Community Health Workers and Their Value to Social Work

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Community health workers (CHWs) play a vital and unique role in linking diverse and underserved populations to health and social service systems. Despite their effectiveness, as documented by empirical studies across various disciplines including public health, nursing, and biomedicine, the value and potential role of CHWs in the social work practice and research literature has been largely absent. Thus, this article introduces social workers to CHWs, their role in promoting culturally appropriate practice, and their utility in collaboration with social workers in community settings. This integrative review also discusses current challenges identified by the CHW literature, including potential barriers to the expansion of CHW programs, as well as issues of training, certification, and sustainability. The review also discusses the close alignment of CHWs with social work values and principles of social justice, suggesting opportunities for enhanced social work practice and research.

KEY WORDS: *community health worker; community organizing; health disparities; policy; racial–ethnic groups*

The use of community health workers (CHWs) as social justice and health advocates has a long and upstanding history both internationally and domestically in disenfranchised communities and in the public health, nursing, and biomedical literature (for example, Eng & Young, 1992; Israel, 1985; Lewin et al., 2005; Navarro et al., 1998; Norris et al., 2006; Swider, 2002; Two Feathers et al., 2005; Witmer, Seifer, Funocchio, Leslie, & O'Neil, 1995). CHWs have become vital to linking underserved populations to health and social service systems. Indeed, national priorities focused on eliminating health disparities, such as Healthy People 2010, call for innovative and effective approaches that address social determinants of health, with CHW interventions emerging as a promising approach in health care settings. Their value and potential role in the social work practice and research literature has been largely absent. Yet social workers and CHWs share a common value base of social justice; client and community empowerment; and commitment to culturally appropriate, effective, and sustained change. Thus, the purpose of this integrative review is to discuss the role of CHWs in promoting social justice and their utility in enhancing the work of social workers in community settings.

CHWs go by many names, including lay health advocates, *promotores(as) de salud*, family health advocates, community health advisors, outreach educators, peer health promoters, peer health educators, community health representatives in Native American Nations, and natural helpers, to name a few. Although there are various definitions of what a CHW is, the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions (HHS, HRSA, BHP, 2007) defined *CHWs* as

> lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve.

Similarly, the CHW Special Primary Interest Group of the American Public Health Association (2006) added the following: "A [CHW] is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served." CHWs often work in partnership with states and health care systems. Rather than replace health care and social service providers, CHWs complement services delivered through formal systems by enhancing the range of comprehensive and supportive services, generally

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in a cost-efficient and effective way (Goodwin & Tobler, 2008).

THE ROLE OF CHWS

Although there is a multitude of roles and responsibilities of CHWs, seven core roles were identified by Rosenthal et al. (1998) in their National Community Health Advisor Study: (1) providing cultural mediation between communities and health and human services systems, (2) providing informal counseling and social support, (3) providing culturally appropriate health education and information, (4) advocating for individual and community needs, (5) ensuring that people obtain necessary services, (6) building individual and community capacity, and (7) providing basic screen services.

A primary function of CHWs is to link community residents and vital health care and social services, acting as a bridge between individuals and families with significant needs and the institutions and organizations that provide assistance and care (Love, Gardner, & Legion, 1997; McElmurry, Park, & Buseh, 2003; Satterfield, Burd, Valdez, Hosey, & Eagle Shield, 2002). CHWs increase access to services by serving as navigators through the complex systems of care. CHWs also provide other services, from case management, referrals, other direct services, such as first aid, to interpretation and translation services (HHS, HRSA, BHP, 2007). For example, in the REACH Detroit Partnership Family Intervention, CHWs assisted in the development and implementation of the project's culturally tailored Journey to Health/*Camino a la Salud* diabetes education curriculum; conducted regular home visits with clients to discuss healthy change goals and provide both instrumental and emotional support; and accompanied clients to clinic visits with their primary care provider to support clients in asking relevant questions about their disease, navigating the system, and providing translation services (Two Feathers et al., 2005).

Like social workers, CHWs also play a significant role in helping to address economic, social, and political rights of individuals and communities in which they work (Pérez & Martinez, 2008). For example, in the *Poder es Salud*/Power for Health Project, CHWs described their role as being not solely that of providers of service, but as community organizers who engaged in leadership development and capacity-building activities as their primary methods of change (Farquhar et al., 2008). A major goal of this project was to address health disparities by addressing community-level social capital. Guided by community-based, participatory research principles (see Israel, Schulz, Parker, & Becker, 1998) and popular education methodology, CHWs worked with faith communities and other community organizations to organize and facilitate community meetings to identify community strengths and needs and create a list of specific goals and solutions (Farquhar, Michael, & Wiggins, 2005). CHWs in this study described how they addressed community concerns by teaching community members how they can solve problems and have the power to effect change through a series of capacity-building projects (Farquhar et al., 2008).

CHWS AND SOCIAL WORKERS: SHARED VALUES

Perhaps the most important reason for believing that CHWs hold great potential for social workers lies in the value base of the profession—for example, empowerment, cultural competency, self-determination, service, human relationships, human rights, dignity and worth of the person, and social justice (NASW, 2008). CHWs promote practical benefits, "demonstrating how the issues that people face in their lives, both those directly related to health and those that result from social, economic, cultural, or political exclusion, impact their life condition" (Pérez & Martinez, 2008, p. 11). Within the framework of empowerment, the use of CHWs builds the capacity of community residents and CHWs alike to develop important skills and abilities and to gain access to resources and mastery over their own lives (Eng, Parker, & Harlan, 1997; Eng & Young, 1992; Plescia, Groblewski, & Chavis, 2008). CHWs also promote shared power in partnership with professionals and with systems that dictate health and well-being. The model takes seriously clients as experts in their own lives and as active claimants who can act to transform their world. It promotes citizen participation to achieve goals through a critical understanding of the sociopolitical environment, building on client strengths, capacities, and resources. Ultimately, these factors can enhance the sustainability of community practice efforts and strengthen the social capital within communities.

Further inquiry into the attributes of CHWs and their working environment may provide greater insight into how CHWs are involved in social change efforts and how their unique position within and

understanding of a community may support efforts to address root causes of disparities (Ingram, Sabo, Rothers, Wennerstrom, & Guernsey de Zapien, 2008). Opportunities to expand CHWs' capacity to advocate on a community level and engage in efforts to pursue structural changes that will address health inequities (Ingram et al., 2008) would align closely with social workers who are involved in community organizing and policy-advocacy efforts, particularly those that engage community residents in addressing community-identified concerns. This is particularly true for organizers who are not from the community of interest or do not share common racial, ethnic, or language characteristics with community residents and therefore take on secondary and tertiary organizing roles (Rivera & Erlich, 1995).

Collaboration with CHWs also represents culturally competent practice. Arizmendi and Ortiz (2004) noted that the CHW approach to organizing closely resembles the Latin American approach advocated by Paulo Freire (1972): "pedagogical action that involves dialogue, reflection and communication, and the creation of a critical consciousness that leads the people to take action against injustice and to accept total responsibility for needed change" (p. 28). Arizmendi and Ortiz stated that an "indispensable precondition" for joining and working with people in their fight against injustice is "trusting the people." This approach is not unlike those that are suggested for culturally competent practice in social work (Spencer & Clarke, 2006; Spencer, Lewis, & Guiterrez, 2000). Beyond cultural competence, the CHW approach promotes *cultural humility,* which has been described by Tervalon and Murray-Garcia (1998) as a lifelong commitment to self-evaluation and self-critique, to redress power imbalances and to develop and maintain respectful dynamic partnerships based on mutual trust. Thus, cultural humility connotes a deference of one's own cultural beliefs and assumptions, which can be clouded by hegemony and racism, and it can be aided by the insights and the participation of CHWs (Chàvez, Minkler, Wallerstein, & Spencer, 2007).

In addition, the CHW approach involves individuals of the community, who typically share social identities—such as race and ethnicity, socioeconomic status, gender, and so forth—and have a common history and cultural values and traditions. The use of CHWs can aid in our national shortage of providers of color who work in low-income, diverse communities (Smedley, Stith, & Nelson, 2003). This is particularly important in communities of new immigrants and refugees, where provider shortages of individuals who share the same language and culture are most widespread, such as communities of newcomers from Southeast Asian and African countries.

CHWs can also curb the historical distrust that clients may have of traditional health and mental health systems, perpetuated by incidents of overt and covert everyday discrimination (Gee, Spencer, Chen, & Takeuchi, 2007; Spencer & Chen, 2004; Williams, Spencer, & Jackson, 1999). In addition to the personal assaults on one's ego, discrimination may also act as a stressor (Clark, Anderson, Clark, & Williams, 1999; Gee, Spencer, Chen, Yip, & Takeuchi, 2007; Harrell, 2000). *Stressors* are "conditions of threat, demands, or structural constraints that question the operating integrity of the organism" (Wheaton, 1999, p. 177). Such stressors may include interactions with professionals who display biases or stereotypic views of low-income communities of color or institutional barriers that result in low service utilization. In a study by Spencer and Chen (2004), perceived discrimination was significantly associated with more informal service use and help seeking from family and friends for mental health problems. The authors recommended increased partnerships between formal and informal service systems as a means of increasing service use among those individuals who have perceived past wrongs, including discrimination, within formal systems. CHWs, in partnership with social workers, provide one avenue for such partnerships.

USE OF CHWS IN THE UNITED STATES

In the United States, the presence of trained workers who work in the capacity of CHWs has been documented since the 1950s (Rosenthal et al., 1998). Early and formally structured lay health worker initiatives are exemplified through community health representative programs in Native American communities, with a lay health care system that is considered to be the oldest and largest formal system in the United States (Satterfield et al., 2002). The 2007 Community Health Workers National Workforce Study summarized four periods of CHW work in the United States as follows: Early CHW programs served as antipoverty strategies to improve access to health care in underserved communities (1966–1972); short-term, grant-funded,

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and university-based research characterized the second phase (1973–1989), with increased attention to examining potential contributions of CHWs to health promotion and access to health care; and recognition for standardized training for CHWs emerged as a priority in the third period (1990–1998), with funding across a variety of sectors and the introduction of bills to support CHWs at national and state levels. Most recently, several states have addressed CHWs through training, certification and credentialing legislation, and the passage of bills mandating the study of the CHW workforce (HHS, HRSA, BHP, 2007).

CHWs serve a variety of populations, in various settings, across a number of social problems in the United States. CHWs are most commonly present in communities of color—including African American (for example, Dennison et al., 2007; Two Feathers et al., 2007), Latino (for example, Michael, Farquhar, Wiggins, & Green, 2008; Reinschmidt et al., 2006; Sixta & Ostwald, 2008), Asian/Pacific Islander (for example, Lam et al., 2003), and Native American communities (for example, Andrews, Felton, Wewers, & Heath, 2004; Satterfield et al., 2002)—and among both women and men. CHWs also have been used in both urban, inner-city settings and rural agricultural communities, typically in places where low-income communities of color are present and have low access to services.

The issues that CHWs address also traverse a wide range of health problems, reflecting the extent of health disparities present in low-income communities of color, including hypertension, cardiovascular disease, diabetes, asthma, end-stage renal disease, sexually transmitted diseases, and cervical and breast cancer. Although often focused on reducing or eliminating chronic illness and disease, CHWs' work extends to preventive care through the promotion of healthy lifestyles (for example, healthy eating and physical activity), self-management of disease and self-care, smoking cessation, immunizations, prenatal care, weight loss, environmental justice, violence prevention, and HIV prevention education.

CHWS IN AN INTERNATIONAL CONTEXT

Although our review focuses largely on CHWs in the United States, we acknowledge, historically, the prior international origin of this health care approach and extensive use of CHWs (or some form of lay health worker) in an international context. We also acknowledge that the domestic and international literature does not adequately represent the historical contributions of indigenous communities and their use of CHWs. Satterfield et al. (2002) previously stated that all cultures have some system of informal lay health care (Leninger, 1991) and that the presence of natural helpers who provide social support in communities predates any formal definition or system of CHWs. Internationally, lay health workers have been identified as "barefoot doctors" in China, who were farmers and regarded by those that they worked with as peers; *feldshers* in Russia; health promoters in Latin America; village health workers in Mexico, Africa, Indonesia, Afghanistan, Bhutan, and Europe; *brigadistas* in Nicaragua; community leaders as health workers in Karelia, Finland; and *shastho shebikas* in Bangladesh, who worked to improve immunization coverage, prenatal nutrition, and community education and identify new tuberculosis cases. This list is certainly not exhaustive of lay and CHWs internationally, but it represents the breadth of locations and communities that have promoted CHWs as one model for providing care for diverse communities, across a variety of health and social problems.

EFFECTIVENESS OF CHWS

Two previous comprehensive reviews have provided a substantial contribution to the literature on the effectiveness of CHWs: a review of outcome effectiveness of CHWs in the United States by Swider (2002) and a review of lay health workers' contribution to primary and community health care in the United States, United Kingdom, and Canada by Lewin et al. (2005). Several themes emerge from the CHW literature reviewed, which also provides key recommendations for future studies, research, and training of CHWs. First, the literature on CHWs indicates that in a variety of settings, with diverse populations, CHWs have played an important role in health prevention, health promotion, and chronic

disease management and are effective in improving access to health care and health care utilization, increasing health knowledge, and improving health indicators (Keane, Nielsen, & Dower, 2004; Lewin et al., 2005; Swider, 2002). The Community Health Worker National Workforce Study (HHS, HRSA, BHP, 2007) identified nine literature reviews published between 2002 and 2006 to evaluate the use of CHWs in specific primary care and medical specialty interventions (see Table 1). These reviews suggested further evidence of CHWs as key participants in the delivery of health care and health education for underserved communities (HHS, HRSA, BHP, 2007). Andrews et al. (2004) said, in their review of studies with ethnic minority women, that CHWs "are effective in increasing access to health services, increasing knowledge and promoting behavior change" (p 358). Brownstein et al. (2005) reviewed studies related to heart disease and stroke and identified CHW interventions as effecting significant improvements in participants' blood pressure care and control, home visits as more effective than group education sessions for improving hypertension control (Morisky, Lees, Sharif, Liu, & Ward, 2002), and CHW and nurse practitioner collaboration as key factors in increasing appointment adherence and contributing to continuity of care (Bone et al., 1989).

Second, reviews of the CHW literature have explored various roles and services of CHWs that contribute to their effectiveness in effecting change (Swider, 2002). However, these studies have been inconclusive. CHWs have been identified as effective in increasing access to care, yet there are questions about the characteristics of CHWs that make their work effective with "hard-to-reach" groups and in low-income and ethnic-minority communities and how exactly the contributions of CHWs generate desired health outcomes (Swider, 2002). For example, CHWs appear to be effective in increasing access to cancer screening and follow-up visits for chronic conditions, but further evaluation is needed to document and understand how CHWs are effective and to understand key elements of CHW activities and the communities that are most open and responsive to CHW interactions (Swider, 2002). Critiques have also suggested there is insufficient understanding of how CHWs should best provide services and how much training of CHWs contributes to their effectiveness (Lewin et al., 2005). The current gap in our understanding and evaluation of CHWs and their effectiveness may be ameliorated in part through the development of resources that combine and chronicle CHW studies and initiatives from local, community, service-providing, higher education, policy, state, and national-level sources.

Another theme to emerge from these reviews is the lack of research to determine cost-effectiveness of CHW work to understand further their potential contributions to health care (Lewin et al., 2005; Swider, 2002). More recently, attention has increasingly been turned to an examination of the financial impact of CHW interventions, with inquiry into the costs of care, particularly pertaining to chronic conditions. Recent studies with CHW interventions have demonstrated decreased asthma-related urgent care and savings in care costs (Kreiger, Takaro, & Song, 2005), decreased emergency room visits and hospitalization among patients with diabetes and subsequent savings due to decreased health care utilization (Fedder, Chang, Curry, & Nichols, 2003) and increased primary and specialty care and decreased urgent care and inpatient and outpatient behavioral health care utilization (Whitley, Everhart & Wright, 2006). In addition, prior studies of CHW effectiveness have been critiqued for lacking standardized measures, which constitutes a limitation for the reliability and validity of the findings (Swider, 2002). Future research should address improvements in the quality of study design—with clear articulation of intervention design, measures, and implementation process—so that studies can be replicated and more can be learned about how and what CHW are doing that makes their work effective (Lewin et al. 2005; Swider, 2002).

CHALLENGES TO RECOGNIZING AND SUSTAINING CHWS

Despite increasing demands and an increased awareness of the value of CHWs as members of multidisciplinary teams engaged in culturally appropriate health and social services delivery, as well as the important role they are beginning to play as members of research and evaluation teams, several major challenges need to be addressed before CHWs will be more widely accepted throughout the various health and social service sectors, including social work. In 2006, the Family Strengthening Policy Center (FSPC) issued a policy brief titled *Community Health Workers: Closing Gaps in Families' Health Resources* that outlined four interrelated critical

Table 1: Literature Reviews of Community Health Workers Research Studies, 2002–2006

Author, Year	Search Limited to	Years Covered	Number of Studies Reviewed	Number of Studies with Results Reported in Terms of:				Location and Population Served: Number of Studies Specifying Each Characteristic[a]							
				Health Care Behaviors	Awareness, Knowledge, and Attitudes	Health-Related Behavior	Clinical Outcomes	Urban	Rural	Men	Women	African American	Latino	Asian	Native American
Andrews et al., 2004	Minority women	1974, 1989–2002	24	15	7	11	2	17	7	0	24	15	5	1	4
Brownstein et al., 2005	Heart disease and stroke	1989–2003	6	4	0	0	4	6	0	3	0	6	1	0	0
HRSA, 2002	All	1991–1999	19[b]	18	6	5	2	12	7	1	7	9	10	1	0
Lewin et al., 2005	All	1972–2001	21[c]	9	1	7	13	20	1	1	13	4	1	0	0
NFME, 2006	All	2002–2005	7	2	0	2	5	5	0	1	1	3	3	0	0
Nemcek & Sabatier, 2003	All	1974–1999	18[d]	9	2	2	5	13	5	2	4	6	8	0	0
Norris et al., 2006	Diabetes	1987–2003	15[e]	4	6	9	11	7	5	0	6	3	7	0	2
Persily, 2003	Prenatal, home visiting	1987–2000	12[f]	9	3	1	5	3	1	0	12	0	2	0	0
Swider, 2002	All	1981–1999	19	14	2	8	3	15	0	1	9	3	4	1	0

Source: Community Health Worker National Workforce Study (U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professionals, 2007).

Note: HRSA = Health Resources and Services Administration; NFME = National Fund for Medical Education.

[a]A study was not counted if the characteristic shown was not specifically mentioned in the review.

[b]Nineteen of 20 studies reviewed were in the United States.

[c]Of 24 U.S. studies, 21 were included and three were excluded because they primarily referred to the provision of paraprofessional clinical care.

[d]Nine of the 18 studies included were program profiles in one report (see HRSA, 1998).

[e]Fifteen of 18 articles reviewed were in the United States.

[f]Twelve of 14 studies reviewed were in the United States.

challenges to gaining greater recognition of CHWs and the expansion of CHW programs.

First, inadequate and unstable funding keeps CHW programs from achieving their potential and sustaining services. Most funding for CHW programs originates from federal, state, and local agencies, as well as private sources such as foundations and private community agencies. To address this barrier, programs use a mixture of grants and other resources, but this action does not lead to stability in funds or to the expansion or sustainability of effective CHW programs (FSPC, 2006; Love et al., 2004; Ro, Treadwell, & Northridge, 2004). Also, many available grants restrict CHW services to a specific disease (such as diabetes or cancer), which impedes CHWs' ability to effectively address the multitude of other issues that clients too frequently face. These kinds of funding situations result in agencies having major restrictions on their CHW programs in terms of time frames, scopes of work, and sizes of programs. This creates another barrier to CHW collaboration with social workers. Continuous funding of CHW programs often relies on the capacity of the host agency to constantly search for funds. A stable source of funding offers CHW programs the opportunity to further develop the CHW field and establish strategies for institutionalizing and integrating CHWs into health and human service systems (Public Health Sector Consultants, Inc., 2007; Ro et al., 2004; Virginia Center for Health Outreach, 2006).

Second, within the health and human service sectors, CHWs often are not recognized as legitimate providers (FSPC, 2006; Ro et al., 2004; Virginia Center for Health Outreach, 2006). Efforts to gather official estimates of the number of CHWs in the United States have been hampered by the absence of a specific occupational code that can be used in official reports for CHWs and the various CHW job titles and roles (HHS, HRSA, BHP, 2007). In addition, a number of challenges in employment and compensation, which are closely tied to the perceived value placed on CHW work, impede the recognition of CHWs as legitimate providers. For example, CHWs are often volunteers or part-time employees who are generally paid low salaries and often do not qualify for benefits because they do not work full time. In addition, CHWs have varying educational backgrounds that range from some on-the-job training to formal community college–based programs that grant certification or an associate's degree (Keane et al., 2004). A study on the career advancement of CHWs, conducted by the Jobs for the Future for the SkillWorks: Partners for a Productive Workforce program (Scott & Wilson, 2006), found that although literature supports the importance of CHWs in improving access to care for underserved populations using culturally appropriate methods, CHWs are often not well rewarded, and their job tenure is unstable. Well-defined career paths are lacking, as are systematic skills sets and credentials recognized across work settings and usable for higher education. As a result, turnover is high, with individuals leaving not only their jobs but also the field itself. In addition, an important challenge to the recognition of CHWs as legitimate providers may come directly from other professionals (for example, diabetes or other health educators, social workers) who perceive that the CHW workforce is encroaching on their scope of practice. This has led some states to develop a standard scope of practice for CHWs (Goodwin & Tobler, 2008).

Third, the lack of public funds and direct reimbursement for CHW services by Medicaid and other programs serving low-income families further complicates the first two challenges (FSPC, 2006; Ro et al., 2004). Although both private and public funds are needed, increasing the availability of public funds would provide a more stable financial base for CHW programs and CHWs. One way to accomplish this is by encouraging states to support CHW programs by fully using outreach and education dollars that are available through Medicaid and the State Children's Health Insurance Plan. According to research gathered, states use four methods to fund CHW services: (1) Medicaid managed care—Medicaid managed care organizations can use the capitated funds they receive from the state to directly employ CHWs or contract with an organization that provides the services; (2) section 1115 waivers—a section 1115 waiver allows for the expansion of services statewide through CHW programs and enables reimbursement for certain of these services; (3) federal support for administrative costs—community-based CHW programs can receive federal matching funds for outreach and coordination; and (4) direct reimbursement—CHWs are defined as billable providers, thus allowing them to bill the Medicaid program directly for services (Goodwin & Tobler, 2008; Public Health Sector Consultants, Inc., 2007; Ro et al., 2004; Virginia Center for Health Outreach, 2006).

The push for standards and advancement of the CHW field at the state and national levels requires advocacy from strong organizations and other stakeholders.

And finally, the lack of accepted CHW standards that include a definition, core competencies, and scope of practice hinders CHWs' ability to link families to a wide range of community services and supports (FSPC, 2006; Virginia Center for Health Outreach, 2006). Frequently, the training offered to CHWs is informal on-the-job training that is program-specific and narrows the scope of roles available to CHWs. Standardized competencies in education and training would enable CHWs to undertake a broad set of CHW roles that at the same time retain the heart of CHWs' effectiveness—their roots in and knowledge of their communities (Kash, May, & Tai-Seale, 2007; Love et al., 2004).

A policy brief of the FSPC (2006) described an emerging debate regarding the use of certification or credentialing and potential implications for establishing and sustaining the practice of CHWs. Although credentialing may advance perceived legitimacy of CHWs within the fields of health and human services and expand employment opportunities for CHWs within these fields, practitioners and experts have also identified potential pitfalls of credentialing that could outweigh the potential gains, including fewer CHWs coming from the communities that they serve; erosion of indigenous qualities that make CHWs effective; loss of highly effective CHWs due to volunteer or immigration status or level of education, if they are required to participate in CHW training program and credentialing; and credentialing fees and training tuition being barriers for low-income CHWs interested in becoming certified (FSPC, 2006).

The push for standards and advancement of the CHW field at the state and national levels requires advocacy from strong organizations and other stakeholders. Nationally, and at the state level, CHW organizations are currently working to further develop and strengthen their associations. Support from NASW and other professional organizations would greatly assist in this effort. Such support is not unprecedented. For example, in Indiana, NASW supported the creation of a CHW program and the inclusion of CHWs in an innovative care coordination team consisting of a registered nurse, a social worker, and a CHW (Kash et al., 2007).

THE POTENTIAL OF CHWS IN SOCIAL WORK

Although social workers, since the days of settlement houses, have enlisted the services of community residents as key informants, gatekeepers, advocates, links between the community and structured services, and mobilizers (Arizmendi & Ortiz, 2004), the research literature on CHWs in social work is largely absent. A search of the term "community health worker" in Social Work Abstracts during the development of this article in September 2008 yielded two articles, the first by Connell (1999) on the use of CHWs who worked with elderly alcohol-dependent adults in New South Wales to become familiar with new policy processes, and the second by Toban (1970), which examined the perceptions of professional and nonprofessional CHWs about 11 social work functions. Both groups believed that nonprofessional CHWs were superior at showing the patient "someone who cares." An article by Arizmendi and Ortiz (2004) used the term "*promotores(as).*" The authors described how community organizers used CHWs in the *colonias* in the U.S. southwest as a means of providing health education and civic information in these hard-to-reach communities. The authors described the role of *promotores* in organizing *colonia* communities as that of initiators and leaders of change, whose efforts ensure the community's self-determination.

The term "natural helpers" yielded more studies (24 citations), but the range of this work often went beyond the trained and purposeful roles of CHWs as defined previously. Some of the more exemplary studies used natural helpers in partnership with professionals to work with families in the child protective services system (Kinney & Trent, 2003), in preventing child abuse and neglect (Ballew, 1985), and in providing informal counseling (McLennan & Greenwood, 1987). Patterson and Marsiglia (2000) found, in a study of 12 Mexican American natural helpers, that they used a more "doing" type of helping style, although a facilitating helping style was also reported.

Although CHWs are fairly invisible in the social work literature, a closely aligned use of CHWs can be found in the peer support and paraprofessional literature. Current models often point to the use of peer support in three forms: (1) naturally occurring mutual support groups for consumers and

caregivers alike; (2) consumer-run services; and (3) the employment of consumers as providers within clinical and rehabilitative settings, in which consumers are used as role models, sources of complementary support, and sometimes as gateways to the mental health system (Davidson et al., 1999). The clubhouse model is one example of consumers of mental health services working side by side with generalist staff—in this case, in the governance and operations of a clubhouse (Mowbray, Lewandowski, Holter, & Bybee, 2006). Clearly, mutual aid self-help groups, such as Alcoholics Anonymous, and other community-based social support groups have used lay helpers in direct care roles. However, these peer support programs have not been closely tied to the CHW literature and, therefore, lack the benefits of shared knowledge that could be had by a more interdisciplinary effort.

Using a more conventional definition of CHWs, research suggests that there is great potential for CHWs to play a significant role in stress reduction and mental health promotion. For example, Spencer et al. (2006) found in a CHW intervention for reducing disparities in diabetes that understanding of diabetes self-management, satisfaction with health care, and support from one's primary health care provider were associated with lower levels of diabetes-related emotional distress among African Americans in Detroit. Similarly, the *Amigos en Salud* (Friends in Health) Research Project in Los Angeles used CHWs to help Hispanic patients with diabetes and co-occurring depression to understand and manage their condition. The findings demonstrated that not only did lipid profiles and overall ratings of health and health behaviors improve, but participants reported improved depression severity scores (Goodwin & Tobler, 2008).

CHWs have been increasingly used in community-based research interventions as part of campus–community partnerships and coalitions. In this capacity, CHWs are involved in all aspects of the research and evaluation of the project and serve an active role in identifying needs and strengths of the community (for example, serving on project steering committees, facilitating focus groups), data collection (for example, conducting interviews, administering questionnaires), analysis and interpretation of the data (for example, assisting in interpreting contradictory findings), and dissemination (for example, presenting findings at community forums and national conferences, serving as coauthors on publications). Pérez and Martinez (2008) described CHWs as "natural researchers" who can observe and relay community realities to outsiders, thereby guiding and informing research endeavors with communities that have grown distrustful toward research that is perceived as not having the community's best interests in mind.

In addition, the CHW model recognizes the assets of the community, the dignity and worth of individuals, and their pursuit for self-determination. Social workers working in partnership with CHWs do not attempt to guide the community's decision making, but rather facilitate a structured process through which the community decides its destiny (Arizmendi & Ortiz, 2004). CHWs, in turn, can promote self-determination and social justice beyond providing services that reduce inequality and disparities by advising residents of their rights and advocating for policy change. Pérez and Martinez (2008) quoted one public policy director who explained that CHWs "create the case and convey the message; they rally the troops and add credibility to policy changes we advocate for" (p. 13). CHWs also can bring some of the most profound stories from the community and bring voice to the public arena from areas that have experienced exclusion from these processes.

CONCLUSION

As the widening gap in health and social disparities continues to challenge our nation and its strained systems of care, CHWs provide one possible solution to the problem of meeting the needs of disenfranchised communities, and they are ready and natural allies for social workers, who share the common goals of social justice and culturally appropriate services. Although social workers have recognized and partnered with CHWs, knowingly or unknowingly, social work professional literature does not reflect the extent to which CHWs can and should be used. Social workers have an opportunity to further social work's interdisciplinary agenda by working with other fields—such as public health, nursing, and the biomedical sciences—that have researched the effectiveness of CHWs more extensively; and they have an opportunity to contribute to this literature through their own value base and practice wisdom. Social workers stand to improve effective and just practice by increasing partnerships with CHW programs and community residents from disenfranchised communities. We attest to the added

value of CHWs in our own practice and research. We hope that as a result of this integrative literature review, organizations like NASW will extend their support for policies that promote CHWs and that social work professionals and social service systems will see the need to incorporate CHWs in their own pursuits of social justice. SW

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