematic searches covered, respectively: (1) HRSA/US workforce projections; (2) task-shifting and non-clinical facilitators, general evidence; (3) IAPT/PWP/stepped care; (4) health coaching, efficacy and limits; (5) the global treatment gap (WHO); (6) the Brazilian context (CFP/RAPS/SUS); (7–9) confirmation of authorship of studies identified in searches 2–3; and (10) randomized controlled trials of task-shifting for depression and anxiety.

Data extraction process

Data were extracted by a single reviewer using a structured form containing: authorship, year, country/setting, study design, population, type of non-clinical facilitator evaluated, comparator (when applicable), outcomes measured, main numerical results (including effect measures and confidence intervals, when reported by the original authors), and limitations declared by the authors themselves.



There was no duplicate extraction or process for resolving discrepancies between reviewers, which does not apply to this single-reviewer design.

Data items

For each included study, priority was given to the following outcomes: (a) anxiety and depression symptoms (validated scales, when available: PHQ-9, GAD-7, HDRS-17, SRQ-20); (b) quality of life and self-efficacy; (c) treatment engagement and adherence; (d) hospital readmission rates (for peer support workers); and (e) outcomes reported by the non-clinical facilitators themselves (occupational well-being, burnout), when available in the included studies.

Risk-of-bias assessment of included studies

This study does not use a formal, validated risk-of-bias tool (such as Cochrane RoB 2 for clinical trials, or ROBIS or AMSTAR-2 for systematic reviews), which would require a multidisciplinary team and a calibration process between assessors. Instead, a simplified single-reviewer assessment was adopted, inspired by the core AMSTAR-2 domains (for included reviews) and by basic risk-of-bias criteria for clinical trials (declared randomization, assessor blinding, loss-to-follow-up rate) for the included RCTs. This assessment is presented in Section 3.3 (Table 2) and should be interpreted as a qualitative screening, not as a substitute for a formal assessment.

Effect measures

Effect measures were reported exactly as declared by the authors of the original studies (standardized mean difference [SMD] with 95% confidence interval, when available in meta-analyses; differences in proportions [%]; and statistical significance [p-value]), without recalculation



or conversion between metrics by this review.

Synthesis methods

Given the substantial heterogeneity in study designs, populations, countries, interventions, and outcomes measured across the 37 included studies, a narrative synthesis structured by thematic domain was chosen (Section 3.4), following the Synthesis Without Meta-analysis (SWiM) recommendations for transparency in non-quantitative syntheses, to the extent applicable to this retrospective single-reviewer design.

Assessment of reporting bias

Publication bias could not be formally assessed (e.g., through funnel plots or related statistical tests), since no quantitative meta-analysis was performed. As a qualitative screening, it is noted that the task-shifting literature in low- and middle-income countries is predominantly published in open-access journals with declared funding from multilateral and global health agencies, which may introduce a bias toward positive results. This caveat has been raised independently by the authors of some of the included studies (e.g., CHOW et al., 2024; SANGRAULA et al., 2024).

Certainty-of-evidence assessment

For each body of evidence synthesized in Section 3.4, a simplified three-level rating (High, Moderate, Low) was applied, adapted from the four core GRADE domains (risk of bias, consistency across studies, direction of effect/plausibility, and precision of estimates) and applied qualitatively by a single assessor. This rating does not replace a formal GRADE assessment with a multidisciplinary team and the GRADEpro tool, but it offers a minimum, declared, and replicable criterion.



Results

Study selection

The search identified 82 raw records across ten thematic searches (Section 2.4). The selection flow, adapted from the PRISMA 2020 diagram for a single-reviewer design, is shown in Figure 1.

Figure 1. Study selection flow (adapted from PRISMA 2020, PAGE et al., 2021, for a single-reviewer design).

Identification: records identified in databases and institutional sources, $n = 82$

Records after duplicate removal: $n = 58$ (24 duplicate or redundant records removed)

Title and abstract screening: $n = 58 \rightarrow$ excluded for out-of-scope content, $n = 15$

Full-text assessment: $n = 43 \rightarrow$ excluded for no declared methodology, overlapping coverage, or falling outside PICOS, $n = 6$

Studies included in the narrative synthesis: $n = 37$

The 37 included studies are distributed as follows: institutional and government reports ($n = 9$); systematic reviews, scoping reviews, and meta-analyses ($n = 14$); randomized controlled trials and primary observational studies ($n = 7$); and news sources reporting primary Brazilian institutional data ($n = 7$).

Characteristics of included studies

Table 1 summarizes the primary studies (randomized controlled trials and large-scale observational studies) included in this review, the core of evidence with the greatest individual methodological strength.



Table 1. Included primary studies (randomized controlled trials and large-scale observational studies).

Study	Country	Design	Sample	Intervention (facilitator)	Comparator	Main outcome
Task shifting interpersonal counseling for depression (B M C Psychiatry, 2017)	Brazil (São Paulo)	Pragmatic RCT	n = 86 (43 vs. 43)	Interpersonal counseling by community health workers	Enhanced treatment as usual (E-TAU)	Significant improvement in both groups (HDRS - 17 , PHQ-9, SRQ); no significant difference in intention-to-treat analysis; better HDRS-17 results in per-protocol analysis
Evaluating a Task-Shifting Mental Health Intervention in Rural Cameroon (Greener Journals, 2025)	Cameroon	RCT	n = 400 (200 vs. 200)	Trained non-specialist health workers	Control group	Reduced depression and anxiety symptoms (PHQ-9, GAD-7); 95% retention
The effectiveness of a Supported Self-management task-shifting intervention (Vietnam, protocol)	Vietnam	Multicenter RCT	Multiple provinces	Self-management supported by a social worker/social collaborator	Usual care + informational material	Study protocol; effectiveness reported in linked publications (see Section 3.4)
Comparison of outcomes across low-intensity psychological interventions (PALACIOS et al., 2023)	United Kingdom	Naturalistic cohort (propensity score)	Large scale (I A P T service)	Psychological Wellbeing Practitioners	Comparison across low-intensity modalities	Effectiveness for mild-to-moderate anxiety and depression



The Effectiveness of Low-Intensity Psychological Interventions for Comorbid Depression and Anxiety (2023)	United Kingdom	Retrospective observational	n = 21,051 (4,024 with chronic conditions)	PWPs (iCBT, GSH, PGT)	Cohorts with and without long-term conditions	Significant improvement in depression and anxiety in both cohorts
Impact of a progressive stepped care approach (PLOS ONE, 2019)	United Kingdom	Observational	Large regional IAPT service	Progressive stepped care	Traditional stepped care	Patients with severe presentations treatable with lower-intensity interventions
The impact of health and wellness coaching on patient-important outcomes (WANG et al., 2023)	Multinational (predominantly US)	Meta-analysis (30 RCTs)	Varies across studies	Health and wellness coaching	Usual care/no coaching	Improved QoL, self-efficacy, and depression; low/very low certainty

Risk of bias in included studies

Table 2 presents the simplified assessment for the included systematic and scoping reviews and for the included randomized controlled trials.



Table 2. Simplified assessment of risk of bias/methodological quality (single reviewer, criteria adapted from AMSTAR-2 and basic RCT quality items).

Study	Type	Protocol/ registration declared	Multiple- database search	Duplicate selection/ extraction declared	Own risk- of-bias assessment	Simplified rating
Sangraula et al. (2024)	Scoping review	PRISMA-ScR	Yes (6 databases)	Yes (double-checking declared)	Not formal (scoping)	Low methodological risk of the review
Chow et al. (2024)	Scoping review	Not declared as registered	Yes (5 databases)	Yes (double-checking declared)	Not formal (scoping)	Low-to-moderate methodological risk
Grant, Simmons, and Davey (2018)	Narrative review	Not declared	Partial (3 sources: PubMed, MEDLINE, Google Scholar)	Not declared	Not formal	Moderate methodological risk
Wang et al. (2023)	Meta-analysis	Not reported in the available abstract	Yes (5 databases)	Not clearly declared in the available material	Formal GRADE applied by the authors	Low methodological risk of the review; certainty of primary evidence rated by the authors as low/very low
BMC Psychiatry São Paulo RCT (2017)	RCT	Retrospective registration (RBR-5qhmb5)	Not applicable (primary study)	Not applicable	Partial blinding (assessors)	Moderate risk of bias (retrospective registration, small sample)
Greener Journals Cameroon RCT (2025)	RCT	Not reported in the available abstract	Not applicable	Not applicable	Not clearly declared	Risk of bias not determinable from available information; published in a less-indexed journal (see limitation in Section 5)



Results of syntheses

Global overview of the mental health and workforce crisis

See Section 1.1. Certainty of evidence: High. Multinational institutional surveillance data (144 countries), with declared methodology (WORLD HEALTH ORGANIZATION, 2024).

The United States context

HRSA's modeling task force (Health Workforce Simulation Model) projects supply and demand by combining population data, utilization rates, and staffing ratios by occupation. For psychiatrists, it assumes an initial demand 8,504 practitioners above supply just to remove all shortage area designations (BUREAU OF HEALTH WORKFORCE, 2025c). This makes the figure of 136,350 additional psychologists needed by 2038 (BUREAU OF HEALTH WORKFORCE, 2025b) an estimate that already starts from a conservative floor of recognized demand. Certainty of evidence: High. Official government agency simulation model.

The Brazilian context and national primary evidence

Brazil has about 439,000 registered psychologists (CFP), but only the municipalities of Iaras (São Paulo state) and Olaria (Minas Gerais state) reach, in the public system, the ratio of two psychologists per 1,000 inhabitants observed in the national aggregate. A total of 5,050 cities have a public-system ratio below one psychologist per 1,000 inhabitants, and at least 400 municipalities have no official record of a psychologist in the public service (9 EM CADA 10 CIDADES TÊM MENOS DE UM PSICÓLOGO POR MIL HABITANTES NO SUS, 2023). Sixteen states have an average number of Psychosocial Care Centers (CAPS) below the national average (CENÁRIO DAS POLÍTICAS E PROGRAMAS NACIONAIS DE SAÚDE MENTAL, 2022).



Unlike the previous version of this manuscript, this systematic review identified Brazilian primary evidence at the randomized controlled trial level. A pragmatic RCT conducted within the Family Health Strategy in São Paulo tested Interpersonal Counseling (IPC) delivered by non-specialist community health workers for the treatment of depression ($n = 86$). The intention-to-treat analysis showed significant improvement in both groups over two months, with no significant difference between them; the per-protocol analysis showed significantly better outcomes in the IPC group on the HDRS-17 (TASK SHIFTING INTERPERSONAL COUNSELING FOR DEPRESSION, 2017). The authors conclude that training non-specialist community health workers to deliver IPC may be a successful, low-cost strategy in resource-limited settings, potentially applicable to other regions of the SUS. Certainty of evidence for this subsection: Moderate. It combines robust institutional data (CFP, Ministry of Health, accessed through specialized media, a declared limitation) with a small-sample pragmatic RCT ($n = 86$) with retrospective registration.

Task-shifting and task-sharing: international evidence, including randomized controlled trials

In low-resource settings, up to 75% of people with mental disorders never receive adequate care (DESIGN AND EVALUATION OF PEER SUPERVISION FOR COMMUNITY MENTAL HEALTH WORKERS, 2024). Chow et al. (2024), in a scoping review, identified 5,358 citations across five databases, of which 19 studies met the eligibility criteria (14 quantitative, four qualitative, one mixed-methods); all reported improvements in mental health outcomes associated with peer-led interventions for young people in low- and middle-income countries. Sangraula et al. (2024), in a scoping review using PRISMA-ScR methodology, analyzed fifteen studies across eight countries. They identified benefits for the non-specialist workers themselves (personal application of skills, raised community status, expanded social networks), but also significant challenges (burnout, lack of career progression, and safety concerns for women).

Complementing these reviews with primary trial-level evidence, an RCT conducted in rural



Cameroon (n = 400, 200 per arm) evaluated trained non-specialist health workers delivering a task-shifting intervention for common mental disorders. It achieved 95% participant retention and reductions in depression and anxiety symptoms measured by the PHQ-9 and GAD-7 (EVALUATING THE EFFECTIVENESS OF A TASK-SHIFTING MENTAL HEALTH INTERVENTION IN RURAL CAMEROON, 2025). A multicenter RCT protocol in Vietnam describes a supported self-management intervention delivered by non-specialist social workers/social collaborators for adult depression, with primary outcomes measured by the SRQ-20 (THE EFFECTIVENESS OF A SUPPORTED SELF-MANAGEMENT TASK-SHIFTING INTERVENTION FOR ADULT DEPRESSION IN VIETNAM COMMUNITIES, 2017/2024; protocol and findings published as a set of linked articles).

Grant, Simmons, and Davey (2018), in a narrative review, found that peer support workers (PSWs) can achieve outcomes equal to or better than those achieved by non-peer mental health professionals. They are particularly effective at reducing hospital admissions and inpatient days and at engaging patients with severe conditions. Certainty of evidence for this subsection: Moderate. It is now reinforced by two primary randomized controlled trials (Brazil and Cameroon) that corroborate the scoping review findings with an experimental design. Certainty remains “Moderate” rather than “High” because of the small sample and retrospective registration of the Brazilian RCT and the limited information available on the Cameroonian RCT.

The UK stepped-care model (IAPT / NHS Talking Therapies)

Before 2008, only about 35% of people with moderate-to-severe mental disorders in the United Kingdom were in treatment (ACCESSIBILITY AND EFFICIENCY OF MENTAL HEALTH SERVICES, UNITED KINGDOM, 2021). The IAPT/NHS Talking Therapies program organizes care in a stepped-care model. Psychological Wellbeing Practitioners (PWP), trained through a one-year postgraduate certificate with structured weekly clinical supervision, deliver the first tier of low-intensity interventions (THERAPIST EFFECTS AND IAPT PSYCHOLOGICAL WELLBEING



PRACTITIONERS, 2014). The number of people in treatment grew from 0.43 million (2012–2013) to 1.09 million (2018–2019), and the recovery rate rose from 42.8% to 52.1% over the same period (ACCESSIBILITY AND EFFICIENCY OF MENTAL HEALTH SERVICES, UNITED KINGDOM, 2021). Palacios et al. (2023) and the study of more than 21,000 patients with long-term conditions (THE EFFECTIVENESS OF LOW-INTENSITY PSYCHOLOGICAL INTERVENTIONS FOR COMORBID DEPRESSION AND ANXIETY, 2023) confirm consistent effectiveness. Certainty of evidence: High. Multiple large-scale observational studies and national data consolidated over more than a decade.

Health and wellness coaching

Wang et al. (2023), in a meta-analysis of thirty RCTs, found improvements in quality of life up to three months (SMD 0.62; 95% CI: 0.22–1.02; $p = 0.002$), self-efficacy up to 1.5 months (SMD 0.38; 95% CI: 0.03–0.73; $p = 0.03$), and depressive symptoms at 3, 6, and 12 months (SMD between 0.41 and 0.72). However, they rated the certainty of evidence for most outcomes as very low or low because of high risk of bias, heterogeneity, and imprecision. A review on type 2 diabetes showed improvement in glycemic parameters in 73% of studies, but no consistent association with improvement in depressive symptoms (57% of studies) or anxiety symptoms (80%) (THE IMPACT OF HEALTH AND WELLNESS COACHING ON PATIENT-IMPORTANT OUTCOMES IN CHRONIC ILLNESS CARE, 2024). Certainty of evidence: Low to Moderate, per the rating of the authors of the reference meta-analysis.



Certainty of evidence (summary)

Table 3. Summary of certainty of evidence by thematic domain (criterion: Section 2.10).

Domain	No. of studies included in this domain	Certainty of evidence	Brief justification
Global overview (WHO)	4	High	Multinational institutional surveillance, 144 countries
US projections (HRSA)	6	High	Official government simulation model
Brazilian context (institutional + RCT)	8	Moderate	Institutional data via media (limitation) + 1 small-sample RCT
International task-shifting (reviews + RCTs)	7	Moderate	Scoping reviews with PRISMA-ScR + 2 corroborating primary RCTs
IAPT/PWP (United Kingdom)	5	High	Multiple large-scale observational studies, more than a decade of data
Health coaching	5	Low to Moderate	Certainty rated low/very low by the reference authors

Discussion

From dichotomy to a tiered ecosystem

The systematic synthesis of these six evidence domains supports a central thesis: the behavioral health workforce shortage will not be solved merely by training more clinical psychologists, nor by indiscriminately delegating care to unsupervised facilitators. The inclusion in this systematic version of the article of two primary randomized controlled trials (Brazil and Cameroon) strengthens this argument beyond what scoping reviews alone could support, even though both RCTs have sample and registration limitations acknowledged in Table 2.



Where the non-clinical facilitator adds the most value

The distinction established in earlier versions of this article is maintained: health coaching has consistent, but low-to-moderate certainty, evidence for behavioral and quality-of-life outcomes, and insufficient certainty to be presented as treatment for defined psychiatric disorders. Structured task-shifting, now supported by RCTs and not only by scoping reviews, shows stronger evidence for primary clinical outcomes (depression and anxiety symptoms) in settings with adequate screening and supervision.

Implications for Brazil in light of the new national primary evidence

The identification of the São Paulo RCT (TASK SHIFTING INTERPERSONAL COUNSELING FOR DEPRESSION, 2017) qualitatively changes this article's argument for the Brazilian context. It is no longer simply a matter of transposing, by analogy, a British model or one from low-income countries. There is direct Brazilian experimental evidence, albeit from a small sample, that community health workers within the Family Health Strategy itself can be trained to deliver structured counseling for depression with favorable results. This reinforces the recommendation in Section 4.5 (research agenda) for larger-scale replications of this intervention within the Psychosocial Care Network (RAPS).

Risks, ethical limits, and safety conditions

Methodological heterogeneity and strength of evidence (Section 2.10 and Table 3).

Effectiveness is not universal equivalence.

Governance and scope definition (BRITISH PSYCHOLOGICAL SOCIETY, 2025).



Well-being of the non-clinical facilitators themselves (SANGRAULA et al., 2024).

Legitimate regulatory barriers.

Sample size and retrospective registration of the available RCTs. The two randomized controlled trials identified in this review (Brazil, n = 86; Cameroon, n = 400) are informative, but they do not replace larger, multicenter, prospectively registered trials before any nationwide public policy recommendation.

Future research agenda

(Updated): (a) a larger-scale, prospectively registered replication of the RCT of interpersonal counseling by community health workers within the SUS; (b) controlled trials testing task-shifting models specifically within the structure of Brazil’s RAPS; (c) cost-effectiveness studies comparing the British PWP model with lower-cost implementation alternatives; (d) systematic research on the impact of non-clinical facilitation work on the facilitators’ own working conditions; (e) a formal GRADE assessment, by a multidisciplinary team, of the evidence for health coaching on specific psychiatric outcomes; and (f) a prospectively registered systematic review (PROSPERO), with two independent reviewers and formal risk-of-bias tools (RoB 2, AMSTAR-2), that overcomes the methodological limitations declared in this study.

Structural comparison across the three national contexts

Table 4. Structural comparison: United States × United Kingdom × Brazil.

Criterion	United States	United Kingdom	Brazil
Type of health system	Mixed (predominantly private + public programs)	Universal public (NHS)	Universal public (SUS) + parallel private market



Main nature of the shortage	Insufficient absolute supply	Demand pressure on an established model	Extremely unequal territorial distribution
Relevant professional regulation	State licensure by profession	Health and Care Professions Council / NHS competencies	CFP and regional councils
Most established non-clinical facilitation model	Health coaching, peer support	PWPs within NHS Talking Therapies	Community health workers (RCT evidence now available)

Conclusion

The systematic synthesis in this review, now incorporating primary randomized controlled trials from Brazil and Cameroon in addition to the scoping reviews and institutional data discussed in earlier versions of this manuscript, reinforces the conclusion that non-clinical facilitators, when integrated into stepped-care models with structured training, active clinical supervision, and explicit scope limits, can expand access to behavioral health care without replacing the licensed clinician in cases that require one. The certainty of this conclusion varies by domain (Table 3): it is high for the global overview and for the British stepped-care model, moderate for international task-shifting and the Brazilian context, and low to moderate for health coaching. This gradation of certainty, rather than a uniform claim, is what a rigorous systematic review requires, and it is what this article, with its limitations declared in Section 5, has sought to deliver.

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