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## EDITORIAL

# Community Health Workers: Potential Allies for the Field of Psychiatric Rehabilitation?

Judith A. Cook  
University of Illinois at Chicago

Kim T. Mueser  
Boston University

Community health workers<sup>1</sup> are indigenous members of patients' communities who have been trained to provide support, education, and care coordination to improve medical outcomes for low-income and at-risk populations. A National Workforce Study conducted by the Health Resources and Services Administration (HRSA, 2007) found that community health workers offer a wide variety of services, including interpretation and translation, culturally appropriate health education, care coordination, advocacy on behalf of individual and community health needs, informal counseling and support regarding health behaviors, and direct services such as first aid and health screening. Their focus on some of the same populations served by the field of psychiatric rehabilitation, as well as the generally poor health of many people in mental health recovery, suggests that community health workers could be natural allies for practitioners in our field.

The history of community health workers in the United States began in the mid-1960s as an experimental response to persistent poverty that was conceived more as an antipoverty strategy than a public health model of disease prevention and care (HRSA, 2007). In the 1970s and 80s, the model developed further through special projects funded by time-limited grants to universities and other organizations, aimed at documenting community health workers' value in increasing access to health care and health promotion. In the 1990s, state and federal initiatives spurred the development of standardized training programs and the growth of community health worker initiatives across categorical funding programs. From 1999 to the present, significant public policy advances resulted in the passage of state and federal legislation supporting community health workers (HRSA, 2007). A 2002 Institute of Medicine report on racial and ethnic health disparities included recommendations regarding use of community health workers to reduce inequities and improve health outcomes for communities of color (Institute of Medicine, 2002). The Department of Labor Bureau of Labor Statistics created a distinct occupation code for community health workers in 2009 (HRSA, 2011), which further

validated the field and stimulated their inclusion in health service reimbursement plans. Passage of the Affordable Care Act in 2010 further encouraged the potential for community health workers to enhance the U.S. health care system, especially section 5313, which authorizes the Centers for Disease Control and Prevention (CDC) to issue grants to organizations using community health workers to improve health in underserved areas (Katzen & Morgan, 2014). As of December 2012, seven states had laws authorizing Medicaid reimbursement for community health worker services (CDC, 2013).

Increasingly, community health workers are being used to provide transitional care interventions to patients who are deemed to be at risk of unplanned readmission following discharge from a medical hospitalization (Kangovi et al., 2014). Once patients have returned home, community health workers provide care coordination and patient navigation to promote greater access to care and integration of complex services required by many health conditions. These kinds of services are designed to ensure the safe and timely movement of patients from the hospital to their homes (Bray-Hall, 2012), while preventing avoidable readmissions and helping to ensure that positive health outcomes can be sustained (Naylor et al., 2011). Use of community health workers in this manner recognizes that low-socioeconomic status patients have lower access to postdischarge primary care (Asplin et al., 2005; Misky et al., 2010), receive poorer care while in the hospital (Rathore et al., 2006), and have higher risks of all-cause hospital readmission and death (Baker et al., 2002; Foraker et al., 2011). It also supports the philosophy that patient-centered medical care should follow individuals who are discharged from the hospital into the community (Lorig et al., 1999). As members of the communities they serve, community health workers are in an excellent position to ensure patient comprehension of aftercare instructions, enhance adherence to outpatient treatment regimens, and promote more equitable medical treatment processes (Schmidt et al., 2015). This is important to the field of psychiatric rehabilitation because evidence suggests that patients discharged after a medical hospitalization are significantly more likely to be readmitted within 30 days if they have a co-occurring mental illness

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Judith A. Cook, Ph.D, Department of Psychiatry, University of Illinois at Chicago; Kim T. Mueser, Ph.D, Departments of Occupational Therapy, Psychology, and Psychiatry, Boston University.

Correspondence concerning this article should be addressed to Judith A. Cook, Department of Psychiatry, University of Illinois at Chicago, 1601 West Taylor Street, M/C912, 4th Floor, Chicago, IL 60612. E-mail: [cook@ripco.com](mailto:cook@ripco.com)

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<sup>1</sup> Also known as community health advisors, lay health advocates, "promotores (as)," outreach educators, community health representatives, peer health promoters, and peer health educators (Goodwin & Tobler, 2008).

than those without co-occurring mental illness (Ahmedani et al., 2015).

Community health worker services are provided in a number of formats, intensities, and contexts. Some community health workers concentrate their efforts on specific health conditions or problems such as diabetes or low birth weight babies, whereas others address a wide range of chronic health conditions. Some community health workers concentrate on health education and disease prevention efforts, whereas others provide care coordination and navigation, and still others provide direct care such as health screening or vaccinations. Some community health workers deliver their services exclusively in patients' homes or surrounding neighborhoods, whereas others operate in clinics, hospitals, or other facility-based settings.

A number of comprehensive research reviews support the positive outcomes achieved by community health workers (Perry & Zulliger, 2012; World Health Organization, 2010). A 2009 assessment of the evidence base for community health worker interventions commissioned by the Agency for Health care Research and Quality (Viswanathan et al., 2009) found that there was moderate to strong evidence for their success in the area of improving health care utilization, enhancing knowledge about disease prevention, and generating positive health outcomes for selected conditions. This evidence base supports the growth of these services with the knowledge that their effectiveness has been established. It also offers assurances to providers in other fields that offer evidence-based services, such as psychiatric rehabilitation.

There are a number of ways in which our field can collaborate with community health workers. One concerns the need for community outreach to people with psychiatric disabilities who are unable or reluctant to leave their homes due to physical infirmities, social isolation, or trauma exposure. In post-Katrina New Orleans, for example, teams of therapists, psychiatrists, primary care providers, and case managers recruited and trained community health workers to identify individuals in need of mental health care and then refer them to appropriate resources (Wennerstrom et al., 2011). Another stimulus for collaboration is the need for natural supports from trusted and familiar members of individuals' own communities to enhance community participation. In St Louis, Missouri, assertive community treatment (ACT) teams used community health workers to assist clients with activities of daily living and to engage them in leisure activities (Wolf et al., 1997). Yet another need is for in-home observation and assessment that can be shared with facility-based mental health, child and youth services, and psychiatric rehabilitation staff. In Oahu, Hawaii, community health workers visited families in which mothers were vulnerable to abuse and depression, and provided in-home child development assessments and observation of parent-child interactions, linking families to mental health, child welfare, and medical care providers (Duggan et al., 2000).

We as psychiatric rehabilitation practitioners can reach out to community health workers and their organizations to explore potential collaborations. A simple Internet search will identify community health worker programs in many states and local communities along with their contact information. Many colleges and universities now offer community health worker training programs, and the website of the Community Health Worker National Education Collaborative (<http://www.chw-nec.org/index.cfm>) contains information about programs by state and tribal commu-

nities that can be used as a source of contacts for collaborative efforts.

One obvious advantage of allying and coordinating our field's efforts with community health workers is their strong links to the people we seek to serve because they are "of and from" these communities. Community health workers are found in rural and remote areas, and in deeply impoverished and often isolated communities where few other services are available, they speak the languages (sometimes multiple languages) of these communities, and they understand the resourcefulness and tenacity of community members, an understanding that is fundamental to applying our field's strengths-based paradigm. We as a field have much to offer community health workers in return. Our behavioral health knowledge base and practice of rehabilitation in real-world settings involves information, professional skills, and competencies that are much sought after by the community health worker community world-wide (Mutamba et al., 2013).

The focus of community health workers on health disparities in vulnerable communities means that they address issues of poverty, while many recipients of psychiatric rehabilitation services live at or below the poverty line. Their focus on improving health in low-income populations of color is in line with some of our field's biggest challenges at this point in history, including poverty, cultural competence, and health comorbidities. By allying with community health workers we have the opportunity to extend our reach into new neighborhoods as well as to better serve our current clientele. By reaching out to local community health worker programs, conducting cross-training, and exploring new funding opportunities presented by health care reform, we may be able to enrich the multidisciplinary, collaborative ethos that makes psychiatric rehabilitation so relevant and effective.

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