Supporting Community Health Workers to Enhance Effectiveness of Behavioral Health-Primary Care Integration

Prepared by:

Seth Doyle, Northwest Regional Primary Care Association
Maribel Montes de Oca, Northwest Regional Primary Care Association
Nathan Thomas, Northwest Regional Primary Care Association
Vision y Compromiso
Noelle Wiggins, Wiggins Health Consulting
**Report Title:** Supporting Community Health Workers to Enhance Effectiveness of Behavioral Health-Primary Care Integration

**Publication Date:** May 2021

**Acknowledgements:** Northwest Regional Primary Care Association would like to thank the RCHN Community Health Foundation for providing the funding that made this study possible. NWRPCA also thanks our partners who helped with various aspects of this project and report, including the University of Washington Latino Center for Health for their support with the focus groups, literature review and data analysis, and The Next Door, Inc., Oregon Community Health Workers Association, Sea Mar, and the Washington CHW/Promotores Network for supporting the focus groups. Additionally, NWPRCA is indebted to all of the participants in the Advisory Group, focus groups, the survey, and informal conversations who generously shared their knowledge and experience. NWRPCA also extends our gratitude to Vision y Compromiso and Noelle Wiggins for their support in writing and preparing this report. Finally, NWRPCA expresses our heartfelt thanks to all of the Community Health Workers and Promotores/as de Salud who so generously shared their wisdom and experience with us. Your work is an inspiration to us and the entire Community Health Center Movement.

**Suggested Citation:** Northwest Regional Primary Care Association (2021). Supporting Community Health Workers to Enhance Effectiveness of Behavioral Health-Primary Care Integration.
# Table of Contents

- Executive Summary 3
- Introduction 5
- Background 5
- Methods 9
- Findings 11
- Discussion 21
- Recommendations 23
- Next Steps 23
- References 24
- Appendices 27
  - Appendix A: Annotated Bibliography 27
  - Appendix B: Suggested Reading List 40
  - Appendix C: Focus Group Guide 44
  - Appendix D: Survey Tool 46
  - Appendix E: Survey Results 51
Executive Summary

Background
In 2018, Northwest Regional Primary Care Association (NWRPCA) received a planning grant from the RCHN Community Health Foundation to identify key principles, current best practices, and workforce development requirements to support the involvement of Community Health Workers/Promotores/as (CHW/Ps) in behavioral health-primary care (BH-PC) integration at Community/Migrant Health Centers (C/MHCs).

Methodology
Methods included a literature review, focus groups, a survey, an advisory group, and informal conversations with colleagues around the country. Quantitative data was analyzed to produce frequencies and percentages for the group as a whole and for selected sub-groups. Qualitative data was analyzed using standard qualitative analysis techniques (i.e. a close reading of the notes and listening to audio recordings followed by the identification of key themes and sub-themes).

Findings

Awareness of and appreciation for CHW/Ps in primary care
- There is a wide range of perspectives and models regarding CHW/Ps in primary care and behavioral health.
- There is general agreement that CHW/Ps have much to offer a stressed mental health system which often lacks cultural competence.
- Primary care and behavioral health providers need to develop a better understanding of the well-established scope of roles of CHW/Ps.
- There is lack of clarity about the value, impact and outcomes of CHW/P interventions.
- Lack of awareness about how CHW/Ps can complement other providers can lead to resistance to their integration.
- CHW/Ps are much more aware of what they bring to integration of BH-PC than are administrators and other providers.

CHW/P contributions to behavioral health
- CHW/P interventions have been associated with reduced stress and depressive symptoms.
- The relationship with the CHW/P is a key factor in promoting improvements in mental health and emotional wellness.
- CHW/Ps can enhance behavioral health services in C/MHCs through their holistic perspective, their strong relationship-building skills, and their understanding of the barriers inherent in the system.
- CHW/Ps increase access by creating bridges among communities and behavioral health services.
- CHW/Ps possess a highly developed understanding of the collective, holistic, culturally specific nature of mental health and emotional wellness.
Addressing social determinants of health is at the core of CHW/P practice.
Many of the activities in which CHWs already engage promote emotional wellness.
CHW/Ps provide emotional support organically, in the midst of other activities.
When adequately supported, CHW/Ps are uniquely positioned to promote emotional wellness and improve mental health.
CHW/Ps tend to view behavioral health services as “very integrated,” likely because they facilitate integration on a daily basis.

**Pressing issues and barriers**
- CHW/Ps face a variety of barriers when they attempt to connect community members to behavioral health services.
- Even when CHW/Ps accompany community members to services, they often face racism, classism and other forms of discrimination.
- Existing training curricula lack focus on behavioral health.

**Improving CHW/P contributions to behavioral health**
- Allocating physical space to CHW/Ps promotes their integration.
- A variety of supports centering around pay, recognition, opportunities for advancement, and supportive and trauma-informed supervision are essential for the success and retention of CHW/Ps.
- In order to benefit fully from the presence of CHW/Ps, systems must engage them as trainers and leaders.

**Recommendations**
Based on the findings in this report, taking the following steps can help to assure that CHW/Ps can make an optimal contribution to the integration of behavioral health services in C/MHCs:
- Provide ongoing education to all members of the primary care and behavioral health team about the well-established scope of roles of CHW/Ps, their value and impact in primary care and behavioral health settings, and how they can complement the work of other providers.
- To enhance their effectiveness, improve recruitment, training and supervision of CHW/Ps in C/MCHs.
- Recruit CHW/Ps as supervisors for other CHW/Ps, and provide training for supervisors about the CHW/P model and reflective and trauma-informed supervision.
- Allocate physical space to CHW/Ps in clinics to communicate value and increase visibility and accessibility.
- Create opportunities for CHW/Ps to educate other providers about a range of topics related to community wellness and behavioral health.
- Provide training and professional development opportunities for CHW/Ps, particularly in areas of mental health (e.g., mental health first aid, motivational interviewing).
- Advocate for funding models, including reimbursement for CHW services, that recognize CHW/Ps as essential members of the primary care team.
Introduction

More and more, community and migrant health centers (C/MHCs) are seeing the positive health benefits of integrating behavioral health care into their patients’ primary care. As C/MHCs work to develop models of team-based care to provide integrated behavioral health services, attention is turning to the roles that Community Health Workers/Promotores/as (CHW/Ps)\(^1\) can play in the promotion of emotional wellness and the provision of mental health services to the community.

In 2018, Northwest Regional Primary Care Association (NWRPCA) received a planning grant from the RCHN Community Health Foundation to identify key principles, current best practices, and workforce development requirements to support the involvement of CHW/Ps in behavioral health-primary care (BH-PC) integration at C/MHCs. The overarching goal of the project was to enhance the effectiveness of BH-PC integration by recognizing and strengthening the role of CHW/Ps. The primary outcome of this initial grant is this report intended for dissemination to C/MHCs as a resource to inform and enhance the role of CHW/Ps as part of BH-PC integrated services.

Key questions guiding this project were as follows:
1. What roles do CHW/Ps play in the C/MHC setting?
2. How well is behavioral health integrated into primary care in C/MHCs?
3. What are current practices, challenges, and opportunities regarding engagement of CHW/Ps in integrated BH-PC settings?
4. What is the work that CHW/Ps do related to behavioral health?
5. Why are bridges to mental health services needed in C/MHCs?
6. How can CHW/Ps be leveraged as a crucial workforce to enhance the effectiveness of integrated BH-PC services?
7. What training do CHW/Ps need to work effectively in integrated settings?
8. To what extent does current CHW/P training incorporate topics related to mental health as well as aspects of BH-PC integrated services?

Background

Who are Community Health Workers/Promotores/as de Salud (CHW/Ps)?
Community Health Workers/Promotores/as de Salud (CHW/Ps) are trusted community members who improve health and reduce health inequities through a variety of strategies. Throughout history, CHW/Ps have improved the health of communities by providing social

\(^1\) In the mid-1990s, health professionals from around the country who went by a variety of titles but shared a common orientation and community membership chose “Community Health Worker” as the umbrella title for their profession. At the same time, they agreed that, in their own communities, they would continue to use the title that held the most cultural and historical relevance. In the Latinx community, this title is “Promotor/a de Salud.” In the Native/American Indian community, the title is Community Health Representative. In this report, we will use the initials “CHW/Ps” to be inclusive of all these professionals, except when specific sources have used another title.
support, culturally centered health education, cultural mediation, direct service, advocacy for individuals and communities and community organization (Rosenthal et al., 2018). In primary care and other clinical settings, CHW/Ps have frequently conducted care coordination, outreach, assessment, and shared prevention services, referrals, and follow-up. Further, CHW/Ps are recognized as effective community organizers (Farquhar et al., 2008), which enables them to work upstream to address the social determinants of health.

Based on their orientation as community members, CHW/Ps naturally understand their community’s health from a holistic or organic perspective rather than a purely physical, clinical perspective. Crucially, they help communities understand the broader societal context that affects the health of individuals and the community. The work of a CHW/P is the work of building mutually beneficial relationships with other community members based on empathy, love and compassion. This love for the community is what motivates CHW/Ps to listen, empathize and do what they can to help others. Empathy and love arise naturally and without pity, enabling CHW/Ps to support community residents’ own empowerment and ability to take steps to create change in their lives (Vision y Compromiso, 2020).

According to a 2018 article by the Association of American Medical Colleges, CHW/Ps are front-line public health workers trained to address a host of obstacles to healthy lives.

What’s more, they possess something that doctors don’t always have: a deep understanding of local issues and resources. CHWs often speak a patient’s language, both literally and metaphorically. And they’ve increasingly become a key part of some patients’ health care team. CHWs might exercise with patients, monitor their blood pressure, go with them to doctor’s appointments, or visit when they’re lonely. Throughout, they help address a vast array of social determinants of health, from food insecurity to lack of health insurance.

A variety of studies that have emerged over the last 10 years have suggested that CHW/Ps can contribute to the achievement of a variety of important goals in clinical settings, when they are well-chosen and well-supported and when their role is clearly understood by everyone on the health care team (Israel et al., 2015; Kangovi et al., 2015; Katigbak et al., 2015).

**Integrated Behavioral Health and Community/Migrant Health Centers (C/MHCs)**

In recent years, as both opioid misuse and suicide have reached epidemic levels in the U.S., the need for integrated BH-PC has become increasingly apparent. It is a top priority for several state and federal agencies within health and human services departments.

---

2 Various sections of this report are drawn, with permission, from content provided by Vision y Compromiso (http://visionycompromiso.org/). Citations to “Vision y Compromiso 2020” refer to the content provided and included in this report.
According to the National Alliance on Mental Illness (2020), 20% of adults in the U.S. experience mental illness each year, and half of all care for common mental health or psychiatric disorders happens in primary care settings (SAMHSA-HRSA Center for Integrated Health Solutions). Nationally, C/MHCs have seen significant increases in the number of both mental health and substance use disorder (SUD) patients served. According to the Uniform Data System of the Health Resources and Services Administration, during the three-year period from 2017-2019 the number of mental health patients increased by 26% and the number of Substance Use Disorder (SUD) patients increased by 93%, making mental and emotional wellness a pressing issue in C/MHCs (HRSA, 2020). At the same time, C/MHCs have increasingly sought models for being able to more effectively integrate behavioral health into primary care. While a single model or solution doesn’t exist, for the purposes of this report and project, NWRPCA referred to the “Standard Framework for Levels of Integrated Healthcare” which identifies six levels of integration within three main categories: coordinated care, co-located care, and integrated care (SAMHSA-HRSA Center for Integrated Health Solutions).

C/MHC patients are living with depression, anxiety, questions about gender identities, isolation, lack of social support, trauma, fear related to being arrested, deported, and/or separated from family, homelessness, food insecurity, substance abuse, lack of culturally relevant resources, language barriers, chronic disease and other chronic barriers. All are issues that may not come up in a routine, time-constrained clinic visit, but all directly affect a patient’s health and well-being, and can destabilize a patient’s future access to health care.

Prevalence data from most studies of mental and emotional wellness find that people with a diagnosed mental health condition represent only a fraction of diagnosable cases (Mental Health America, 2020). Those who meet the criteria for one or more mental health conditions are just the tip of the mental health iceberg. These data represent individuals who have been seen at least enough times to diagnose their condition. However, there are many more individuals “below the surface” who are simply struggling with the pressures of everyday life, who do not meet the classification of a disorder, and who simply need support to overcome the less acute conditions of emotional distress. These individuals could benefit from learning to identify and more effectively manage the causes of their distress; unfortunately, they are not easily identified nor diagnosed, and local community services to support them are almost nonexistent (Vision y Compromiso, 2020).

CHW/Ps and Behavioral Health Integration
Until recently, the work of CHW/Ps has gone largely unnoticed and unappreciated by the health care system generally and the behavioral health system in particular. However, CHW/Ps have always promoted emotional wellness and addressed mental health problems as part of their work.

---

3 A partial exception to this rule are peer support specialists, who support patients with mental illness and/or SUD based on their own personal experience of these conditions. While peers and CHW/Ps share the characteristic of community membership, they are distinct in other ways.
Useful models and precedents for CHW/Ps integration in behavioral health in C/MHCs also exist. In the late 1980s, physicians at La Clínica del Cariño (LCDC, now One Community Health), a C/MHC in Hood River, Oregon, began to notice a preponderance of Latina immigrants coming in with vague, non-specific complaints, which the providers loosely labeled “depression visits.” Fortunately, LCDC had established a CHW/P program in 1988; the seven female CHW/Ps in that program were also well aware of the problem of isolated and depressed women within their community.

Responding to this need in their community, the CHW/Ps began to organize “cooking classes.” These classes brought together Latina women and their children from remote farmworker camps. While the children were cared for, the CHW/Ps facilitated interactive classes about topics ranging from depression to domestic violence. They then moved to the kitchen, where the women prepared familiar dishes using healthy ingredients. The classes ended with chatting and socializing over the meal the women had cooked, where they were joined by the children (Hayes et al., 1994; Wiggins & Castañares, 1993).

The pilot project was formalized and extended in 1991, when LCDC received a grant for a program that specifically focused on promoting emotional wellness and ameliorating mental health problems among Latinx farmworking women and teens. In 1992, staff from MHP Salud (then called the Midwest Migrant Health Information Office) in Saline, Michigan, visited the program at LCDC in preparation for developing their own emotional wellness promotion program, which is now well-developed (MHP Salud, 2020).

The CHW/P has an advantage over most mental health providers in understanding the emotional and mental health of the community. Understanding a person’s context takes time. CHW/Ps interact frequently, often daily, with their friends and neighbors, which allows them to develop a deeper, more realistic understanding of how residents are affected by and cope with daily stressors. They understand that most “mental health” issues in the community are not called “mental health” issues but referred to as “worries,” “stress,” “nerves,” or simply “things I’m dealing with.” They are dealt with in culturally familiar ways by talking things out with a trusted individual, spending time with a social support network, participating in community events, and building community with neighbors (Vision y Compromiso, 2020).

CHW/Ps have a unique ability to listen to the community. They understand the social and cultural factors that affect a person’s emotional well-being. With additional training, CHW/Ps can support residents to understand and manage the many factors that affect their emotional wellness. CHW/Ps who work in mental health clinics can benefit from participating in training on topics that include resiliency, motivational interviewing, stress management, nutrition and physical activity, social determinants of health, mental health first aid and how to create social support networks, among others (Vision y Compromiso, 2020).
The insights they gain as they develop a deeper understanding of the community’s needs regarding emotional wellness can help increase understanding of how clinic staff can best approach their community’s overall mental and emotional health needs from a more holistic perspective. CHW/Ps become powerful advocates for improved services and play a vital role in increasing community participation in organized advocacy activities to address the root causes impacting the mental health and well-being of the entire community (Vision y Compromiso, 2020).

**Methods**

Methods used to answer key questions in this study included a literature review, a survey, focus groups, an advisory group, and informal conversations with colleagues around the country. Quantitative data collected via the survey was analyzed to produce frequencies and percentages for the group as a whole and for selected sub-groups. Qualitative data collected via the focus groups, advisory group, and informal conversations was analyzed using standard qualitative analysis techniques (i.e. a close reading of the notes and listening to audio recordings followed by the identification of key themes and sub-themes).

**Literature Review**

The purpose of the literature review was to explore what is currently known about CHW/Ps (and to a limited degree, peer support specialists), their roles in integrating behavioral health into primary care, and what makes them successful. The review was expanded to include roles of CHW/Ps and/or peers in primary care generally, and CHW/P models, focusing on those in the Latinx community.

A preliminary query was conducted in PubMed, ResearchGate, and the Springer database. Criteria for article selection included material in biomedical, behavioral health, and public health academic journals, and was limited to studies conducted in the United States. Search terms used were Community Health Workers, Promotoras, Lay Health Advisor, Peer Advisor, Peer Support Staff, Peer Delivered, Community Interventionist, Care Coordinator, Peer-to-Peer Worker, Mental Health Services, Mental Health, Behavioral Health, Chemical Dependency, Crisis Counseling, Stress Management, Integration, Primary Care, Community Health Center, and Neighborhood Health Center.

A secondary search for grey literature from governmental and non-governmental sources was conducted using Google and Google Scholar. Sources included committee reports, policy papers, and organizational training resources. Search terms included: barriers in using CHW/Ps, peer advocates and capacity to deliver services; roles in mental health service delivery for peer advocates; roles and functions of promotores in behavioral health; roles and functions of CHW/Ps; capacity of CHW/Ps in delivering mental health interventions; and promotores in mental health service delivery.
In sum, the searches indicate that literature is emerging that emphasizes the role of CHW/Ps in providing mental health services within primary care settings. Most of the literature is recent, which may indicate that literature on this topic can be expected to increase. A total of twenty sources were identified that dealt with CHW/Ps and/or peer support specialists and/or primary care and/or behavioral health. Only 12 of 20 dealt with CHW/Ps’ and/or peers’ role in behavioral health and only nine of these focused on CHW/Ps (rather than peers). However, these nine include two systematic reviews, indicating there is additional literature that can be included in future searches. An annotated bibliography of articles included in the literature review is provided as Appendix A. Articles that did not meet the criteria for the review were organized into a suggested reading list (see Appendix B).

Focus Groups

A total of four focus groups were conducted, two with a variety of C/MHC staff and two with CHW/Ps exclusively.

In October 2019, two focus groups with C/MHC staff were facilitated by two faculty members from the University of Washington Latino Center for Health. A total of 16 participants responded to an invitation to join a focus group that would examine the roles that CHW/Ps play related to physical and behavioral health. These focus groups were held on consecutive days during NWRPCA’s Fall Primary Care Conference held in Seattle, WA. Along with one CHW/P, participants included clinicians, administrators, behavioral health providers, and quality improvement staff and represented a variety of states including Alaska, Montana, Oregon and Washington.

The focus group guide, which was developed in collaboration with NWRPCA staff, is included as Appendix C. Questions inquired about roles of CHW/Ps, types of services CHW/Ps provide, how CHW/Ps support behavioral health in the community and at C/MHCs, the integration CHW/Ps in the provision of services, and the training and supervision of CHW/Ps. Based on audio recordings and notes taken during the focus groups, researchers provided a summary of themes to NWRPCA staff.

A second set of focus groups were conducted by NWRPCA staff and consultants with CHW/Ps. One focus group took place at the Annual Conference of the Oregon CHW Association in Medford, OR, in August of 2019. Dinner was served and the focus group drew 18 participants. The second focus group was conducted in Skagit, WA, in September 2019, drawing 8 participants. A different focus group guide which used popular education techniques was used. Popular education, also referred to as “people’s education,” creates settings in which people most affected by inequities can share what they know, learn from others in their community, and use their knowledge to create a more just and equitable society. Popular education and the CHW/P model grew out of many of the same historical roots and share key principles, such as ideas that people most affected by inequity are the experts about their own lives, and that experiential knowledge is just as important as academic knowledge.
After an introduction, the setting of group agreements, a dinámica and the signing of a consent form, facilitators inquired about participants’ experiences serving community members with mental health issues, the types of support they provide, the ways in which CHW/Ps promote emotional wellness, the support they have and the support they need, and the training they have and the training they need.

Detailed notes were taken during the two latter focus groups. Based on these notes, themes were later identified, and data was summarized into categories.

**Survey**

A 14-question survey was created by staff at NWRPCA and fielded using Survey Monkey between June 27 and July 26, 2019. Links to the survey with a request to participate were sent via NWRPCA’s distribution list; recipients were also requested to share the survey with their colleagues. Analysis of survey results was conducted by faculty at the University of Washington Latino Center for Health. The survey tool is provided as Appendix D.

**Advisory Group and Informal Conversations**

An advisory group composed of staff (primarily CHW/Ps and program managers) from community health centers, primary care associations, and local and national community-based organizations met monthly from February through December of 2019. The makeup of the group was somewhat fluid, with about 20 different individuals participating at some point in the process, and five to six individuals participating consistently. Group members helped develop the survey tool, provided insight into the focus group structure and methodology, shared their own individual and organizational perspectives about CHW/Ps and behavioral health integration, and in general served as a sounding board for NWRPCA staff, who shared ideas and updates about the direction of the project. In addition, NWRPCA staff reached out to approximately 10 individuals over the course of the project to gain their input via informal conversations.

**Findings**

Below, results of each data collection activity are provided separately, followed by a summary of the findings.

**Literature Review**

One notable finding from the literature review was the wide range of perspectives of the authors. These ranged from extremely top-down (indicated by the use of phrases like “instructing the promotores” and “received the intervention”) to grassroots and empowerment-oriented. Program models were similarly varied, ranging from clinically oriented models that were based on minimal knowledge of the CHW/P model, to community-based models that sought to address underlying disparities in power and resources. There was general agreement that CHW/Ps and peers have much to offer a stressed and often culturally incompetent mental health system, especially in marginalized communities where culturally appropriate services are especially scarce.
Many studies indicated the need for a clearer understanding among primary care and behavioral health providers of the well-established scope of practice of CHW/Ps (Wiggins & Borbon, 1998; Rosenthal et al., 2018), and for improved recruitment, training and supervision strategies. (For suggestions, see Brown et al., 2019). One article (Early et al., 2016) identified the need for training programs that center the language, culture and reading level of the CHW/Ps. Study authors uniformly agreed that more study is needed to understand and optimize the role of CHW/Ps in behavioral health.

Notable studies included a 2018 systematic review by Barnett and colleagues of behavioral health interventions involving CHW/Ps in low- and middle-countries (LMICs), as well as high-income countries. It found that most articles meeting inclusion criteria had been published since 2010, and that CHW/Ps in LMICs have a more involved role in providing psychosocial interventions than CHW/Ps based in the U.S. The primary rationale cited for employing CHW/Ps was to fill gaps caused by shortages of degreed mental health workers. Authors also express hope that employing CHW/Ps would destigmatize and demystify behavioral health.

One study by Daniels and colleagues (2017) suggests that people with different mental health needs might be best served by different kinds of CHW/Ps. Peer Support Specialists, who have historically worked with people with experience of substance use and/or severe and persistent mental illness, seem to be especially suited for working with specific behavioral health concerns or complex illnesses, according to this study. This contrasts with CHW/Ps, who may be more suited to promoting emotional wellness through generalized activities. It is also possible that, with training and experience, CHW/Ps can provide both general and specific supports to patients working to realize their mental health.

CHW/Ps have also been shown to be able to facilitate effective behavioral health programs when trained to do so. An article by Sternberg and colleagues (2019) indicates that not only is it possible to train CHW/Ps to provide stress management programs but these programs have successfully decreased depressive symptoms and stress. The key takeaway here is that with proper support, CHW/Ps can provide a valuable skillset to meet community mental health needs. One additional study (Tran et al., 2014) documented reduced stress and depressive symptoms associated with a promotora-led intervention.

A qualitative study by Perales et al. (2018) reinforced the idea that the value of CHW/Ps goes beyond supporting patients’ interactions with services. This study provides evidence that the professionalism and rapport from CHW/Ps promotes positive relationships and lifestyle behavior changes. In this study, the only participants who reported consistently poor scores for anxiety, depression, or both, were also those who reported neutral or negative experiences with the CHW/Ps, emphasizing the importance of the CHW/P-participant relationship.
Survey
Complete survey results are presented in Appendix E. A total of 209 individuals from 11 states responded to the survey. The greatest number of respondents were from Oregon (36.8%) and Washington (23.4%). The largest percentage of respondents (47%) worked in C/MHCs. The most common role identified by respondents was CHW/P (47%), followed by Management/Administration (23%). The vast majority of respondents either were CHW/Ps themselves or worked with CHW/Ps. Respondents identified multiple titles used for and by CHW/Ps in their organizations, but the fact that more than half (53.1%) use “Community Health Worker” reflects that the field is coalescing around that title. Other common titles include Promotor/a de Salud and Outreach and Enrollment Specialist, both at 22.5%.

In terms of the kinds of behavioral health activities in which CHW/Ps are engaged, the most common are those related to addressing social determinants of health (59.3%), those oriented toward improving wellness and healthy living (58.9%), outreach (57.4%), one on one interactions (56.9%), and facilitating classes and trainings (55%). (This question allowed respondents to choose all that apply, so percentages do not add up to 100.)

Overall, most survey participants (43%) expressed that behavioral health was very integrated in their organization. This was also true when looking at just those working at C/MHCs (49%). Comparing across roles, those in management and provider roles were more likely to say that their organization was “somewhat integrated,” (43.6% and 45.5%, respectively) while CHW/Ps were more likely to say that their organization was “very integrated” (45.3%).

Qualitative responses to an invitation to elaborate on the question about level of integration revealed that sites that are very integrated appear to have case managers and counselors who participate in clinic team huddles and preplan visits for clients depending on their needs. At one site that noted being “very integrated,” behavioral health providers are members of the patient’s care team and analyze patient data to determine which patients should be seen by a behavioral health provider. Barriers to integration identified by respondents include varying levels of miscommunication, lack of support, and lack of time for behavioral health and medical providers to coordinate their work. Respondents at a location that is “somewhat integrated” report that CHW/Ps frequently consult on cases but are typically driven by present needs or reactive to presenting issues.

According to survey respondents, there is a great deal of consistency between the types of behavioral health-related trainings in which CHW/Ps currently participate (Q10), and those that CHW/Ps need to enhance behavioral health services (Q11). In both cases, the top four responses were Mental Health First Aid, Working with Patient/Client, CHW/Promotor, and Trauma/PTSD.

Majorities of CHW/Ps, managers and providers answered “yes” to the question about whether CHW/Ps can play a larger role in enhancing behavioral health in their organizations (Q12); the percentage of providers who responded “yes” was smallest at 51.6%. Qualitative responses to the “please elaborate” prompt fell into three general
categories related to infrastructure needed to make this happen, concrete roles CHW/Ps can play, and training needed by CHW/Ps and other members of the primary care team.

Focus Groups

*Focus group conducted by the University of Washington Latino Center for Health*

**Titles and Roles.**

Echoing findings in the literature review, participants shared that multiple titles continue to be used for CHW/Ps. Despite the plurality of titles used, participants held similar understandings regarding the qualities of CHW/Ps. Several participants identified the community embeddedness of the work of CHW/Ps and the importance of their trusted relationship with the community. Others stated that CHW/Ps play the role of a hub, a connector and a liaison for services.

Focus group participants shared that the roles of CHW/Ps are not uniformly understood across providers and team members in primary care and behavioral health settings. “There still appears to be some nebulosity around roles and titles; that may be more of a provider, than a community concern,” one participant stated. According to another, “some [CHW/Ps’] roles are not fully understood by clinicians and providers in the clinic.”

Participants also reported lack of clarity about the impact of CHW/Ps. “Not enough people understand how CHWs can make a difference,” stated one participant. While a few affirmed the value of CHW/Ps as providing a “huge return on investment with using follow-up care” and provide significant cost savings to the organization, others reported that it remains “hard to quantify the effectiveness of CHW/Ps.”

**Behavioral Health Integration.**

Integrating behavioral health and primary care services is a dominant paradigm in the health field, yet challenges persist. As one CHW/P lamented, “Providers still have the impression that behavioral health is for mental health or addiction issues only, so behavioral health workers are not fully utilized.” Participants revealed that while many entities are in the process of working towards integration of behavioral health services, success varies by location and across levels.
Several participants acknowledged the lack of inclusion of CHW/Ps on teams, limiting their voice and contributions. “[No CHW/Ps] have direct connection to our Integrated Behavioral Health Program,” one participant stated.

One respondent expressed that “CHW/Ps are effective in helping” behavioral health integration. Another respondent indicated that CHW/Ps are helpful for screening patients in primary care. Such screening is informative for the primary care physician but also can expedite referral of patients to behavioral health when warranted. On the other hand, one participant noted that behavioral health providers at times resist the integration of CHW/Ps.

Noteworthy is the experience within one organization where CHW/Ps are fully integrated on one service but in another service, they are not integrated at all. A contributing factor to this dynamic is the provision of designated physical space in the organization. CHW/Ps who had such space were viewed as integral members of the team and were valued by other team members. This was not the case for CHW/Ps who lacked physical workspace. The allotment of space to CHW/Ps in the clinic or the same building appears to contribute to their integration within teams.

Training.

Congruent with findings from the literature review, findings from the focus groups affirmed the need to provide more specialized training in order to maximize the effectiveness of CHW/Ps, particularly within communities that often go underserved. One participant remarked, “We want to train CHW/Ps to participate and work with RNs.” (It is hoped training will also be provided to the RNs.) Several participants acknowledged that in Washington State, requirements for training of CHW/Ps are lax. Another noted that a tension exists regarding the desire for more training. “Tension exists with training/standardization [because of] fear [among CHW/Ps] that professionalism will diminish the potency of interaction and veer away from a peer-to-peer working model.” Indeed, several focus group participants revealed that a major strength of CHW/Ps is their person-to-person relationship with patients, compared to practitioners’ clinician-to-patient relationship.

Among CHW/P focus group participants, training ranged from none to 80 hours and one participant acknowledged, “we have a difficult time getting people to go through training.” One participant expressed that, “standardized training may not fully meet the full needs of the community.” This comment foreshadows comments made in the CHW/P focus groups about the need for training that is based in popular education and that reinforces the unique skills and perspectives of CHW/Ps.

Barriers.

Respondents revealed several significant barriers concerning the role and integration of CHW/Ps, namely, 1) lack of coordination of work responsibilities of CHW/Ps across behavioral health and health care settings, 2) limited funding to train and pay CHW/Ps, 3) inability to bill for services rendered by CHW/Ps, and 4) lack of physical space in clinic sites when CHW/Ps are embedded on teams.
According to participants, the lack of ability to bill for CHW/P services limits the expansion of their services, which is deemed to be useful and needed. Participants pointed out that lack of space can signal that the CHW/P is not seen as integral to the care team and can result in the CHW/P voice not being included in decision-making to inform culturally responsive care.

**Focus groups conducted by NWRPCA**

**Mental and Emotional Health Issues in the Latinx Community.**

Focus group participants identified a variety of pressing mental health concerns and risk factors among the Latinx community members they serve. These issues include anxiety, depression, generational issues between elders and youth, gender identity and sexual orientation issues among youth, isolation, chronic stress (caused by immigration issues among other causes), homelessness, substance abuse and self-medication, stigma around mental health issues, and lack of culturally centered mental health care and services. Notably, these issues are virtually unchanged from those identified in an earlier study of mental health issues among Latina migrant and seasonal farmworkers served by a C/MHC (Wiggins & Castanares, 1993).

**Roles of CHW/Ps in Promoting Emotional Wellness.**

Participants in the focus groups spoke eloquently and passionately about the important work of CHW/Ps in promoting emotional wellness and ameliorating mental health problems in their communities. CHW/Ps’ contribution is based on a highly developed understanding of the collective, holistic, culturally specific nature of mental and emotional wellness. In the words of a participant in the Medford focus group, “That’s what we do as CHW/Ps; we do the collective work instead of the individual work. We bring people together and that’s mental health work.” A participant in the Skagit focus group summed it up this way: “*Porque la salud de ellos es la salud de nosotros. Es la salud pública, salud preventiva.*” (Because their health is our health. It’s public health, it’s preventive health.) Emphasizing the importance of social support in mental wellness, another Medford participant succinctly stated, “We promote bonding. We combat isolation. We do the collective work.”

Because of their understanding of the nature of health, CHW/Ps know that many activities in which they normally engage promote mental and emotional wellness:

- Charlas [talks or classes], outreach, home visits, healthy cooking classes, bailoterapia [dance therapy], migrant camp visits, homeless patient support, maternity support services, travel and transportation are all behavioral health activities. These activities sometimes facilitate the first touch with a patient. The activities and work that [CHW/Ps] do involve meeting patients where they are at, which may include going to their work, directly to their home, going to their community, speaking their language.

(Medford Focus Group, 2019)
They further articulate that they provide emotional support organically, in the midst of doing other work, like filling out applications:

Sometimes people come in for a simple thing like filling out an application with me. From there we get to talking while I’m doing the application. They start to share more things with me, they relate, they share stories [and] concerns. They come in with all of this stress due to the application and other things that are going on … They’ve shared with me they’ve gone to speak with providers and they weren’t able to connect; perhaps it was because they weren’t Latinos … Then they share with me that they feel better … I assure them that their paperwork is done, [that] what they shared is safe and that we did what we needed to do. (Medford Focus Group Participant, 2019)

CHW/Ps relate that their culturally appropriate activities help to counteract the individualism so prominent in dominant culture in the U.S. A participant in the Medford focus group shared that “Our work [as CHW/Ps] is related to emotional/behavioral health [in] that in this country/culture it’s a very individualistic society [where] everyone does their own thing …”

Focus group participants repeatedly emphasized the importance of building relationships, and how this allows them to create access by building bridges between community members and behavioral health services:

[CHW/Ps] listen, they take time to build relationships and trust with patients, they have a culturally tuned ear to listen to the nuances of what people need. [CHW/Ps] promote relationships and bonding with [CHW/Ps], with the health center, with other resources and providers, by doing so addressing issues of access to health care [and] access to resources. In order for patients to get the services they need, they need to feel comfortable connecting to the spaces where these resources can be provided; this is part of the critical bridging CHW/Ps do. (Medford Focus Group Participant, 2019)

Summing up the absolutely essential role of cultural bridging, a Skagit focus group participant stated, “Sin puente cultural no se conectan con estas comunidades.” (Without cultural bridges, you cannot connect to these communities.)

CHW/Ps are well aware of their ability to comfort and support community members, and use that knowledge as evidence that they are effectively improving behavioral health:

I tell [families] that my job is to connect families with the resources that they need, but in reality, we do much more than that. Today [while I was] at the conference, a client called me in crisis. I was able to support her, I reassured her, I told her I was here far away, but I talked and listened. By the time I needed to hang up to go to a workshop, I was able to hear that she was calmer. I assured her that I would see her when I get back. … I think that shows that I’m doing this work and I’m doing it right. (Medford Focus Group Participant, 2019)
A final comment from a participant in the Medford focus group clearly identifies the nature of CHW/Ps’ behavioral health work, and concludes that CHW/Ps are uniquely suited to doing this work:

The work that [CHW/Ps] lead is the culturally relevant, culturally accessible interpretation of non-clinical behavioral health work that is critical to supporting patients’ mental health and emotional well-being. CHW/Ps are critically equipped to do this work. (Medford Focus Group, 2019)

Integration into Behavioral Health.

Participants in the focus group expressed confidence that CHW/Ps can make a unique contribution to behavioral health given the right conditions:

CHW/Ps are positioned to do ... behavioral health interventions ... at a better level with better outcomes than any social worker or psychologist; it’s just getting the right understanding of how the western system works and the community to better integrate the two. (Medford Focus Group Participant, 2019)

However, they also mentioned a number of barriers and challenges related to behavioral health interventions. The first was resistance among community members to engaging in behavioral health services because of the taboo nature of mental health. A second was lack of capacity within the system. In the words of one participant, “We convince them to [go for an appointment] and then once they go, the demand it’s too high; it’s one to six months out. They end up not going and it gets worse.” If community members actually go for an appointment, the kinds of questions they are asked can increase resistance, making them feel vulnerable and increasing their sense of powerlessness. In the case of teen-parent conflicts, community members fear that genuine answers may trigger involvement with child protective services. All these barriers are heightened if the therapist is not culturally congruent or at least culturally responsive. “It’s frustrating when I have worked hard to convince someone to go to a therapist, doctor, counselor, and then they go and they don’t have a good experience,” stated one focus group participant.

Participants also stressed that for referrals to be effective, they need to go with the community member to the service, partly to assure that community members are treated with respect and dignity, even though this doesn’t always work. “Sometimes even when I go with them,” stated one participant, “we still experience racism, classism; we are still invisible.” In addition, the fact that CHW/Ps are often out of the clinic making these connections can cause frustration on the part of team members, who want CHW/Ps to be at their desks when they need them. CHW/Ps must negotiate a complicated set of dynamics in order to improve community wellness.
Support Received and Support Needed.

CHW/Ps in the focus groups mentioned a variety of kinds of support that help them to feel valued and be effective. These include regular supervision sessions, an open-door policy on the part of supervisors, job descriptions that prioritize experience over formal education, supervisors who really understand the work they do, and perhaps most crucially, supervisors who have been CHW/Ps themselves. Just like the community members they serve, CHW/Ps need to feel valued and have people who will listen when they need to talk. In one clinic where the supervisor was a CHW/P, this sense of value is expressed through an annual picnic:

For example, we have an annual “retreat” after our Migrant Health Clinics. We all get in the van, we go to the park, we play guitar and music on the drive, we all get together we make a carne asada (barbecue). We feel the season lift from us. [Supervisors] understand the work is hard and we get to celebrate. This is something we look forward to every year.

When supervisors have not been CHW/Ps or do not know enough about the work CHW/Ps do, then CHW/Ps must take on the additional job of educating their supervisors. In the words of one participant, “I have worked at the same organization for (x) years and I have gone through 5-6 supervisors and every time I see a new supervisor, I have to start all over again.” Particular barriers were mentioned with supervisors who are clinicians. Also, respondents stressed that having supervisors go to trainings about their role is often not enough; they suggested that supervisors accompany them when they are doing the work in order to understand it better.

When asked what they need, participants in the focus groups mentioned better pay; opportunities for advancement that are not dependent on, but do include opportunities to get more formal education; recognition that their work can lead to vicarious trauma and support to deal with this; and having CHW/Ps as leads in the PCMH model. They also need cultural humility on the part of providers: “Western culture is so clinical; we need culturally relevant, culturally humble support from providers.” Finally, repeating a theme that has been heard from CHW/Ps for many years, participants mentioned that other providers can see them as a threat, perceiving (usually incorrectly) that they may be replaced by CHW/Ps.

Training received and training needed.

When asked about the training they have received, participants mentioned the 90-hour certification training provided through the Oregon CHW Association; trainings about trauma-informed care and dealing with burnout, grief and loss; suicide prevention; popular education; motivational interviewing; and a variety of other topics. Participants wanted more training about the Public Charge rule and immigration generally; domestic and family violence; vicarious trauma; popular education; and LGBTQ2I issues. Notably, they also want to develop their leadership through opportunities to co-facilitate and lead meetings. And finally, participants recognize that they are not the only ones who need training. In the words of one participant: “People in power need training from us. Take off your badge, listen!”
Summary of Findings

Awareness of and appreciation for CHW/Ps in primary care

- There is a wide range of perspectives and models regarding CHW/Ps in primary care and behavioral health.
- There is general agreement that CHW/Ps have much to offer a stressed mental health system which often lacks cultural competence.
- Primary care and behavioral health providers need to develop a better understanding of the well-established scope of roles of CHW/Ps.
- There is lack of clarity about the value, impact and outcomes of CHW/P interventions.
- Lack of awareness about how CHW/Ps can complement other providers can lead to resistance to their integration.
- CHW/Ps are much more aware of what they bring to integration of BH-PC than are administrators and other providers.

CHW/P contributions to behavioral health

- CHW/P interventions have been associated with reduced stress and depressive symptoms.
- The relationship with the CHW/P is a key factor in promoting improvements in mental health and emotional wellness.
- CHW/Ps can enhance behavioral health services in C/MHCs through their holistic perspective, their strong relationship-building skills, and their understanding of the barriers inherent in the system.
- CHW/Ps increase access by creating bridges among communities and behavioral health services.
- CHW/Ps possess a highly developed understanding of the collective, holistic, culturally specific nature of mental health and emotional wellness.
- Addressing social determinants of health is at the core of CHW/P practice.
- Many of the activities in which CHWs already engage promote emotional wellness.
- CHW/Ps provide emotional support organically, in the midst of other activities.
- When adequately supported, CHW/Ps are uniquely positioned to promote emotional wellness and improve mental health.
- CHW/Ps tend to view behavioral health services as “very integrated,” likely because they facilitate integration on a daily basis.

Pressing issues and barriers

- CHW/Ps face a variety of barriers when they attempt to connect community members to behavioral health services.
- Even when CHW/Ps accompany community members to services, they often face racism, classism and other forms of discrimination.
- Existing training curricula lack focus on behavioral health.
Improving CHW/P contributions to behavioral health

- Allocating physical space to CHW/Ps promotes their integration.
- A variety of supports centering around pay, recognition, opportunities for advancement, and supportive and trauma-informed supervision are essential for the success and retention of CHW/Ps.
- In order to benefit fully from the presence of CHW/Ps, systems must engage them as trainers and leaders.

Discussion

The lack of documentation of CHW/Ps’ role in behavioral health contrasts with what we found in our own research and outreach to partners: that CHW/Ps are uniquely prepared to facilitate effective behavioral health interventions because of their connection to the community. CHW/Ps tend to be enmeshed in their communities and have intimate knowledge of the social determinants which affect community members' mental and physical health (Vision y Compromiso, 2020). They tend to be familiar with resources for addressing these social determinants in ways that clinicians may not be.

Focus group participants reported that CHW/Ps “always work with social determinants of health...offering time, support, [and] openness to families for connection to mental health supportive services.” In doing so, CHW/Ps “diminish mistrust of health care entities and reduce stigma within communities, both of which serve as potent barriers for communities of color and marginalized population to access and utilize health care services.” CHW/Ps are clearly key to promoting wellness and getting resources to communities.

This suggests that amplifying the role of CHW/Ps in behavioral health work is one way to combat burnout among clinicians. Burnout occurs when clinicians do not feel able to address the social determinants of their patients’ health, like housing instability, violence in the community, or insufficient nutrition. CHW/Ps can also be effective at filling the gap for behavioral health workforce shortages. In Alaska, Behavioral Health Aids are trained and employed by tribal health organizations. Their unique training and location suit them to provide valuable mental health support where physicians cannot go. This is reflected in our review of the literature, which shows that there is an uptick in CHW/Ps facilitating psycho-social interventions for behavioral health conditions.

Additionally, our study reveals that the term “mental health” has a negative connotation for many communities who associate it with being “crazy.” This acts as a barrier to care for those in need of services but also limits community understanding of effective behavioral health interventions. CHW/Ps provide context that promotes the priority of emotional wellbeing, reframing the question as not one of lack of mental health but of promoting well-being.
In the words of Vision y Compromiso (2020), “people in the community express that what they need to manage their own emotional wellness and lessen the need for intensive mental health services is a trusted individual to talk to, who is non-judgmental, has an empathic ear, can help the person identify their own solutions and understand the resources in the community that can help them have a healthier emotional lifestyle.”

CHW/Ps do face difficulties when trying to provide care to their communities. Most notably, CHW/Ps have to straddle the divide between marginalized communities and medical institutions. That work often sees them vying for the trust of their communities. This concern is reflected in a 2019 commentary by Garfield and Kangovi:

[CHW/Ps] increasingly are transitioning from their grassroots, community-based origins to become integrated members of health care teams. The marriage of community health and formal health care is powerful, but it’s also tricky. If CHW/Ps lose their identity and become medicalized, their effectiveness in the community is lessened. Health care leaders must grapple with a fundamental question: How do we integrate a grassroots workforce into health care without totally coopting it?”

A unique barrier for CHW/Ps is the system they are asked to promote among the community. The further this system is from community understanding and agreement, the harder the CHW/P must work to promote it. In a bid for professional recognition, CHW/Ps can run the risk of seeming too much like members of a medical system and not enough like members of the community. CHW/Ps must strike a delicate balance between being health professionals and representatives of the community.

Another barrier CHW/Ps face is the lack of awareness of their roles, and lack of high-quality supervision and training across medical establishments. Though an integral part of many care teams and care models, CHW/Ps’ well-established set of roles has not been consistently implemented in those models. This means that CHW/Ps are not always supported to play a wide range of roles across the health care system. Different health care communities have different definitions of CHW/Ps, different conceptions about what they do, and different ways of measuring their success and effectiveness. CHW/Ps have to be mindful that the medical communities they work within frequently do not know the value they bring to the care team and the best ways to employ their skills for the patients’ benefit. Efforts like the CHW Common Indicators Project are seeking to address this gap, by collaboratively identifying common process and outcome indicators for CHW practice (Wiggins et al., in press).

CHW/P involvement in mental health services is so powerful precisely because of the intimate relationship between the CHW/P and the patient seeking services. CHW/P involvement can be crucial to patients’ positive outcomes and self-reported outlook. The lack of awareness of the CHW/Ps’ scope of practice has the potential to negatively impact patient care as well. This usually comes in the form of CHW/Ps having difficulty communicating in their care teams.
A 2018 study by Slantz et al. suggests that CHW/Ps bring more to their teams than they might be getting credit for. Clearly communicating their roles to the care team could positively impact not just the CHW workforce but the care team’s orientation to the patient receiving services. Clearly spelling out CHW scope and impact would likely help not just the CHW profession but patient outcomes as well.

**Recommendations**

Based on the findings in this report, taking the following steps can help to assure that CHW/Ps can make an optimal contribution to the integration of behavioral health services in C/MHCs:

1. Provide ongoing education to all members of the primary care and behavioral health team about the well-established scope of roles of CHW/Ps, their value and impact in primary care and behavioral health settings, and how they can complement the work of other providers.
2. To enhance their effectiveness, improve recruitment, training and supervision of CHW/Ps in C/MCHs.
3. Recruit CHW/Ps as supervisors for other CHW/Ps, and provide training about the CHW/P model and reflective and trauma-informed supervision.
4. Allocate physical space to CHW/Ps in clinics to communicate value and increase visibility and accessibility.
5. Create opportunities for CHW/Ps to educate other providers about a range of topics related to community wellness and behavioral health.
6. Provide training and professional development opportunities for CHW/Ps, particularly in areas of mental health (e.g. mental health first aid, motivational interviewing).
7. Advocate for funding models, including reimbursement for CHW services, that recognize CHW/Ps as essential members of the primary care team.

**Next Steps**

Having completed this pilot project, NWRPCA will now seek to cement its support for CHW/Ps and the integration of CHW/Ps into C/MHCs via the development of a Community Health Worker Institute. Through this Institute, NWRPCA will leverage state, regional, and national partnerships to accomplish three goals: 1) provide capacity building, leadership and professional development training for CHW/Ps to enhance their capacity to work in integrated settings; 2) provide resources, training, and technical assistance that helps CHCs establish scopes of practice for CHW/Ps that fit the needs of their local communities and supports integration of CHW/Ps into clinical and community-based teams; and 3) support policy development to finance and sustain CHW services.
References


Health Resources and Services Administration [Internet]. Uniform Data System Resources. Retrieved 10-29-2020 from: https://bphc.hrsa.gov/datreporting/reporting/index.html


Mental Health America. (2020) [Internet]. The State of Mental Health in America. Available at: [https://www.mhanational.org/issues/state-mental-health-americ](https://www.mhanational.org/issues/state-mental-health-americ)

MHP Salud [Internet]. Mental Health News and Updates. Retrieved 10-29-2020 from: [https://mhpsalud.org/online-resources/blog/mental-health/](https://mhpsalud.org/online-resources/blog/mental-health/)


Appendix A
Annotated Bibliography


This report examines the undertaking involved in utilizing community health workers (CHWs) in delivering evidence-based behavioral health interventions for underserved communities, both domestically and internationally. The authors noted prior use of CHWs in addressing physical malady and inferred that incorporating them into behavioral health would help ease the strain of substantial shortages of mental health professionals. Furthermore, their use may also prove helpful in destigmatizing and demystifying behavioral health malady.

The authors conducted a systematic review to identify pertinent research from 1990 to 2015. Literature included randomized control trials, pre-post non-experimental trials, and quasi-experimental trials while also excluding single-subject design studies. Likewise, key qualifiers were the inclusion of CHWs, participants had to reside in a Low or Middle Income Country (LMIC) or be composed of racial/ethnic minorities if studies were done in the U.S., the interventions had to have a primary focus on preventing or treating mental health disorders or symptoms, and outcome measures needed to have patient-level behavioral health outcomes as a primary outcome.

Of the articles assessed, 43 of 95 eligible articles met criteria for inclusion in the study. Although the literature search extended to 1990, most articles that met the inclusion criteria were published after 2010. This indicates a recent uptick in research specific to CHWs role in delivering psycho-social interventions for behavioral health conditions. Similarly, a curious result is that CHWs in LMIC countries have a more involved role in delivering psychosocial interventions than CHWs based in the U.S. This may also reflect differences in resources and workforce expectation. Additional research is needed to ascertain a better understanding of how to sustain efforts to incorporate CHWs in service delivery.

This report utilizes a “theory of change” framework to connect intervention and support activities across different levels of policy, delivery of care, and human resource development, to act in integrating critical elements into health care teams in California. Care coordination is of special note in care delivery, and especially with chronic care prevention and management for higher cost populations that receive services. Another purpose with this paper is in calculating how new care delivery is impacted by incrementing the roles of CHWs in care teams.

The study incorporates a two-pronged project which synthesizes literature on policy specific to CHWs in clinical settings and provides insights from established and evolving CHW programs to enhance readiness in integrating promotores and CHWs in health care delivery in California. The exploratory research design was done with the intention of obtaining insight on impediments and driving factors concerning implementation of CHWs through various lenses.

Results from the study included pathways and action-oriented steps to encourage CHW integration. These actions items included formalizing knowledge and sharing best practices, formalizing partnerships and encouraging collaboration between clinical and CHW-oriented community organizations. Additional steps include streamlining training pathways and utilizing targeted training. This paper clarifies trajectories for future strategies in integrating CHWs for addressing social determinants of health.


Daniels and peers examine the role of Community Health Workers and Peer Support Specialists in this paper. The purpose of the piece is to make distinctions between the roles and responsibilities of these two positions. Likewise, an added point of discussion is in identification of instances in which different tasks necessitate a different approach, provided that the task and intervention may differ based on need.

The authors note that the key is in understanding what a role requires. For instance, CHWs are often versed in promoting education, outreach and health care engagement. In contrast, PSSs are more attuned to supporting individuals based on shared experience, fostering hope, and use activation tools and resources to support self-care, collaborative decision-making, and consistency with treatment plans.

Utilization of both workforces are critical in successfully applying interventions for patients. The authors note that for individuals with generalized symptoms and conditions, CHWs offer excellent intervention. For patients who have a more specific behavioral health concern or complex illnesses, the use of PSSs may prove fruitful in helping support and reinforce treatments. Both offer an opportunity to engage patients in a way that is centered around their specific needs. Incorporating a framework that allows for proper supports is critical to recovery and successful use of interventions.

This study examines published literature from 2005 to 2015 to provide evidence of the role of promotores as trusted resources in providing preventive and primary care. The review delves into evidence of promotores’ key role in advancing health outcomes for Latina women, families, and communities. Eight categories emerged from the final sample of 63 articles, including motivating factors that lead to individuals becoming promotores, descriptive characteristics of the workforce, health issues most commonly addressed, the effectiveness of programs that utilize promotores and CHWs, the effect of workers’ self-efficacy, role in community health advocacy, occupational challenges, and best practices for training and supporting promotores.

Findings from this paper affirm the effectiveness of promotores and CHWs in promoting preventive care and aiding patients in recovery. Furthermore, a key element addressed in the study is in the proliferation of information and the way that promotores are key in this endeavor, with public information rippling through the community by way of established community networks among women. This evolving role among promotores is noteworthy as standardization of training emerges at a more consistent rate.

This study also illuminates the need for crafting a training protocol that meets community needs with language, culture, and reading level of promotores. This is one component that may inhibit a cookie-cutter approach to standardization and regimentation of training. Specific socio-cultural context notwithstanding, the authors make a good case for incorporating promotores in primary care to address emergent public health needs.


This article outlines the areas of future growth as well as possible trajectories in utilizing a peer workforce, identified as people in recovery that offer specific peer-support proficiencies, to integrate behavioral health services into pre-existing health delivery. The article further examines the challenges in integration of services and addresses the role of peer workers in melding behavioral and physical healthcare services. The article also delves into implications of the work and possible areas for further research.

The article draws upon previous research around the roles of peer workers, namely, in how they have been used for integrated healthcare teams, crisis service teams, medication-assisted treatment for people with opioid use disorders, criminal justice settings, as well as use in assertive community treatment teams. According to the authors, methodological challenges exist in pointing affirmatively to quantitative metrics that confirm outright that peer workers have a statistically significant role in reducing clients’ use of emergency and crisis services. By the same token, qualitative data appears to suggest that the use of peer workers in supportive capacity after treatment, reduces inpatient...
service utilization, improved relationship with primary care providers, better commitment with follow-up care, client empowerment, and higher optimism for recovery.

As the authors note, additional vigorous research is necessary to demonstrate evidence-based results. Furthermore, the authors conclude that as the landscape rapidly changes and peer workers see a shift in roles, training, certification, reimbursement for family peers and reimbursement of recovery coaches should be programmed into the infrastructure. This in turn will aid in addressing workforce shortages and help provide appropriate support for people with behavioral and physical health conditions.


Hartzler and peers analyze 30 studies in an effort to provide guidance in the integration of CHWs in primary care. The literature review identified 12 functions including social support, health coaching, resource linking, and case management, among others. Likewise, three prominent functions were also identified as key components of CHW work, such as clinical services, resource navigation in the community, and health education and coaching.

The authors conclude that the categorization of clinical services, resource navigation, and health education, will be essential in informing future design of practice. They also conclude that new strategies are required to provide adequate support and supervision for CHWs who do home visits. By the same merit, they also conclude that utility of roles should be defined by the needs of patients, care teams, fiscal viability, and clinical workflows, among others. As such, roles should meet material conditions specific to the populace in any given location.

Roles of CHWs within Primary Care provision are critical in providing an added layer of support for patients. Future integration of CHWs has to be mindful of local conditions to ensure that the skillsets of CHWs are maximized to their potential. Given the proper support, CHWs can provide the knowledge and extend the reach of care to help patients in recovery.


Islam and colleagues utilize this white paper to outline best practice for integration of CHWs into existing primary care systems. A key argument is that the use CHWs is helpful in work with patients with chronic disease, and low cost by way of behavior change, support, and goal planning among others. The authors use case samples of a diverse array of models of integration to strengthen their argument in favor.
The authors conclude with a set of recommendations for health systems in aiding integration into primary care teams. These recommendations including making a business case for CHW integration, clearly defining roles, developing the infrastructure to provide feedback to care teams, and incorporate a strong supervision and administration apparatus to support CHWs. The authors also emphasize that this transition will aid in meeting the needs of vulnerable and underserved populations.

The paper is critical in gaining an understanding of needs specific to New York. Likewise, the set of recommendations appear promising as far as laying a foundation for utilizing the totality of CHWs’ skillsets. Similarly, this document helps frame a tangible method for replicating integration of CHWs with best practices, in other locations.


Laderman and Mate used expert interviews and a non-systematic literature review to distinguish proper community-based interventions for clients with psychological and physiological maladies. In the process, the authors honed in on CHWs as primary interveners for patients. The study further examined the challenges as well as the benefits of incorporating the use of CHWs in an expanded role.

Two key challenges outlined by the authors include the absence of a standardized approach to supervising, recruiting, and training CHWs, as well as overuse and overreliance of CHWs. The authors suggest incorporating improvement science to measure and offer feedback to ensure proper adaptation of programming. Furthermore, a method that simplifies and develops standard methods for training, supervising, and recruiting CHWs may be fruitful in maximizing the effectiveness of CHWs in providing care.

This study is essential in providing literature necessary in outlining the complexity of integrating CHWs into medical and behavioral health needs. One critical element will be the use of metrics to find best practices not only for recruitment and training, but also to define the key roles where CHWs can provide their best work. Proper integration will be important to address the needs of communities that often go underserved.


This framing paper examines the role of promotores in 1) providing needed support for community engagement to improve local environments, 2) increasing awareness of factors that impact health, and 3) helping transform communities to enable others to thrive. The central focus of this report is to illustrate how the “Promotor Model” can be used to build healthy communities. This model is especially important for historically marginalized communities.
The testimonies collected in this work represent the “collective experience” offered by promotores, as well as “wisdom that comes from life” for promotores who participated in this study. Key organizations involved in this project include: Esperanza Community Housing in Los Angeles, Latino Health Access in Santa Ana, and Vision y Compromiso as a statewide association in California. This collaborative effort highlights the values and characteristics of promotores, institutional readiness, promotor best practice, integration of promotor programming, as well as the outreach, education, advocacy and community engagement roles of promotores. In addition, the authors identify three stages of a promotor model including relationship building, information sharing, and community participation through individual and collective action.

This paper is critical in laying a foundation for the use of promotores and community health workers as a whole in the implementation of services. One important aim is to incorporate a structure that is egalitarian in nature and that centers community health needs. In this effort, those who work at a more direct level often have a more direct line of communication with community members. It is for this reason that authors also suggest proper training, supervision, and structural support for promotores to help improve health outcomes, impact social and economic determinants of health, and promote justice for communities.


This paper explores the utilization of peer workers in the process of delivering behavioral health and primary care services in California. It also emphasizes the critical role that peer workers play in helping patients during the recovery process, by helping with the navigation process, and providing support. Even more critical, is in how the use of peer workers in integrated care settings help reduce both institutional and personal stigma during recovery.

The paper offers a set of recommendations for incorporating peer workers within a continuum of services that supports patients. These recommendations are aimed at solidifying peer work by way utilizing data collection for establishing a “business case” for services that are more cost effective in the long run, disseminating resources across different settings that speak to the value of peer workers, and providing ongoing support, as well as certification and professional development.

There are several parallels to be drawn between peer workers and community health workers. They both offer a direct connection to patients and are critical in helping navigate resources. Likewise, the issue of training and development of professional skill are essential in not only integration, but also in ensuring the retention of experienced workers.

Noor examines CHWs roles and their effectiveness in delivering health care for underserved communities. Noor’s analysis synthesizes these roles in terms of quality, health care services, cost health services, and the ability to navigate resources within underserved communities. Noor compiles 65 peer-reviewed articles which hint at the effectiveness of CHWs in providing a skillset that improves medical outcomes at a lower cost for underserved communities.

Some key points addressed by Noor is that the lack of clarity with roles makes it difficult to properly quantify the effectiveness of CHWs in some studies that were reviewed. Similarly, inadequate training, the absence of institutional support, and limited skills has a tendency to limit long-term effectiveness. Though this study is nearly a decade old, the fact remains that additional studies are necessary to further bolster the case for using CHWs in primary care.

A consistent link between this study and others covered is that utilizing CHWs is critical in providing additional support for patient recovery. In many cases, CHWs are members of the community have a better understanding of contextual nuances in the way of culture, language, and experience, and provide the needed perspective necessary to develop a broader view of challenges that patients may encounter. Furthermore, CHWs also provide the adequate support structure to help close the gaps in health care access disparities.


The authors of this study offer an interesting examination of service delivery from the perspective of Latino participants. The study was informed by 28 participants who received mental health services from CHWs and is oriented toward studying the relationship dynamics between participants and CHWs, and how community-delivered interventions impacted behavioral change in participants. The participant sample was primarily female and had a mean age of 50 years. Semi-structured interviews were conducted in the participants’ preferred language, and transcribed interviews were analyzed until concept saturation was realized.

Findings from the study suggest a positive results as participants noted the professionalism and rapport built by CHWs in facilitating positive relationships and lifestyle behavior changes. The authors also note that per this study, the only participants who reported consistently poor scores for anxiety and depression, or both, reported
neutral or negative experiences with the CHWs. One consideration addressed by the authors was pertinent to knowledge about participants’ anxiety and depression scores, as knowledge of scores may have reflected differently as CHWs may have taken different approaches to meet presenting needs.

This paper was valuable in collecting a qualitative analysis from participants’ perspectives. Furthermore, resulting data fortifies the need for integrating CHWs into behavioral health care modules to meet community needs. Additional studies will be critical in bolstering the case for using properly trained and supervised CHW programs to help provide culturally relevant and responsive care in areas that lack services.


Rhett-Mariscal's policy paper explores the role of promotores in improving the mental health of Latino communities in the State of California. This paper also delves into the challenges present in the Latino community and looks at the characteristics of promotores in their roles in addressing community health needs. The analysis is also followed by recommendations that are drafted to help inform the evolution and support apparatus for continuing promotores’ work.

As with other policy papers, this work also offers a set of recommendations to facilitate integration of promotores into the patient care infrastructure. Recommendations from Rhett-Mariscal include, developing promotores programs, building capacity, and incorporating quality assurance and improvement. As the author noted in the conclusion, these recommendations emanate from the collective experiences of promotores, community agencies, and county and state officials.

As the author notes, enough funding, support, expertise, and deliberate planning are critical for properly implementing CHWs in delivering mental health interventions. To this end, this policy paper is intended to guide successful implementation. This is noteworthy giving the emergent need for service providers in the Latino community.


This paper examines how peer-oriented, integrated behavioral health services are implemented in Los Angeles County, California. The study was conducted in 2013 and used teams of implementation monitors to conduct full-day on-site visits at 24 pilot programs. The visits also incorporated semi-structured interviews with program staff members, as well as case-study analysis.
The paper concluded that in underserved ethnic communities, the inclusion of peer providers was influenced by an environment where mental illness was stigmatized. The authors noted that enhancing training of peer providers in areas of mental and physical health, utilizing a cultural lens, is necessary to promote the effectiveness of peer providers, and increase acceptance of services in the community. This process will aid in making services more accessible to underserved community members.

Siantz and peers offered an interesting analysis for peer worker integration into service delivery. Per results of the paper, there is more a reluctance in utilizing services based on shared experience, versus shared socio-cultural traits. More study is needed to verify if this is an impediment as little empirical evidence exists to bolster the claim that fewer patients will acquire assistance from peers with similar behavioral health conditions. Similarly, strategies are needed to build organizational capacity to promote the inclusion of peer providers.


This study examines the experiences of peer workers within newly minted integrated mental health and primary care pilot programs within a sizeable mental health system in Los Angeles County, California, which is among one the most ethnically diverse counties in the United States. The study also incorporates a layered approach that acknowledges miscommunication between peer workers and other service providers, as well as an understanding of how relatable experience can aid in serving traditionally neglected communities. Similarly, the role of peer providers also promotes social justice concerns and the inclusion of persons who are directly afflicted by mental illness, while also lending credibility to peer interventions.

The study was conducted within integrated physical and mental health pilot programs funded by the Los Angeles County Department of mental Health. Twenty-four integrated pilot programs were implemented beginning in 2012. Of the programs, 5 were co-located clinics that utilized an integrated clinic model, 5 others focused on homeless populations while utilizing a housing-first model, the majority however, 14 programs, were community-designed with the intended purpose of targeting specific underserved communities. Of these programs, 24 peer providers were recruited, with a total of 19 interviewed. Semi-structured interviews were used for collecting qualitative data specific to peer providers’ experiences in delivering care.

Findings from this article revealed that some workers in peer roles did not have disclosed lived experience with mental illness but did share a similar cultural background and experience with physical maladies. Furthermore, one primary challenge identified by peer providers was how their credibility and qualifications for delivering care were perceived in integrated teams. Inversely, some participants described a highly inclusive environment that facilitated effective communication, which appears to be rooted in intentional programmatic leadership. Per this study’s authors, future trajectories in research should incorporate perspectives from other providers, as well consumer perspectives.

This study documents the feasibility of instructing promotores to deliver a stress management program for Spanish-speaking Latinas in a community setting. Promotores participating in the study, 10 in number, were trained to provide an 8-week intervention program comprised of evidence-based cognitive-behavioral stress techniques. Participants in the study, 50 in number, received the intervention. Results suggested significantly improved scores on depressive symptoms, perceived stress, and immigration stress.

Building on a growing body of literature on promotores and their possible utilization in providing interventions to improve mental health in Latino communities, this study’s findings illustrate that it is feasible to train promotores to provide stress management programs. Also, results point to the possibility of incorporating promotores to help fill emergent need within the Latino community. One key component identified by the authors is that promotores-led programming require identification of appropriate promotores, monitoring of program fidelity, significant training, and needs assessment for successful implementation.

A key takeaway from this study is that with proper support and implementation promotores can provide a valuable skillset to meet community mental health needs.


This article examines the results of a pilot promotora intervention entitled Amigas Latinas Motivando el Alma (ALMA) that used promotoras to help decrease stress and depressive symptoms among Latina immigrants. The focus is designed to address stress incurred during the process of migration and acculturation into a new space beyond “traditional gateway communities,” as noted be the authors. Likewise, the purpose also intentionally addresses disparities in mental health care that are amplified by fewer culturally specific services and limited supportive social infrastructure.

The Amigas Latinas Motivando el Alma (ALMA) intervention was provided in three North Carolina Counties (Chatham, Durham, and Wake) where residents of Latino ancestry comprised a minimum of 10% of the population in each county. Criteria for inclusion in the study was that participants had to be Latina-identified women over the age of 18. There was a preference for recruitment of recently migrated women, however, this did not serve as exclusionary criteria. Further, the study measured for depression, stress, social support and coping measures, and Demographic variables.
Results from the pilot program suggest that participants in the intervention reported decreased levels of perceived stress and acculturation stress. Similarly, the findings also infer that social support and use of coping methods also potentially moderate depressive symptoms. Likewise, the study also reports that there is likelihood that some women will need more formalized mental health services given the overall unmet need at the community-wide level that is also compounded by institutional barriers to healthcare access. One critical takeaway is in how the utilization of peer support and guided intervention led to desired outcomes in stress and depressive symptom reduction. This is helpful in providing a snapshot of the possibilities available with community health worker interventions.


This report reveals findings from a variety of community voices regarding workforce development. Stakeholders included supervisors, program managers, department heads, executive leadership, and employers, along with leaders within the promotor movement. A major focus of this report is to highlight workforce priorities for the community transformation model in order to change discourse on the promotor and community health worker workforce at various levels.

This report outlines a tangible model for incorporating a workforce infrastructure that is sustainable and that will encourages the use of community workers. The authors used a community transformation model to address health inequities in under-resourced communities. The intent of this model is to challenge the impacts of the inequitable distribution of power and resources that place marginalized communities at a disadvantage.

Findings from the report reflect systemic challenges and opportunities including the use of the promotor model as a model of community transformation, training and professional development, core competencies and curricula, credentialing and qualifications, supervision of promotores, and funding and program sustainability. This report highlights that community workers are uniquely placed to address emergent community needs and as such, should be imbedded as best possible in institutions that provide community services.


Waitzkin and colleagues offer a preliminary glimpse of promotoras' role in delivering mental health services. A structured training program was utilized to form a working collaboration between promotoras and primary care physicians to provide appropriate support with prescribed medication, consultation with mental health professionals, and direct examination of sources of depression within socio-cultural
context. In finding predictors for depressive symptoms, this intervention examined four key areas including: inadequate housing, food insecurity, underemployment, and violence.

The study was conducted in New Mexico and utilized a randomized sample of 120 participants from a larger pool of 464 participants who were offered intake interviews. The design for the study also incorporated quantitative tools and ethnography to examine the predictors. Limitations were present within the study in the way of infrastructure at the health centers, limitations with promotoras’ roles, and territorialism among medical assistants.

Preliminary data suggests that findings were mixed. Ethnographic data appeared to indicate that the promotora intervention was well received by several stakeholders including patients, primary care physicians, and administrators. In contrast, quantitative data from this study also indicated that there did not appear to be a statistically significant confirmation of promotoras’ positive impact on depression outcomes, which may also be reflective of infrastructural challenges in fully implementing this intervention. A clear outcome is that the topic merits more attention than it has received prior to the initiation of this study.


This policy paper was produced by the Community Health Worker Task Force, which convened for the purpose of developing recommendation and policy to align the CHW workforce with the Healthier Washington Initiative. The Healthier Washington Initiative was organized as three-pronged goal that aimed to build healthier communities through a regional, collaborative approach, ensure that health care focused on the whole person, and that there was improvement in how services were paid for. Recommendations from the task force in helping align with the initiative included the utilization of overarching guidelines and strategies, defining roles, skills, and qualities, training and education, as well finance and sustainability considerations.

In order to properly address and meet the goals of the initiative, the authors of the report also recommended the use of four overarching strategies to direct the development of policies related to CHWs. These strategies include, 1) describing the CHW Model as innovative in health, educational, and social service systems; 2) including CHWs and key leaders in all decision-making forums affecting CHW work; 3) build the CHW Model into Healthier Washington’s strategic and operational plans; and 4) convene a group of leaders to further develop and design flexible and secure funding mechanisms. These strategies were produced to facilitate the integration of CHWs within the initiative and to support health reform efforts.

This report outlines a set of recommendations to help develop an infrastructure for integrating CHWs into existing health initiatives in Washington State. Training and educational development are key considerations, as are the appeals for sustaining a workforce that will meet the emergent needs of Washington State residents. These
recommendation were produced in an effort to ease CHW transition and to meet the goals for the Healthier Washington Initiative.


Weaver and Lapidos examine mental health interventions with Community Health Workers in the U.S. with a systematic review. As the authors note, some research has been conducted about the role of CHWs in supporting physical health treatment with clients, but the literature specific to mental health interventions is still emerging. The purpose of the review is to incorporate mental health service provision into the existing body of knowledge with CHWs roles in physical health care.

According to the authors, nine studies met the criteria for inclusion into the systematic review. The studies were identified from published research searches that were conducted from March to July 2016. Criteria for inclusion included the use of CHWs, the primary intervention addressed mental health needs, studies conducted in the U.S., and studies published in peer-reviewed journals.

Findings indicate that mental health interventions are feasible with CHWs in the United States. This is especially noteworthy when implemented amid underserved communities where access to traditional mental health care is truncated by language, culture, location, and socioeconomic positionality. Further research is needed to ensure that interventions are implemented with more rigorous fidelity to models used across studies.


Wennerstrom and colleagues conducted a study to measure improvement in integrating Community Health Workers to support behavioral health implementation into primary care. Participants were trained and placed at health centers. Supervisors were also provided training to help facilitate integration.

A 48-hour behavioral health curriculum was created that helped reinforce nationally recognized core competencies. The curriculum also outlined a range of roles that CHWs could meet depending on structural needs of the agency they are employed with. A researcher who was unaffiliated with the training conducted a 3-month post-implementation interviews to assess perceptions of the training.

Findings reveal that CHWs can serve an important role as team members, especially in conducting screenings and coordinating care for patients. Further research is warranted to quantify the best methods for utilizing CHWs to their full potential and to examine generalizability beyond the study’s location in Texas.
Appendix B
Further Readings List: NWRPCA CHW Behavioral Health-Primary Care Integration Project

Integration of CHWs into Primary Care and Behavioral Health


Functions and Roles of CHWs


Barriers and Challenges to Integration


Role of CHW/Ps in Implementing Health Initiatives


Role of CHWs/Ps for Mental Health and Primary Care interventions in Latinx Community


**Literature about Washington State**


Appendix C
NWRPCA Focus Group Guide

This focus group is to help us understand, from the perspective of someone working at a community health center, how community health workers are being used to support behavioral health activities and specifically, the integration of behavioral health with primary care.

We will start with some questions about community health workers.

1. In your organization, please describe the role of CHWs? How many CHWs “work” in your organization?

2. In your organization, what types of services do CHWs provide or carry out?

3. In your organization, to what extent and in what ways are CHWs valued as members of the care team?

4. Please describe how CHWs are supervised in your organization and by whom? Is supervision provided on a weekly basis? Bi-weekly? Monthly basis?

5. How would you describe the level of understanding within the CHC regarding the role(s) of CHWs? Very low, low, fair, good, excellent

6. Are there certain staff that understand the role better than others? Please specify.

Now we are going to talk about how community health workers support behavioral health in your community health center.

7. In your organization, are CHWs used to support the behavioral health of patients? If so, in what ways? If not, why not?

8. If your organization was to use CHWs to support the behavioral health of patients what do you see as needed steps/efforts?

Now thinking about the integration of behavioral health and primary care.

9. How integrated is behavioral health in your organization?

10. To what extent do you feel that CHWs are integrated in the provision of services in your organization?
11. How might CHWs help facilitate the integration of behavioral health and primary care?

12. What barriers exist that minimize or prevent the use of CHWs as useful contributors to the integration of behavioral health services?

Now thinking about the training of community health workers.

13. Please describe the types of professional development opportunities that are offered or provided to CHWs through your organization (e.g. specialized trainings)

   a. Probe for mental/behavioral health related training

14. From your perspective, what training would be most useful to CHCs that are seeking to integrate CHWs more fully as part of their behavioral health integration services? The training could be specifically for CHWs for their professional development or it could be more systems-oriented to assist CHCs with integrating CHWs into care teams.

Lastly, we want to discuss a few issues related to the administration and supervision of community health workers.

15. Please describe how CHWs are financed in their organizations; such as through grant funding, Medicaid (or other insurance) reimbursement.

16. From your perspective, what would it take to enhance organizational support to make better and effective use of CHWs in your organization?
Appendix D
CHWs in Behavioral Health Support Roles Survey

NWRPCA is engaged in a year-long planning grant project funded by RCHN Community Health Foundation to identify ways that CHWs are participating/have participated in CHC behavioral health integration. The project will result in a literature review, an environmental scan, targeted interviews, and Region X-wide focus groups in order to provide context and to develop recommendations for CHW participation in behavioral health integration in primary care settings. The goal is to create a resource that outlines promising practices for CHW support of behavioral health in primary care settings.

Thank you for supporting our work to learn about Region X's work with Community Health Workers (CHWs) in behavioral health settings. Your answers to the questions below will help us to get a better picture of the ways CHWs participate in and support behavioral health care in their health centers and communities. No identifying information will be shared with your responses. For more information, questions, concerns or if you need support filling out this survey please contact Maribel Montes de Oca, mmontesdeoca@nwrpca.org, (206) 519-5053 or Nathan Thomas, nthomas@nwrpca.org, (206) 519-5051.

*For purposes of this survey we are using the American Public Health Association’s definition of CHW's. “A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

1. The type of organization I work for is:
   □ Community/Migrant Health Center
   □ Primary Care Association
   □ HRSA National Cooperative Agreement
   □ Community-based organization
   □ Health Department (state/local)
   □ Federal agency
   □ Academic institution
   □ Hospital
   □ Other (please specify)__________________________________
2. Where is your organization located?
   - □ Alaska
   - □ Washington
   - □ Idaho
   - □ Oregon
   - □ Other (Please specify) _______________________________________

3. How would you describe your role at your organization?
   - o Community Health Worker
   - o Outreach and Enrollment
   - o Front Desk / Reception
   - o Management / Administration
   - o Senior Leadership
   - o Primary Care Provider
   - o Behavioral Health Provider
   - o Other Clinical Staff
   - o Volunteer
   - o Other (Please specify) ________________________________

4. What is your relationship to CHWs at your organization? (select all that apply)
   - □ I am a CHW.
   - □ I work on a care team with CHWs.
   - □ I supervise CHWs.
   - □ I do not work with CHWs.
   - □ Other (Please specify) ________________________________

5. Please select the title or titles are used for CHWs in your organization (select all that apply)
   - □ Community Health Advisor
   - □ Community Health Aide
   - □ Community Health Liaison
   - □ Community Health Navigator
   - □ Community Health Representative
   - □ Community Health Worker
   - □ Community Outreach Coordinators
   - □ Community Outreach Worker
   - □ Health Advocate
   - □ Health Ambassador
   - □ Lay Health Advisor
   - □ Outreach and Enrollment Specialist
   - □ Outreach Worker
6. Please select the behavioral health activities that CHWs engage in at your organization (select all that apply)
- □ Addressing Mental Health Stigmas
- □ Anxiety / Depression
- □ Group Conversations / Charlas
- □ Chronic Disease Management
- □ Chronic Pain Management
- □ Classes / Trainings
- □ Emotional Support
- □ Homeless Patient Support
- □ Immigration Education
- □ Interpreting / Translating
- □ Maternity Support Services
- □ Migrant Camp Visits
- □ One-on-One (In Clinic Consultations, Home Visits, and/or Outreach)
- □ Outreach Work
- □ Social Determinants of Health-Related Activities
- □ Substance Use Disorder / Opioid Use Disorder
- □ Support Groups / Peer Support Groups
- □ Travel / Transportation
- □ Wellness & Healthy Living
- □ Unsure
- □ Other (Please specify) ___________________________________________

7. What behavioral health services does your organization provide? (select all that apply)
- □ Counseling / Consultations / Therapy
- □ Enabling Services (transportation, interpretation, etc.)
- □ Support Services (peer to peer, chronic disease, maternal, grieving, etc.)
- □ Group Services
- □ Substance Use Disorder Support
- □ Other (Please specify) ___________________________________________
8. In your opinion how integrated is behavioral health in your organization? Please refer to the SAMHSA-HRSA framework on levels of integration:
☐ Not integrated
☐ Minimally integrated
☐ Somewhat integrated
☐ Very integrated

Please elaborate . . .

______________________________________________________________________
______________________________________________________________________

9. What kinds of providers deliver mental health / support services at your organization? (Select all that apply)
☐ Licensed Clinical Social Worker (LCSW)
☐ Licensed Mental Health Counselor (LMHC) / Licensed Therapist
☐ Psychiatrist / Psychologist
☐ CHWs
☐ Other Behavioral Health Specialist (Please specify) _______________________

10. Please identify trainings that CHWs at your organization receive related to behavioral health/ mental health________________________
______________________________________________
______________________________________________________________________

11. What additional trainings are needed for CHWs to best enhance the behavioral health services provided at your organization?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
12. In your opinion are there ways that CHWs can be better utilized to enhance behavioral health services in your organization?

☐ Yes
☐ No
☐ Unsure

Please Elaborate . . .

____________________________________________________________________

____________________________________________________________________

13. May we contact you to discuss your responses to this survey?

☐ Yes (Please include your contact information) ____________________________

☐ No

14. If you’d like to be entered to win one of two $50 gift cards please give us your email!

_________________________________________________________
Appendix E
CHW Survey Results
N = 209

QUESTION 1: The type of organization I work for is:

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community / Migrant Health Center</td>
<td>99</td>
<td>47.4</td>
</tr>
<tr>
<td>Community Based Organization</td>
<td>60</td>
<td>28.7</td>
</tr>
<tr>
<td>Health Department (state/local)</td>
<td>29</td>
<td>13.9</td>
</tr>
<tr>
<td>Primary Care Association</td>
<td>11</td>
<td>5.3</td>
</tr>
<tr>
<td>Academic Institution</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Hospital</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Federal Agency</td>
<td>2</td>
<td>1.0</td>
</tr>
</tbody>
</table>

This table shows the different types of organizations that survey participants worked in. The majority (47%) worked in community and migrant health centers.

QUESTION 2: Where is your organization located?

<table>
<thead>
<tr>
<th>State</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>77</td>
<td>36.8</td>
</tr>
<tr>
<td>Washington</td>
<td>49</td>
<td>23.4</td>
</tr>
<tr>
<td>Colorado</td>
<td>25</td>
<td>12.0</td>
</tr>
<tr>
<td>California</td>
<td>18</td>
<td>8.6</td>
</tr>
<tr>
<td>Arizona</td>
<td>17</td>
<td>8.1</td>
</tr>
<tr>
<td>Alaska</td>
<td>10</td>
<td>4.8</td>
</tr>
<tr>
<td>Idaho</td>
<td>8</td>
<td>3.8</td>
</tr>
<tr>
<td>Montana</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>Nevada</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>New Mexico</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>Utah</td>
<td>1</td>
<td>.5</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1</td>
<td>.5</td>
</tr>
</tbody>
</table>

This table shows the states that survey participants were located in. The majority came from Oregon (37%) and Washington (23%).
### QUESTION 3: How would you describe your role at your organization?

<table>
<thead>
<tr>
<th>Role</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Worker</td>
<td>98</td>
<td>46.9</td>
</tr>
<tr>
<td>Management/Administration</td>
<td>48</td>
<td>23.0</td>
</tr>
<tr>
<td>Outreach and Enrollment</td>
<td>39</td>
<td>18.7</td>
</tr>
<tr>
<td>Senior Leadership</td>
<td>24</td>
<td>11.5</td>
</tr>
<tr>
<td>Behavioral Health Provider</td>
<td>20</td>
<td>9.6</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>7</td>
<td>3.3</td>
</tr>
<tr>
<td>Front Desk/Reception</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Volunteer</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Other Clinical Staff</td>
<td>3</td>
<td>1.5</td>
</tr>
</tbody>
</table>

- This table shows the types of roles that survey participants had. The majority were community health workers (47%).

### QUESTION 4: What is your relationship to CHWs at your organization?

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a CHW</td>
<td>100</td>
<td>48.3</td>
</tr>
<tr>
<td>I work on a care team with CHWs</td>
<td>42</td>
<td>20.3</td>
</tr>
<tr>
<td>I supervise CHWs</td>
<td>36</td>
<td>17.4</td>
</tr>
<tr>
<td>I do not work with CHWs</td>
<td>26</td>
<td>12.6</td>
</tr>
<tr>
<td>Administrator providing funding for CHW’s</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>positions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- This table shows the relationship of survey participants to community health workers in their organization. Most were community health workers themselves (48%), others worked with community health workers (20%), or supervised community health workers (17%).

### QUESTION 5: Please select the title or titles used for CHWs in your organization.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Worker</td>
<td>111</td>
<td>53.1</td>
</tr>
<tr>
<td>Outreach and Enrollment Specialist</td>
<td>47</td>
<td>22.5</td>
</tr>
<tr>
<td>Promotor(a) de Salud</td>
<td>47</td>
<td>22.5</td>
</tr>
<tr>
<td>Outreach Worker</td>
<td>45</td>
<td>21.5</td>
</tr>
<tr>
<td>Community Outreach Worker</td>
<td>41</td>
<td>19.6</td>
</tr>
<tr>
<td>Community Health Navigator</td>
<td>34</td>
<td>16.3</td>
</tr>
<tr>
<td>Community Outreach Coordinator</td>
<td>27</td>
<td>12.9</td>
</tr>
<tr>
<td>Activity</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Social Determinants of Health-Related Activities</td>
<td>124</td>
<td>59.3</td>
</tr>
<tr>
<td>Wellness and Healthy Living</td>
<td>123</td>
<td>58.9</td>
</tr>
<tr>
<td>Outreach Work</td>
<td>120</td>
<td>57.4</td>
</tr>
<tr>
<td>One-on-One</td>
<td>119</td>
<td>56.9</td>
</tr>
<tr>
<td>Classes/Training</td>
<td>115</td>
<td>55.0</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>109</td>
<td>52.2</td>
</tr>
<tr>
<td>Homeless Patient Support</td>
<td>96</td>
<td>45.9</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>94</td>
<td>45.0</td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>92</td>
<td>44.0</td>
</tr>
<tr>
<td>Interpreting/Translating</td>
<td>89</td>
<td>42.6</td>
</tr>
<tr>
<td>Addressing Mental Health Stigmas</td>
<td>87</td>
<td>41.6</td>
</tr>
<tr>
<td>Transportation</td>
<td>84</td>
<td>40.2</td>
</tr>
<tr>
<td>Group Conversations/Charlas</td>
<td>75</td>
<td>35.9</td>
</tr>
<tr>
<td>Maternity Support Services</td>
<td>69</td>
<td>33.0</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>67</td>
<td>32.1</td>
</tr>
<tr>
<td>Support Groups</td>
<td>66</td>
<td>31.6</td>
</tr>
<tr>
<td>Immigration Education</td>
<td>58</td>
<td>27.8</td>
</tr>
<tr>
<td>Chronic Pain Management</td>
<td>46</td>
<td>22.0</td>
</tr>
<tr>
<td>Migrant Camp Visits</td>
<td>33</td>
<td>15.8</td>
</tr>
</tbody>
</table>

**QUESTION 6:** Please select the behavioral health activities that CHWs engage in at your organization.
Among the Community/Migrant Health Center Respondents (N=99):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach Work</td>
<td>63</td>
<td>63.6</td>
</tr>
<tr>
<td>Social Determinants of Health-Related Activities</td>
<td>59</td>
<td>59.6</td>
</tr>
<tr>
<td>One-on-One</td>
<td>56</td>
<td>56.6</td>
</tr>
<tr>
<td>Wellness &amp; Healthy Living</td>
<td>56</td>
<td>56.6</td>
</tr>
<tr>
<td>Classes/Trainings</td>
<td>53</td>
<td>53.5</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>46</td>
<td>46.5</td>
</tr>
<tr>
<td>Homeless Patient Support</td>
<td>46</td>
<td>46.5</td>
</tr>
<tr>
<td>Interpreting/Translating</td>
<td>44</td>
<td>44.4</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>39</td>
<td>39.4</td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>38</td>
<td>38.4</td>
</tr>
<tr>
<td>Travel/Transportation</td>
<td>37</td>
<td>37.4</td>
</tr>
<tr>
<td>Addressing Mental Health Stigmas</td>
<td>33</td>
<td>33.3</td>
</tr>
<tr>
<td>Group Conversations/Charlas</td>
<td>29</td>
<td>29.3</td>
</tr>
<tr>
<td>Immigration Education</td>
<td>29</td>
<td>29.3</td>
</tr>
<tr>
<td>Support Groups</td>
<td>29</td>
<td>29.3</td>
</tr>
<tr>
<td>Maternity Services Support</td>
<td>26</td>
<td>26.3</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>26</td>
<td>26.3</td>
</tr>
<tr>
<td>Migrant Camp Visits</td>
<td>25</td>
<td>25.3</td>
</tr>
<tr>
<td>Chronic Pain Management</td>
<td>20</td>
<td>20.2</td>
</tr>
</tbody>
</table>

- Community health workers were more likely to identify outreach work as their primary activity compared to the total sample. The total sample identified social determinants of health activities as the primary activity.

**QUESTION 7:** What behavioral health services does your organization provide?

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling/Consultations/Therapy</td>
<td>159</td>
<td>76.1</td>
</tr>
<tr>
<td>Support Services</td>
<td>121</td>
<td>57.9</td>
</tr>
<tr>
<td>Enabling Services (Transportation, Interpretation)</td>
<td>115</td>
<td>55.0</td>
</tr>
<tr>
<td>Substance Use Disorder Support</td>
<td>110</td>
<td>52.6</td>
</tr>
<tr>
<td>Group Services</td>
<td>99</td>
<td>47.4</td>
</tr>
</tbody>
</table>
Among the Community/Migrant Health Center Respondents (N=99):

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling/Consultations/Therapy</td>
<td>92</td>
<td>92.9</td>
</tr>
<tr>
<td>Group Services</td>
<td>68</td>
<td>68.7</td>
</tr>
<tr>
<td>Support Services</td>
<td>65</td>
<td>65.7</td>
</tr>
<tr>
<td>Enabling Services (Transportation, Interpretation)</td>
<td>61</td>
<td>61.6</td>
</tr>
<tr>
<td>Substance Use Disorder Support</td>
<td>51</td>
<td>51.5</td>
</tr>
</tbody>
</table>

QUESTION 8: In your opinion how integrated is behavioral health in your organization?

<table>
<thead>
<tr>
<th>Level of Integration</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Integrated</td>
<td>87</td>
<td>43.3</td>
</tr>
<tr>
<td>Somewhat Integrated</td>
<td>84</td>
<td>41.8</td>
</tr>
<tr>
<td>Not Integrated</td>
<td>19</td>
<td>9.5</td>
</tr>
<tr>
<td>Minimally Integrated</td>
<td>11</td>
<td>5.5</td>
</tr>
</tbody>
</table>

Among the Community/Migrant Health Center Respondents (N=99):

<table>
<thead>
<tr>
<th>Level of Integration</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Integrated</td>
<td>49</td>
<td>49.5</td>
</tr>
<tr>
<td>Somewhat Integrated</td>
<td>38</td>
<td>38.4</td>
</tr>
<tr>
<td>Minimally Integrated</td>
<td>8</td>
<td>8.1</td>
</tr>
<tr>
<td>Not Integrated</td>
<td>1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Among Respondents in CHW, Management, or Provider Role (N=201):

<table>
<thead>
<tr>
<th>Level of Integration</th>
<th>CHW N=106</th>
<th>Percent</th>
<th>Management N=62</th>
<th>Percent</th>
<th>Provider N=33</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Integrated</td>
<td>48</td>
<td>45.3</td>
<td>24</td>
<td>38.7</td>
<td>14</td>
<td>42.4</td>
</tr>
<tr>
<td>Somewhat Integrated</td>
<td>44</td>
<td>41.5</td>
<td>27</td>
<td>43.6</td>
<td>15</td>
<td>45.5</td>
</tr>
<tr>
<td>Minimally Integrated</td>
<td>8</td>
<td>7.6</td>
<td>8</td>
<td>12.9</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>Not Integrated</td>
<td>6</td>
<td>5.7</td>
<td>3</td>
<td>4.8</td>
<td>2</td>
<td>6.1</td>
</tr>
</tbody>
</table>

- Overall, most survey participants (43%) expressed that behavioral health was very integrated in their organization. This was also true when looking at just those working at C/MHCs (49%).
- Comparing across roles, those in management and provider roles were more likely to say that their organization was “somewhat integrated,” while CHW/Ps were more likely to say that their organization was “very integrated.”
**Question 9:** What kinds of providers deliver mental health / support services at your organization?

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed clinical social worker</td>
<td>146</td>
<td>69.9</td>
</tr>
<tr>
<td>Licensed mental health counselor/Licensed therapist</td>
<td>94</td>
<td>45.0</td>
</tr>
<tr>
<td>Psychiatrist/Psychologist</td>
<td>92</td>
<td>44.0</td>
</tr>
<tr>
<td>Community health workers</td>
<td>80</td>
<td>38.3</td>
</tr>
</tbody>
</table>

*Among the Community/Migrant Health Center Respondents (N=99)*:

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed clinical social worker</td>
<td>85</td>
<td>85.8</td>
</tr>
<tr>
<td>Licensed mental health counselor/Licensed therapist</td>
<td>52</td>
<td>52.5</td>
</tr>
<tr>
<td>Psychiatrist/Psychologist</td>
<td>51</td>
<td>51.5</td>
</tr>
<tr>
<td>Community health workers</td>
<td>34</td>
<td>34.3</td>
</tr>
</tbody>
</table>

**Question 10:** Please identify trainings that CHWs at your organization receive related to behavioral health / mental health.

<table>
<thead>
<tr>
<th>Training Received</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health First Aid/101</td>
<td>59</td>
<td>28.2</td>
</tr>
<tr>
<td>Working with Patient/Client</td>
<td>59</td>
<td>28.2</td>
</tr>
<tr>
<td>CHW/Promotor</td>
<td>46</td>
<td>22.0</td>
</tr>
<tr>
<td>Trauma/PTSD</td>
<td>30</td>
<td>14.4</td>
</tr>
<tr>
<td>Substance Use/Chemical Dependence</td>
<td>14</td>
<td>6.7</td>
</tr>
<tr>
<td>Suicide Screening/Prevention</td>
<td>12</td>
<td>5.7</td>
</tr>
<tr>
<td>Physical/Preventive Health</td>
<td>10</td>
<td>4.8</td>
</tr>
<tr>
<td>Self-Care</td>
<td>9</td>
<td>4.3</td>
</tr>
<tr>
<td>Cultural Competency/Language</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td>Abuse/Neglect</td>
<td>5</td>
<td>2.4</td>
</tr>
</tbody>
</table>
**Question 11:** What additional trainings are needed for CHWs to best enhance the behavioral health services provided at your organization?

<table>
<thead>
<tr>
<th>Training Needed</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with Patient/Client</td>
<td>27</td>
<td>12.9</td>
</tr>
<tr>
<td>Mental Health First Aid/101</td>
<td>21</td>
<td>10.1</td>
</tr>
<tr>
<td>CHW/Promotor</td>
<td>20</td>
<td>9.6</td>
</tr>
<tr>
<td>Trauma/PTSD</td>
<td>14</td>
<td>6.7</td>
</tr>
<tr>
<td>Cultural Competency/Language</td>
<td>12</td>
<td>5.7</td>
</tr>
<tr>
<td>Self-Care</td>
<td>8</td>
<td>3.8</td>
</tr>
<tr>
<td>Substance Use/Chemical Dependence</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td>Physical/Preventive Health</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td>Abuse/Neglect</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Suicide Screening/Prevention</td>
<td>3</td>
<td>1.4</td>
</tr>
</tbody>
</table>

**Question 12:** In your opinion are there ways that CHWs can be better utilized to enhance behavioral health services in your organization?

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>135</td>
<td>64.6</td>
</tr>
<tr>
<td>Unsure</td>
<td>53</td>
<td>25.4</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>5.3</td>
</tr>
</tbody>
</table>

*Among the Community/Migrant Health Center Respondents (N=99):*

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>65</td>
<td>65.7</td>
</tr>
<tr>
<td>Unsure</td>
<td>27</td>
<td>27.3</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>3.0</td>
</tr>
</tbody>
</table>

*Among Respondents in CHW, Management, or Provider Role (N=199):*

<table>
<thead>
<tr>
<th>Response</th>
<th>CHW N=108</th>
<th>Management N=60</th>
<th>Provider N=31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>71</td>
<td>48</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>65.7</td>
<td>80.0</td>
<td>51.6</td>
</tr>
<tr>
<td>Unsure</td>
<td>30</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>27.8</td>
<td>16.7</td>
<td>41.9</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6.5</td>
<td>3.3</td>
<td>6.5</td>
</tr>
</tbody>
</table>