

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

Building a Gateway for Prison Re-Entry: An Interview with Change Agent Philip Cooper

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In this interview, Operation Gateway Chief Change Agent Philip Cooper discusses his organization, working to reduce the stigma of recovery and re-entry, and various policies impacting community-based organizations' ability decrease prison recidivism.

Introduction

In Western North Carolina, Operation Gateway's staff are "change agents" working every day to help people manage the transition from incarceration back into society. Philip Cooper is Operation Gateway's Chief Change Agent.¹ A formerly incarcerated person himself, Philip leans heavily on his lived experience to understand stigma, pressures, and needs among formerly incarcerated people.

In this interview, Philip discusses Operation Gateway's work and how his organization has adapted in recent years. He discusses his personal experience transitioning from prison, and he talks about social determinants of health and how he has looked to key health indicators in Healthy North Carolina 2030 as he works to reduce the stigma of recovery and re-entry.²

He also talks about Medicaid, the Healthy Opportunities Pilots, and how recent changes in North Carolina have helped people successfully transition from prison with support for things like housing and food.

This interview has been edited for length and clarity. To listen to this interview, [click here](#).

Brady Blackburn: Phillip, thank you so much for joining us today. To get us started, could you introduce yourself and tell me about Operation Gateway and how you do your work to decrease recidivism?

Philip Cooper: Yeah, glad to be here. Thank you for this opportunity to be a voice of the people, to be a voice for those who are directly impacted, trying to make a change by way of leveraging their lived experience.

My name is Phillip Cooper. I am the Founder and Chief Change Agent at Operation Gateway Incorporated. One hundred percent of our staff at this time are formerly incarcerated people who are now in recovery. As far as how

we do the work to decrease recidivism, we are all about addressing the person with a holistic approach. And we love our friends in the public health space because they always talk about social determinants of health, social drivers of health. What are the root causes?

For us, that looks like providing whole-person services, not just, you know, siloed into one sector, but we're more like the navigators of the ecosystem, the coordinators of the ecosystem when we look at re-entry. So that's food. It's transportation. It's health care. It's education. There's economic stability, whether it's getting them a job or helping them know how to budget their money, you know, reconnecting with their families. Social and community context, getting them connected to build social capital by way of faith communities or recovery communities. You know that social capital is everything.

And then looking at neighborhood and built environment. What types of neighborhoods, what types of re-entry programs do they need when they first come out of prison so that they can have a healthy reintegration into society?

Brady Blackburn: So, what led you to this line of work, and how did you come to found Operation Gateway?

Philip Cooper: So, I'm formerly incarcerated myself. I gave up the high cost of low living on January 16, 2009, which is my sobriety date. But I went into prison. Well, my sentence started in like 2007, so I did a little over 3 years in prison. And while I was in prison, a light came on. I had a spiritual awakening. I re-dedicated my life to Christ. I seen that I had more potential than what I was displaying, right? There was a reinvention. And I seen the power of peer support. I actually worked as a peer support [specialist] while I was incarcerated. And so, when I came home and I got into the field.

And then what I seen was that the issues that needed to be addressed needed to be directly addressed. They didn't need to get put on the back burner. And for me to be able to truly address the disparities, you know, that I was experiencing myself, that I seen other people experiencing, it had to come from the grassroots level because we can't expect people who work in the bureaucracy to do certain things. That is an unrealistic expectation. And so I seen, it's going to take me doing this work from outside and partnering with those on the inside.

Brady Blackburn: So I feel like I'm already getting a sense for this with the passion you're bringing to talking about the work you do, but you're Operation Gateway's chief change agent, and I'm really curious to hear from you what the meaning is behind that title and how it reflects the way you approach your work.

Philip Cooper: Well, I got to take it back. I'll take you back to when I got out of prison. I was going to AB Tech Community College, my alma mater. I was in the Human Services Technologies program, which is an amazing program, and I'm so excited that our state has passed legislation to where people like myself, who completed that amazing program, that human services program, are now considered qualified professionals in the mental health and substance use space.

And so, when I was in my schooling, right at AB Tech Community College, I was taking a class, "Intro to Human Services," and I heard the name "change agent," talking about human services professionals. And I grabbed ahold of that thing quick, real quick. You hear me? And so, I started going by "Change Agent."

And so "Change Agent" has been tied to me strongly over the past about 7, 8 years, fam. And so, whenever we started this organization, I wanted us to be seen not with necessarily a hierarchical structure, though that is needed within the infrastructure of a nonprofit, I still wanted us to see each other as change agents.

Brady Blackburn: So, another term that I've read about, and heard you talk about that I'm curious to hear more on is in-reach. And I'm curious if you could tell me a little bit about in-reach, what that term refers to and what types of in-reach work you do at Operation Gateway?

Philip Cooper: Well, what I'll tell you is in-reach is the best practice, right? So, I started doing this re-entry work pro bono. It was never a job. It was me doing the work pro bono. And when I was doing the work then, I didn't have a strategy. All I knew was, "help people." And I was helping people who was getting out. So I wasn't getting connected to them until they was getting out. Somebody from the community, faith community, or so on and so forth, would then hit me up like, "Hey, I know somebody that needs some help." And so, I was getting them like that.

But then once I got into the field, I started getting connected on LinkedIn. I started getting connected from speaking engagements I was doing, following different people. And, I had connected with—in Washington DC, they have a Mayor's Office on Returning Citizen Affairs—and I connected with a guy named Lamont Carey at the time. He was just giving me the game and giving me pointers on how to do re-entry, you know, and he basically provided mentoring for me. One of the things he told me back then, this was like the year 2018 or 2019, he was like, "Bro, if you're not connecting with them until get out then you're not properly serving them. You've got to connect with them before they get out to assess their needs."

I didn't know that. But then when he said it, it made so much sense, you know. So, in-reach is when we connect with people before they get out of prison, connect with people before they get out of a treatment center, you

dig? To assess their needs, establish rapport, and create an individualized re-entry plan. Because if we're talking about holistic re-entry, we're talking about health care. We're talking about budgeting. We're talking about driver's license restoration. We're talking about family reunification. We need to be putting together a plan before you get out. Because once you get out, you got so many options. And one of the things that we do see happens to a lot of our people that we don't get to connect with why they're on the inside, by the time they get out, they got so many options. They got something that we like to call "analysis paralysis." They got so much going on where they don't know what to do, and they oftentimes freeze up. Or guess what else? Uh oh. They oftentimes will revert to something else to get the edge off, which is typically an illicit substance.

The best practice, though, Brady, would be us being able to go inside the prison, offer a group, some type of group, some type of curriculum. But we're not able to do that right now. I would say it's mostly because the prisons are short staffed, and the staffing impacts what programs can come inside the prisons. And so in-reach is not being done the way that it's supposed to be done right now. And I can empathize with the prison staff who are working, you know, because right now, after the budget cuts, I'm wearing multiple hats myself, and I see how staffing can impact the overall operation.

Brady Blackburn: Before we move on, I want to ask a quick follow up question there, because you've mentioned budget cuts and a staffing shortage both on, it sounds like, the end of the of the prisons themselves, but also on the end of organizations like yours that are working to do this kind of in-reach work. So, you're seeing this impact in-reach efforts and make it so they're not happening the way that you would like to see them happening?

Philip Cooper: Yes. Correct.

Brady Blackburn: Gotcha. So I actually want to ask a little bit more about that later on when we talk about Medicaid. But for now, I want to take a step back and talk about incarceration and behavioral health in North Carolina in general. Could you give me a quick snapshot of where North Carolina stands in your eyes in terms of incarceration, especially for marginalized populations?

Philip Cooper: Well, I'll say, you know, that Black people are overrepresented in the in the prison population nationwide. There's that. Also, when we look at the United States of America, we incarcerate more people than the rest of the world.

Incarceration, mass incarceration: public health crisis. It's a public health crisis that's impacting more than just the incarcerated person, but it also impacts the family. If you refer to the Healthy [North Carolina] 2030 report, you see when they talk about improving outcomes for marginalized, they

mentioned two things: out of school suspensions and incarceration rates, because they correlate. And so, if we're looking at incarceration and we're understanding that mass incarceration is a public health crisis, we have to look at alternatives to incarceration. What are we doing in North Carolina as we talk about behavioral health, as we talk about prisons?

I will say there's some great work that's starting to cook up. I'm not going to just say that we suck. I'm going to say there are some things that are cooking up right now. I know they got these new justice re-entry teams with the managed care organizations like Vaya Health. You know, Trillium, Alliance, Partners Behavioral Health. They have these justice re-entry teams in which the managed care organizations are working closely with the social workers, right, to get referrals for folks who have severe mental illness, or violent crimes.

But it's still dependent upon a referral from the social workers, fam. And that's the hard part. Now we're expecting—the success of this person is dependent upon whether or not a person puts in a referral or not. That has been challenging, and I believe that we're looking to make some improvements with that.

They recently implemented these Forensic Assertive Community Treatment teams. I don't know a ton about it. I just seen the email that went out in Hot Topics from Kelly Crosby, and I'm excited about that as well, because you have a team and you have that lived experience baked in. I love it when they honor lived experience, because lived experience plays a major role in instilling hope to people who are hopeless.

So, on the behavioral health side, where there's room for improvements, if you ask me, I will say we need to have more access. People with lived experience need to have more access to the people while they on the other side.

I believe there needs to be more communication between the social workers, the MCOs, and the community-based organizations. I believe that ecosystem requires communication amongst each other, right? Especially those who are going to be providing what we call “boots on the ground services” for, say, an individual. We're going to be the ones that make sure that they get to the appointment that the people at the managed care organization schedule. We're the ones that's going to take them to the appointment. We're the ones that's going to take them to the grocery store. We're the ones that's going to potentially take them to a 12-step meeting or a faith-based meeting. We're the ones that have focus groups for the returning citizens to come to, in-person or virtual, for people that have transportation as a barrier.

And so having community-based organizations heavily involved in the behavioral health work for the returning citizens should be priority, because we're the ones that's helping navigate the resources when they come home.

In years past, people used to give them a sheet of paper and say, okay, you go do this, or give them a guide and say, “Do this. Call this person. Call that person.” But sometimes those guides and those lists be outdated, right? And that’s why we have to lean on community-based organizations. And that’s why I love my public health people so much, because they put the value on the community health workers, because they understand the role that we play.

Brady Blackburn: We actually just finished we just recently conducted an interview with Honey Estrada, who’s the president of the North Carolina Community Health Workers Association, and there’s a lot of parallels between what she spoke about and what you’re talking about here, especially when it comes to coordination between all of these sometimes disjointed services, making sure that they can work together, run smoothly, and how especially community health workers can be that glue working between something like a direct care provider, community-based organization, and individual who needs the services.³

Philip Cooper: Yeah, we navigate it, man. Because like even with the Federally Qualified Health Centers, I’m grateful for them. And I’m grateful for the leadership of Dr. Evin Askin, who started the NC FIT program. North Carolina Formerly Incarcerated Transition Program. And we host the program site. So, Operation Gateway, we are the program site of NC FIT. When you pass Charlotte, we’re the only one that exists. Shout out to Dr. Askin and that model because they’re at least able to prioritize getting people streamlined connections and appointments.

Brady Blackburn: At the at the North Carolina Institute of Medicine in the North Carolina Medical Journal, we’re taking a look at all of the different health indicators specified in Healthy North Carolina 2030, one of which is incarceration rate, to mark the halfway point in this decade. The Healthy North Carolina process centered around addressing the social determinants of health. How does addressing the full spectrum of health-related needs help with incarceration and recidivism?

Philip Cooper: Well, I’ll tell you from my lived experience, I self-medicated a condition that I didn’t get treatment for. That led to criminogenic activities. And so, we’ve done a lot in the harm reduction space in the state of North Carolina. I feel that in 2026, we need to do more in the prevention space, the relapse prevention space, the prevention space for youth.

We need to talk about prevention way more. And so, as we look at how that addresses the full spectrum of health needs, a person who is not mentally stable is not going to consistently partake into any kind of service, because their life is unstable. And so, as we look at social determinants of health

and we look at access to health, one of the things I love to do when I have speaking engagements is I'll have the crowd chant back to me, "mental health is health," right?

For us, if we're looking to decrease recidivism, we have to be ready to deal with the trauma that the people experience whenever they're in prison and the trauma that they experience pre-incarceration. Because guess what? A lot of people have—I don't know if you ever heard of it—but the adverse childhood experiences, right? When you look at people's adverse childhood experiences, that also has a correlation with criminogenic activities my brother! And so, as we look at addressing that health piece, we got to take into mind that mental health piece and we got to do it pre-release.

We got to address stigma. We got to address stigma because when you look at marginalized communities, especially in Black and Brown communities, nobody wants to talk about mental health. And matter of fact it's, "You better not talk about what goes on in this house, because what goes on in this house stays in this house." And see that has paralyzed and been a generational curse for people.

Brady Blackburn: To transition real quick, I do want to ask about your mission statement. You said that your mission statement recently changed. Could you tell me a little bit about what changes you made to your mission statement, why you wanted to change your mission, and what that means?

Philip Cooper: So, like before, I was telling you in the earlier part of the interview when I was saying I started Operation Gateway to meet the needs of prison re-entry, it was solely prison re-entry because they were the ones that was getting the short end of the stick.

We have, especially in this area, amazing programs in the jails. They even had medication—starting people on medication for opioid use disorder while they are in the jails. They have a lot of great programs, but the people coming out of prison was having the hardest time. So, I started the organization to meet the needs specifically for them.

But then, the more I done the work, the more connections I got, the more they started requesting us to do more, right? When we looked at who we were serving and how we were serving them—we were getting a significant amount of referrals coming from halfway houses, we're getting referrals coming from jails, treatment centers—and so we had to revisit our mission.

And the main reason why we had to revisit our mission is because when we look at recidivism, which is tracked on a 1-, 3-, and 5-year [scale], somewhere around there, typically with organizations, right? For us to truly impact

recidivism, and by way of what our mission was saying, address the social determinants of health, we got to have a residential re-entry program. And we don't have a residential component.

We got money—shout out to the North Carolina Department of Health and Human Services—we got money to be able to pay to get a person into a halfway house, because around here, halfway houses cost anywhere between \$800 to \$1000 a month. And so we was getting this grant money, and then we pay that money to get a person into the house. Then they got to hurry up and find a job. They're not worried about health care. They're not worried about financial literacy. They're not worried about nothing else but to hurry up and get a job so I can pay the halfway house man what I owe him, so they don't kick me out, you see. And so, for us to truly have re-entry done the best practice way in a way that we need, we got to have a residential program.

Until we get a residential program, we can't stand by that mission because we've seen a significant amount of people go back to their way of life because of housing instability. And that housing instability is preceded by what they call collateral consequences. Because you got a record, it's harder for you to get a job. So, you might not be able to hurry up and go get a job that's going to avail you opportunity, that pay what it costs to live in that halfway house, pay your probation fees, your child support, buy your own food. You see what I'm saying?

Having a residential re-entry program is what's needed. And that's why we changed our mission from, "We are decreasing recidivism by addressing the social determinants of health," because one of the main determinants of health, we are not sustainably addressing.

The new mission statement that we got, is something that I allowed the team to have input on. The staff, the board. Now, as we move forward, we got the change agents involved contributing to what the mission is. And our new mission is, "Together." You'll notice the first word we start with is "Together, we leverage lived experience to transform lives and reduce the stigma of recovery and re-entry."

That's what we do. We reduce stigma. And the system can't stop us. See, the system can stop us from decreasing recidivism. The system ain't got to partner with us. They ain't got to honor and respect lived experience. They don't have to. But we can still impact stigma because we can recover out loud. We can make sure we got the resources, and we can leverage your lived experience to transform lives. That's what we can do.

Brady Blackburn: Absolutely. Well, thank you for explaining that. I think that that makes a lot of sense. And I've—I know I've read in other interviews you talking about that that other phrase, "Recovering out loud." And I can definitely see that through your mission and through the way that you're answering all of these questions, so thank you.

Another important topic in health care right now that I want to talk about is Medicaid, with significant policy changes both on the immediate horizon and in recent history here in North Carolina. Two that carried implications for incarcerated people were Medicaid expansion and North Carolina's Section 1115 waiver. Could you tell me a little bit about that 1115 waiver, what it is, and how it helps support people during re-entry?

Philip Cooper: I'm not going to say that I'm an expert with the 1115 waiver—I will say before it passed, one of the funding streams that we have now, interestingly enough, the innovation started while I was at one of those hearings where they have public comment. And I went up there because they was talking about this portion of the 1115 waiver that I'm about to discuss.

So, the thing that's exciting is with the 1115 waiver, they start to engage with people pre-release, as far as it relates to their services. And, you know, we all about in-reach and we all about pre-release.

But one of the things that I said back then when I was in public comment was like, "You can't expect a short-staffed prison to do one more thing." Let's be realistic about what's going on, because oftentimes people that come up with these policies and everything, they're not close to the problem, and those who are closest to the problem are closest to the solution, right?

I'm optimistic about what can be done with getting people connected before they get out. Everything that we can connect them with before they get out is a big win, if you ask me. Come on, man, pre-release engagement is what's needed because by the time they get out, they got all these options and we don't want them to suffer from analysis paralysis.

And so with that 1115 waiver and that Medicaid piece, that helps the people be able to get the treatment, health care, and all the things that they need.

Brady Blackburn: Absolutely. So, in a similar vein, the Healthy Opportunities Pilot, HOP, is another program that's been in the news, that also has an uncertain funding future. You've spoken about HOP and how it also helps support returning citizens. Could you tell me a little bit about that? How the Healthy Opportunities Pilots have supported housing, transportation, and those behavioral health needs among this population?

Philip Cooper: Man, HOP was amazing, fam. I have people that work for Operation Gateway now who got released from prison less than, you know, 3 years ago. We got one that got out 2 years ago. We got one that got out a little over a year ago. So, we have staff on our team who are benefiting from the services with HOP. You know, they were getting fresh produce. They were getting mental health treatment. There are people on my team right now who was able to move into an apartment, and the Healthy Opportunities Pilot was

able to help them with moving into their apartment. This is how impactful it was, and I'm talking about, it helped people who are now change agents working in the field, right?

Healthy Opportunities Pilot was big and it's so sad, you know, it's so sad that we don't have it right now. It's devastating. Especially right now. It's even more devastating because of what's going on with SNAP.

There was also a lot of people who lost jobs. You know, we have a part time person on our team now who was working on a full-time job and the whole company shut down whenever that happened with HOP. And so, there are people who are close to me that have been impacted. She's a single mom, you know what I'm saying?

The biggest thing that I'll say was with the food, because everybody can't get food stamps. That's the thing that people also don't know: there are certain drug charges that indefinitely disqualify people from getting food stamps, man, and Healthy Opportunities Pilot was able to help them.

You know, we miss HOP, and I wish HOP would come back because, I mean, we need it more than ever right now because especially in Asheville, when you look at Hurricane Helene, man, and the impact it had on people.

Brady Blackburn: Absolutely. And it's amazing how much all of these different things are connected, especially when you can think about it in terms of something like Hurricane Helene, this single point in time that does shed light on all of the above: food access, behavioral health needs, mental health needs, access to primary care, and then how folks, like formerly incarcerated people or anybody who fits into any of the different marginalized populations, already start with less access. Once you have a disaster like that, you really do see just how much that lack of access means.

So looking forward, I want to just ask one more question about what you see happening on the horizon. There's definitely been progress made in recent years. There's also challenges that have come up, especially recently, in this line of work. As you look forward, I'm sure you have a laundry list of changes that are yet to be made. What are some things, either policy changes, programs that need to be launched, or efforts that need to be funded that are at the top of your priority list?

Philip Cooper: So let's talk about the residential re-entry program that I was telling you about earlier, right? So having a residential re-entry program, a 120-day re-entry program is what I would like to see. It would be 120 days that people can transition there, out of prison, to come and get their life together, then transition out, like along in a continuum, to move into a halfway house after that.

I would like to see that happen. I know the Department of Adult Corrections has contracts with certain vendors throughout the state to provide what they call “transitional housing.” Okay, this is something that exists. I don’t know how much funding they got total, but I know that it’s something that exists because we get referrals from one of the partners right now.

FIRST at Blue Ridge, which is where our partners are out in Black Mountain. We have a great partnership with them and get referrals from them. They have a contract for transitional housing with the Department of Adult Corrections. We need more of those. We need more money going into that, because that is a tactic that will decrease recidivism. It is able to address the whole person because they don’t have to hurry up and go to work to pay to live there. They can actually have a reintegration into society. So that’s one.

The MacArthur Foundation funded a planning grant here in Buncombe County, and it was headed up by an organization called Thrive Asheville. And so, we partnered strongly with Thrive Asheville on this planning grant. And we’ve been putting on focus groups that are speaking to what’s missing for those who are formerly incarcerated as it relates to housing.

We’ve done a significant amount of focus groups—we got a focus group tonight, the last one. And so what we do is we interview people who got out of prison, not on post-release, now living and working in Buncombe County, and ask them, “What was needed for you coming out of prison? What types of supports are needed for people coming out of prison? What type of housing is needed for people coming out of prison? What did you need?”

And we doing all of these focus groups and we’re gathering all of this information to then, in turn, have our county apply for an implementation grant from the MacArthur Foundation, which could be up to \$5 million. And I have reason to believe that that would be the perfect opportunity for Operation Gateway to implement a residential re-entry program.

Brady Blackburn: So before we close it out, one last question I always like to ask is, is there anything else that’s on your mind that you think’s important that we have not talked about today?

Philip Cooper: As a reverend, I’ll say that I would like to see more churches who have unused real estate—there’s a significant amount of real estate that belongs to churches—I would like to see more churches utilizing and repurposing their real estate to provide services for the least of these. For people coming out of prison, for people coming out of, you know, long-term treatment, recovery treatment.

I like to see us start having more conversations with faith leaders intentionally. Because I know there's a significant amount of churches that are just sitting. You know, congregations are just starting to get smaller and smaller and smaller. Meanwhile, we're talking about a need for real estate to provide services to help people get their lives together.

So, I believe that with the right voices at the table, with the right leadership, we will be able to recruit some churches that will be willing to be good stewards of their property and repurpose it for the needs of those who will turn their lives around.

Brady Blackburn: Well, Philip Cooper, thank you so much for taking the time to talk with us for the North Carolina Medical Journal. We really appreciate your time.

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Acknowledgments

The interviewee has no conflicts of interest to declare.

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