

Practical Guide for Expanding the Community-Based Behavioral Health Workforce



Practical Guide for Expanding the Community-Based Behavioral Health Workforce

Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number 75S20322D00049/75S20323F42002 with SAMHSA, U.S. Department of Health and Human Services (HHS). Donelle Johnson served as contracting officer representative.

Disclaimer

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA. Nothing in this document constitutes a direct or indirect endorsement by SAMHSA or HHS of any non-federal entity's products, services, or policies, and any reference to a non-federal entity's products, services, or policies should not be construed as such.

Public Domain Notice

All material appearing in this publication is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access

This publication may be downloaded from <https://store.samhsa.gov>.

Recommended Citation

Substance Abuse and Mental Health Services Administration: *Practical Guide for Expanding the Community-Based Behavioral Health Workforce*. SAMHSA Publication No. PEP24-06-004. Rockville, MD: National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 2024.

Originating Office

National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857. SAMHSA Publication No. PEP24-06-004. Published 2024.

Nondiscrimination Notice

The Substance Abuse and Mental Health Services Administration (SAMHSA) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). SAMHSA does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

Publication No. PEP24-06-004

Released 2024

Abstract

Community-initiated care (CIC) and behavioral health support specialists (BHSS) have emerged from community efforts to address the significant shortage of behavioral health services. CIC is offered by community members who are not within the traditional healthcare system but who may have lived experience and who have received training and acquired behavioral health knowledge, skills, and competencies to deliver screening and intervention services. Behavioral health support specialists are health workers, such as peer specialists and paraprofessionals, who support community members in achieving overall wellness.

Even though they help fill critical gaps in behavioral health services, CIC and BHSS are not always well understood by the behavioral health field. This Practical Guide presents strategies and best practices for expanding the community-based behavioral health workforce through increased use of CIC and BHSS. This strategy has demonstrated promise in addressing behavioral health disparities in underserved communities. The Guide also offers examples of community-based models of care and provides resources for communities and policy makers working to ensure the well-being of community members.



MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Practical Guide for Expanding the Community-Based Behavioral Health Workforce*.

SAMHSA is committed to leading public health and service delivery efforts that promote mental health, prevent substance use, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes. SAMHSA's National Mental Health and Substance Use Policy Laboratory developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policy makers, and others with the information and tools to incorporate evidence-based practices in their communities or clinical settings.

As part of the series, this Practical Guide presents strategies and best practices for expanding the community-based behavioral health workforce. Community-initiated care (CIC) and behavioral health support specialists (BHSS) have emerged from community efforts to fill workforce gaps.

The Guide highlights evidence supporting the roles of CIC and BHSS in addressing the behavioral health needs of communities. It also describes how community leaders, policy makers, and community members can take action to expand CIC and BHSS in their own communities.

I encourage you to use this guide to learn more about how advancing the roles of CIC and BHSS creates opportunities for communities to build behavioral health capacity and support the broader well-being of underserved communities.

Miriam E. Delphin-Rittmon, PhD

Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

The Substance Abuse and Mental Health Services Administration defines [behavioral health equity](#) as the right of all individuals, regardless of race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality and affordable healthcare services and support.

Advancing behavioral health equity means working to ensure that every individual has the opportunity to be as healthy as possible. In conjunction with access to quality services, this involves addressing social determinants of health—such as employment and housing stability, insurance status, proximity to services, and culturally responsive care—all of which have an impact on behavioral health outcomes.

Content of the Guide

1 CHAPTER 1. INTRODUCTION

Chapter 1 provides an introduction to key concepts, such as community-initiated care and behavioral health support specialists.

- 2 | 1.1 Communities Respond to the Crisis

3 CHAPTER 2. RE-ENVISIONING THE BEHAVIORAL HEALTH WORKFORCE: A COMMUNITY-DRIVEN RESPONSE

Chapter 2 describes evidence supporting strategies to re-envision the behavioral health workforce.

- 4 | 2.1 Understanding the Research: Community-Defined Evidence for Community-Driven Support

9 CHAPTER 3. CASE STUDIES

Chapter 3 offers examples of community-based models of care, including in-depth descriptions of initiatives.

- 9 | 3.1 The Confess Project: Barbers as Gatekeepers to the Community
- 11 | 3.2 Choose Healthy Life: A Faith-Based Example
- 12 | 3.3 Georgia Forensic Peer Mentor Training Project

14 CHAPTER 4. EXPANDING COMMUNITY-INITIATED CARE: INFRASTRUCTURE CONSIDERATIONS

Chapter 4 provides infrastructure considerations to support and promote the uptake of community-based models of care.

- 14 | 4.1 Education, Training, and Certification
- 17 | 4.2 Building Community Collaboration and Partnerships
- 18 | 4.3 Measuring Outcomes: Collecting and Analyzing Community-Based Data
- 18 | 4.4 Sustainable Funding at the Core

19 CHAPTER 5. EXPANDING THE COMMUNITY-BASED BEHAVIORAL HEALTH WORKFORCE: A CALL TO ACTION

Chapter 5 summarizes key takeaways from the evidence by audience.

- 19 | 5.1 Providing Support in the Community, by the Community
- 20 | 5.2 Taking the Next Step: A Call to Action for Communities

25 REFERENCES

32 ACKNOWLEDGMENTS

Key Terms

Key terms in the guide are listed below. Key terms are **bolded** the first time they appear in the text.

Term	Definition
Behavioral health	Behavioral health is the promotion of mental health, resilience and well-being; the treatment of mental health conditions and substance use disorders; and efforts to support those in recovery, as well as their families and communities. ¹
Behavioral health equity	“Behavioral health equity is the right of all individuals, regardless of race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality and affordable behavioral health services and support.” ²
Behavioral health support specialists (BHSS)	Behavioral health support specialists are behavioral health workers who play important roles in delivering nonclinical behavioral health services in the community. ³
Community-initiated care (CIC)	Community-initiated care is a “concept commonly cited as ‘task-sharing’ or ‘task shifting’ – a model of intervention that is not dependent on licensed clinicians and has been successfully used internationally to provide care through non-specialized, trained healthcare workers, and even ‘lay’ members of the community (p. 1).” ⁴
Community health workers (CHWs)	A community health worker “is a frontline public health worker who lives in or is trusted by the community. A CHW connects people to health and social services by breaking down barriers related to the social determinants of health” (p. 1). ⁵ <i>Promotores</i> , also known as <i>promotores de salud</i> , are Spanish-speaking CHWs who work with Hispanic and Latino populations. ⁶ CHWs also may be referred to as community health representatives in some tribal communities.
Gatekeepers	Gatekeepers serve as informal connections, with the knowledge, skills, and confidence to identify people at elevated risk for suicide, provide support, and, when indicated, help connect them to appropriate care. ⁷
Harm reduction	Harm reduction is “[a] practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower people who use drugs (PWUD) and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them” (p. 4). ⁸
Lay helpers or lay health workers	Lay helpers or lay health workers are community members who provide direct support to members of the communities they serve. ⁹ As an example, the Confess Project offers mental health gatekeeping training to local barbers and grooming professionals, empowering them to serve their communities as lay mental health workers. ¹⁰
Mental health conditions and substance use disorders	Mental health includes a person’s emotional, psychological, and social well-being. It affects how people think, feel, and act. Mental health helps determine how people handle stress, relate to others, and make choices. Mental health conditions or mental disorders range from mild to severe and affect a person’s thinking, mood, and/or behavior. “Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.” ¹¹

Term	Definition
Paraprofessionals	Paraprofessionals is an umbrella term used to capture such roles as peer specialists (defined below), community health workers, and behavioral health technicians/aides. ¹²
Patient navigators	Patient navigators “work one-on-one with clients to encourage continued commitment and adherence to medical treatment, access to social services, improved communication, and prompt re-engagement in care.” ¹³
Peer specialist or peer worker	A peer specialist (or peer worker) is any person with lived experience in recovery from problematic substance use, mental disorders, or both, who provides, in a professional or volunteer capacity, nonclinical recovery support to people in or seeking recovery. “Peer specialists (short for peer recovery support specialists) refers specifically to peer workers with some training, including those working in a professional capacity, whether certified or not. Peer workers who have received certification or credentialing to provide peer support services are commonly referred to as certified peer specialists” (p. xiv). ¹⁴
Prevention specialists	Prevention specialists help communities reduce risk for and address pressing substance use disorders and other behavioral health challenges. ^{15,16}
Recovery	<u>Recovery</u> —which can occur via many pathways—is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” Recovery occurs when positive changes and values become part of a voluntarily adopted lifestyle. ¹⁴
Recovery capital	Recovery capital refers to the internal and external resources a person can access to support their recovery process. ^{14,17}
Recovery orientation	Recovery orientation refers to the degree to which supports aim to promote a person’s recovery (i.e., living a meaningful life, achieving one’s full potential, and improving one’s health and wellness in the presence of mental health conditions or substance use disorders). ¹⁸
Social determinants of health	Social determinants of health are the conditions in which people are born, live, learn, work, and age that affect a wide range of health and quality-of-life outcomes. ¹⁹



Chapter 1.

Introduction

Over the past two decades, the nation’s drug overdose and **mental health** crises have contributed to a decline in life expectancy,^{20,21} underscoring the urgent need for an effective **behavioral health** workforce.²² Compounding these challenges are significant, widespread behavioral health workforce shortages—a problem that continues to worsen.^{3,23–32} As of May 2024, more than one-third of the U.S. population (122 million people), lives in mental health professional shortage areas,* according to the Health Resources and Services Administration (HRSA).³³ More than 6,100 practitioners are needed to fill this workforce gap.³³ These shortages may have direct and negative implications for people with **mental health conditions and substance use disorders.**^{34,35}

Behavioral health workforce shortages are more likely to affect underserved populations.^{3,36–42} People of color; those who identify as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQI);³⁹ people in rural communities;³⁸ tribal populations;^{37,43} people with disabilities;⁴⁰ people whose primary language is not English;⁴⁴ and those living in poverty⁴⁵ are more likely to face significant challenges finding and accessing behavioral health services. People of color may have limited access to behavioral health care as a result of historical, structural, and systemic racism and discrimination.⁴⁶ These challenges are worsened by medical mistrust among underserved populations due to negative stereotyping by and encounters with care professionals.⁴⁶

Rural areas and some lower-socioeconomic urban areas also have fewer options for behavioral healthcare services.³⁸ The availability of mental health providers is lowest in U.S. communities experiencing the highest poverty rates.⁴⁷ Although telehealth has increased opportunities to access services in rural areas,⁴⁸ the shortage of mental health professionals in rural counties continues to be higher than in urban areas.⁴⁹

The behavioral health workforce shortage has been tied to many factors, including high levels of stress and burnout, low pay and benefits, and limited career paths and supervisory support.^{23,50,51} Other factors include misdistribution of treatment resources, such as low provider supply and Medicaid acceptance.²³ Compared with primary care physicians, psychiatrists are less likely to accept new patients with Medicaid because they are reimbursed at a lower rate for services provided to patients with mental health conditions or substance use disorders.^{52,53}

*Mental health professional shortage areas are designated by HRSA as facilities, population groups, and geographic areas in which there are “too few mental health providers and services” to meet expected need. For more information, see <https://bhw.hrsa.gov/shortage-designation/hpsa-criteria>.

Compounding these issues is the lack of racial and ethnic diversity in the current behavioral health workforce.⁵⁴ A workforce that more closely aligns with the community it serves may alleviate stigma and barriers to seeking support or treatment, and providers and patients who are of the same ethnic background may forge stronger connections.⁵⁵ The lack of diversity in the behavioral health workforce is linked in part to structural racism, which has restricted people of color and others from historically oppressed and/or underserved communities from entering and remaining in the behavioral healthcare field.^{27,56} For instance, oppressed populations have historically been denied access to education in behavioral health and other health-related fields.⁵⁶ Healthcare workers of color have reported experiences of racism from patients and fellow workers at the workplace.^{57,58}

LGBTQI+ people are also underrepresented in the behavioral health workforce due to high rates of employment discrimination and workplace harassment despite federal protections.^{59,60} As a result, LGBTQI+ people seeking behavioral healthcare may have difficulty finding a provider or a program that meets their needs.^{61,62}

1.1 Communities Respond to the Crisis

The current behavioral health workforce shortages and related challenges highlight the need for improved community-based involvement in behavioral healthcare. **Community-initiated care (CIC) and behavioral health support specialists (BHSS)** represent some community efforts to help address workforce shortages.

People working in CIC and BHSS roles expand community services and partnerships.^{14,34,64-68} This strategy has demonstrated promise in addressing behavioral health disparities in underserved communities.^{4,69,70,71} Despite their promise, the roles of CIC providers and BHSS are not always well understood by the field or stakeholders, including by clinicians⁷² or communities; policy makers, such as elected officials and executive agency staff; and the public.^{3,73}

This Practical Guide presents strategies and best practices for expanding the community-based behavioral health workforce through increased use of CIC and BHSS. It also highlights community-based models of care and provides resources for communities and policy makers working to ensure the well-being of community members.

Examples of CIC and BHSS Workers

CIC and BHSS workers include:

- Behavioral health aides/psychiatric technicians (also known as aides)
- Community coalition members
- Community health workers/community health representatives/*Promotores*
- Crisis response staff
- Doulas
- Faith-based leaders
- Harm reduction workers
- Health educators
- Lay health workers
- Paraprofessionals
- Patient navigators
- Peer specialists or peer workers
- Prevention specialists
- Members of the community

The CIC model relies on many roles to support its work. Not all roles within the CIC or BHSS workforce are certified or credentialed; however, they are all naturally or formally specialized in providing support aligned with the unique needs of communities.⁶³

KEY TAKEAWAY: Understanding CIC and BHSS

CIC and BHSS have begun to address essential functions in the behavioral health workforce. By working directly in communities, CIC and BHSS can help reach historically underserved populations, translate information, build trust, connect people to community resources, bridge gaps in communication between clinical providers and patients, and navigate systems of care.⁷⁴ People in these roles can expand the reach of services beyond traditional medical settings into the community, making services more accessible.⁴⁷

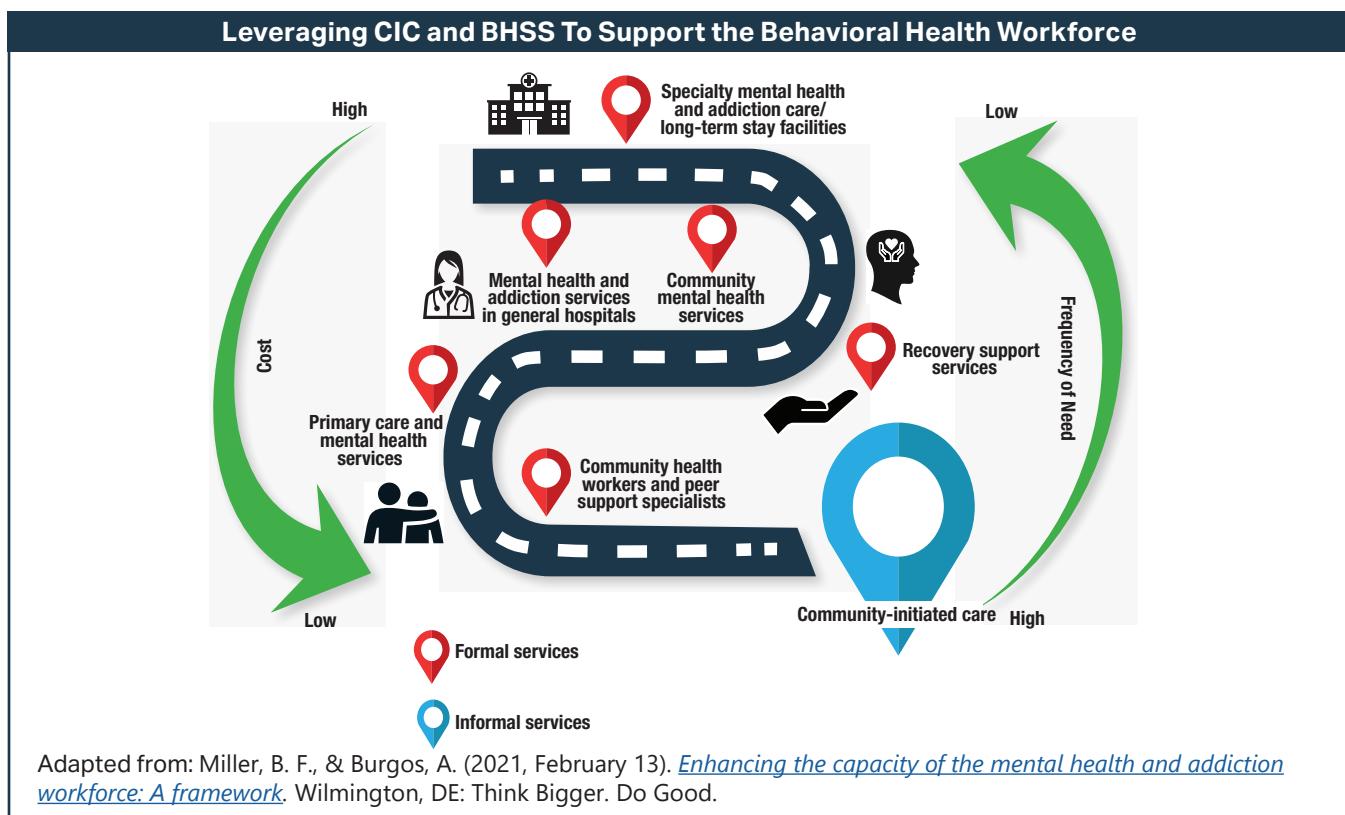


Chapter 2.

Re-Envisioning the Behavioral Health Workforce: A Community-Driven Response

Community-initiated care (CIC) and behavioral health support specialists (BHSS) are critical parts of the solution to the behavioral health crisis. This chapter summarizes the evidence supporting CIC and BHSS initiatives and their roles in addressing behavioral health needs in communities.

The diagram below illustrates the interaction between the clinical behavioral health workforce and the CIC and BHSS workforce (shown as community health workers and peer specialists). Of note is that communities frequently need CIC and BHSS support, which is cost effective compared with specialty services and substance use treatment.⁷⁵



2.1 Understanding the Research: Community-Defined Evidence for Community-Driven Support

The evidence base supporting the use of CIC and BHSS to address behavioral health needs in communities continues to grow.⁶⁹ In the United States, this evidence has largely been defined at the community level, and is driven by locally informed outcomes.⁶⁹ In some cases, the research support for these approaches may not meet the level of the traditional gold standard in research—randomized controlled trials. Instead, community-based work may be evaluated according to whether it effectively meets that community's needs.



Available experimental evidence related to psychosocial interventions delivered by nonspecialist, **lay health workers** in low- and middle-income countries showed that these interventions might have a clinically relevant effect, although strength of associations and the credibility of the evidence were variable. These interventions have also shown promising results in the United States and other high-income countries.^{69,76,77}

Evidence of Effectiveness

The evidence highlighted below suggests that CIC providers and BHSS offer many benefits, including developing stronger connections between community members and reducing barriers to treatment.⁷⁰ This evidence is particularly important in underserved communities that have experienced historical, structural, and systemic racism and discrimination that have limited community members' access to health care.^{46,78}

Peer Support Services

Peer specialists work with adults and youth in or seeking recovery, and with their families.¹⁴ These workers can facilitate greater **recovery orientation** within organizations that adopt peer support services.¹⁴ Settings featuring peer support services include emergency departments,⁸² psychiatric and criminal justice settings,⁶⁶ schools, collegiate recovery programs, recovery residences, recovery community centers, and recovery community organizations that provide coaching services,⁸³ primary care offices, workplaces, and recovery fitness centers and organizations.¹⁴

Peer specialists use their training and lived experience to empower and support people with self-directed goal setting, diminish stigma, and increase **recovery capital**.^{14,17} Studies suggest that peer support services are associated with positive outcomes related to treatment engagement, community integration, and self-efficacy to reduce symptoms of serious mental illness.⁸⁴

TIP: Gender and Sexuality Alliances: Peer Support for Students

Gender and Sexuality Alliances (GSAs) are student-led and student-run organizations that support lesbian, gay, bisexual, transgender, queer/questioning, and intersex youth in schools and communities.⁷⁹ They offer peer support and advocacy for students and connect members to resources. Research indicates that participation in a GSA may be associated with lower rates of peer victimization, substance use conditions, and suicidal behaviors.^{80,81}

RESOURCES

For more information about peer support specialists and services, see:

- Substance Abuse and Mental Health Services Administration's (SAMHSA)'s [Treatment Improvement Protocol 64, Incorporating Peer Support Into Substance Use Disorder Treatment Services](#).
- SAMHSA's [Core Competencies for Peer Workers](#).
- SAMHSA's [Peer Support Services in Crisis Care](#).

Peer specialists offer emotional and informational support; provide assistance through referrals, linkage, and service coordination (instrumental support); and create connections and a sense of community and belonging (affiliational support).¹⁴ For example, peer specialists who support people with problematic substance use offer clients hope, encouragement, and skill building—which may result in an increase in medication adherence and reduction in substance use.⁸⁵

Credentialing for peer specialists is promoted in a variety of ways across states. SAMHSA's [National Model](#)

[Standards for Peer Support Certification](#) promote continuity and reciprocity, meaning that those who hold out-of-state certifications can be certified in a receiving state.⁸⁶



Community Health Workers

Community health workers (CHWs), who include outreach workers, **patient navigators**, and **Promotores**, share lived experience and values, along with cultural and linguistic alignment to link members of their communities to health services, including behavioral health support.^{87,88} CHWs deliver services integral to specific cultural norms or communities of residence or origin, and they typically act as extensions of the healthcare system.

Studies indicate that CHWs can positively affect the management of chronic conditions, decrease healthcare costs, improve linkages to preventive care, and enhance patient care experiences.^{72,89} In one study, CHWs were linked to improvements in patient-reported quality of care, as well as reduced hospitalizations and 30-day readmissions.⁹⁰ CHWs are also associated with advancing health equity in communities through their work to address the **social determinants of health**.⁸⁹ CHWs may also reduce the unnecessary use of emergency services⁹¹ and yield cost-saving benefits to the health system.⁹²

In a systematic review of 43 articles examining the role of CHWs in delivering mental health interventions to underserved communities, the authors noted that CHWs delivered mental health interventions addressing a range of mental health conditions, including depression, anxiety, and psychological trauma.⁶⁹ The same article noted that "given accumulating evidence that CHW can effectively deliver evidence-based and informed practices, training and supporting CHW to address mental health disparities seems like a promising approach to improve care for underserved communities" (p. 11).⁶⁹

Lay Health Workers

Like peer specialists and CHWs, lay health workers support community members by personally connecting with people who underutilize routine and preventive care or who may be reluctant to seek help.⁹³ They rely on shared identities, cultures, and experiences to bridge behavioral health gaps.⁷⁰ Research suggests that lay health workers may decrease engagement disparities and help to address the social determinants of health by offsetting structural barriers, such as food insecurity,⁹⁴ inadequate childcare, financial distress, and housing and transportation instability.⁶³



By providing support, help with system navigation, and information, lay health workers teach skills community members may use for symptom management or adapt for accessing and engaging in such services as counseling and case management.⁹³ Lay health workers may also bridge gaps in care by providing support to people in underserved areas. For example, people living in rural and frontier areas may struggle with a lack of access to care, which may be worsened by educational inequities and a limited number of available clinicians.⁹⁵

Studies of lay health workers have indicated that they can encourage community members to receive physical and mental health support.⁹⁶ Discussed further in [Chapter 3](#), emerging research shows that lay health workers, such as barbers and beauticians, can help monitor mental health and provide mental health resources, especially in African American communities.⁹⁶

Patient Navigators

Patient navigators may assist underserved populations with overcoming structural barriers, or barriers resulting from policies, practices, or entities that affect a group disproportionately.⁹⁷ They can help patients, families, and caregivers navigate the healthcare system, including patient-centered linkages to care.⁶⁸ Navigators can also arrange for patients to get timely access to care.^{98,99} They work in a variety of program settings serving diverse populations^{100,101,102} over time durations usually determined by the patient.¹⁰³

The use of patient navigators has been shown to reduce emergency room visits for people with serious mental illness,¹⁰⁴ and may increase engagement across the behavioral health continuum, although further investigation is necessary.¹⁰⁰ Research supports the role of navigators in facilitating patient-provider communication, increasing access to care, and reducing health disparities.¹⁰³ According to a study of their effectiveness in supporting Hispanic and Latino populations with serious mental illness, navigators provide emotional support.¹⁰² Other research found that navigators contributed to increased quality of life, improvements in housing, and improvements in the physical and mental health of African Americans with serious mental illness who experienced homelessness.¹⁰²

Harm Reduction Workforce

Harm reduction is an evidence-based approach that incorporates practical strategies to empower people who use drugs (PWUD) to reduce risk and live self-directed, healthy lives.¹⁰⁵ The current focus on harm reduction is directly tied to efforts to reduce morbidity and mortality associated with drug use.^{8,105} The harm reduction workforce is varied, comprising PWUD, peer specialists, lay health workers, and CHWs.⁸

Studies of the impact of harm reduction efforts in communities have demonstrated their potential to reduce both overdose deaths and the prevalence of infectious diseases.⁸ For example, communities may experience a reduction in opioid overdose mortality when more people are enrolled in an overdose education and naloxone distribution program.⁸

Additional factors influencing the efficacy of harm reduction efforts reaching vulnerable populations include building trust and expressing compassion,¹⁰⁶ leveraging credibility associated with lived experience,¹⁰⁷ and offering cultural and linguistic accommodations.¹⁰⁸

RESOURCES

The following resources provide more information about harm reduction:

- SAMHSA's [Harm Reduction Website](#) and [Harm Reduction Framework](#)
- SAMHSA's [Opioid Response Network](#)

Prevention Specialists

Prevention specialists work across the primary prevention continuum, especially with youth, to prevent substance use and other use disorders by promoting resiliency and fostering protective factors.¹⁰⁹ As with peer specialists, prevention specialists may be credentialed with certifications that meet national standards for reciprocity among states.¹¹⁰ States also have their own [certification requirements for prevention specialist roles](#).

Prevention specialists use their knowledge of risk and protective factors, their communities, and environmental strategies described in the SAMHSA

[Strategic Prevention Framework \(SPF\)](#)¹¹¹ to build local capacity for community change. As such, these specialists must be attuned to their communities¹¹² and be trained in cultural responsiveness.¹¹³ Prevention specialists leverage community linkages to engage populations at increased risk for substance use, community stakeholders, parents and caregivers, and policy makers in effecting change.¹¹⁴



Gatekeepers

Gatekeepers serve as informal connections, with the knowledge, skills, and confidence to identify people at elevated risk for suicide, provide support, and, when indicated, help connect them to appropriate care.⁷ Gatekeepers may be able to reduce the likelihood of a person "slipping through the cracks."⁷ Gatekeeper training, which can teach community members to identify signs of depression, suicidal ideation, and other concerning behaviors, is appropriate for a broad range of populations and a variety of settings, such as schools and workplaces.^{7,115}

Faith-Based Community Initiatives

Faith-based organizations and their leaders often serve as trusted advisers to their communities. They have been increasingly called upon to support the health of their communities.^{116,117,119} For example, some community members will contact a religious leader before they reach out to a doctor for advice. Faith-based approaches with culturally competent messages of trauma-informed health promotion¹¹⁹ may be instrumental in reaching underserved communities.^{118,120}

A nationally representative survey of religious congregations in the United States ($N=1,327$) found that nearly one-quarter of surveyed congregations provided some type of health-related programming.¹²¹ Of those surveyed, more than 31 percent belonged to a congregation that provided mental health programming.¹²¹ Partnerships between faith-based organizations and behavioral health stakeholders have facilitated novel strategies for supporting community members who might not otherwise seek care.^{122,123} In a randomized controlled trial of lay health education provided in faith-based Appalachian settings, participants' odds of smoking cessation increased with increased participation in the trial.¹²⁴

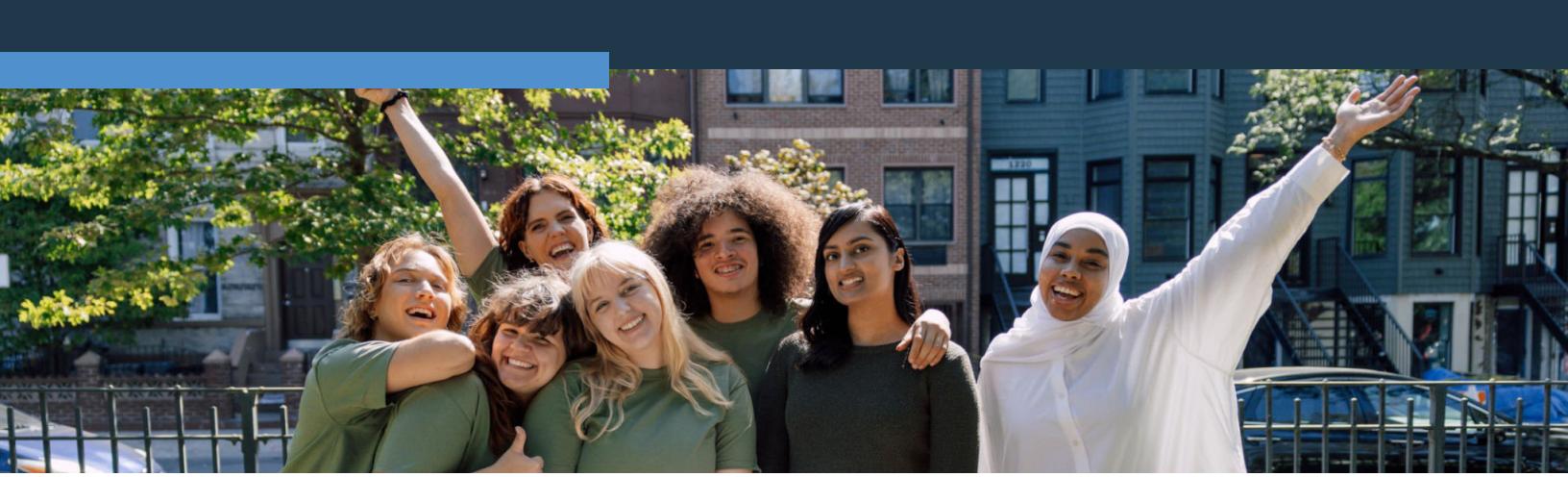


Faith leaders can directly influence community members on health-related issues.^{125,126,127} For example, the COVID-19 pandemic highlighted the role of churches as trusted authorities in African American and Latino communities by disseminating information and vaccinating and screening community members.^{126,128,129} More examples of faith-based efforts to expand behavioral health interventions in the community are discussed in [Chapter 3](#).

KEY TAKEAWAY: Role of CIC Providers and BHSS in the Behavioral Health Workforce

CIC providers and BHSS are not intended to replace clinical providers in the health system who offer assessment and treatment services. Rather, they supplement and strengthen the existing behavioral health workforce⁷⁵ by offering community-driven and person-centered approaches that:

- Include and normalize mental health conditions as part of the human experience⁷⁵
- Build on existing positive coping skills⁷⁰
- Promote engagement in meaningful and fulfilling relationships⁷⁰
- Reduce the risk of future mental health conditions and substance use disorders⁷⁰
- Encourage additional types of help-seeking⁷⁰



Chapter 3.

Case Studies

The case studies summarized in this chapter represent a range of community-driven and community-delivered strategies in underserved communities.

The case studies describe key challenges that these communities face and how they address these challenges. Successful community interventions consider the context of the communities in which they are implemented and require sustained collaborations, funding, training, support, and evaluation.⁷³

3.1 The Confess Project: Barbers as Gatekeepers to the Community

The [Confess Project of America](#) was founded in 2016 to provide mental health support for African American communities. The Project educates and trains barbers and beauty professionals to serve as community gatekeepers and mental health advocates.¹³⁰ The Project has expanded to 61 cities and 32 states nationwide since inception.¹³⁰

KEY TAKEAWAYS

The case studies described below demonstrate how community-initiated care (CIC) can help meet a community's behavioral health needs and create stronger community partnerships and connections in underserved communities. CIC may have the ability to⁷⁰:

- Encourage community members to reach out to others in need
- Change the culture of communities by fostering and enhancing social connectedness, as the lay health worker is from the same community and may share life experience with the people they treat
- Leverage existing community resources and networks to connect community members who need support



Purpose of the Initiative

- The Confess Project of America is a national organization working to address mental health challenges in African American communities.¹³⁰ It aims to empower "frontline workers, barbers and grooming professionals to be mental health gatekeepers."¹³⁰ The Project focuses on the connectedness and dialogue that naturally occurs in African American barbershops and salons.¹³¹

Population Served

- This initiative is primarily delivered in African American urban communities.¹³¹

Method of Delivery

- The Confess Project offers free mental health advocacy training to barbershop and beauty professionals as part of a year-long course designed to encourage dialogue and promote emotional health.^{131,132} The course was designed in consultation with experts in mental health and education.^{131,132}

Funding

- The Confess Project is funded through corporations, government grants, family foundations, and private donations.¹³⁰

Evaluation

- This intervention has been studied through quantitative and qualitative (thematic analyses from focus groups) methods.¹³¹ In 2022, data from more than 100 barbers were analyzed, along with qualitative data collected from 29 barbers who participated in 1 of 5 focus groups.¹³¹ Harvard University has also evaluated the curriculum used to train barbers.¹³⁰

Results

- Analyses show statistically significant increases in barber knowledge about mental health conditions, including stigma.¹³¹ Barbers are seen as mental health advocates and gatekeepers in the community, breaking the stigma around mental health conditions and providing connections to clinical support.¹³³ As one study noted, "the barbers felt that they may be the only ones intensively listening to their customers while also providing a boost to their value and self-worth" (p. 5).¹³²

Infrastructure and Implementation Issues/Barriers

- A key barrier is the lack of an infrastructure and ongoing training to support the intervention and reduce potential staff turnover.⁷³

Translatability

- This intervention is primarily delivered in African American urban areas, but it is expanding into other underrepresented communities.¹³⁰ Barbers are located all over the country,¹³⁰ expanding the potential reach of this type of initiative.

Role in Addressing Gaps in the Behavioral Health Workforce

- The Project has reached about 4 million people in the United States to date, and has trained approximately 4,000 barbers.¹³⁰ Barbers and beauty professionals strive to help community members who may be struggling with mental health conditions to overcome stigma and consider mental health services.

3.2 Choose Healthy Life[‡]: A Faith-Based Example

[Choose Healthy Life](#) (CHL) is a national faith-based partnership with African American churches around the country. It was established in 2021 to address the impact of the COVID-19 pandemic on African American communities and has since expanded to offer wellness exams in various communities and states.

Purpose of the Initiative

- Choose Healthy Life is a nonprofit, faith-based organization that empowers African American churches to address health disparities in hard-to-reach communities. CHL ensures churches—the oldest and most trusted institutions in the African American community—receive the necessary resources, training, and support to deliver health services and community wellness programs. The organization aims to improve health equity and reduce morbidity and mortality in African American communities, addressing social determinants of health.

Population Served

- The initiative primarily serves African American communities across the United States, focusing on people who are overlooked and often do not trust traditional healthcare systems.

Method of Delivery

- CHL works with African American churches to establish and sustain a faith-based health workforce, to promote wellness, address health inequity, and ensure pandemic preparedness in the community. Under the guidance of clergy, each church employs a congregant to serve as a full-time health navigator and receive training. These navigators bridge the gap between faith and science to deliver health services effectively. The National Black Clergy Health Leadership Council and the Medical Advisory Board provide oversight. Although initially established to address the COVID-19 pandemic in Black communities, CHL has expanded its focus to address broader health inequities and social determinants of health. This focus is exemplified by implementation of the Blueprint for Wellness (BFW) from Quest Diagnostics. BFW is a customized offering that provides comprehensive health screenings from a safe blood draw, allowing participants to engage with healthcare professionals, to assess their individual disease risks.

Funding

- CHL's public-private partnerships provide substantial financial support. Initially funded with approximately \$5 million from the Quest Diagnostics Foundation, CHL also received \$11 million from the Health Resources and Services Administration and additional private funding that includes commitments from the Siemens Foundation, Novo Nordisk, and Novartis during its first year of operation.

Evaluation

- The initiative measures success through community engagement, testing and vaccination events, and health screenings.

Results

- The initiative has data on several COVID-19-related outcomes, such as:
 - Engaging more than 24 million people in underserved communities
 - Hosting more than 4,800 events related to health services
 - Administering more than 250,000 COVID-19 vaccines and tests
 - Conducting nearly 128 events for BFW
 - Providing nearly 14,000 people with BFW comprehensive health screenings
 - Training 117 health navigators on core public health skills
 - Certifying 90 health navigators with 15-hour training sessions

[‡] Information and data presented in the case study were provided and verified by the program.

Infrastructure and Implementation Issues/Barriers

- Challenges include lack of sustainable funding and partners to support further expansion. However, CHL continues to adapt, addressing broader health inequities beyond the COVID-19 pandemic.

Translatability

- CHL has demonstrated its model's scalability and effectiveness in different regions. The effort has expanded to 120 churches across 13 states and the District of Columbia, with 5 cities (Atlanta, GA; Detroit, MI; Newark, NJ; New York, NY; and Washington, DC) conducting BFW events.

Role in Addressing Gaps in the Behavioral Health Workforce

- CHL has trained 117 health navigators on core public health skills and has increased health workforce representation in the African American community. Health navigators play a crucial role in bridging gaps in the healthcare system, particularly in underserved communities.

3.3 Georgia Forensic Peer Mentor Training Project[‡]

Consumers of behavioral health services in the state of Georgia created the [Georgia Mental Health Consumer Network](#) in 1991. The organization's mission is to "promote mental health recovery and wellness through advocacy, education, employment, and peer support while advancing the priorities elected annually by Georgia's mental health recovery community."¹³⁴ As part of its work, the Network provides peer support services through multiple programs, including a Forensic Peer Mentoring Project.

Purpose of the Initiative

- Established in 2015, [Georgia's Forensic Peer Mentoring Project](#) trains peer mentors to provide "support, linkage, and care coordination to promote the successful community reintegration of adults with behavioral health diagnoses returning to the community following incarceration."¹³⁵ These forensic peer mentors are people living in recovery from mental health conditions and/or problematic substance use who also have lived experience with the criminal justice system.¹³⁶

Population Served

- The project works with people within 3–18 months of their release date/tentative parole month from the criminal justice system. Peer mentors connect with people at an assigned state correctional facility, in a Georgia day reporting center, or in the community upon their release. The project provides peer support to people in 27 state prisons, 4 transition centers, and integrated treatment facilities. Peers also provide services in 10 accountability courts, 7 day reporting centers, and 5 assisted outpatient treatment programs.

Method of Delivery

- Forensic peer mentors are certified peer specialists or certified addiction recovery empowerment specialists who participate in a week-long intensive training, called Ready4Reentry. The training helps the peer mentors use their lived experience of past involvement with the criminal justice system and their recovery from a mental health condition and/or problematic substance use to provide support with transition/release planning.

Funding

- The program receives state and federal funding.

[‡] Information and data presented in the case study were provided and verified by the program.

Evaluation

- The project tracks related outcomes for program participants, such as recidivism, housing and employment outcomes, and enrollment in community mental health services.

Results

- Since 2015, the program has trained and certified 289 forensic peer mentors and provided peer support to nearly 4,400 returning citizens. In 2022, of those served in the community, 80 percent were employed or receiving benefits, 100 percent were enrolled in community mental health services, and 100 percent were housed. Similarly, of those receiving peer support at a day reporting center, 60 percent were employed or receiving benefits, 74 percent were enrolled in community mental health services, and 99 percent were housed.

Infrastructure and Implementation Issues/Barriers

- Current challenges facing the program include managing the increased number of trainees and filling positions.

Translatability

- The program is translatable to other communities, as the training and processes are highly structured. Similar programs are being implemented in other states, such as Pennsylvania. Program staff have expressed interest in assisting other states in implementing similar initiatives.

Role in Addressing Gaps in the Behavioral Health Workforce

- The program addresses a gap by providing critical behavioral health and other supports to people involved in or leaving the criminal justice system. Georgia has the highest incarceration rate of any state,¹³⁷ and supporting the behavioral health needs of this population is critical.



Chapter 4.

Expanding Community-Initiated Care: Infrastructure Considerations

Communities develop and implement interventions for addressing behavioral health workforce shortages that leverage the unique knowledge, skills, and abilities that community-initiated care (CIC) providers and behavioral health support specialists (BHSS) offer. Communities may need to address several infrastructure issues to support these interventions, including offering education, training, and certification programs; developing collaboration and community partnerships; addressing program evaluation and data needs; and building sustainable funding.

4.1 Education, Training, and Certification

Education and training pathways for CIC providers and BHSS can help expand the community-based behavioral health workforce, especially to reach underserved populations.³ High-quality, ongoing education and training ensure that these providers can continue to develop necessary skills and maximize their potential to improve health outcomes, healthcare access, and healthcare utilization, especially among underserved populations.¹³⁸ More global organizations like the World Health Organization are investing resources in CIC,¹³⁹ demonstrating the ongoing need for behavioral health-related education and training.^{69,70}

Training Needs To Support the Expansion of Community-Initiated Care

Developing training programs that actively incorporate the needs and insights of community health workers (CHWs) can help them effectively deliver mental health support to community members.¹⁴⁰ Yet, CHWs have reported that they have only limited training opportunities to equip them with the skills needed to address community mental health needs.¹⁴⁰ A 2024 report reiterated such training gaps and stressed the importance of including CHWs in multidisciplinary care teams.¹⁴¹

BHSS have reported the need for training to develop skills and knowledge in communication tools, symptom identification and screening, strength-based approaches, and overcoming mental health stigma.¹⁴⁰ Similarly, as many states require peer certification for paid peer work, the need for training and ongoing education is critical to advancing BHSS skills and knowledge.¹⁴ Other CIC roles, such as crisis response staff, are also in need of training to support their work.¹⁴²

Sample Training Curriculum To Support CIC Implementation⁷⁰

Kohrt et al. (2023) developed a curriculum to educate and provide skills to lay helpers to enable them to deliver CIC to people with mental health needs in the community. The curriculum includes eight modules focusing broadly on the following concepts and skills:

- Introducing CIC and information about mental health conditions
- Recognizing who may benefit from CIC and how to identify signs of mental distress
- Understanding how to initiate conversations with people who may need support, including how to build trust
- Developing skills for working with people in distress to identify their strengths and challenges
- Understanding how to work collaboratively with the person to determine a first step toward addressing their challenges
- Assessing available community resources
- Developing follow-up strategies, such as how to evaluate progress
- Educating the lay helper on tools for self-care



Creating Pathways for the Community-Based Behavioral Health Workforce

Establishing career pathway programs to engage the future workforce helps to engage more workers and supports job satisfaction and retention.^{14,143,144} Despite opportunities in the behavioral health field for some roles (e.g., CHWs), such pathways have been lacking for others (e.g., peer specialists), which contributes to shortages in the behavioral health workforce.¹⁴ Expanding career pathways for CIC and BHSS roles in underserved communities may be particularly beneficial.^{3,145} Additionally, expanding recruitment efforts and building incentives may increase interest in these roles.^{146,147}

Career pathway programs for BHSS roles can be implemented as early as grades K–12, and may be developed through partnerships with the education sector, employers, and community-based organizations.¹⁴³ For example, there may be opportunities to develop partnerships with the U.S. Department of Education to increase knowledge about career opportunities in behavioral health support services. Engaging youth in K–12 programs that provide knowledge about and familiarity with career options in the behavioral health field can expand opportunities in BHSS roles.

Partnerships To Support and Expand Careers in Health Care¹⁴⁸

[HOSA](#) is a global, student-led organization that partners with SAMHSA, the U.S. Department of Education, other federal and state agencies, as well as nongovernmental organizations, to empower middle school, high school, and college students to become leaders in the global health community. The organization promotes career opportunities in health fields to enhance the delivery of quality health care to all people. The programming focuses on leadership development, motivation, and recognition for students, to expand their interests in health professions.

Community college programs offer another avenue for creating career pathways for BHSS roles. Community colleges receive funding to support career pathway programs, and many offer students the opportunity to transfer education and credentials to their chosen fields.¹⁴³

In addition, undergraduate programs can serve as another means of expanding career pathways for the behavioral health workforce. Some states are taking action to support career pathway programs in undergraduate education for BHSS roles. For example, in 2021, the Missouri State University Board of Governors approved the Associate of Applied Science in Community Behavioral Health Support degree in its schools, which will provide direct opportunities to enter this growing field.^{149,150}

According to an analysis of state regulations related to BHSS roles and credentialing, many states have developed tiers that align with education and/or experience requirements, and additional levels of services can be provided by higher-tier roles.¹² This approach enables growth and development among BHSS. It may also be an opportunity to create a ladder to other positions in the behavioral health field.¹²

Role of Collegiate Recovery Programs in Recruiting for BHSS Roles

A collegiate recovery program (CRP) is a college or university program that offers a safe and supportive environment within the campus culture to students in recovery from substance use.¹⁵¹ CRPs are located around the country, including in historically Black colleges and universities. These programs provide an opportunity to expand knowledge about and recruit into the behavioral health field, including in BHSS roles in underserved communities.¹⁵¹ For more information, visit the [Association of Recovery in Higher Education](#).

Certification and Licensing

Certification and licensing requirements related to BHSS roles differ by state, locality, and sometimes program. This lack of standardization can make it challenging for those interested in entering the field to seek appropriate training and funding to cover costs related to certification. As a result, there have been similar challenges in the development and implementation of national certification standards for these roles.¹⁴

As of 2024, 25 states have CHW certification programs.¹² In many states, certification is required to access Medicaid funding. To become certified, states often require state-approved or state-administered training that aligns with CHW competencies outlined in the [CHW Core Consensus Project](#). States may also require documentation of hours of experience.¹² Also, the [National Academy for State Health Policy](#) offers information on how states are defining, training, certifying, and paying for the CHW workforce.

Similarly, states have a range of certification requirements for peer specialists seeking certification.¹⁴ These requirements may include passing an examination, participating in trainings, or obtaining formal or continuing education.¹⁴ The type and duration of training, education, and work-related experience vary across states, which can pose challenges.⁷¹ Certifications may only be recognized by individual states, making reciprocity difficult.¹⁴ In 2023, SAMHSA developed the [National Model Standards for Peer Support Certification](#), which provides guidelines for substance use, mental health, and family peer certifications. SAMHSA's [Issue Brief, Expanding Peer Support and Supporting the Peer Workforce in Mental Health](#), also provides information about the benefits of peer support and discusses how states can support inclusion of the peer workforce across the behavioral health continuum.

Other certification and credentialing programs include New York University's [Crisis Counselor Certificate Program](#), which offers training for frontline workers to learn how to deliver trauma-informed and culturally sensitive crisis counseling to diverse populations. Additionally, the [International Certification & Reciprocity Consortium](#) offers a wide range of certifications for prevention, substance use disorder, and recovery professionals.

When establishing training and certification requirements, organizations should consider financial barriers that may prevent potential participants from accessing trainings and meeting certification standards.¹⁴ Evidence-based trainings, strength-based approaches, and cultural responsiveness are key elements of certification and training that could support BHSS.

4.2 Building Community Collaboration and Partnerships

Community support and partnerships are critical to furthering CIC in underserved communities.⁷³ Communities can also be engaged in the codesign of an initiative to ensure that it meets their needs,⁷⁵ through respectful dialogue and formal partnerships with community-based organizations and other relevant stakeholders, such as faith-based organizations, the criminal justice system, or members of underserved groups.⁷⁵

Additionally, CIC needs to be integrated with healthcare networks, to ensure continuity of care. Communities may wish to develop a process that helps them identify and develop connections, partnerships, and referral pathways with other community and social service organizations,⁷⁵ especially those that support underserved populations.

Building strong partnerships in the community is critical to ensuring that CIC and BHSS can support communities with their behavioral and other health needs and address social determinants of health.

4.3 Measuring Outcomes: Collecting and Analyzing Community-Based Data

Developing a strong evidence base to support evaluation and understanding of CIC is critical but challenging. Although some studies support this work, most initiatives are community driven, and may not be developed with the specific intention of rigorously evaluating outcomes.^{72,152,153}

Instead, some studies of outcomes have been based on community-partnered approaches. For example, some studies examining the effect of BHSS in the community have relied on community-based participatory research.⁶⁹ Programs can use community-based participatory approaches to adapt interventions in local cultures and contexts.⁶⁹ Community selection of intervention components is based on the understanding that communities are in the best position to choose activities that fit their needs and cultural and linguistic contexts.¹⁵⁴

In addition to community-driven initiatives, communities can use resources that provide national data such as SAMHSA's [National Survey on Drug Use and Health](#) to justify needs assessments, policy evaluations, and strategies for implementing CIC and leveraging BHSS.

4.4 Sustainable Funding at the Core

Sustainable funding is necessary to support CIC interventions and BHSS roles and requires the attention of the behavioral health field, as well as of program and community leadership. Programs continue to struggle to support these interventions, even with the greater availability of funding through grants, Medicaid coverage, and private health insurance reimbursement for peer support services.^{14,155}

A [2024 SAMHSA report](#) identified Medicaid fee-for-service financing—specifically, low reimbursement rates—as a barrier to ensuring availability and expansion of peer recovery support services.¹⁴⁷ These challenges can be addressed through Federal Government guidance on financing peer support services, infrastructure support, and use of innovative payment models.¹⁴⁷

More attention to CIC is needed to address this significant challenge. One approach may be to expand knowledge within communities about how to identify and apply for funding, as well as to harness opportunities to braid and blend funding sources.¹⁵⁵

[Chapter 5](#) further discusses funding challenges related to supporting CIC and BHSS roles.

TIP: Community-Based Participatory Research

Community-based participatory research is an approach that engages and promotes the equal participation of people affected by an issue or problem.¹⁵⁴ It recognizes and appreciates the unique strengths and resources of each person.¹⁵⁴ It is a "cooperative, empowering, co-learning process that involves systemic development and local community capacity-building (p. 46)."¹⁵⁴ For more information, see the University of California, Los Angeles' [A Short Guide to Community Based Participatory Action Research](#).





Chapter 5.

Expanding the Community-Based Behavioral Health Workforce: A Call to Action

Promising strategies have been proposed for expanding the reach of behavioral health services, and addressing infrastructure issues that may arise when implementing community-driven interventions.^{3,70,73,75} These initiatives can be applied in underserved communities to address health disparities and increase health equity. This chapter provides an overview of how community leaders, policy makers, and community members can take action to support community-initiated care (CIC) and behavioral health support specialists (BHSS).

5.1 Providing Support in the Community, by the Community

CIC and BHSS are flexible approaches that enable communities to leverage their resources and support networks to provide evidence-based behavioral health services.³ These efforts can be scaled and translated in other communities, especially in those with underserved populations.^{70,75} Community collaboration and partnerships are vital to expanding the community-based behavioral health workforce.¹⁵⁶ Also, successful community-based behavioral health interventions are anchored in their communities. They rely on sustained collaborations, funding, training, support, evaluation, and monitoring.⁷³

TIP: Strategies for Advancing CIC

Researchers have offered strategies by which community-initiated care can promote and strengthen mental health in communities and can inform future work in this area. They offer the following strategies to stakeholders for advancing CIC⁷⁵:

- Collect data and work with CIC experts to implement monitoring, evaluation, and learning strategies that ensure quality outcomes.
- Finance and fund CIC initiatives by using evidence to motivate funders and decision makers to allocate money and resources.
- Engage stakeholders through conversations about CIC roles in the community.
- Adapt and tailor CIC through engagement of community members and local partners.
- Integrate CIC with existing care services by locating referral pathways and fostering new partnerships.
- Build capacity by identifying community members who are interested in CIC and training them to use evidence-based competencies and skills.
- Provide technical assistance and mentorship to support learning pathways and community conversations.
- Reach out to communities using targeted awareness and communication plans.
- Support leadership by providing training.
- Provide evidence-based support that “meets communities where they are” through safe, equitable, person-centered care.

5.2 Taking the Next Step: A Call to Action for Communities

Community leaders, policy makers, and community members all have critical roles to play in expanding CIC and BHSS in underserved communities and can take action to advance this work.

What Community Leaders Can Do

Community leaders can take the following steps to advance CIC and the role of BHSS:

- **Examine community needs.** Knowledge of a community's behavioral health needs can inform implementation needs for CIC and BHSS. To assess community behavioral health needs, data on the state of its behavioral health need to be systematically and comprehensively collected and analyzed. Community leaders can use this information to identify gaps, strengths, weaknesses, and opportunities for partnerships and to prioritize and leverage resources for this assessment. Hospitals and health departments may be recruited as partners to facilitate robustness of the community health assessment.^{157,158}
- **Assess natural supports and community capital.** Community leaders can examine what is working well in their communities and identify ways to leverage these resources to develop interventions. A useful tool is a community-based asset map, which is similar to a strengths assessment for an individual, but for an entire community.¹⁴
- **Gather stakeholders and engage the community, including policy makers.** Communities can build multisector partnerships that can bring together CIC providers, BHSS, and other community members to address critical behavioral health challenges. Community engagement helps leaders to build support for CIC. Creating a community coalition around CIC may be a way to start developing the foundational infrastructure to support this work.
- **Develop local solutions and identify funding.** Community leaders can help identify and pursue funding for CIC interventions and BHSS roles. For example, community leaders can investigate federal, state, local, and private/philanthropic funding that supports the use of community-based strategies to build capacity. There may be opportunities for communities to find funding to support a CIC program or related staff. For example, communities can consider how to braid and blend funding sources. For more information, see SAMHSA's report, [Examining the Use of Braided Funding for Substance Use Disorder Services](#).
- **Implement and evaluate.** As discussed in [Chapter 4](#), embedding evaluation into the design of CIC is critical. Evaluation efforts should be grounded in locally meaningful outcomes. These outcomes can be used to promote community engagement, increase adherence, improve scalability, and minimize stigma, particularly in underserved communities.^{75,152} Outcomes can also be helpful in engaging funders. Additionally, community leaders may want to consider partnering with colleges, universities, or nonprofits to develop community-based participatory research initiatives. These organizations often have the expertise to support a more rigorous understanding of CIC implementation, which community leaders can use to fine-tune the initiatives.



KEY TAKEAWAY: Questions for Community Leaders To Consider

Leaders can consider the following questions as they take steps to expand CIC and the role of BHSS in their communities:

- What are the most pressing behavioral health needs in my community (based on available data)? What gaps exist?
- How can addressing behavioral health needs support other community health priorities?
- What natural supports are available in my community?
- What are the community's strengths and weaknesses?
- Who are the key stakeholders to engage in discussions of CIC?
- What are the funding needs to support implementation or expansion of CIC in my community?
- What federal, state, tribal, territorial, and local funding sources are available?

What Policy Makers Can Do

Policy makers can support communities by making their members aware of the benefits of CIC and BHSS, facilitating a favorable policy and regulatory environment and sustainable funding to support the work, engaging local government leaders in mobilizing resources, encouraging wide adoption and uptake by diverse stakeholders, and sustaining initiatives over the long term.⁷⁵ Policy makers can accomplish these goals by:

- **Improving knowledge about CIC and BHSS.** Working with communities, policy makers can learn about CIC and BHSS and their potential in the community. To build trust in the community, policy makers may want to consider meeting with community members in person. They can also learn about and recognize the value of solutions supported by community-defined evidence as a step toward improving access to behavioral health care.
- **Creating policies that support CIC and BHSS.** Policy makers can support the expansion of CIC and the BHSS workforce by creating and promulgating policies that facilitate and expand funding opportunities for scaling these interventions and further supporting BHSS. For example, to address barriers related to Medicaid financing for peer support, potential opportunities could include supporting “unified federal government guidance on financing PRSS, infrastructure support, and the use of innovative payment models” (p. 1).¹⁴⁷ Another area of opportunity encouraged the use of opioid settlement funds allocated to states and localities to address the opioid crisis, to “provide care transformation support to recovery community organizations (RCOs) and community-based providers to improve their capabilities to use Medicaid as a sustainable funding source” (p. 27).¹⁴⁷
- **Expanding CIC and BHSS career and training opportunities.** CIC providers and BHSS require ongoing training and support to ensure that they are adequately prepared to address the needs of their communities. This need for training is reinforced in a recent report that states that policy makers should support efforts to expand training for community health workers.¹⁴¹ Another recent report encouraged policy makers to enhance pathways for BHSS to enter the licensed workforce and pursue professional development opportunities.³
- **Supporting diversification of the BHSS workforce.** Strengthening career pathways for those in BHSS roles, including with respect to race, ethnicity, gender, sexuality, disability, geographic location, and socioeconomic status can help diversify the workforce.¹⁴¹ To support this goal, policy makers can monitor and document how their policies affect behavioral health workforce diversity.

- **Assessing barriers to implementation.** Policy makers can work directly with community leaders to assess and understand key barriers to expansion of community-based initiatives, including those related to the development and/or implementation of national certification standards for BHSS roles (see [Chapter 4](#)). However, policy makers will want to consider that quality indicators traditionally used to evaluate formal mental health treatment programs may not be applicable to CIC and BHSS. Instead, policy makers can support an environment where these indicators do not become requirements that inadvertently impede implementation of CIC and BHSS.⁷⁵

What Community Members Can Do

As highlighted in the case studies ([Chapter 3](#)), community members play an active and vital role in supporting behavioral health needs in their communities. Community members can support the expansion of CIC and BHSS by:

- **Connecting with local leaders to discuss the community's behavioral health needs and supports.** Community members often know their community well and are in a strong position to assess its behavioral health needs and strengths. Communicating this information to local leaders will facilitate a formal assessment of the state of the community's behavioral health, the first step in creating CICs.
- **Increasing knowledge of the data and interventions.** Community members can be encouraged to learn more about the importance of data collection that could inform policy makers about the need for increased community-friendly funding and keep them abreast of progress and barriers. Community members can also consider their roles in supporting a community-based behavioral health system.
- **Using personal connections to maximize role as community gatekeepers.** Community members may be uniquely positioned to offer community-delivered support and facilitate information flow, particularly in underserved areas.

KEY TAKEAWAYS: Messages To Share About CIC and BHSS

- Community members have relationships that allow them to proactively prevent mental and substance use conditions and to recognize people in distress. They share social factors and lived experiences, giving them a unique perspective and understanding of the community's needs.⁷⁵
- CIC and BHSS encourage community members to help address the behavioral health needs by building on community relationships, expanding the reach of services beyond traditional medical settings into the community, helping to "meet people where they are," and reducing barriers to care access by making services available in their preferred settings.⁷⁵
- CIC and BHSS are not intended to replace clinical providers in the health system who provide assessment and treatment services. Rather, they supplement and strengthen the behavioral health workforce⁷⁵ by offering community-driven programs that meet the needs of community members. These approaches can promote engagement in meaningful and fulfilling relationships and reduce the risk of future mental health conditions and substance use disorders.
- Communities may need to address infrastructure issues to support and expand CIC and BHSS roles, including ensuring necessary education, training, and certification opportunities; developing strong collaboration and community partnerships; addressing program evaluation and data needs; and building sustainable funding.

Resources for Community Leaders, Policy Makers, and Community Members

Community needs assessment

- The Centers for Disease Control and Prevention's [Community Planning for Health Assessment: Frameworks & Tools](#) webpage describes common elements for health assessments and planning frameworks.
- The National Association of County and City Health Officials' [Community Health Assessment and Improvement Planning](#) webpage offers resources to help conduct all aspects of a community health improvement process

Asset mapping

- The Advancement Project Healthy City's [Participatory Asset Mapping—A Community Research Lab Toolkit](#) helps communities "develop, implement, and disseminate data/mapping projects, tools, and workshops" to promote knowledge sharing and active research.
- Google's [My Maps](#) is a no-cost tool used to create local, community-based asset maps.

Taking action

- The University of Kansas' [Community Tool Box](#) provides a wide range of resources for community members interested in community development.
- SAMHSA's [988 Partner Toolkit](#) offers various social media, video, print, radio, FAQs, messaging, and other marketing materials promoting the 988 Suicide & Crisis Lifeline that partners can use or adapt to meet the needs of their communities.

Contact information for federal, state, and local officials for your community

- Federal elected officials, including information about [U.S. senators](#) and [U.S. representatives](#)
- State elected officials, including information about [state governors](#) and [state legislators](#)
- [Tribal leaders directory](#)
- Local elected officials, including information about [mayors](#), [county executives](#), and other [officials](#)

Funding sources and assistance

- [Administration for Children and Families' Community Services Block Grant](#)
- [U.S. Department of Justice Grants](#)
- Health Resources and Services Administration (HRSA) Grants, Education, and Training Programs
 - [HRSA's Health Workforce Programs](#)
 - [HRSA's Behavioral Health Workforce Education and Training \(BHWET\) Program for Paraprofessionals](#)
- [Medicaid](#) and [Medicare](#)
- [SAMHSA Grants](#)
- [Grantmakers in Health](#)

Training and technical assistance

- [University of North Carolina Behavioral Health Workforce Research Center](#)—Serves as a hub for research on workforce issues affecting people who deliver mental health and substance use services.
- [SAMHSA Program to Advance Recovery Knowledge \(SPARK\)](#)—Provides resources on "equitable recovery supports including recovery-oriented care, recovery supports and services, and recovery-oriented systems for people with mental health/substance use disorders and co-occurring disorders."
- [Tribal Training and Technical Assistance Center](#)—Provides guidance to tribal communities to support wellness.
- [African American Behavioral Health Center of Excellence](#)—Provides resources on behavioral health equity for Black/African American people.

Resources for Community Leaders, Policy Makers, and Community Members (continued)

- [Hispanic/Latino Behavioral Health Center of Excellence](#)—Offers resources for serving the Hispanic or Latino community.
- [Center of Excellence on LGBTQ+ Behavioral Health Equity](#)—Provides guidance on enhancing culturally responsive care for this population.
- [Rural Opioid Technical Assistance Regional Centers \(ROTA-R\)](#)—Provides training and technical assistance addressing opioid and stimulant use affecting rural communities.
- [State Opioid Response/Tribal Opioid Response Technical Assistance \(SOR/TOR-TA\)](#)—Connects states, communities, and individuals to local consultants that provide free training on the prevention, treatment, and recovery of opioid use disorders and stimulant use.
- [Suicide Prevention Resource Center \(SPRC\)](#)—Provides a virtual learning lab for state- and community-level partnerships to help build and improve prevention efforts.
- [Technology Transfer Centers \(TTC\) Program](#)—Develops and strengthens the specialized behavioral healthcare and primary healthcare workforce who provide prevention, treatment, and recovery support services for substance use disorder and mental illness.

Other resources

- [HRSA's Behavioral Health Workforce Projection Data](#)—Provides data on the U.S. healthcare workforce, including projected behavioral health workforce supply and demand, to help “policymakers and other stakeholders make decisions about behavioral health workforce education, training, and delivery of care.”
- SAMHSA's [Evidence-Based Practices Resource Center](#)—Offers resources and tools to help communities, clinicians, policy makers, and practitioners incorporate evidence-based practices into their communities or clinical settings.



References

- 1 Substance Abuse and Mental Health Services Administration. (n.d.). *Behavioral health integration*. <https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf>
- 2 Substance Abuse and Mental Health Services Administration. (2024). *Behavioral health equity*. <https://www.samhsa.gov/behavioral-health-equity>
- 3 Gilbert, M., Hartnett, T., Hoagland, G. W., Kim, O. J., Serafini, M., Strong, K., & O'Brien, J. (2023). *Filling the gaps in the behavioral health workforce* Bipartisan Policy Center Report. <https://bipartisanpolicy.org/report/filling-gaps-in-behavioral-health/>
- 4 Well Being Trust. (2021). *Community initiated care (CIC): Building skills to improve mental health*. <https://wellbeingtrust.org/wp-content/uploads/2021/07/Community-Initiated-CareFAQJune2021.pdf>
- 5 Centers for Disease Control and Prevention. (n.d.). *Resources for community health workers*. <https://www.cdc.gov/chronic-disease/php/community-health-worker-resources/index.html>
- 6 MHP Salud. (2024). *Who are promotoras and community health workers?* <https://mhpsalud.org/programs/who-are-promotoresas-chws/>
- 7 Holmes, G., Clacy, A., Hermens, D. F., & Lagopoulos, J. (2021). The long-term efficacy of suicide prevention gatekeeper training: A systematic review. *Archives of Suicide Research*, 25(2), 177–207. <https://doi.org/10.1080/13811118.2019.1690608>
- 8 Substance Abuse and Mental Health Services Administration. (2023). *Harm reduction framework*. <https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf>
- 9 Barnett, M. L., Luis Sanchez, B. E., Green Rosas, Y., & Broder-Fingert, S. (2021). Future directions in lay health worker involvement in children's mental health services in the U.S. *Journal of Clinical Child & Adolescent Psychology*, 50(6), 966–978. <https://doi.org/10.1080/15374416.2021.1969655>
- 10 The Confess Project. (2024). Empowering frontline heroes and sheroes. <https://www.theconfessprojectofamerica.org/>
- 11 Substance Abuse and Mental Health Services Administration. (2023). Mental health and substance use disorders. <https://www.samhsa.gov/find-help/disorders>
- 12 National Governors Association. (2024). *The emerging field of behavioral health paraprofessionals*. <https://www.nga.org/publications/the-emerging-field-of-behavioral-health-paraprofessionals/>
- 13 Centers for Disease Control and Prevention. (2023). STEPS to care: Patient navigation. <https://www.cdc.gov/hiv/effective-interventions/treat/steps-to-care/dashboard/patient-navigation.html>
- 14 Substance Abuse and Mental Health Services Administration. (2023). *Incorporating peer support into substance use disorder treatment services*. Treatment Improvement Protocol (TIP) Series 64. (Publication No. PEP23-02-01-001). Retrieved from <https://store.samhsa.gov/sites/default/files/pep23-02-01-001.pdf>
- 15 Prevention Technology Transfer Center Network. (2024). Video series: *What do prevention specialists do?* <https://pttcenter.org/video-series-what-do-prevention-specialists-do>
- 16 United States Coast Guard. (n.d.). *Substance abuse prevention and treatment program*. <https://www.dcms.uscg.mil/Our-Organization/Assistant-Commandant-for-Human-Resources-CG-1/Health-Safety-and-Work-Life-CG-11/Office-of-Work-Life-CG-111/Substance-Abuse-Prevention-Program-SAPP-Office-of-Work-Life-CG-111/>
- 17 Best, D., & Hennessy, E. A. (2022). The science of recovery capital: Where do we go from here? *Addiction*, 117(4), 1139–1145. <https://doi.org/10.1111/add.15732>
- 18 Davidson, L., Rowe, M., DiLeo, P., Bellamy, C., & Delphin-Rittmon, M. (2021). Recovery-oriented systems of care: A perspective on the past, present, and future. *Alcohol Research: Current Reviews*, 41(1), 09. <https://doi.org/10.35946/arcr.v41.1.09>
- 19 U.S. Department of Health and Human Services. (n.d.). Social determinants of health. <https://health.gov/healthypeople/priority-areas/social-determinants-health>
- 20 Harper, S., Riddell, C. A., & King, N. B. (2021). Declining life expectancy in the United States: Missing the trees for the forest. *Annual Review of Public Health*, 42, 381–403. <https://doi.org/10.1146/annurev-publhealth-082619-104231>
- 21 Vigo, D., Jones, L., Thornicroft, G., & Atun, R. (2020). Burden of mental, neurological, substance use disorders and self-harm in North America: A comparative epidemiology of Canada, Mexico, and the United States. *Canadian Journal of Psychiatry*, 65(2), 87–98. <https://doi.org/10.1177/0706743719890169>
- 22 National Center for Health Statistics. (2023). *Suicide mortality in the United States, 2001–2021*. NCHS Data Brief No. 464. <https://www.cdc.gov/nchs/products/databriefs/db464.htm>
- 23 Health Resources and Services Administration, National Center for Workforce Analysis. (2023). *Behavioral health workforce 2023*. Retrieved from <https://bhq.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf>
- 24 Adams, E., Watanabe-Galloway, S., Baerentzen, M. B., Grennan, A., Schneider, E. O., & Doyle, M. (2022). The Behavioral Health Education Center of Nebraska: A creative solution to a persistent behavioral health workforce shortage. *Psychiatric Clinics of North America*, 45(2), 259–270. <https://doi.org/10.1016/j.psc.2022.03.004>

- 25 National Council for Mental Wellbeing. (2022). *Behavioral health workforce is a national crisis: Immediate policy actions for states*. <https://www.thenationalcouncil.org/wp-content/uploads/2022/04/Immediate-Policy-Actions-Policy.pdf>
- 26 Al Achkar, M., Bennett, I. M., Chwastiak, L., Hoeft, T., Normoyle, T., Vredevoogd, M., & Patterson, D. G. (2020). Telepsychiatric consultation as a training and workforce development strategy for rural primary care. *The Annals of Family Medicine*, 18(5), 438–445. <https://doi.org/10.1370/afm.2561>
- 27 Altschul, D. B., Bonham, C. A., Faulkner, M. J., Farnbach Pearson, A. W., Reno, J., Lindstrom, W., Alonso-Marsden, S. M., Crisanti, A., Salvador, J. G., & Larson, R. (2018). State legislative approach to enumerating behavioral health workforce shortages: Lessons learned in New Mexico. *American Journal of Preventive Medicine*, 54(6 Suppl 3), S220–S229. <https://doi.org/10.1016/j.amepre.2018.02.005>
- 28 Baker, M. W., Dower, C., Winter, P. B., Rutherford, M. M., & Betts, V. T. (2019). Improving nurses' behavioral health knowledge and skills with mental health first aid. *Journal for Nurses in Professional Development*, 35(4), 210–214. <https://doi.org/10.1097/hnd.0000000000000543>
- 29 Beck, A. J., Manderscheid, R. W., & Buerhaus, P. (2018). The future of the behavioral health workforce: Optimism and opportunity. *American Journal of Preventive Medicine*, 54(6), S187–S189. <https://doi.org/10.1016/j.amepre.2018.03.004>
- 30 Beck, A. J., Singer, P. M., Buche, J., Manderscheid, R. W., & Buerhaus, P. (2018). Improving data for behavioral health workforce planning: Development of a minimum data set. *American Journal of Preventive Medicine*, 54(6), S192–S198. <https://doi.org/10.1016/j.amepre.2018.01.035>
- 31 Bernson, J., Hedderich, P., & Wendling, A. L. (2021). Examining access to psychiatric care in Michigan's Upper Peninsula. *PRIMER*, 5, 44. <https://doi.org/10.22454/PRIMER.2021.501713>
- 32 Chapman, S. A., Phoenix, B. J., Hahn, T. E., & Strod, D. C. (2018). Utilization and economic contribution of psychiatric mental health nurse practitioners in public behavioral health services. *American Journal of Preventive Medicine*, 54(6), S243–S249. <https://doi.org/10.1016/j.amepre.2018.01.045>
- 33 Health Resources and Services Administration. (2024). Health workforce shortage areas. <https://data.hrsa.gov/topics/health-workforce/shortage-areas>
- 34 Alegría, M., & O'Malley, I. (2020). Leveraging innovation in behavioral health treatment and its workforce. *Harvard Review of Psychiatry*, 28(2), 69–71. <https://doi.org/10.1097/hrp.0000000000000250>
- 35 Glied, S., & Aguilar, K. (2023). *The behavioral health workforce shortage: Can we make better use of the providers we have?* USC-Brookings Schaeffer Initiative for Health Policy. <https://www.brookings.edu/wp-content/uploads/2023/04/Glied-and-Aguilar-Workforce-Paper-1.pdf>
- 36 Office of Minority Health. (2024). Mental and behavioral health—Black/African Americans. <https://minorityhealth.hhs.gov/mental-and-behavioral-health-african-americans>
- 37 Substance Abuse and Mental Health Services Administration. (2024). Priorities for working collaboratively through the tribal behavioral health agenda. <https://www.samhsa.gov/tribal-affairs/national-tribal-behavioral-health-agenda/working-collaboratively>
- 38 Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science*, 4(5), 463–467. <https://doi.org/10.1017/cts.2020.42>
- 39 Kaiser Family Foundation. (2023). *Mental health care needs and experiences among LGBT+ people*. <https://www.kff.org/mental-health/issue-brief/mental-health-care-needs-and-experiences-among-lgbt-people>
- 40 Substance Abuse and Mental Health Services Administration. (2019). *Mental and substance use disorder treatment for people with physical and cognitive disabilities* (Publication no. PEP19-02-00-002). <https://store.samhsa.gov/sites/default/files/pep19-02-00-002.pdf>
- 41 Rodriguez, J. A., Saadi, A., Schwamm, L. H., Bates, D. W., & Samal, L. (2021). Disparities in telehealth use among California patients with limited English proficiency. *Health Affairs*, 40(3), 487–495. <https://doi.org/10.1377/hlthaff.2020.00823>
- 42 Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus (American Psychiatric Publishing)*, 18(1), 16–24. <https://doi.org/10.1176/appi.focus.20190028>
- 43 Substance Abuse and Mental Health Services Administration. (2018). *Behavioral health services for American Indians and Alaska Natives. Treatment Improvement Protocol (TIP) Series 61*. Retrieved from https://store.samhsa.gov/sites/default/files/tip_61_ainian_full_document_020419_0.pdf
- 44 The Commonwealth Fund. (2023). *Understanding the U.S. behavioral health workforce shortage*. <https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage>
- 45 National Council for Mental Wellbeing (n.d.). *Study reveals lack of access as root cause for mental health crisis in america*. <https://www.thenationalcouncil.org/news/lack-of-access-root-cause-mental-health-crisis-in-america/>
- 46 Substance Abuse and Mental Health Services Administration. (2023). Black/African American. <https://www.samhsa.gov/behavioral-health-equity/black-african-american>
- 47 Wachino, V. (2023). *Moving mental health care out of the office: Policy options to expand services in “nontraditional” settings*. Schaeffer Initiative on Health Policy at Brookings https://www.brookings.edu/wp-content/uploads/2023/07/Wachino_NTS_Final.pdf
- 48 McBain, R. K., Schuler, M. S., Qureshi, N., Matthews, S., Kofner, A., Breslau, J., & Cantor, J. H. (2023). Expansion of telehealth availability for mental health care after state-level policy changes from 2019 to 2022. *JAMA Network Open*, 6(6), e2318045–e2318045. <https://doi.org/10.1001/jamanetworkopen.2023.18045>

- 49 Rochford, B., Pendse, S., Kumar, N., & De Choudhury, M. (2023). Leveraging symptom search data to understand disparities in US mental health care: Demographic analysis of search engine trace data. *JMIR Mental Health*, 10, e43253. <https://doi.org/10.2196/43253>
- 50 Brabson, L. A., Harris, J. L., Lindhiem, O., & Herschell, A. D. (2020). Workforce turnover in community behavioral health agencies in the USA: A systematic review with recommendations. *Clinical Child and Family Psychology Review*, 23(3), 297–315. <https://doi.org/10.1007/s10567-020-00313-5>
- 51 Bukach, A. M., Ejaz, F. K., Dawson, N., & Gitter, R. J. (2017). Turnover among community mental health workers in Ohio. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(1), 115–122. <https://doi.org/10.1007/s10488-015-0706-1>
- 52 Wen, H., Wilk, A. S., Druss, B. G., & Cummings, J. R. (2019). Medicaid acceptance by psychiatrists before and after Medicaid expansion. *JAMA Psychiatry*, 76(9), 981–983. <https://doi.org/10.1001/jamapsychiatry.2019.0958>
- 53 Mark, T. L., Parish, W., Zarkin, G. A., & Weber, E. (2020). Comparison of Medicaid reimbursements for psychiatrists and primary care physicians. *Psychiatric Services*, 71(9), 947–950. <https://doi.org/10.1176/appi.ps.202000062>
- 54 Gale, J., Janis, J., Coburn, A., & Rochford, H., Mueller, K. J., Knudson, A., Lundblad, J. P., MacKinney, A. C., & McBride, T. D. (2019). *Behavioral health in rural America: Challenges and opportunities*. <https://rurpri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf>
- 55 National Academy for State Health Policy. (2021). *State strategies to increase diversity in the behavioral health workforce*. <https://nashp.org/state-strategies-to-increase-diversity-in-the-behavioral-health-workforce/>
- 56 Dent, R. B., Vichare, A., & Casimir, J. (2021). Addressing structural racism in the health workforce. *Medical Care*, 59, S409–S412. <https://doi.org/10.1097/mlr.0000000000001604>
- 57 Kyere, E., & Fukui, S. (2023). Structural racism, workforce diversity, and mental health disparities: A critical review. *Journal of Racial and Ethnic Health Disparities*, 10(4), 1985–1996. <https://doi.org/10.1007/s40615-022-01380-w>
- 58 Hennein, R., Tineo, P., Bonumwezi, J., Gorman, H., Nguemeni Tiako, M. J., & Lowe, S. R. (2022). “They wanted to talk to a ‘real doctor’”: Predictors, perpetrators, and experiences of racial and ethnic discrimination among healthcare workers. *Journal of General Internal Medicine*, 37(6), 1475–1483. <https://doi.org/10.1007/s11606-021-07143-3>
- 59 Equal Employment Opportunity Commission. (n.d.). *Moving towards equality in the workplace for LGBTQI+ employees*. <https://www.eeoc.gov/moving-towards-equality-workplace-lgbtqi-employees>
- 60 Sears, B., Mallory, C., Flores, A. R., & Conron, K. J. (2021). *LGBTQ people’s experiences of workplace discrimination and harassment*. Williams Institute, University of California, Los Angeles. <https://williamsinstitute.law.ucla.edu/publications/lgbt-workplace-discrimination>
- 61 Martos, A. J., Wilson, P. A., Gordon, A. R., Lightfoot, M., & Meyer, I. H. (2018). “Like finding a unicorn”: Healthcare preferences among lesbian, gay, and bisexual people in the United States. *Social Science & Medicine*, 208, 126–133. <https://doi.org/10.1016/j.socscimed.2018.05.020>
- 62 Williams, N. D., & Fish, J. N. (2020). The availability of LGBT-specific mental health and substance abuse treatment in the United States. *Health Services Research*, 55(6), 932–943. <https://doi.org/10.1111/1475-6773.13559>
- 63 Barnett, M. L., Lau, A. S., & Miranda, J. (2018). Lay health worker involvement in evidence-based treatment delivery: A Conceptual Model to Address Disparities in Care. *Annual Review of Clinical Psychology*, 14, 185–208. <https://doi.org/10.1146/annurev-clinpsy-050817-084825>
- 64 Rosenthal, J. (2019). *Behavioral health workforce innovations: How Massachusetts and New York engage community health workers and peers to address racial and ethnic disparities*. <https://nashp.org/behavioral-health-workforce-innovations-how-massachusetts-and-new-york-engage-community-health-workers-and-peers-to-address-racial-and-ethnic-disparities/>
- 65 Anvari, M. S., Kleinman, M. B., Dean, D., Rose, A. L., Bradley, V. D., Hines, A. C., Abidogun, T. M., Felton, J. W., & Magidson, J. F. (2023). A pilot study of training peer recovery specialists in behavioral activation in the United States: Preliminary outcomes and predictors of competence. *International Journal of Environmental Research and Public Health*, 20(5), 3902. <https://www.mdpi.com/1660-4601/20/5/3902>
- 66 Chapman, S. A., Blash, L. K., Mayer, K., & Spetz, J. (2018). Emerging roles for peer providers in mental health and substance use disorders. *American Journal of Preventive Medicine*, 54(6), S267–S274. <https://doi.org/10.1016/j.amepre.2018.02.019>
- 67 Cook, J. A., Steigman, P. J., Swarbrick, M., Burke-Miller, J. K., Laing, T. B., Vite, L., Jonikas, J. A., & Brown, I. (2023). Outcomes of peer-provided individual placement and support services in a mental health peer-run vocational program. *Psychiatric Services*, 74(5), 480–487. <https://doi.org/10.1176/appi.ps.20220134>
- 68 Gagne, C. A., Finch, W. L., Myrick, K. J., & Davis, L. M. (2018). Peer workers in the behavioral and integrated health workforce: Opportunities and future directions. *American Journal of Preventive Medicine*, 54(6), S258–S266. <https://doi.org/10.1016/j.amepre.2018.03.010>
- 69 Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing community health workers to address mental health disparities for underserved populations: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(2), 195–211. <https://doi.org/10.1007/s10488-017-0815-0>
- 70 Kohrt, B. A., Miller, B. F., & Patel, V. (2023). Community initiated care: A blue-print for the practical realization of contextual behavioral science. *Journal of Contextual Behavioral Science*, 27, 54–60. <https://doi.org/10.1016/j.jcbs.2022.11.008>
- 71 Substance Abuse and Mental Health Services Administration. (2024). *Expanding peer support and supporting the peer workforce in mental health*. (Publication No. PEP24-01-004). Retrieved from <https://store.samhsa.gov/sites/default/files/issue-brief-expanding-peer-support-pep24-01-004.pdf>

- 72 Bochicchio, L., Tuda, D., Stefancic, A., Collins-Anderson, A., & Cabassa, L. (2023). "Getting the staff to understand it:" Leadership perspectives on peer specialists before and after the implementation of a peer-delivered healthy lifestyle intervention. *Community Mental Health Journal*, 59(5), 904–913. <https://doi.org/10.1007/s10597-022-01074-x>
- 73 Siddiqui, S., Morris, A., Ikeda, D. J., Balsari, S., Blanke, L., Pearsall, M., Rodriguez, R., Saxena, S., Miller, B. F., Patel, V., & Naslund, J. A. (2022). Scaling up community-delivered mental health support and care: A landscape analysis. *Frontiers in Public Health*, 10, 992222. <https://doi.org/10.3389/fpubh.2022.992222>
- 74 National Institute for Health Care Management (NIHCM) Foundation. (2023). The behavioral health care workforce. <https://nihcm.org/publications/the-behavioral-health-care-workforce-shortages-solutions>
- 75 Breuer, E., Morris, A., Blanke, L., Pearsall, M., Rodriguez, R., Miller, B. F., Naslund, J. A., Saxena, S., Balsari, S., & Patel, V. (2023). A theory of change for community-initiated mental health care in the United States. *Global Mental Health (Camb)*, 10, e56. <https://doi.org/10.1017/gmh.2023.49>
- 76 Singla, D. R., Lawson, A., Kohrt, B. A., Jung, J. W., Meng, Z., Ratjen, C., Zahedi, N., Dennis, C.-L., & Patel, V. (2021). Implementation and effectiveness of nonspecialist-delivered interventions for perinatal mental health in high-income countries: A systematic review and meta-analysis. *JAMA Psychiatry*, 78(5), 498–509. <https://doi.org/10.1001/jamapsychiatry.2020.4556>
- 77 Barbui, C., Purgato, M., Abdulmalik, J., Acarturk, C., Eaton, J., Gastaldon, C., Gureje, O., Hanlon, C., Jordans, M., Lund, C., Nosè, M., Ostuzzi, G., Papolla, D., Tedeschi, F., Tol, W., Turri, G., Patel, V., & Thornicroft, G. (2020). Efficacy of psychosocial interventions for mental health outcomes in low-income and middle-income countries: An umbrella review. *Lancet Psychiatry*, 7(2), 162–172. [https://doi.org/10.1016/s2215-0366\(19\)30511-5](https://doi.org/10.1016/s2215-0366(19)30511-5)
- 78 Schouler-Ocak, M., Bhugra, D., Kastrup, M. C., Dom, G., Heinz, A., Küey, L., & Gorwood, P. (2021). Racism and mental health and the role of mental health professionals. *European Psychiatry*, 64(1), e42. <https://doi.org/10.1192/j.eurpsy.2021.2216>
- 79 Leung, E., Kassel-Gomez, G., Sullivan, S., Murahara, F., & Flanagan, T. (2022). Social support in schools and related outcomes for LGBTQ youth: A scoping review. *Discover Education*, 1(1), 18. <https://doi.org/10.1007/s44217-022-00016-9>
- 80 Lessard, L. M., Puhl, R. M., & Watson, R. J. (2020). Gay-straight alliances: A mechanism of health risk reduction among lesbian, gay, bisexual, transgender, and questioning adolescents. *American Journal of Preventive Medicine*, 59(2), 196–203. <https://doi.org/10.1016/j.amepre.2020.02.020>
- 81 Kaczkowski, W., Li, J., Cooper, A. C., & Robin, L. (2022). Examining the relationship between LGBTQ-supportive school health policies and practices and psychosocial health outcomes of lesbian, gay, bisexual, and heterosexual students. *LGBT Health*, 9(1), 43–53. <https://doi.org/10.1089/lgbt.2021.0133>
- 82 Watson, D. P., Staton, M. D., & Gastala, N. (2022). Identifying unique barriers to implementing rural emergency department-based peer services for opioid use disorder through qualitative comparison with urban sites. *Addiction Science & Clinical Practice*, 17(1), 41. <https://doi.org/10.1186/s13722-022-00324-3>
- 83 Jason, L. A., Salomon-Amend, M., Guerrero, M., Bobak, T., O'Brien, J., & Soto-Nevarez, A. (2021). The emergence, role, and impact of recovery support services. *Alcohol Research: Current Reviews*, 41(1), 04. <https://doi.org/10.35946/arcr.v41.1.04>
- 84 Muralidharan, A., Peeples, A. D., Hack, S. M., Fortuna, K. L., Klingaman, E. A., Stahl, N. F., Phalen, P., Lucksted, A., & Goldberg, R. W. (2021). Peer and non-peer co-facilitation of a health and wellness intervention for adults with serious mental illness. *Psychiatric Quarterly*, 92(2), 431–442. <https://doi.org/10.1007/s11126-020-09818-2>
- 85 Jack, H. E., Anvari, M. S., Abidogun, T. M., Ochieng, Y. A., Ciya, N., Ndamase, S., Rose, A. L., Kleinman, M. B., Myers, B., & Magidson, J. F. (2023). Applying a mutual capacity building model to inform peer provider programs in South Africa and the United States: A combined qualitative analysis. *International Journal of Drug Policy*, 120, 104144. <https://doi.org/10.1016/j.drugpo.2023.104144>
- 86 Substance Abuse and Mental Health Services Administration. (2023). *National model standards for peer support certification*. <https://www.samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards>
- 87 Smithwick, J., Nance, J., Covington-Kolb, S., Rodriguez, A., & Young, M. (2023). "Community health workers bring value and deserve to be valued too:" Key considerations in improving CHW career advancement opportunities. *Frontiers in Public Health*, 11, 1036481. <https://doi.org/10.3389/fpubh.2023.1036481>
- 88 National Heart, Lung, and Blood Institute. (2014). *Role of community health workers*. <https://www.nhlbi.nih.gov/health/educational/healthdisp/role-of-community-health-workers.htm>
- 89 Knowles, M., Crowley, A. P., Vasan, A., & Kangovi, S. (2023). Community health worker integration with and effectiveness in health care and public health in the United States. *Annual Review of Public Health*, 44(44), 363–381. <https://doi.org/10.1146/annurev-publhealth-071521-031648>
- 90 Kangovi, S., Mitra, N., Norton, L., Harte, R., Zhao, X., Carter, T., Grande, D., & Long, J. A. (2018). Effect of community health worker support on clinical outcomes of low-income patients across primary care facilities: A randomized clinical trial. *JAMA Internal Medicine*, 178(12), 1635–1643. <https://doi.org/10.1001/jamainternmed.2018.4630>
- 91 Jack, H. E., Arabadjis, S. D., Sun, L., Sullivan, E. E., & Phillips, R. S. (2017). Impact of community health workers on use of healthcare services in the United States: A systematic review. *Journal of General Internal Medicine*, 32(3), 325–344. <https://doi.org/10.1007/s11606-016-3922-9>
- 92 Moffett, M. L., Kaufman, A., & Bazemore, A. (2018). Community health workers bring cost savings to patient-centered medical homes. *Journal of Community Health*, 43(1), 1–3. <https://doi.org/10.1007/s10900-017-0403-y>
- 93 Well Being Trust. (2021). *Community initiated care: Building skills to improve mental health. Frequently asked questions*. <https://wellbeingtrust.org/wp-content/uploads/2021/07/Community-Initiated-CareFAQJune2021.pdf>

- 94 Barnett, M. L., Klein, C. C., Gonzalez, J. C., Sanchez, B. E., Rosas, Y. G., & Corcoran, F. (2023). How do lay health workers engage caregivers? A qualitative study to enhance equity in evidence-based parenting programs. *Evidence Based Practice in Child and Adolescent Mental Health*, 8(2), 221–235. <https://doi.org/10.1080/23794925.2021.1993111>
- 95 American Academy of Child and Adolescent Psychiatry (AACAP). (2023). Clinical update: Child and adolescent behavioral health care in community systems of care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 62(4), 367–384. <https://doi.org/10.1016/j.jaac.2022.06.001>
- 96 Palmer, K. N. B., Okechukwu, A., Mantina, N. M., Melton, F. L., Kram, N. A., Hatcher, J., Marrero, D. G., Thomson, C. A., & Garcia, D. O. (2022). Hair stylists as lay health workers: Perspectives of Black women on salon-based health promotion. *Inquiry*, 59, 469580221093183. <https://doi.org/10.1177/00469580221093183>
- 97 Magasi, S., Papadimitriou, C., Panko Reis, J., The, K., Thomas, J., VanPuymbrouck, L., & Wilson, T. (2019). Our Peers—Empowerment and Navigational Support (OP-ENS): Development of a peer health navigator intervention to support Medicaid beneficiaries with physical disabilities. *Rehabilitation Process and Outcome*, 8, 1179572719844759. <https://doi.org/10.1177/1179572719844759>
- 98 Kim, J. Y., Higgins, T. C., Esposito, D., & Hamblin, A. (2017). Integrating health care for high-need medicaid beneficiaries with serious mental illness and chronic physical health conditions at managed care, provider, and consumer levels. *Psychiatric Rehabilitation Journal*, 40(2), 207–215. <https://doi.org/10.1037/prj0000231>
- 99 Rollins, M., Milone, F., Suleman, S., Vojvoda, D., Sgro, M., & Barozzino, T. (2018). Patient navigators: Mapping the route toward accessibility in health care. *Paediatrics & Child Health*, 24(1), 19–22. <https://doi.org/10.1093/pch/pxy057>
- 100 Corrigan, P. W., Kraus, D. J., Pickett, S. A., Schmidt, A., Stellon, E., Hantke, E., & Lara, J. L. (2017). Using peer navigators to address the integrated health care needs of homeless African Americans with serious mental illness. *Psychiatric Services*, 68(3), 264–270. <https://doi.org/10.1176/appi.ps.201600134>
- 101 Krulic, T., Brown, G., & Bourne, A. (2022). A scoping review of peer navigation programs for people living with HIV: Form, function and effects. *AIDS and Behavior*, 26(12), 4034–4054. <https://doi.org/10.1007/s10461-022-03729-y>
- 102 Sheehan, L., Torres, A., Lara, J. L., Paniagua, D., Larson, J. E., Mayes, J., Doig, S., Esquivel, J., Lehmann, M. L., Muñoz, P., Ortiz, J., Perez-Aviles, M., Rodriguez, T., Santiago, N., Suarez, R. R., Corrigan, P. W., & The Latino Consumer Research Team. (2018). Qualitative evaluation of a peer navigator program for Latinos with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 45(3), 495–504. <https://doi.org/10.1007/s10488-017-0839-5>
- 103 Harris, S. A., Harrison, M., Hazell-Raine, K., Wade, C., Eapen, V., & Kohlhoff, J. (2023). Patient navigation models for mental health of parents expecting or caring for an infant or young child: A systematic review. *Infant Mental Health Journal*, 44(4), 587–608. <https://doi.org/10.1002/imhj.22075>
- 104 Kelly, E. L., Hong, B., Duan, L., Pancake, L., Cohen, H., & Brekke, J. S. (2021). Service use by Medicaid recipients with serious mental illness during an RCT of the Bridge Peer Health Navigator Intervention. *Psychiatric Services*, 72(10), 1145–1150. <https://doi.org/10.1176/appi.ps.201900615>
- 105 Substance Abuse and Mental Health Services Administration. (2023). Harm reduction. <https://www.samhsa.gov/find-help/harm-reduction>
- 106 Regis, C., Gaeta, J. M., Mackin, S., Baggett, T. P., Quinlan, J., & Taveras, E. M. (2020). Community care in reach: Mobilizing harm reduction and addiction treatment services for vulnerable populations. *Frontiers in Public Health*, 8, 501. <https://doi.org/10.3389/fpubh.2020.00501>
- 107 Pedroso, J. M. G., Araujo, C. N. d. P., & Corradi-Webster, C. M. (2024). The joy and pain of being a harm reduction worker: A qualitative study of the meanings about harm reduction in Brazil. *Harm Reduction Journal*, 21(1), 56. <https://doi.org/10.1186/s12954-024-00962-7>
- 108 Riazi, F., Toribio, W., Irani, E., Hughes, T. M., Huxley-Reicher, Z., McBratney, E., Vu, T., Sigel, K., & Weiss, J. J. (2021). Community case study of naloxone distribution by hospital-based harm reduction program for people who use drugs in New York City. *Frontiers in Sociology*, 6, 619683. <https://doi.org/10.3389/fsoc.2021.619683>
- 109 New England PTTC. (2021). *New England prevention specialist: Onboarding and orientation roadmap*. <https://pttcnetwork.org/wp-content/uploads/2021/08/New-England-Onboarding-8.19.2021.pdf>
- 110 Prevention Technology Transfer Center Network. (2024). *Prevention specialist certification states*. <https://pttcnetwork.org/prevention-specialist-certification-states/>
- 111 Substance Abuse and Mental Health Services Administration. (2019). *A guide to SAMHSA's Strategic Prevention Framework*. Retrieved from <https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf>
- 112 Substance Abuse and Mental Health Services Administration. (2022). *Implementing community-level policies to prevent alcohol misuse*. (Publication No. PEP22-06-01-006). Retrieved from <https://store.samhsa.gov/sites/default/files/pep22-06-01-006.pdf>
- 113 Substance Abuse and Mental Health Services Administration. (2021). *Prevention core competencies*. (Publication No. PEP20-03-08-001). Retrieved from <https://store.samhsa.gov/sites/default/files/pep20-03-08-001.pdf>
- 114 Substance Abuse and Mental Health Services Administration. (2017). *Focus on prevention*. (Publication No. (SMA) 10-4120). Retrieved from <https://store.samhsa.gov/sites/default/files/sma10-4120.pdf>
- 115 Mueller-Williams, A. C., Hopson, J., & Momper, S. L. (2023). Evaluating the effectiveness of suicide prevention gatekeeper trainings as part of an American Indian/Alaska Native youth suicide prevention program. *Journal of Community Mental Health*, 59(8), 1631–1638. <https://doi.org/10.1007/s10597-023-01154-6>
- 116 Schoenberg, N. E. (2017). Enhancing the role of faith-based organizations to improve health: A commentary. *Translational Behavioral Medicine*, 7(3), 529–531. <https://doi.org/10.1007/s13142-017-0485-1>

- ¹¹⁷ Kitzman-Ulrich, H., & Holt, C. L. (2017). Community-based participatory research studies in faith-based settings. In S. S. Coughlin, S. A. Smith, & M. E. Fernandez (Eds.), *Handbook of Community-Based Participatory Research* (pp. 71–80). Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780190652234.003.0006>
- ¹¹⁸ Berkley-Patton, J., Thompson, C. B., Bradley-Ewing, A., Berman, M., Bauer, A., Catley, D., Goggin, K., Williams, E., Wainright, C., Petty, T., & Aduloju-Ajijola, N. (2018). Identifying health conditions, priorities, and relevant multilevel health promotion intervention strategies in African American churches: A faith community health needs assessment. *Evaluation and Program Planning*, 67, 19–28. <https://doi.org/10.1016/j.evalproplan.2017.10.012>
- ¹¹⁹ Clements, A. D., Cyphers, N. A., Whittaker, D. L., Hamilton, B., & McCarty, B. (2021). Using trauma informed principles in health communication: Improving faith/science/clinical collaboration to address addiction [Conceptual Analysis]. *Frontiers in Psychology*, 12. <https://doi.org/10.3389/fpsyg.2021.781484>
- ¹²⁰ Caplan, S. (2019). Intersection of cultural and religious beliefs about mental health: Latinos in the faith-based setting. *Hispanic Health Care International*, 17(1), 4–10. <https://doi.org/10.1177/1540415319828265>
- ¹²¹ Wong, E. C., Fulton, B. R., & Derose, K. P. (2018). Prevalence and predictors of mental health programming among U.S. religious congregations. *Psychiatric Services*, 69(2), 154–160. <https://doi.org/10.1176/appi.ps.201600457>
- ¹²² Cutts, T., Gunderson, G., Carter, D., Childers, M., Long, P., Marisiddaiah, L., Milleson, H., Stamper, D., Archie, A., Moseley, J., Vivrette, E., & Baker, B. (2017). From the Memphis Model to the North Carolina Way: Lessons learned from emerging health system and faith community partnerships. *North Carolina Medical Journal*, 78(4), 267–272. <https://doi.org/10.18043/ncm.78.4.267>
- ¹²³ Gourley, M., Starkweather, S., Roberson, K., Katz, C. L., Marin, D. B., Costello, Z., & DePierro, J. (2023). Supporting faith-based communities through and beyond the pandemic. *Journal of Community Health*, 48(4), 593–599. <https://doi.org/10.1007/s10900-023-01193-w>
- ¹²⁴ Schoenberg, N. E., Studts, C. R., Shelton, B. J., Liu, M., Clayton, R., Bispo, J. B., Fields, N., Dignan, M., & Cooper, T. (2016). A randomized controlled trial of a faith-placed, lay health advisor delivered smoking cessation intervention for rural residents. *Preventive Medicine Reports*, 3, 317–323. <https://doi.org/10.1016/j.pmedr.2016.03.006>
- ¹²⁵ Chaudhary, A., Dosto, N., Hill, R., Lehmjoki-Gardner, M., Sharp, P., Daniel Hale, W., & Galiatsatos, P. (2019). Community intervention for Syrian refugees in Baltimore City: The lay health educator program at a local mosque. *Journal of Religion and Health*, 58(5), 1687–1697. <https://doi.org/10.1007/s10943-019-00893-9>
- ¹²⁶ Levin, J., Idler, E. L., & VanderWeele, T. J. (2022). Faith-based organizations and SARS-CoV-2 vaccination: Challenges and recommendations. *Public Health Reports*®, 137(1), 11–16. <https://doi.org/10.1177/00333549211054079>
- ¹²⁷ Berkley-Patton, J., Thompson, C., Williams, J., Christensen, K., Wainwright, R., Williams, R., Bradley-Ewing, A., Bauer, A., & Allsworth, J. (2021). Engaging the faith community in designing a church-based mental health screening and linkage to care intervention. *Metropolitan Universities*, 32, 104–123. <https://doi.org/10.18060/24059>
- ¹²⁸ Centers for Disease Control and Prevention. (2021). *Baltimore African-American faith community is key in promoting vaccine confidence*. <https://www.cdc.gov/vaccines/covid-19/health-departments/features/baltimore.html>
- ¹²⁹ Syed, U., Kapera, O., Chandrasekhar, A., Baylor, B. T., Hassan, A., Magalhães, M., Meidany, F., Schenker, I., Messiah, S. E., & Bhatti, A. (2023). The role of faith-based organizations in improving vaccination confidence & addressing vaccination disparities to help improve vaccine uptake: A systematic review. *Vaccines (Basel)*, 11(2). <https://doi.org/10.3390/vaccines11020449>
- ¹³⁰ The Confess Project. (2024). The Confess Project of America. <https://www.theconfessprojectofamerica.org>
- ¹³¹ De Veauuse Brown, N., Barger, S., B., & Salmon, A. G., J. Hill, J. Berger. (2023). *Training Georgia Black barbers to be mental health advocates: Pilot study of The Confess Project*. <https://digitalcommons.georgiasouthern.edu/gapha-conference/2023/2023/103/>
- ¹³² Gelzhiser, J. A., & Lewis, L. (2023). Black barbers as mental health advocates, and interpersonal violence and suicide preventors in the local community. *Mental Health & Prevention*, 31, 200291. <https://doi.org/10.1016/j.mhp.2023.200291>
- ¹³³ Stand Together. (2024). *The Confess Project: Starting a mental-health movement in Black barbershops*. <https://standtogether.org/stories/health-care/the-confess-project-mental-health-movement-in-black-owned-barbershops>
- ¹³⁴ Georgia Mental Health Consumer Network. (n.d.). About GMHCN. <https://www.gmhcn.org/about>
- ¹³⁵ Georgia Mental Health Consumer Network. (n.d.). Peer Mentoring and Forensic Peer Mentoring. <https://www.gmhcn.org/peer-mentoring-forensic-peer-mentor>
- ¹³⁶ Sizemore, L., & Braucht, G.S. (2023). *Celebrating crime desistance with forensic peer mentors*. December 18, 2023, presentation, SE Mental Health Technology Transfer Center.
- ¹³⁷ Prison Policy Initiative. (2021). Georgia profile. <https://www.prisonpolicy.org/profiles/GA.html>
- ¹³⁸ Centers for Medicare & Medicaid Services. (2021). *On the front lines of health equity: Community health workers*. Retrieved from <https://www.cms.gov/files/document/community-health-worker.pdf>
- ¹³⁹ World Health Organization. (2022). Friendship benches: In support of mental health. <https://www.who.int/initiatives/sports-and-health/friendship-benches>
- ¹⁴⁰ Garcini, L. M., Kanzler, K. E., Daly, R., Abraham, C., Hernandez, L., Romero, R., & Rosenfeld, J. (2022). Mind the gap: Identifying training needs of community health workers to address mental health in U.S. Latino communities during and beyond the COVID-19 pandemic. *Frontiers in Public Health*, 10. <https://doi.org/10.3389/fpubh.2022.928575>
- ¹⁴¹ Commonwealth Fund. (2024). *Advancing racial equity in U.S. health care: The Commonwealth Fund 2024 State Health Disparities Report*. <https://www.commonwealthfund.org/publications/fund-reports/2024/apr/advancing-racial-equity-us-health-care#footnote46>

- ¹⁴² Inseparable. (2024). A better response: *Policies to improve America's mental health crisis system*. <https://www.inseparable.us/wp-content/uploads/2024/06/Inseparable-2024CrisisReport.pdf>
- ¹⁴³ National Conference of State Legislatures. (2023). *Leveraging career pathway programs: State strategies to combat health care workforce shortages*. <https://www.ncsl.org/health/leveraging-career-pathway-programs-state-strategies-to-combat-health-care-workforce-shortages>
- ¹⁴⁴ Baum, N., & King, J. (2020). *The behavioral health workforce in rural America: Developing a national recruitment strategy*. Ann Arbor: Center for Health Research Transformation, University of Michigan. <https://chrt.org/wp-content/uploads/2020/02/Recruitment-and-Retention-of-BH-Providers-Brief-2.2020-.pdf>
- ¹⁴⁵ Panaite, A. C., Desroches, O. A., Warren, É., Rouly, G., Castonguay, G., & Boivin, A. (2024). Engaging with peers to integrate community care: Knowledge synthesis and conceptual map. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, 27(2), e14034. <https://doi.org/10.1111/hex.14034>
- ¹⁴⁶ National Conference of State Legislatures. (2022). *State strategies to recruit and retain the behavioral health workforce*. <https://www.ncsl.org/health/state-strategies-to-recruit-and-retain-the-behavioral-health-workforce>
- ¹⁴⁷ Substance Abuse and Mental Health Services Administration. (2024). *Financing peer recovery support: Opportunities to enhance the substance use disorder workforce*. <https://store.samhsa.gov/sites/default/files/financing-peer-recovery-report-pep23-06-07-003.pdf>
- ¹⁴⁸ HOSA. (n.d.). What is HOSA? <https://hosa.org/what-is-hosa/>
- ¹⁴⁹ Missouri State University, West Plains (n.d.). Associate of Applied Science in Community Behavioral Health Support. https://catalog.wp.missouristate.edu/preview_program.php?catoid=2&poid=90&returnto=110
- ¹⁵⁰ Missouri State University, West Plains. (2021). *Board approves new AAS in Community Behavioral Health Support degree*. <https://news.wp.missouristate.edu/2021/02/19/board-approves-new-aas-in-community-behavioral-health-support-degree/>
- ¹⁵¹ University of California, San Diego. (n.d.). *Collegiate recovery program*. <https://healthpromotion.ucsd.edu/collegiate-recovery/index.html>
- ¹⁵² Chibanda, D., Weiss, H. A., Verhey, R., Simms, V., Munjoma, R., Rusakaniko, S., Chingono, A., Munetsi, E., Bere, T., Manda, E., Abas, M., & Araya, R. (2016). Effect of a primary care-based psychological intervention on symptoms of common mental disorders in Zimbabwe: A randomized clinical trial. *JAMA*, 316(24), 2618–2626. <https://doi.org/10.1001/jama.2016.19102>
- ¹⁵³ Moon, K. J., Montiel, G. I., Cantero, P. J., & Nawaz, S. (2021). Addressing emotional wellness during the COVID-19 pandemic: The role of promotores in delivering integrated mental health care and social services. *Preventing Chronic Disease*, 18, E53. <https://doi.org/10.5888/pcd18.200656>
- ¹⁵⁴ Substance Abuse and Mental Health Services Administration. (2022). *Community engagement: An essential component of an effective and equitable substance use prevention system*. (Publication No. PEP22-06-01-005). Retrieved from <https://store.samhsa.gov/sites/default/files/pep22-06-01-005.pdf>
- ¹⁵⁵ Substance Abuse and Mental Health Services Administration. (2024). *Examining the use of braided funding for substance use disorder services*. <https://store.samhsa.gov/sites/default/files/cfri-braided-funding-report-pep23-06-07-002.pdf>
- ¹⁵⁶ Coleman, S. F., Mukasakindi, H., Rose, A. L., Galea, J. T., Nyirandagijimana, B., Hakizimana, J., Bienvenue, R., Kundu, P., Uwimana, E., Uwamwezi, A., Contreras, C., Rodriguez-Cuevas, F. G., Maza, J., Ruderman, T., Connolly, E., Chalamanda, M., Kayira, W., Kazoole, K., Kelly, K. K., . . . Smith, S. L. (2021). Adapting Problem Management Plus for implementation: Lessons learned from public sector settings across Rwanda, Peru, Mexico and Malawi. *Intervention Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, 19(1). https://doi.org/10.4103/INTV.INTV_41_20
- ¹⁵⁷ National Association of County and City Health Officials. (n.d.). Community health assessment and improvement planning. <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment>
- ¹⁵⁸ Internal Revenue Service. (2024). Community health needs assessment for charitable hospital organizations - Section 501(r)(3). <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>

Acknowledgments

The content of this guide incorporated the thoughtful input of SAMHSA staff and review by subject matter experts throughout its development.

SAMHSA Staff

Brian Altman, JD, National Mental Health and Substance Use Policy Laboratory

Mogens Bill Baerentzen, PhD, CRC, LMHP, Center for Mental Health Services*

Lauren Barnes, MPH, Center for Substance Abuse Prevention*

Kimberly Beniquez, MS, Office of Intergovernmental and Public Affairs*

Mitchell Berger, MPH, National Mental Health and Substance Use Policy Laboratory*

LT Jalima Caulker, MSW, LICSW, LCSW-C, BCD, CCM, National Mental Health and Substance Use Policy Laboratory*

Loubna Elhelu, National Mental Health and Substance Use Policy Laboratory*

Anne-Marie Gomes, PhD, MSW, MPH, Office of Behavioral Health Equity*

Sara Hairgrove, MPH, Office of Behavioral Health Equity*

Kristen Harper, MEd, Office of Recovery*

CAPT Arlin Hatch, PhD, Center for Substance Abuse Prevention*

Larke Huang, PhD, Office of Behavioral Health Equity*

CAPT Donelle Johnson, PhD, MHSA, National Mental Health and Substance Use Policy Laboratory*

Jill Mays, MS, LPC, Behavioral Health Crisis Coordinating Office*

CAPT Corey Palmer, MPH, MS, Behavioral Health Crisis Coordinating Office*

Stephanie Peng, MA, LPC, Center for Substance Abuse Treatment*

Krishnan Radhakrishnan, MD, PhD, MPH, National Mental Health and Substance Use Policy Laboratory*

Mary Roary, PhD, MBA, Center for Behavioral Health Statistics and Quality*

Carter Roeber, PhD, National Mental Health and Substance Use Policy Laboratory

Jennifer Salach, MPH, National Mental Health and Substance Use Policy Laboratory*

Walker Tisdale III, DSW, MPH, MA, Office of Behavioral Health Equity*

Caroline Waterman, MA, CRC, LRC, Center for Substance Abuse Treatment*

Justine Whelan, Office of Communications*

Rebecca Zornick, JD, MSSW, Office of the Assistant Secretary*

Subject Matter Experts

Randi Dent, PhD, MS, ECHOES Consulting Group

Michele Gazda, MPH, Bipartisan Policy Center

Lorenzo Lewis, MPA, The Confess Project

Keris Jän Myrick, MS, MBA, Inseparable

*Members of the Planning Team



Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

Publication No. PEP24-06-004



SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.
1-877-SAMHSA -7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov