

Community Health

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The Community Health Interest Group (CHIG) includes over 300 SCRA members who are committed to advancing the intersections of community psychology, public health, and healthcare delivery. In this commentary, Venoncia M. Baté-Ambrus, a Co-Chair of the CHIG, offers practical guidance for forging these intersections through Community Health Workers. As Baté-Ambrus highlights, the community health worker model and the field of community psychology are “kindred spirits” with an “historic and symbiotic relationship” that can be built upon to promote health for individuals and their communities. The passage of the landmark Affordable Care Act has heightened the value and role of community health workers for promoting health equity. Community psychologists working on health-related topics in diverse contexts will benefit from seeking partnerships with community health workers to identify mutually beneficial opportunities to advance health and social justice.

KINDRED SPIRITS: COMMUNITY PSYCHOLOGISTS, COMMUNITY HEALTH WORKERS (CHWS) AND THE CASE FOR MUTUAL SUPPORT

by Venoncia M. Baté-Ambrus, PhD candidate (CHW and Community Health Psychologist)

Back to the Beginning

The birthplace of U.S. American Community Psychology is widely accepted as the 1965 Swampscott Conference in Massachusetts at which clinical psychologists convened to explore pedagogies that could be adopted to prepare psychologists to meet the growing needs of clients in community mental health centers. An output of this conference was an admonishment that psychologists could not be passive purveyors of therapeutic services but rather active participants in addressing community problems, i.e. change agents and political activists. The prevention model of public health and community action approaches were espoused as orientations for the young community psychology discipline (Dalton, Elias & Wandersman, 2007).

Peer educators also known as Lay Health Advisors (LHAs), Community Health Workers (CHWs) and various other titles are advocates, teachers and facilitators. Their roots can be traced into antiquity. As long as there have been communities there have been trusted members within them revered for their knowledge, ingenuity and ability to help others solve problems and access resources. In the 1950s-60s U.S. CHWs began to flourish with the support of Lyndon Baines Johnson’s Great Society Programs. The earliest official U.S. CHW programs were on Native American reservations to aid indigenous people in accessing vital health and community resources in culturally appropriate ways (Baté, 2013).

Since the 1960s Dr. Robert Reiff, a pioneer of the burgeoning field of community psychology, advocated for the deployment of indigenous, non-professional workers, such as CHWs, to serve as facilitators between professional workers and the low income people that they serve (Dalton et al., 2007). Hence from the origin of our vocations, there has been

an historic and symbiotic relationship between community psychologists and community health workers.

Beyond common origin to shared cosmology: CP and CHW definitions, roles, competencies and scopes of practice

Both vocations were borne out of a strong need and desire to empower communities, improve access to services and value diverse cultures. To gain a better understanding of paradigms of CP and CHWs, the seminal texts for each was explored for definitions, roles, competencies and scopes of practice. Additionally, Dr. Judah Viola, Community Psychologist was consulted for his recent research on common roles and responsibilities for Community Psychologists.

Dalton, Elias and Wandersman (2007) in *Community Psychology: Linking Individuals and Communities* offered the following definition: Community Psychology concerns the relationships of individuals with communities and societies. By integrating research with action, it seeks to understand and enhance quality of life for individuals, communities and societies. Community psychology is guided by its core values of individual and family wellness, sense of community, respect for human diversity social justice, citizen participation and community strengths, and empirical grounding (p. 15).

The American Public Health Association (APHA) CHW definition: A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community being served. This trusting relationship enables CHWs to serve as a liaison/link/ intermediary between health and 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 (Berthold, Miller & Avila-Esparza, 2009, p. 9). Boxes below compare roles, competencies and scopes of practice.

Box 1.1 Community Psychology Roles	Community Health Workers Roles
Community liaison/building multi-sectorial partnerships	Cultural mediations between communities and health & social service systems
Program evaluation (non-profit, government agencies, community health, schools)	Informal counseling and social support
Connecting stakeholders, finding gate keepers	Providing direct services and referrals Assuring people get the services that they need
Public health advisor/Health-related advocate/ Academician	Providing culturally appropriate health education

Executive directors/program managers	Advocating for individual and community needs
Collaboration and outreach coordinator	Building individual and community capacity
Community-based researchers	Participating in community-based participatory research (emerging interest)
Organizational development/consultation	Training and Supervision (emerging interest)

Box 1.2 Community Psychology Competencies	Community Health Workers Competencies
Small and Large Group Processes	Communication Skills
Ethical, Reflective Practice	Interpersonal Skills
Sociocultural and Cross-Cultural Competence	Knowledge base about the community, health issues and available services
Prevention and Health Promotion	
Participatory Community Research	
Program Development, Implementation and Management	Service Coordination Skills
Program Evaluation	
Ecological Perspectives	
Community Organizing and Community Advocacy	Advocacy Skills
Public Policy Analysis, Development and Advocacy	
Consultation and Organizational Development	Organizational Skills
Community Education, Dissemination, and Building	Teaching Skills
Public Awareness	
Community Leadership and Mentoring	Capacity-building Skills
Collaboration and Coalition Development	
Community Inclusion and Partnership	
Community Development	

Resource Development	
Empowerment	
Box 1.3 Community Psychology Scope of Practice	Community Health Worker Scope of Practice
Developing and evaluating culturally and linguistically appropriate health education and information	Providing culturally and linguistically appropriate health education and information
Developing, coordinating and evaluating programs and services	Providing informal counseling and peer support
Engaging in CBPR and other participatory research modalities	Recruitment of clients or study participants, including provision of informed consent
Conducting interviews with organizational clients	Conducting initial interviews with new clients
Developing systems to aid patient access	Supporting clients to access services
Supporting organizational clients in better understanding their own questions, resources, knowledge, and options for action and services	Supporting clients in better understanding their own questions, resources, knowledge, and options for action and services
Supporting communities in communicating their questions and concerns	Supporting clients in communicating their questions or concerns
Supporting organizational/community clients in developing and implementing a plan to reduce risks and to enhance health	Supporting clients in developing and implementing a plan to reduce risks and to enhance their health
Assessing effectiveness of behavioral change strategies and programs	Supporting clients in changing behaviors
Helping communities develop and access resources	Providing case management services and referrals
Community organizing and advocacy	Community organizing and advocacy
Grant writing/Grant management	Grant implementation

Note. Boxes 1.1-1.3 were created utilizing community psychology roles (J. Viola, personal communication, February 4, 2014), competencies (Dalton & Wolfe, 2012), and scopes of practice (J. Viola, personal communication, February 4, 2014) and Community Health Worker roles, scopes of practice and competencies (Berthold et al., 2009).

A Call to Action: Making the Case for Mutual Support

As indicated in the tables above, community psychologists and community health workers share similar value propositions and orientations including: *Prevention, intervention and health promotion, advocacy, community organizing, community development, diversity, empowerment, equity and social justice*. Additionally both vocations have similar origins, reasons for being and trajectories. Likewise community psychology and community health work have similar challenges as non-clinical occupations within hierarchical systems based upon the traditional medical model in which intervention is more common than prevention. Moreover both vocations must increase visibility and explicate value to stakeholders who may be unfamiliar with their worth.

Advantageous to both community psychologists and community health work is a paradigm change catalyzed by the Affordable Care Act which is moving healthcare from “fee-for-service” to “pay-for-performance.” This shift means new opportunities for community-based interventions to improve the individual’s experience of care, the health of the population and reduce cost of care (Triple Aims). The Federal Register (July 14, 2013) Part 440 Section 130 Diagnostic, Screening, Preventive and Rehabilitative Services states that services can be prescribed by a physician or licensed professional of the healing arts if intended to prevent disease, disability and other health conditions or their progression, prolong life and promote physician and mental health and efficiency. This opens the door for non-clinical services such as those of CHWs to be reimbursable under Medicaid, pending state approval.

How can Community Psychologists and Community Health Workers Collaborate to Capitalize on New Opportunities?

- 1. Community psychologists** can determine whether their municipality, county, township or state has a CHW coalition. If yes, community psychologists can work with coalitions to advance the CHW agenda, typically around issues of funding/sustainability, research and evaluation, training/curriculum development, policy/advocacy, workforce development, certification and social marketing. If no, community psychologists can collaborate with CHWs to form coalitions.
- 2. CHWs** can specifically request the services of community psychologists in developing, evaluating and sustaining their coalitions and/or advancing their agenda, understanding that community psychologists are poised to assist because of similar histories, challenges and values.
- 3. Community psychologists** can advocate alongside of CHWs for state officials to approve Medicaid reimbursement for preventive services provided by CHWs under Rule 440-130.
- 4. CHWs and Community psychologists** can work together on Community-Based Participatory Research and other participatory research methods.
- 5. CHWs and Community psychologists** can collaborate on increasing the visibility of both professions, advocate for mutual employment opportunities in public health, healthcare, social service, education and other sectors.
- 6. CHWs and Community psychologists** can work with healthcare systems and communities to implement the Affordable Care Act’s Triple Aims.

7. CHWs and Community psychologists can support the work of one another to empower communities, promote health, advocate for positive change and advance social justice.

References

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