NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS (NACHW)

WHAT WORKS TOOLKIT SERIES

WHAT WORKS IN CHW APPROACHES AND INNOVATION SERVING PEOPLE IN REENTRY FROM INCARCERATION

NACHW
NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

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SUBJECT MATTER EXPERTS (SMES)

Subject Matter Experts (SMEs) provided guidance and advisement to steer the development of the What Works Toolkit Series (WWTS). SMEs met bi-weekly in steering workgroups (a SME workgroup advised each of the four toolkits) for six months to design and develop the WWTS.

SMEs are CHWs and CHW-allies, each with decades of expertise serving people in re-entry or working with CHWs with lived experience. We are immensely grateful for the expertise and dedication SMEs brought to this work by centering equity, inclusion and CHW self-determination.

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CHW CONTRIBUTORS

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ABOUT NACHW

NACHW is the national voice for Community Health Workers (CHWs). A non-profit, member-driven organization, NACHW's mission is to unify CHWs across geography, ethnicity, sector and experience to support communities in achieving health, equity and social justice. NACHW supports CHWs (including Community Health Representatives (CHRs), Promotoras(es), and other workforce members) in promoting self-determination, integrity and social justice; advancing CHW professional identity; and amplifying CHW leadership and capacity building. NACHW's over 2250 active individual and organizational members hail from all 50 states, over 30 Indigenous tribes, U.S. territories and Freely Associated States. There are over 8,000 people on our national email listserv and over 15,000 in our COVID listserv.

Initiatives. NACHW cultivates and amplifies CHW professional identity, policy leadership and CHW Network capacity; centers racial equity, social justice, diversity and inclusion in our values and work; and promotes policies that respect, protect and authentically partner with CHWs and their Networks. We disseminate research and best practice for sustainability of CHW roles, services and organizations through reports, playbooks, tools, webinars and conferences and collect national data on CHW workforce trends, experiences, skills and opportunities. We are building a national feedback loop (database, mobile app, campaigns and engagement events) to activate members; we are national advisors regarding CHWs' roles during COVID-19 and for future pandemic response and resiliency.

Recognizing that progress emerges from collective effort, NACHW works in collaboration with individual CHWs and their local/state CHW Networks, Coalitions and Associations and in partnership with organizations supporting community health work - including the White House COVID-19 Response and Hunger, Nutrition and Health Initiatives, the U.S. Centers for Disease Control, Department of Labor, various U.S. federal agencies (HRSA, SAMHSA, Indian Health Services, the Office of Minority Health, and the Office of the Assistant Secretary for Health), national technical assistance nonprofits, state and location health departments, and a diverse set of partners who are CHW employers, researchers, service providers, advocates, and those committed to building CHW sustainability.

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Unique Experience and Perspective. NACHW is the only national professional organization, led by CHWs in the Executive and Board positions, who deeply understand the CHW profession and its history, and who have developed major CHW led initiatives, including authoring seminal national research and workforce studies, the creation of a DOL classification for CHWs, created the APHA CHW Section, articulated core competencies, and launched dozens of state associations. Our north star is CHW self-determination, actualization and sustainability. Our skills and capacity to ignite national discussion and advocacy, inform federal, state and employer policies, and establish strategic partnerships to address CHW workforce challenges, emanate from our authentic participatory approach, expertise in organizing, and amplification of CHW leadership. NACHW's board represents the diversity of the CHW field and elevates CHWs in leadership.

NACHW amplifies and disseminates CHW-led, culturally diverse and proven strategies and approaches and deepens partnerships between community-based organizations, public health, healthcare and social services, to create a more accessible infrastructure for marginalized populations to improve their health.

The What Works Toolkit Series (WWTS) was launched to address the underrecognized, under-resourced, and undervalued leadership voice of CHWs to 1) understand complex health equity issues facing communities they serve and 2) lead, advocate, and develop innovative approaches that drive solutions.

WWTS focuses on four populations experiencing disproportionate health burdens: Native Americans/Alaska Natives (NA/AN), people experiencing homelessness, people who were formerly incarcerated, and Native Hawaiians and Pacific Islanders (NHPI)

THIS TOOLKIT SERIES AIMS TO:

- Explore the importance of CHWs' leadership voice to innovate in four key communities which experience wide-ranging health inequities: Native Americans/ Alaska Natives (NA/AN), people experiencing homelessness, people who were formerly incarcerated, and Native Hawaiians and Pacific Islanders (NHPI).
- Describe key elements of CHW-led public health innovation,
- Highlight "what works" in CHW-led innovation and highlight case examples, and
- Identify next steps for public health systems, funders, policymakers, CHW employers, and other partners.

APPROACH

To learn about "What Works" as well as CHW-led innovations in serving these communities, we invited CHWs to share their expertise through a national survey, listening sessions, and individual interviews. An environmental scan was also completed to learn more about specific health and social needs, CHW roles, and the landscape of community-based and CHW-led innovations. Methods are described more fully in the Methods section.

A framework for understanding CHW-led efforts and innovation was developed based on the findings of the survey and listening sessions. The model is used as a framework to discuss "what works" and describe CHW-led innovation in serving each of the four populations. Case examples of CHW-led innovations are highlighted and "what works" for partners (policymakers, funders, other partners) aiming to advance best practices and CHW-led innovation.

Reentry from the Inside

By Renee Chavez-Maes, CCHW, CPSW, CCSS

No matter what length of time someone spends behind bars, once they begin the reentry process, things can become overwhelming quickly. As a formerly incarcerated person transitioning back into the community, we must juggle things like probation requirements, behavioral health program and treatment plans, gaining employment, and sometimes family reunification with our children.

As a formerly incarcerated person, we are challenged with first things like acquiring basic needs, shelter and community support. Some can adapt quickly as some may take longer. From the first day of our release, we are mandated by the justice system to find a way to the probation and parole office. Once we are there, we must spend at least two hours filling out paperwork, providing a uranalysis, and taking a photograph to attach to their file. Formerly incarcerated people are required to have a phone, address and be able to call the UA line daily and check in one to three times a week.

All of this may seem manageable and may just take some creative calendar innovations, right?

Ok, what if you don't have any family support, transportation, a phone, finances or life skills. How do you navigate a complex system without any of these things in place? Well, if we look at our recidivism rate within our state. You don't. Most of the time you just give up. Some of our returning citizens will find themselves discouraged, homeless, hungry and without support. So, they stop checking in with their probation officer and go back to the neighborhood in which they are familiar with and end up using some sort of substance to self-medicate. Once this happens, the formerly incarcerated person will likely stop trying, and checking in with the reentry system. This is one of the vicious cycles of addiction and re-incarceration. Between 2018–2019 the state of New Mexico had approximately 6,700 males and 768 female incarcerated persons in adult prisons.

CHWs/peers including many with lived experience of incarceration actively support individuals returning to their communities after incarceration.

BACKGROUND

CHWS/PEERS AND REENTRY

CHWs serving people in reentry often draw on their own lived experience of incarceration and reentry and have many different titles including CHW, peer support specialist (PSS), forensic peer specialist, peer outreach worker, peer mentor, re-entry specialist, peer navigator, peer health educators, peer recovery coaches.[1]

> *For the purposes of inclusivity, we use the terms CHW/peer in this toolkit; however, we recognize and acknowledge the efforts to further define distinctions between CHWs and peer support workers [2] and do not aim to make a statement on this distinction for the purposes of this toolkit.*

CHWs and peers are sometimes discussed as separate professions due to distinct training, professional development, advocacy and oftentimes funding mechanisms.[2] Peers share lived experience of incarceration, and sometimes with mental health and/or substance use (MH/SUD) and trauma. CHWs may share other experiences or communities with clients, and do not necessarily have experience of incarceration or mental health and/or substance use disorders (MH/SUD), though they often do.

In the literature and in the combined practice experience of our advisory, the distinction between CHWs and peers is frequently blurred and there has been a lack of consensus on the distinctions.[2] Many move fluidly between peer and CHW roles or combine aspects of each role in practice, "creating a more fluid, complicated workforce than the separate titles would suggest." [3] The titles are often used interchangeably and CHWs/peers are often seen as part of the same professional workforce.[1,3]

CHW/PEER ROLES SERVING PEOPLE IN REENTRY

CHWs/peers including many with lived experience of incarceration actively support individuals returning to their communities after incarceration.[4,5] CHWs/peers work across multiple systems and often address needs for MH/SUD treatment access along with a range of other healthcare and health-related social needs for people in reentry.

CHWs not only are positioned to provide essential linkages and support for individuals reentering the community, CHWs also have been highlighted for their potential to transform systems including public safety and mass incarceration due to their proven effectiveness and participatory care model.[6]

MH/SUD support extends beyond connecting clients with services like therapy, psychiatry, and mental health treatment programs. CHWs/peers see mental health as part of a whole person, impacted by trauma, and is interwoven with social and resource needs. Development of a trusted, caring relationship with a CHW/peer who deeply understands the challenges of reentry, having been through it themselves, provides an invaluable health service with potential to improve health outcomes, reduce system costs, and interrupt cycles of trauma. CHWs/peers are being trained

and deployed to support people in reentry nationally.[7-9]

CURRENT STATE OF HEALTH EQUITY FOR PEOPLE IN REENTRY

At a rate higher than any other country, almost 2 million people are incarcerated across state and federal prisons, jails, juvenile corrections facilities, and several additional criminal legal systems, costing almost 200 billion dollars per year. Over half of this population is in state prisons. [10]

A "civil rights, human rights, and public health crisis" mass incarceration continues systematic racial injustice that can be traced directly back to slavery, colonization and socioeconomic oppression. Black and Native American, and Hispanic communities are disproportionately impacted.[11,12.] The prison system has been called the de facto mental health system or the "new asylums" due to its role disproportionately capturing people with mental health and/or substance use (MH/SUD) conditions[13,14]

SOCIAL DETERMINANTS (SDOH) OF HEALTH AND HEALTH-RELATED SOCIAL NEEDS (HRSN)

Incarceration is harmful to mental and physical health and social support networks. The trauma of incarceration felt by those in reentry has been given a name—post-incarceration syndrome (PICS)—to describe the harm caused by incarceration in the form of mental, emotional and social difficulties for those re-entering the community.[15] In addition to the loss of autonomy and removal from the community, conditions like overcrowding, exposure to violence, and solitary confinement can worsen mental health and cause trauma.[15]

Physical and mental health (including substance use): People returning from incarceration have high rates of the following:

- physical health needs, infectious and chronic health conditions
- mental health conditions
- substance use and risk of overdose
- social, service, and resource barriers (reduced wages, barriers to housing)[16]

Mental health and substance use: Despite high rates of MH/SUD (including trauma), mental health treatment options for people in reentry are limited and fragmented. Formerly incarcerated people are at risk of getting trapped in the "revolving door" between community, homelessness, MH/SUD, emergency services, and incarceration, a continuation of the adverse childhood experiences (ACE) to prison pipeline.[17]

Access to behavioral healthcare: Mistrust of mental health providers, prejudice and discrimination, and cultural barriers can further challenge access to needed care. People with

Mental health and need for mental health services was the most commonly identified health issue facing the clients of CHW survey respondents (98% of respondents) followed by access to healthcare (88%), trauma (82%), and substance use and need for substance use treatment (80%) and lack of social support (73%).

severe mental health conditions, often referred to as serious mental illness (SMI), and those with co-occurring mental health and substance use disorders experience additional challenges accessing needed supports and treatment.[11]

Due to the high rates of MH/SUD in the reentry population, this toolkit focuses on the roles of CHWs/peers in serving people reentering from incarceration with a focus on MH/SUD.

Immediate basic needs and health-related social needs (HRSN): The most common client HRSN reported by CHWs/peers were housing and poverty/cost of living (86% respectively), followed by food insecurity (78%), job opportunities (76%) and reentry specific challenges (65%).

POLICY AND PRACTICE LANDSCAPE

Peer support (e.g., peer mentoring, peer education) has been used widely to support individuals while incarcerated and in reentry.[18-22] CHWs with lived experience have been deployed through national initiatives such as the Transitions Clinic Network to support people returning to the community and CHWs have been highlighted as offering a promising approach to improve health and help people avoid adverse outcomes.[23]

Despite their effectiveness in serving people in reentry, CHWs/peers with experience of incarceration face barriers to certification, complex certification requirements and barriers to employment.[23]

CHW-led, Community-based Innovation

WHAT IS INNOVATION IN PUBLIC HEALTH?

Innovation includes strategies and practices that advance progress toward meeting public health goals. This includes developing new ways of doing things as well as improving current approaches.

The Framework for Public Health Innovation (FPHI) identifies important components for public health innovation and types of innovations.[24]

WHY IS CHW-LED INNOVATION IMPORTANT?

Decades of public health evidence demonstrates CHWs' effectiveness as essential frontline providers addressing social determinants of health (SDoH) and reducing health inequities in communities experiencing disproportionate health burdens. Despite this proven track record, CHWs are often overlooked as community health experts in designing and developing innovative approaches to meet community public health needs – communities they serve and which CHWs often are from or share common health barriers. Due to this unique position, CHWs bring essential expertise anchored in professional and lived experience.

Programs that CHWs implement are often designed and developed by other providers, administrators, or researchers without full CHW partnership and equitable engagement. In a national CHW survey conducted by NACHW in 2022, only half of CHW respondents reported being able to lead discussions to improve services where they worked.25

Furthermore, CHWs often work in roles that are under-paid, limited term (e.g., grant funded), and lack autonomy and authority to innovate.20,21 Despite these challenges, CHWs are actively developing new approaches to improve public health systems, build community health capacity, reduce health inequities, and advance the overall health of all communities they serve. Often this work comes at personal cost, extra hours, and unpaid labor, out of pocket costs, and lacks funding and support for evaluation and sustainability. As a result, it is largely not found in evidence-based literature and our public health systems lose out on this potential well of innovation to improve community health.

Public health institutional leaders, including Federal Government agencies (e.g., HUD) and public health NGOs (NASHP), among others, have highlighted the importance of engaging communities and people with lived experience (PwLE) in the design of policies and programs and cross sector investment in community health.[27,28]

"CHWs are versatile and natural leaders. They can effectively work across community and healthcare providers to accelerate community engagement among underserved populations and structural competency of healthcare providers and, ultimately, lead to patient-centered care and population health improvement for diverse communities."

– Trinh-Shervin et al, 2019

However, CHWs have not been adequately highlighted for their essential role in driving public health innovation and policy development as unique stakeholders with shared community and cultural backgrounds, identities, and oftentimes lived experience of incarceration, homelessness, health conditions, and more. CHWs must be included in these efforts to ensure innovations are community-driven, culturally relevant, and locally responsive.

WHAT IS UNIQUE ABOUT CHWS' PERSPECTIVES?

CHWs are deeply immersed in the communities they serve - either as members of the community or as trusted partners. They build trusted relationships with clients and community partners, centering culturally aligned and trauma-informed approaches, and drawing on their own lived experiences.

CHWs strengthen the health of communities by responding to multifaceted individual and community needs and by developing community public health infrastructure, partnerships and collaborations. Their unique position provides CHWs with expertise and understanding of the immediate and long-term needs of clients and communities.

CHW-LED INNOVATION

TYPES OF CHW-LED INNOVATION (ADAPTED FROM (GARNEY ET AL., 2022) TO REFLECT CHW-LED INNOVATION APPROACHES).

Adaptation or new component: The addition of a new component to a public health program which does not change the overall intervention, including modifying how a program is implemented, often to make it more relevant for different populations.

New approach to addressing a public health challenge: Developing a new way of carrying out a program, establishing a new initiative or founding an organization.

Paradigm shift / Reframing the way a problem is understood or addressed: Upstream innovation, policy or system improvement, including building new community health infrastructure, and system transformation to change the root causes of health inequities.

> *"Innovation is iterative, so people become more familiar with the process as they participate. Through these interactions, people develop the capacity for innovation."* [24]

CHW Approaches and Innovations Areas of Focus

What Works:
CHW-led Innovations and Approaches

Key themes in CHW impact and innovation and selected case examples are described below according to each domain of focus:

Community is at the center of CHW work and innovation. CHW-led innovation across all domains is community-driven, informed by deep understanding of the community served, builds relationships and partnerships across sectors and expertise, prioritizes the desires of the community, and ensures community buy-in and accountability to the community served.

CHW-led efforts and innovations may operate along the continuum of prevention. While some innovations aim to address **individual health and social needs** (e.g., access to healthcare, diabetes management), others focus upstream through **program development and improvement**, targeting multiple social determinants of health, building community infrastructure or advocating for **policy or systems change**.

WHAT WORKS: CHW APPROACHES TO SERVING PEOPLE IN RE-ENTRY

Trust enables CHWs/peers to build positive connections through which health information, honest communication, health behaviors, and connection with resources can be supported.[29] The quality of this relationship is essential to the positive outcomes observed in CHW interventions.

CHWs/peers described several examples of "what works" in building trust with community members in reentry, as the foundation to addressing health and social needs, including:

- Deep connections within the community, knowledge of community partners and resources
- Speaking the "same language"
- Lived experience as expertise: "We are the people we serve" or "I am who I serve"
- Sharing lived experience of incarceration helps clients feel more comfortable

Best practices and emerging innovations across all areas of focus are essential for meeting the challenge of solving cross cutting and longstanding health inequities.

- Care, patience, compassion, understanding, collaboration, follow-through
- Continuity and consistency – "support every step of the way"
- Transferring knowledge and education to the community

Two key ingredients: Relentlessness and caring relationships

- **Relentlessness:** CHWs discussed the importance of being relentless in addressing the complex needs of people in reentry due to overlapping MH/SUD, housing, food, legal and safety needs, the trauma of incarceration and the challenges of reentry itself.
- **Caring relationships:** CHWs, especially those with lived experience talked about the way of relating with clients in a way that helped people feel they were not alone. This was described as like family, a professional but deeply caring relationship that helped people feel supported.

WHAT WORKS ACROSS DOMAINS

INDIVIDUAL HEALTH AND SOCIAL NEEDS

CHW/peer survey and listening session participants described many elements of "what works" in serving people in reentry. While this toolkit focuses on behavioral health needs, CHWs/peers described how immediate needs for things like safe housing often must be prioritized over other pressing needs. Basic needs and HRSN are essential components of successful reentry. CHWs promote successful reentry and access to behavioral health care by addressing the range of overlapping health, social and resource needs, bringing a deep understanding of the many challenges of reentry. Examples of "What Works" in addressing HRSN include:

Immediate basic needs: CHWs/peers working with people in re-entry are often must balance competing priorities between addressing immediate basic needs (e.g., food, shelter, transportation, legal system requirements) and ongoing or long-term needs (e.g., permanent housing, employment).

- Due to the number of competing needs, CHWs/peers discussed having to prioritize immediate needs sometimes at the expense of being able to focus on medium and longer-term re-entry needs.

Transition needs: While leaving prison represents a positive milestone, it can be extremely challenging and stressful. In addition to addressing client material and healthcare needs, CHWs/peers described the urgency of social and relational needs for people in reentry.

- Drawing on their own lived experiences of incarceration, CHWs/peers emphasized the importance of rest, social support and time to mentally adjust - limited time when people don't have to worry about food and shelter or obtaining employment to allow for social and emotional adjustment during a stressful transition.

Mental health and substance use: CHWs/peers help clients access mental health or substance use treatment when needed and provide essential emotional support, health education, as well as hope, encouragement, and belief in clients.

Social support and connection: The relationships CHWs/peers build and impact of CHW/peer support was often described as like a family relationship rather than a distant clinical relationship.[30] The trauma of incarceration and difficulty of reentering society are personally and deeply understood by CHWs/peers.

- This understanding allows CHWs/peers to anticipate and flexibly respond to individual needs and prepare them for the many material, psychological and social steps required for re-integration into the community.

POLICY

CHWs engage in policy advocacy as individual experts, organize other CHWs and providers to advocate, and educate policymakers about the needs of community members and strategies to improve the health of their constituents. For people in reentry, CHWs described advocating for changes to laws related to housing barriers and funding, and shared personal stories with policymakers to educate them.

COMMUNITY

CHWs build community and social connection and cohesion, key social determinants of health, at a time when the U.S. Surgeon General has reported an epidemic of social isolation,[31] build capacity within communities and mobilize community members to address community needs and advocate for public health priorities.[32]

PROGRAM

Program-level innovation includes improving the way a program serves clients, advocating for changes to the way something is done (e.g., advocating to make a program trauma-informed or culturally relevant) and starting new initiatives or organizations to address unmet community health needs. CHWs spur innovation and improvement in existing programs by advocating for changes, contributing their expertise, and drawing on lived experience to transform the way programs operate.

Several program components were seen as representative of "what works" on a program level including building essential (but not directly funded) operations components into program budgets and MOUs/partnerships with trusted and culturally responsive healthcare systems. In addition to program delivery, ensuring CHWs are paid a living wage (and especially that CHWs should not need to work multiple jobs) reflects an essential and foundational program/organizational priority.

CHW-LED INNOVATION: CHW'S LEADERSHIP VOICE TO INNOVATE

We selected case examples of CHW -led innovations highlighting the strengths, assets, barriers and potential to transform and improve health among people in reentry. Case examples were selected from among WWTS respondents, word of mouth recommendations, and a landscape scan to identify, of CHW-led efforts.

Almost half (21 out of 51) of survey respondents shared examples of innovative work they took on to address the health and social resource needs of their clients and communities. These innovative efforts included advocacy to add components to or change approaches of existing programs, developing new programs or organizations, and engaging in policy advocacy to address upstream SDoH.

ADVOCATING FOR PROGRAMS TO ADOPT TRAUMA-INFORMED CARE

CHW leader: Wanda Price, Des Moines, Iowa

A critical form of innovation carried out by CHWs is advocating for changes within programs to improve the way services are delivered and transform organizations to more effectively accomplish their missions.

While working at a recovery house organization for people with MH/SUD, many of whom were returning from incarceration, Wanda was concerned by the way clients were moved through the program. The organization was not using person-centered language, trauma-informed care or collaborative practices like motivational interviewing. People were returning to the streets or substance use, which led to additional incarceration because their mental health needs and trauma weren't being addressed.

"They were no longer incarcerated, and they shouldn't be treated as such."

Wanda, a CHW in recovery herself, knew she had to do something to improve the services. Wanda found allies and began advocating for a trauma-informed approach within the organization. She explained that the organization needed to stop "talking down" to people and instead meet people where they were at. Wanda explained data on trauma, recidivism and reentry to demonstrate the need for change to agency leadership. Wanda's advocacy was mirrored in shifts at the state level. State funding mandates have shifted to include a focus on trauma-informed care.

The agency is now working on adopting these key components of trauma-informed care and training agency staff accordingly. A more person-centered approach supports clients by addressing intersecting and concurrent reentry, substance use and mental health needs.

FORMERLY INCARCERATED PEER SUPPORT (FIPS) GROUP

CHW leader: Thad Tatum, Louisiana

The need for innovation: Mental health needs during reentry extend beyond accessing behavioral health treatment. Along with the high levels of trauma that is common before incarceration, the stresses, challenges, isolation, and trauma of incarceration and reentry are experiences that only those who have lived it truly understand. In addition to high rates of SMI, these additional mental health burdens are even more prevalent.

Knowing that the best support comes from others who understand, Thad Tatum started the Formerly Incarcerated Peer Support (FIPS) Group to help peers help each other in reentry. When he got out of Angola Prison in Louisiana, Thad experienced many common challenges of reentry. Along with a small group of peers, Thad built a peer support curriculum focused on helping people navigate these challenges.

The challenges of reentry are often daily, many of which may seem automatic for others can present significant challenges from paying bills to learning new technology. In addition, the survival skills that help people survive prison can be a liability in the outside community. For those who have been incarcerated for decades, entering this new world can be full of roadblocks.

For African American men in particular, talking about mental health can be stigmatized and there is historic mistrust of mental health providers. Thad sees his job as one of lessening that fear, and providing space for them to talk about their mental health.

Thad explained his own challenges adjusting mentally after incarceration: "the stuff we had to endure being in a place like Angola…when I first went there it was a few years removed from being the bloodiest place in the nation. To have a mind to adjust to that kind of environment, it was confined in that violent environment. You can't escape it there."

Now home for 12 years, Thad continues to facilitate FIPS bi-weekly. Some of the group members have been incarcerated up to 60 years, with a median of 18-20 years.

Why is it innovative? The first and only peer support curriculum developed by and for formerly incarcerated people (FIP), FIPS' motto is "Us helping Us." A peer-led, peer-designed support group focused on the common challenges represents a promising innovation for supporting the mental health and adjustment of formerly incarcerated people.

The curriculum addresses common mental health related challenges during reentry such as culture shock, authority and managing conflict, relationships, parenting skills, managing basic needs and responsibilities. FIPS curriculum guides the group, but the discussion is open and includes common challenges such as substance use, housing, social networks and more. Outside of the group and the curriculum, Thad takes care of his community. He remains aware of

"We trust each other, we talk about things it's almost impossible to talk about with others—people who haven't been through what we've been through. We feel more comfortable knowing we can talk about it in a group. We don't have to worry about it going outside the room."

group members who might be struggling or relapsing and provides support and listens proactively and serves as a trusted peer and resource. Thad also trains peers to become peer support leaders.

Challenges: Despite substantial national attention and accolades and two peer-reviewed articles,[33–37] FIPS remains volunteer-led. A lack of dedicated funding for this work has meant that Thad's leadership as a peer CHW is completely uncompensated. While Thad's mission and dedication keep him focused, funding remains needed to enable him to sustain this work to build sustainable reentry support pathways, educate others around the country about his curriculum and approach, and ensure he can support himself to continue this essential service.

IMPACT:

This peer-facilitated support group has been associated with feelings of acceptance, improved insight and ability to manage triggering situations and stressors, and better ability to navigate relationships with people who have not been incarcerated.[33]

ST. JOHN'S COMMUNITY HEALTH, REENTRY INTEGRATED SERVICES, ENGAGEMENT, AND EMPOWERMENT (RISE)

CHW Leaders: Jackie Morris & Yoselin Tovar, Los Angeles, California

The Reentry Integrated Services, Engagement, and Empowerment program (RISE) at St. Johns Community Health provides comprehensive services and support to people returning to the community following incarceration. Started in 2017, RISE employs a team of 10 CHWs and peers, all of whom have lived experience of incarceration.

Jackie Morris, RISE Program Manager, was hired about five months after leaving prison after spending 40 years incarcerated. He now leads a team of CHWs/peers helping others successfully return to the community. Along with a close ally, Chief Programs Officer Elena Fernandez, Jackie and team members built RISE to what it is today with strong support of RISE leadership committed to hiring people from the community to serve the community. This is essential to the effectiveness of their work and ability to help clients navigate reentry because "[the CHWs/peers] all have had the same needs themselves."

RISE addresses the social determinants of health (SDoH) by providing comprehensive case management services for individuals immediately upon reentry, helping connect people with medical care and mental health care, "working outside the box" to address all clients' needs as best as they can. RISE holds a peer CHW led support group for formerly incarcerated people (FIP), allowing them a space to connect with others, share experiences and also connect with case managers.

Clients' needs depend on how long they have been incarcerated. The longer people have been out of the community the more needs and barriers they experience during reentry. The three prongs of RISE address the range of typical needs seen - housing, employment

"CHWs are the tip of the spear, foundation and backbone of reentry. The other programs are follow ups from seeing a CHW."

"Our goal is to serve the entire community as if they were family members themselves"

and connection to behavioral health services. Many of their clients need mental health care due to the trauma of incarceration, though some are more profoundly impacted than others. CHWs help with enrolling in healthcare, SSI, prepare people for employment and job search, and meet individual needs through relentless advocacy. As Jackie says, "if St. John's Community Health doesn't have a resource to meet a client's need, the CHWs go out and find it in the community."

RISE also helps connect people with legal services to help with things like expungements and immigration paperwork. RISE CHWs are trained in motivational interviewing, harm reduction, and cultural sensitivity.

IMPACT:

RISE has housed 185 formerly incarcerated people, all of whom may not have had a roof over their heads otherwise. With the support of Jackie and his team, they can now focus on longer term goals, like saving up to purchase a vehicle and setting themselves up for successful reentry.

"We have success stories daily" – Jackie Morris

Stories are how RISE really learns about its impact. The stories are "innumerable" and the impact often can't be fully captured in data and metrics. Even what might seem like small things such as providing an answer to a question can be impactful—"for somebody that has nothing, even a little something improves their lives."

JOURNEY OF HOPE UTAH

CHW leader: Shannon Miller-Cox, Founder, Starsha Vario, Acting Executive Director

The need for innovation: Incarceration does not occur in a vacuum. Without sufficient support, adverse childhood experiences (ACEs) and trauma due to community and gender-based violence, domestic violence and sexual assault (DV/SA), human trafficking, as well as other ACEs, too often lead to cycles of substance use and then arrest and incarceration.

If formerly incarcerated women don't receive care for these underlying needs, and with felony convictions, they can't get housing, jobs, and other needs to safely reenter the community.

Journey of Hope (JOH) sees that the majority of women in prisons have been incarcerated due to the cumulative impacts of poverty, racism, trauma and resulting addiction and homelessness. In Utah, this is exacerbated by strict laws - it is a felony to shoplift three times, even for as little as a water bottle, or snack for a child. The resulting system costs and taxpayer burden are enormous.

About: Shannon Miller-Cox started Journey of Hope Utah 10 years ago and has seen it grow into a worker-led organization to address and interrupt the ACE to prison pipeline, and the racial and health injustices that have defined the status quo in the U.S. for decades. Many of the clients they serve are survivors of childhood trauma in addition to traumas like gang violence, human trafficking, and sexual violence.

"The sooner you intervene the less work you have to do in the long run."
- Shannon Miller-Cox

As a CHW and survivor of trauma, Shannon draws on her lived experience to better understand the needs of the community. JOH's acting Executive Director, Starsha Vario, is a CHW and survivor of sexual violence, gang violence, incarceration, and mental health and substance use challenges. JOH aims to combat the deeply ingrained racial and health injustices that perpetuate the ACE to prison pipeline among the people they serve, the broader community and state, and within the worker collective itself.

To this end, JOH has developed a trauma-informed care (TIC) community health model integrating and person-centered, evidence-based practices and community partner development to ensure wrap-around, holistic, collaborative care for people returning from incarceration.

Key programs and approaches include:

HOPE Prison Mentoring Program provides CHW case management for women in reentry using an evidence-based, trauma-informed and gender-responsive approach, the Women's Case Management Model. The program matches women with peer mentors 3–6 months before release to plan for transition, and up to 12 months following to help navigate the many health and social resource needs. To prevent gaps in which women can fall through the cracks, mentors "walk them out of prison," perform case advocacy, and help them find safe housing and safe employment.

"We wrap holistic care until they don't need us anymore. We walk with them until they can do it for themselves."
- Shannon Miller-Cox

CARE Triage Community Support: Women, youth, and LBGTQIA individuals in the community can contact JOH for support including: social resource needs - housing support and navigation; employment support, training, and navigation; legal support—divorce and domestic violence, protective orders, child and family reunification supports, interacting with law enforcement; addiction and mental health support—medication management and relapse intervention supports.

Survivor Emergency support and navigation: for women fleeing DV/SA (domestic violence and sexual assault) as well as sexual exploitation and human trafficking.

Partnerships are a core strategy to ensure that marginalized communities across the state have access to JOH's expertise and services. Partnerships include:

- PIK2AR, a CHW-led organization serving NHPI community members.
- Utah Department of Corrections (UDC) – Referral and transition planning and support for reentry. JOH's founder had previously trained 150 UDC agents to incorporate trauma informed and gender responsive approaches into their work.
- JOH serves on several Anti-violence task forces, including UTIP (Utah Trafficking In Persons) Task Force with the Utah Attorney General's Office; with UDVC (the Utah Domestic Violence Council);and UCASA (Utah Coalition Against Sexual Assault).
- DAY WON/Salt Lake DA Peace Circle Collaboration - JOH partners with formerly incarcerated former gang members teaching healing peace circle practices to youth in collaboration with the Salt Lake County District Attorney's office. These amazing men and women are helping to transition youth out of gangs, stop gang warfare in our communities, and go into the Utah State Prison with JOH to do healing peace work inside the prison.
- Project Rainbow, Flourish Counseling - JOH provides affirmative support, mentors, and the partners for LGBTQIA community, provide an understanding of the ACE to Prison to Early Death pipeline so they can fully support the holistic health needs of their community as a whole.
- Utah Women's Empowerment Project - Partner in addressing women's economic disempowerment, violence in the community and more.

Why is it innovative?: JOH represents a transformative approach to addressing the cycles of ACE trauma, incarceration and mental health and substance use (i.e. ACE to prison to early death pipeline) that are a hallmark of the intersectionality of gender, racial and health injustices built into the criminal justice system.

Equity is built into the organizational structure. As a worker co-op, JOH shares leadership and decision making to ensure equal power among workers which includes women from marginalized groups, disabilities, survivors, and who are formerly incarcerated. An equal starting livable wage (i.e., equitable pay), equal vote in decision-making when possible, and democratic leadership selection represent innovative

approaches to seeding equity into all aspects of organizational structure. This structure flattens hierarchies that can sow distrust and cause retraumatization not just in relation to the community they serve but also within JOH as an organization. Everyone in the organization takes a leadership role in some part of the organization and with community partners, when they are ready and equipped.

Partnership development and community health infrastructure - JOH has built partnerships across the board - from grassroots CBOs to government agencies to help establish a strong statewide infrastructure for collaboration.

Challenges: Like most small CBOs, JOH relies on funding mechanisms that often are siloed, piecemeal or short-term. To build in sustainability, JOH has sought to integrate braided funding and continues to seek partnerships to build sustainable infrastructure, so it can continue to focus on doing what it does best - helping some of the most marginalized members of the community to get on their feet, heal, and return to the community safely and sustainably.

What's next? JOH continues to expand its services to reach the most marginalized women, men and LGBTQIA+ individuals in the community. Current plans include:

- JOH is expanding outreach to Weber County, where almost 60 percent of women in state prisons come from, stemming from the legacy of redlining and discriminatory policies.
- Ensuring trauma responsive supervision and support for all of its workers due to the extent of vicarious trauma they experience.
- JOH is seeking to expand programming to support victims of trafficking and to prevent further trafficking of vulnerable youth
- JOH is adding peer leadership classes, process support groups, and additional programming to support the trauma-related mental health needs of its clients.

IMPACT:

In 2023, JOH served over 300 active clients and their families, fielded 139 DV/SA/HT crisis calls. Hope Prison mentoring program has seen 17% recidivism in three years, far below national averages, and the state's recidivism rate of 80%, one of the highest in the nation. JOH's evaluation has found that they have saved state taxpayers millions of dollars over the last ten and a half years with the HOPE Prison Mentoring program alone.

JOH's successes can also be seen in requests for referrals, training and expansion of its services. The Utah DOC has requested that JOH bring their program to the men's system, and JOH is now adapting their evidence-based principles and practices for the men.

THE IMPACT OF TRUST, RELENTLESSNESS, AND CARING RELATIONSHIPS

HANNA'S STORY*

Hanna is from a small rural community in the northeast side of the great State of New Mexico. Hanna experienced several adverse and traumatic experiences as a child and an assault as an adolescent, but she persevered without support. Hanna now has three school-aged children. Hanna was in a marriage with a long history of domestic violence, which escalated until a particularly rough fight broke out that led to her incarceration.

Hanna was sentenced to state prison, where she would serve over 10 years. During her stay, she was shuffled around from housing unit to housing unit. Hanna was diagnosed with a serious mental health condition and was required to take several psychiatric medications for the duration of her sentence, which left her feeling sedated and on edge. Despite her needs, she did not receive any therapeutic treatment. Hanna did not receive any visits while incarcerated and had very limited phone communication with family members. Once her time for release came up, she was told that due to her behavioral health needs, she would have to find a treatment program and would not be able to return to her hometown.

While incarcerated, Hanna had heard stories of a woman who had spent most of her life incarcerated at the women's facility where Hanna was held, and who had opened a transitional living home for women since getting out. This story was talked about all over the prison, in hallways, at med-line or during chow call. Hanna decided to apply to this transitional living home. Finally, her much anticipated release day had come. Hanna was shackled by her hands and feet; she was placed in the back of a department of corrections box truck, anxious and scared. Arriving at the program after a decade of the daily stresses of incarceration, Hanna was in a state of trauma – with high anxiety and very fearful and mistrusting of those around her.

Outside of the transitional living home, Hanna had no place to live, no financial resources, and could not pay rent. Due to her mental health needs, Hanna has trouble maintaining compliance with her probation and parole visits, which leaves her at risk of further legal system involvement or even reincarceration. She also has tremendous difficulty with managing basic needs like hygiene as well as forming relationships with peers.

CHWs at the program, through trauma-informed approaches centering patience, kindness and consistency, have supported Hanna to slowly build a new life for herself and to learn to cope with her mental health needs. For example, a CHW at the program works with Hanna daily on coping with her anxiety and teaches basic life skills using creative

approaches. Hanna has applied for services and resources with assistance of the CHWs including social security, individual psychotherapy, and psychiatric medication management. Hanna also attends a support group where she can speak about and receive support around her experiences from a group of women who have had similar experiences.

Each day, she is beginning to acclimate to the world around her, something that can take significant time for people in reentry after long incarceration. Hanna is learning new skills daily and talks about her needs with the program's CHWs. While she still struggles with her mental health, she has only needed to access crisis services once, has not fallen back into substance use, is on a more therapeutic and stable medication regimen, and receives regular outpatient psychotherapy to manage her mental health. With the support of the CHWs, she is beginning to see long awaited family reunification.

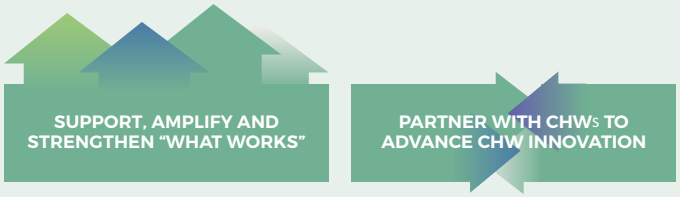
This is a composite of some of the many stories that CHWs see daily working with the reentry community. It is hard to imagine what Hanna's story would be to this day if she did not have the support of a CHW-led transitional recovery home.

** Hanna's story is a composite story, which blends common experiences among clients served by transitional living program led by CHW/Peer and SME Renee Chavez-Maes.*

What Works for Partners:

How policymakers, funders and other partners help support, elevate, enhance and sustain CHW-led efforts to advance health for people in re-entry

CHW participants shared their perspectives about "what works" in terms of actions, principles and strategies taken by partners that have positively impacted their work serving clients experiencing homelessness. Many themes discussed by CHWs and SMEs aligned with the existing pillars of the NACHW SUSTAIN Framework for CHW Sustainable Financing[28] and the NACHW Policy Platform.[29]



SUPPORT AND SUSTAIN CHW LEADERSHIP IN ADVANCING "WHAT WORKS" AND CHW-LED INNOVATION

Partners including funders, employers, and policymakers can partner with CHWs to sustain and advance "what works" and develop innovative solutions to addressing pressing community health needs. The following principles provide a preliminary set of guidelines—a starting point—for partners interested in partnering with CHWs to understand, improve, scale, and sustain community health for people in reentry.

Key principles for partnering with CHWs to advance and sustain "What Works" and CHW-led innovation:

- Respect, center, and protect CHW leadership and expertise
- Provide expertise, training and support to support CHW professional development to build capacity around innovation, leadership and organizational development.
- Ensure equity, flexibility, and sustainability in funding CHW efforts and innovations
- Maintain CHW leadership in evaluation and dissemination

RESPECT, CENTER, AND PROTECT CHW LEADERSHIP AND EXPERTISE

Respect and protect CHW leadership: Partners seeking to support development or expansion of CHW-led innovation to serve communities must ensure equity and respect for CHWs' unique expertise, time, and effort. This includes:

- CHWs are fairly and equitably compensated;
- Engagement of CHWs by partners is sustained, equitable and inclusive, CHWs as full partners and leaders;
- Center CHW leadership: CHW leadership in innovation extends far beyond informing programs developed by others.
- Recognize CHWs for their essential contributions to individual, community and social health and wellbeing.

CHWs can be effective when paid a fair, thriving wage and receive full and equitable compensation including health insurance and other benefits. This includes ensuring funding for CBOs to cover living wages, health insurance, administrative costs, programmatic costs to reduce barriers for clients (e.g., transportation, incentives, food), and more.

PROVIDE EXPERTISE, TRAINING AND SUPPORT TO SUPPORT CHW PROFESSIONAL DEVELOPMENT TO BUILD CAPACITY AROUND INNOVATION, LEADERSHIP AND ORGANIZATIONAL DEVELOPMENT.

- **Provide expertise, training and support:** in activities like data and evaluation, administrative tasks, fundraising, connecting CHW leaders with organizations or agencies with similar missions, providing in-kind resources and space, and more.
- **Help build relationships and connections with policy makers and funders:** connecting CHW leaders with organizations or agencies with similar missions.

ENSURE EQUITY, FLEXIBILITY, AND SUSTAINABILITY IN FUNDING CHW EFFORTS AND INNOVATIONS

Equity: Ensure equity in funding recipient and grantee selection: Funding must be directed to authentic CHW-led initiatives and CBOs that have roots in the community and community health work are prioritized. Funders should work to build internal capacity to understand the essential work that CHWs do, the local landscape of CHWs and CBOs, and avoid deepening inequities by restricting funding or inequitable funding.

> *The best thing a policy maker, funder, or provider can do is to listen to the life experience of those that have become successful out of climbing out the bottom. But few do listen and few have walked in our shoes. They make policies that create barriers and harm.*
>
> *– Wanda Price, CHW*

Flexibility: Ensure funding and programmatic flexibility (e.g., timeline, determining funding priorities), remove funding silos: CHWs respond to immediate, ongoing, and long-term needs in difficult and changing environments, in close collaboration and partnership with community members. This requires adaptation, flexibility and responsiveness to changes.

- **CHW Employers:** Ensure CHW employees have time, flexibility, and autonomy to innovate, adapt and improve programs and services.
- **Funding flexibility is essential for effective CHW-led innovation, including:**
  - **Ensure time for community buy-in and acceptance,** this can require time-intensive planning, relationship building, and ongoing engagement with community partners for innovations to be sustained and effective.
  - **When possible, remove restrictions** (e.g., overhead, administrative and indirect costs, diverse programs and activities) and barriers to eligibility (e.g., requirements of audited documents, operations budget to match funds)—these can prevent CHWs from accessing needed startup funds.
  - **Funding for less recognized activities that improve programming and promote CHW leadership development** like travel to present at conferences, building capacity in different locations, incentives for community members to attend an event, and translate culturally relevant materials to the community.

Support sustainability of funding: Partners must support a pathway toward sustainability for existing CHW programs and emerging CHW-led innovations.

- The SUSTAIN[38] framework provides guidance around sustainable financing for CHW programs and roles to enable CHWs to build on and sustain "what works." The ability of CHWs to innovate requires sustainable, flexible funding—if innovations aren't sustained, community members lose the trust that is the hallmark of CHW work. Examples of support for sustainability may include:
  - unrestricted funding or long-term targeted funding
  - funding that builds toward sustainability through activities such as evaluation, capacity building, advocacy, business development, and ongoing fundraising.

MAINTAIN CHW LEADERSHIP IN EVALUATION AND DISSEMINATION

Support CHW leadership in evaluation and dissemination: Ensure that CHW-led innovations are included in the public health evidence base through integration of CHW leadership in program evaluation, funding for evaluation of CHW-led innovations, support for dissemination and championing CHW-led innovations.

In addition, addressing upstream social, economic and political determinants of health is critical to advancing "what works." The social failures to address upstream determinants of health erodes CHWs ability to focus on addressing long-term immediate needs such as affordable housing, cost of living, immigration barriers, language access, and barriers to accessing healthcare. These immediate needs often took precedence and took focus away from longer term needs to close the gaps in health equity.

WHAT WORKS
Innovation Worksheet for CHWs

Below are some suggested questions to guide you in developing an innovation plan. This is for your own reference to help identify areas where you may need more support or next steps. Not all questions will be relevant to each CHW or innovation or idea.

MY INNOVATION IDEA

PHASE 1: DESIGN AND DEVELOPMENT - BEFORE LAUNCHING THE INNOVATION

What is the need in the community that I want to address?

What are the changes I hope to see?

COMMUNITY ENGAGEMENT

How have I learned about the needs and desires of community members?

Do I have community buy-in for the innovation?

Which community voices am I most aware of? Are any missing?

PARTNERS AND ALLIES

Who are trusted allies, partners or champions that can help advocate, provide support, or help obtain funding? *Examples: other CHWs, other providers, organizational leaders, researchers, policy makers, funders.*

What are some ways I can build support and relationships with allies and partners?

What are the funding needs for each phase of the work?

What do I need to learn or do to obtain funding?

SKILLS AND TRAINING

What skills or training do you need? *(e.g., grant writing, financial management, policy advocacy)*

How can you get these skills? *(reminder: local and state CHW Networks and Associations often offer training opportunities)*

PHASE 2: IMPLEMENTATION - "THE WORK" OF THE INNOVATION

Who will be "doing the work" of the innovation?

What challenges do I anticipate?

How can I prepare to address these challenges?

How will I sustain operations and funding while carrying out the work? *Examples: volunteer assistance, support from partners.*

EVALUATION AND DISSEMINATION

How will I know what the impact of the innovation is? *Examples: satisfaction surveys, asking community members for feedback, collecting data, partnering with a researcher*

How will I let people know about this work? *Examples: sharing with CHW Networks and Associations; writing blogs, articles or other materials; talking to people in the community about it; building a website*

References

1. McDonough M, Hernández J. Advocacy Tool Kit for Peer Support: Giving a Voice to Community Health Workers. National Council of La Raza; 2014. https://unidosus.org/wp-content/uploads/2021/07/AdvocacyToolKitPeerSupport.pdf
2. Daniels AS, Bergeson S, Myrick KJ. Defining Peer Roles and Status Among Community Health Workers and Peer Support Specialists in Integrated Systems of Care. *Psychiatr Serv*. 2017;68(12):1296-1298. doi:10.1176/appi.ps.201600378
3. Alavi S, Nishar S, Morales A, Vanjani R, Guy A, Soske J. 'We Need to Get Paid for Our Value': Work-Place Experiences and Role Definitions of Peer Recovery Specialists/Community Health Workers. *Alcohol Treat Q*. 2024;42(1):95-114. doi:10.1080/07347324.2023.2272797
4. Aminawung JA, Harvey TD, Smart J, et al. Formerly Incarcerated Community Health Workers Engaging Individuals Returning From Incarceration Into Primary Care: Results From the Transition Clinic Network. *Front Public Health*. 2021;9. doi:10.3389/fpubh.2021.681128
5. LA CRISP: The Role of Community Health Workers and Peer Support Specialists in Reentry.; 2024. Accessed May 6, 2024. https://www.youtube.com/watch?v=X3KY0_GQfAs
6. Reinhart E. How Community Health Workers Can End Mass Incarceration. TIME. Published online May 11, 2023. Accessed May 6, 2024. https://time.com/6278659/how-community-health-workers-can-end-mass-incarceration-rebuild-public-safety/
7. Community Health Workers. Center for Nonviolence and Social Justice. April 18, 2024. Accessed November 21, 2024. https://drexel.edu/cnsj/projects/community-health-workers/
8. RISE - Los Angeles Reentry Programs | St. John's Health. Accessed November 21, 2024. https://sjch.org/rise-re-entry-program/
9. FIT Team. FIT Clinic. Accessed November 21, 2024. https://www.fitclinicnola.com/fit-team
10. Wager P. Mass Incarceration: The Whole Pie 2024. Prison Policy Initiative; 2024. Accessed November 11, 2024. https://www.prisonpolicy.org/reports/pie2024.html
11. APHA. Public Health Support for People Reentering Communities from Prisons and Jails.; 2013. Accessed March 28, 2024. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/47/public-health-support-for-people-reentering-communities-from-prisons-and-jails
12. Brinkley-Rubinstein L, Cloud DH. Mass Incarceration as a Social-Structural Driver of Health Inequities: A Supplement to AJPH. *Am J Public Health*. 2020;110(S1):S14-S15. doi:10.2105/AJPH.2019.305486
13. Hall D, Lee LW, Manseau MW, Pope L, Watson AC, Compton MT. Major Mental Illness as a Risk Factor for Incarceration. *Psychiatr Serv*. 2019;70(12):1088-1093. doi:10.1176/appi.ps.201800425
14. Treatment Advocacy Center. Serious Mental Illness Prevalence in Jails and Prisons. 2016. Accessed November 11, 2024. https://www.tac.org/reports_publications/serious-mental-illness-prevalence-in-jails-and-prisons/
15. Quandt K, Jones A. Research Roundup: Incarceration can cause lasting damage to mental health. Prison Policy Initative. 2021. Accessed November 11, 2024. https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/
16. Wang L. Chronic Punishment: The Unmet Health Needs of People in State Prisons. Prison Policy Initiative; 2022. Accessed September 3, 2024. https://www.prisonpolicy.org/reports/chronicpunishment.html

17. Stensrud R, Gilbride D, Bruinekool R. The Childhood to Prison Pipeline: Early Childhood Trauma as Reported by a Prison Population. Rehabil Couns Bull. 2019;62(4). Accessed November 18, 2024. https://journals.sagepub.com/doi/abs/10.1177/0034355218774844

18. Barrenger SL, Hamovitch EK, Rothman MR. Enacting lived experiences: Peer specialists with criminal justice histories. *Psychiatr Rehabil J*. 2019;42(1):9–16. doi:10.1037/prj0000327

19. Marlow E, Grajeda W, Lee Y, Young E, Williams M, Hill K. Peer Mentoring for Male Parolees: A CBPR Pilot Study. Prog Community Health Partnersh *Res Educ Action*. 2015;9(1):91–100. doi:10.1353/cpr.2015.0013

20. Matthews E. Peer-focused prison reentry programs: Which peer characteristics matter most? Incarceration. 2021;2(2). Accessed May 6, 2024. https://journals.sagepub.com/doi/full/10.1177/26326663211019958

21. McLeod KE, Korchinski M, Young P, et al. Supporting women leaving prison through peer health mentoring: a participatory health research study. *CMAJ Open*. 2020;8(1):E1-E8. doi:10.9778/cmajo.20190106

22. Wright N, Bleakley A, Butt C, et al. Peer health promotion in prisons: a systematic review. *Int J Prison Health*. 2011;7(4):37-51. doi:10.1108/17449201111256899

23. O'Connor CA, Boufides CH, Shavit S, Steiner A. Community Health Workers with Lived Experience of Incarceration Are Uniquely Suited to Serve Reentering Populations—But Legal Obstacles Impede Hiring Them. Network for Public Health Law. 2023. Accessed May 6, 2024. https://www.networkforphl.org/news-insights/community-health-workers-with-lived-experience-of-incarceration-are-uniquely-suited-to-serve-reentering-populations-but-legal-obstacles-impede-hiring-them/

24. Garney WR, Wilson KL, Garcia KM, et al. Supporting and Enabling the Process of Innovation in Public Health: The Framework for Public Health Innovation. *Int J Environ Res Public Health*. 2022;19(16):10099. doi:10.3390/ijerph191610099

25. National Association of Community Health Workers. National CHW Survey. 2021. Accessed November 17, 2024. https://nachw.org/nationalchwsurvey/

26. Cherrington A, Ayala GX, Elder JP, Arredondo EM, Fouad M, Scarinci I. Recognizing the Diverse Roles of Community Health Workers in the Elimination of Health Disparities: From Paid Staff to Volunteers. *Ethn Dis*. 2010;20(2):189.

27. U.S. Department of Health and Human Services. Centering Lived Experience. Accessed November 17, 2024. https://www.hudexchange.info/programs/coc/centering-lived-experience

28. Greene K, Wilkniss S, Fiscus M, Roth E, Stevenson S, Tewarson H. Public Health Modernization Toolkit: Key Commitments, Priorities, and Strategies to Advance Collaboration between Public Health and Health Systems. NASHP; 2023. Accessed November 17, 2024. https://nashp.org/public-health-modernization-toolkit-key-commitments-priorities-and-strategies-to-advance-collaboration-between-public-health-and-health-systems/

29. Gampa V, Smith C, Muskett O, et al. Cultural elements underlying the community health representative – client relationship on Navajo Nation. *BMC Health Serv Res*. 2017;17:19. doi:10.1186/s12913-016-1956-7

30. Manno MS, Bickerton A, Barden B, Leiva N, Schwartz M. A Promising Approach to Coordinated Community-Based Reentry Services. Published online 2023.

31. U.S. Surgeon General. Our Epidemic of Loneliness and Isolation. Published online 2023.

32. Trinh-Shevrin C, Taher M, Islam N. Community Health Workers as Accelerators of Community Engagement and Structural Competency in Health. In: Hansen H, Metzl JM, eds. *Structural Competency in Mental Health and Medicine: A Case-Based Approach to Treating the Social Determinants of Health*. Springer International Publishing; 2019:167–177. doi:10.1007/978-3-030-10525-9_14

33. Boles W, Nguyen L, Tatum T, et al. A Qualitative Program Evaluation of a Digital Peer Support Group for Formerly Incarcerated People. Prog Community Health Partnersh *Res Educ Action*. 2024;18(2):167–182.

34. Thad Tatum "Us Helping Us: Peer Support for Formerly Incarcerated People" | Events & Calendars | Thad Tatum "Us Helping Us: Peer Support for Formerly Incarcerated People." Accessed November 25, 2024. https://www.amherst.edu/news/events/calendar/node/911200

35. Boles W, Tatum T, Wall J, et al. Us helping us: The evolution of a peer support group for formerly incarcerated people. *Front Psychiatry*. 2022;13:920640. doi:10.3389/fpsyt.2022.920640

36. Fadulu L. Next Arena for Criminal Justice Reform: A Roof Over Their Heads. The New York Times. https://www.nytimes.com/2019/09/03/us/politics/criminal-justice-reform-housing.html. 2019. Accessed April 30, 2024.

37. Rearick L. Why This Man Crusades For Mental Health After Nearly 30 Years In Prison. HuffPost. Published online June 2018. Accessed April 30, 2024. https://www.huffpost.com/entry/prison-mental-health_n_5b2b9bc1e4b0040e274032d0

38. Moeti R, Smith D, Rivera M. Approaches for Community Health Worker Sustainable Financing. Presented at: 2024; Envision Summit.

39. NACHW. The National Association of Community Health Workers Calls on Public and Private Institutions to Respect, Protect, and Partner with Community Health Workers to Ensure Equity During the Pandemic and Beyond. Published online 2023. www.nachw.org

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NACHW
NATIONAL ASSOCIATION OF COMMUNITY HEALTH WORKERS

The National Association of Community Health Workers (NACHW) is a 501(c)(3) nonprofit membership-driven organization with a mission to unify CHWs across geography, ethnicity, sector and experience to support communities to achieve health, equity and social justice.