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'We Need to Get Paid for Our Value': Work-Place Experiences and Role Definitions of Peer Recovery Specialists/Community Health Workers

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ABSTRACT

Despite growing research on peer recovery specialists and community health workers (CHWs) in fields such as substance use disorder (SUD) treatment and recovery support, their workplace experiences are little understood. Through semi-structured interviews with 21 CHWs and peer recovery specialists working within substance use disorder treatment and/or traditional health care settings, we identified six prevalent themes: Benefits/Pleasures of the Role; Reciprocity; Challenges; Duality of Lived Experience; Relationships with Medical Professionals and Supervisors; and Defining Metrics. These themes reveal a complex narrative of system failures, organizational hierarchies, and experiential realities in which shared experiences and personal connections with clients undergird both positive and negative aspects of the role. In the words of one study participant: "We have not taken a vow of poverty, we need to get paid for our value."

Introduction

Across the United States, substance use disorder (SUD) treatment providers and traditional healthcare organizations have increasingly invested in integrating peer recovery specialists (PRSs) and community health workers (CHWs) into care teams (Centers for Disease Control and Prevention (CDC), 2011; Findley et al., 2014, Jones & Burrell, 2022; Rosenthal et al., 2010). The PRS and CHW roles are characterized by their individualized approaches to connecting with clients with whom they share life experiences or a common community-based identity (Daniels et al., 2012). Although distinct in their histories and role definitions, many individuals are trained for both roles, move back and forth between jobs defined as PRS and/or CHW positions, or combine different aspects of these roles in practice – creating a more fluid, complicated workforce than the separate titles would suggest. Both roles can be understood as part of a broader workforce that we will call Community-Based Health Workers (CBHWs). CBHWs strive to increase engagement with groups that treatment and health care systems fail or stigmatize given that CBHWs

themselves face the same forms of exclusion and discrimination (American Public Health Association [APHA], 2009; Logan, 2020). The benefits of such engagement – usually considered in the form of improved population health outcomes, reduced healthcare costs, and increased utilization of services – are often cited as evidence for the potential of CBHWs to address health disparities, although more research is still needed to demonstrate effectiveness for specific outcomes (Eddie et al., 2019; Scott et al., 2018).

CBHWs serve a more expansive and varied range of functions in SUD treatment and healthcare than abstract terms such as "resource brokers" and "systems navigators" convey. They "translate" between providers and clients (Sørly et al., 2022; Stewart et al., 2012); advocate for clients in the face of stigma (Anvari et al., 2022); and provide encouragement and logistical support for continued treatment engagement (Huffnagle et al., 2022). In combination with these and other more ad hoc functions (such as pandemic contact tracing), CBHWs can identify vulnerable households and assist with basic needs such as transport and food (Wells et al., 2021). Given the scales of the housing and overdose crises, harm reduction work (such as distributing naloxone and responding to overdoses) and housing support are often major components of the CBHW role, even when they work in areas seemingly unrelated to substance use and homelessness. More specific to the field of SUD treatment and recovery support services, CBHWs integrate clients within community-based recovery supports such as recovery community centers, 12-Step, and other mutual help-groups (Haberle et al., 2014; Myrick & Del Vecchio, 2016); work with clients to create wellness plans and/or plans to prevent reoccurrence of use (Suzuki et al., 2023); and provide strengths-based support using tools such as motivational interviewing (Martin et al., 2023). In the context of the current high demand for therapists and lengthy-waiting lists, in practice some CBHWs are serving as interim therapists (Guy et al., 0000) even though psychotherapy is outside their training and role definition.

Despite growing evidence suggesting the positive impacts of CBHWs, researchers have only recently started to explore the experiences of individuals holding these roles in the context of their work places and professional lives (Felton et al., 2023; Kirk et al., 2023; Sørly et al., 2022; Tate et al., 2022). This absence is striking because the CBHW's lived experience is central to how these roles are conceptualized. Literature focusing on how CBHWs themselves understand their roles is limited, indicating the need for further investigation of the day-to-day experiences of the broader CBHW workforce (Dunklee & Garneau, 2018; Alexander-; Scott et al., 2018). Such research holds the potential to highlight the joys, challenges, and barriers to wellbeing that CBHWs experience.

The scale of the workforce crisis in mental health care and health care more broadly, combined with the historic increase in demand for treatment in the wake of the COVID-19 pandemic, has led to calls to expand the use of CBHWs from voices as diverse as editorials in the *American Journal of Public Health* (Rodriguez, 2022) and Walmart's chief health equity officer (Southwick, 2023). An increase in the peer support specialist workforce is at the center of the 2023–2026 Substance Abuse and Mental Health Services Agency (SAMHSA) strategic plan to address the behavioral health and overdose crises (SAMHSA, 2023). Simultaneously, an emerging body of literature is raising concerns about burnout (Brady et al., 2022; Tate et al., 2022; Unachukwu et al., 2023), emotional exhaustion (Pasman et al., 2022), high workforce turnover (Jones et al., 2022), and economic exploitation among CBHWs (Ballard et al., 2023; Wennerstrom and Smith, 2023), many of whom are in early recovery from SUD or live with mental illness and are therefore vulnerable to reoccurrence. CBHWs face particular challenges

working in traditional health care and mental health settings – such as hospitals, community mental health centers, primary care offices, and SUD treatment centers – where leadership and staff committed to clinical models of care may have an incomplete or inadequate understandings of these roles (Malcarney et al., 2017). If we hope to undertake the expansion of this workforce in a form that is both sustainable and meets the ambitious public health goals now being placed on CBHWS, while avoiding the perpetuation of new forms of harm, we need a far more empirically robust account of CBHW role responsibilities and challenges in practice. A first step toward achieving this understanding is listening to the experts: CBHWs themselves.

Methodology

All study materials and practices were approved by the Lifespan Health System Institutional Review Board. Participants provided verbal informed consent prior to participation.

This study is based on semi-structured interviews with 21 CBHWs who work in the state of Rhode Island. Interviews were conducted between September 2020 and August 2021. Given that individual participants determined whether they shared experience with clients, and people trained as CHWs and PRSs work under many job titles (CHW, CPRS, outreach worker, case manager, harm reduction worker, peer supervisor, community engagement coordinator, to name only the most common), our sampling strategy allowed for a degree of flexibility based on the self-identification of study participants. Participants were recruited from organizations that are not peer-led in an effort to focus our analysis on integration into traditional SUD treatment, physical health care, and mental health care organizations. The Community Health Worker association of Rhode Island circulated a study flyer among its members; we also recruited participants through word-of-mouth recruitment by our CBHW study advisors and snow-ball sampling (referrals by participants). Sampling was purposeful to capture experiences in a range of settings and to include a racially and ethnically diverse group of CBHWs. Participants worked in primary care clinics, emergency departments, community mental health centers, addiction treatment centers, and other similar settings.

The interview guide included questions about how the participant came to their role; their day-to-day responsibilities and how they would describe their work to someone who had never heard of it; their relationship with employer and supervisor; how they understand success in their position; the methods they use to cope with any accompanying emotional stress; and how they see their professional future. Interviews were conducted by phone or Zoom and transcribed by a professional service. Three collaborators in CBHW roles assisted in the development of the interview guide. Findings were shared iteratively at two stages of data analysis with a group of CBHWs employed at the Lifespan Transitions Clinic and Rhode Island Hospital Emergency Department. The principal investigator on this study (JS) is a person in long-term recovery from drug and alcohol addiction and formerly part of the Rhode Island training team for CPRS certification. Two other authors (SN and LM) have extensive experience in peer support work and three authors (LM, AG, and JS) identify as being in long-term recovery from addiction. The entire process was informed by the COBRE on Opioids and Overdoses document, "Shaking the Tree of Science: Principles of Community Empowered Research" (Center for Biomedical Research Excellence on opioids and overdose 2022).

Interviews were analyzed using reflexive thematic analysis (Braun & Clarke, 2006; Byrne, 2022). Transcripts were independently coded by three coders and reconciled through an

iterative process. Broader themes were developed following a second round of coding in conjunction with input from community engagement through the Lifespan Transition Clinic and public presentations of initial results to the broader community of CBHWs in Rhode Island.

Sample Characteristics

Four (4) of our participants self-identified as men, 15 as women, and 1 as other. (Note: because 1 participant declined to complete the demographics survey, the demographic statistics sum to 20, rather than 21). Fifteen (15) participants identified as white, 2 identified as African American, 1 as Asian, 1 as Native American, and 1 as other. One (1) participant had worked as a CBHW for less than 1 year; 8 for 1–3 years; 4 for 3–5 years; 4 for 5–7 years; and 1 for more than 7 years. Participants reported incomes ranging from less than 15.00 per hour to 23.00 per hour, with half (0.5) participants earning 18.00–20.00 dollars an hour. For 15 participants (0.75), their CBHW work was their sole source of income; 5 (0.25) participants had others sources of income.

Results

Benefits and pleasures of the role

"Loving the Work"

With few exceptions, interviewees emphasized the meaningful nature of their role. "Loving the work" was often associated with having the opportunity to change people's lives, form personal connections with others, and determine their own daily schedule (see Box 1). Participants celebrated their relationships with clients and emphasized the importance of working with people from their own communities. This theme underscores that trust, personal connection,

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Box 1 – Benefits and Pleasures of the Role: *"Loving the Work"*

"I've just been so happy in this position. Very blessed in a lot of ways. It keeps it very real for me of like it reminds me of what I used to be like when I was drinking, and that hopeless desperation. I hope that sometimes I'm that little sliver of sunshine for people to be like, 'It's okay. I know where you're at.' I think people relate to that a lot more when you have that lived experience to be like, 'Yeah, I've been in a psych ward. *[Laughter]* I've been through detox. I know what you're going through, and what that feels like.' I think it's I'm making a really big difference. It's like this is very enjoyable for me." –Interview #9, CHW and PRS, Female

"I love that it's out of a box. If I want to, I can say, 'Well, let's go meet at the park and go sit on a bench and take a walk, or let's go to a coffee shop,' and people are like, 'This is so cool. I could have never had this conversation sitting in my doctor's office. Sitting out here, I can have this conversation.' It's non-traditional in a lot of ways, and I like that." –Interview #20, PRS, Male

"That's what I love about this job is that you – just to see somebody, or just a glimmer of hope in somebody's eyes, and you know that they're gonna get there. Maybe they won't, but just so they still have that hope in them. Maybe, you can give them a little bit more saying, "You know what? I believe in you still." I think that's most important that somebody is, "You know what, I believe in you. You might not believe in yourself, ever. I know you can do this." To be able to walk away knowin' that you gave somebody that little bit of hope that there's still a chance. That, to me, is the beautiful thing." –Interview #19, PRS, Female

"Well, I love my job. It's a hard job. It's a hard topic to talk about, but it's incredibly rewarding, and it feels like everything that I went through that was so hard has more meaning because it allows me to connect with other people in a way that I never would've been able to if I hadn't have had such a hard struggle. I really like sharing my story, starting to be seen as a leader in the community, and I'm invited to speak in all different settings." –Interview #20, PRS, Male

and identification with the communities being served are not only central to the effectiveness of these roles for the client, but the meaningfulness of the role for CBHWs themselves.

Reciprocity in peer work

Overwhelmingly, participants described their role as reciprocal. The CBHW provides services and support to clients, and the work and clients likewise support the CBHW in ways that span from the psychological (providing meaning and self-worth) to the practical (learning of services that the themselves could utilize) (see Box 2). Several participants explained that being a CBHW allowed them to assign meaning to past experiences of trauma, addiction, or other forms of suffering because they can now utilize these experiences to help others. Participants also stated that providing meaningful service to others allowed them to maintain their own recovery from SUD and/or mental illness. Being able to maintain personal emotional well-being was key to fulfilling the responsibilities of the CBHW, but it was also a benefit that several participants derived from the role.

Box 2 – Reciprocity in Peer Work

"The best thing is that for seven and a half hours every day, five days a week, I am helping other people live their best lives, but I'm also working on my own recovery. Every conversation, not just with the clients, but in my interactions with fellow staff, I'm always conscious of being nonjudgmental and open-minded and wanting to hear what people have to say as opposed to what most of us do in conversations, which is we're just basically waiting for our chance to talk. This has been transformative in my entire life. It's improved every relationship in my life. The best part of my job is that I am becoming a better person every time I have an interaction." –Interview #21, PRS, Female

"Part of the incentive for staying focused on my recovery is my work. It motivates me. At that time, I think it was motivating me because I hadn't had a lot of things come together for the years preceding that." –Interview #8, PRS, Male

"I think this role helps you. I think that one of the things that have really, like is it helps me be thankful for the life that I have, that it could always – my situations could always be worse. I'm not happy that they're in that situation, but it makes me more humbled and more – it makes me a better parent. It makes me a better daughter. It makes me more aware of things that I can get into without realizing. It helps me mentor my family. It expands my understanding of human beings." –Interview #15, CHW, Female

"The community, yeah. I felt like maybe if I can help some guys get straight and get them off the street, and get them into some type of drug treatment program, that I'd feel better about me, but I'd also feel like I'd be doin' somethin' to help somebody else out." –Interview #16, CHW, Male

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Multiple participants also reported deriving self-esteem and self-worth from their relationships with clients. They explained that working as a CBHW made them "better" at other roles such as family member, friend, and coworker. Other value gains included learning from clients about new resources to share with others or even utilize themselves and receiving "peer support" in return from clients. As one participant reflected, "...the idea behind peer work, too, is that there's a sense of mutuality there ... This idea of trying to make the interactions be as mutual as possible, people often will – they will say something or ask the question to support me, too. That's really special when that happens."

Challenges of the role

Wages and benefits

The most common challenges associated with being a CBHW were insufficient wages and benefits (see Box 3). CBHWs emphasized both a financial and an emotional dimension to limited compensation. Primarily, participants stated that their wages were not adequate to support themselves and their families. In several cases, working as a full time CBHW resulted in a decrease in real income compared to being unemployed or partially employed. Because they now made slightly more than the cut off for SNAP, housing assistance, and Medicaid, their job resulted in the increase of insurance costs simultaneous to reduced access to services and government assistance. This reality led several participants to put off seeking medical care that they would have been able to access prior to their current role. More than one interviewee described the irony of working to connect patients to high quality care while being unable to access affordable medical services. Additionally, as one interviewee observed, "it takes time to be poor:" waiting for public transportation, traveling to agencies and food banks, filling out forms, advocating for services are time-consuming activities. Full-time employment meant that participants no longer had time to organize and self-advocate for these kinds of resources.

Multiple participants compared their earnings to the substantially higher salaries of a social worker, describing differences in pay despite their perception that a similar type and amount of work done by each role. As one participant said, "We get mistaken as social workers a lot." A few CBHWs shared that they had considered becoming a social worker in order to receive higher compensation. One participant described the financial barriers to becoming a social worker, stating, "I always wanted to be a social worker . . . Unfortunately, I didn't have the degree. I wasn't able to go to college. I had started college and didn't finish. I already had a bunch of student loans." Another shared that his primary reason for working toward an MSW is "higher pay" followed by "a lot more opportunities."

Box 3 – Challenges of the Role: *Wages and Benefits*

"I did lose my Medicaid and my food stamp. It was a big hit. It was a big hit. It still is sometimes. My co-payments – they used to not have co-payments now I have $24 co-payments, and it definitely makes me question do I need that appointment. Buy a couple more weeks without that appointment, things, 'cause I don't have a lot to spare, I don't qualify for heating assistance anymore, so . . . " –Interview #20, PRS, Male

" . . . it's just this unspoken type of title sort of thing where it's like social work and CHW, MSW type of thing. You could just tell the difference, and I think it has to do a lot with pay . . . 'Cause even at my workplace, I feel like we both do the same type of thing. MSW, CHW, we all do – we literally both do the same type of thing. I can tell you that right now. The only difference is the pay." –Interview #12, CHW, Female

"If anything, they should be taking better care or just total care of people like us that are trying to help the other people, right? Aren't they saving money in the long run by us helping them get to their appointments? Hello? We should be taken care of the best. You know what I mean? That's how I feel. I have, in the past, like I said, not engaged in care because of not being able to afford it, whereas in the past, when I had my state medical and stuff, you just go to the doctor because it's free." –Interview #3, Case Worker, Female

"This is a labor of love. Again, I just wanna say, stress this, that we love our work, and it's a calling, but we are not nuns and priests. We have not taken a vow of poverty, so we need to make more money and get paid for our value." – Interview #21, PRS, Female

In addition to the financial impact, there is an emotional and social-symbolic dimension to compensation that reflects the CBHWs' feeling of status and value within the context of their employment. Participants associated lower wages with the perception that their work was not valued by employers or the healthcare system as a whole. Many interviewees asserted that the positive impact that they are able to have on patient outcomes should translate to greater compensation. This association between value and compensation was further emphasized by multiple participants who felt valued as an employee when supervisors and other colleagues advocated for increased wages on their behalf.

Funding

Nearly all of the CBHWs that we interviewed worked in grant funded positions, with grants limited to one to three years. CBHWs reported being unclear whether their position would continue after the grant's duration, contributing to ongoing concerns over job security (see Box 4). Participants shared that supervisors often used the need to retain grant funding to pressure CBHWs to increase their client load, take on additional responsibilities, or pressure clients to accept services despite lack of willingness to engage. These grants require additional paperwork which CBHWs explained detracts from the time they can spend with clients. State, federal, and research grants sometimes require documentation in addition to that required by the employer. The cumulative demands of paperwork could make large caseloads unsustainable even for experienced CBHWs, and these responsibilities were even more burdensome for CBHWs who have limited computer literacy due to lack of training provided by employers, age, history of incarceration, and/or educational disadvantage.

Box 4 – Challenges of the Role: *Funding*

"They got the grant money because they want to show that community health workers are needed more in person and on call, but also, it's not – the data is not gonna show that it wasn't the clients that didn't want to meet with us. It's just gonna show that we didn't meet with them. I think that's also important because there's only so much you can help a person with if they're not willing to help themselves. We could keep trying, but if they keep saying no, it's not like I'm gonna be like, okay, I'm forcing myself to go visit you at your house right now. Also, it's COVID, so people are just like, "If I could do it over the phone, I'm gonna do it over the phone." –Interview #1, CHW, Female

"...last week, I would say I did get bummed out in a meeting because they were like, "No. Those calls are not good enough. That's not why we didn't get the grant money." Then that's adding pressure to me 'cause I'm just like, all right. It's a pandemic. I just can't show up in someone's house without looking crazy. It was just like, okay. You could only meet your clients where they're allowed you to, and there's only so much you could push ... just hearing that you have to meet in person once a week with each client is unrealistic because a lot of these clients are not stable, so it's like, okay, you have to – not everyone's perfect. Not everything is perfect." –Interview #1, CHW, Female

"The compensation or feeling like you – we'll never know if we're ever gonna be compensated at a higher rate *[laughter]*. Even job security. You know a lot of this stuff that's grant funded – there's always that looming, "Oh, the grant's up in three years. It's up in five years." –Interview #19, PRS, Female

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Box 5 – Challenges of the Role: *Working Hours*

"This is all an emergency and then someone will call me and that's the emergency. How do you juggle that? How do you decide which one is more important?" –Interview #10, CHW and PRS, Female

"Someone texts me at 1:00 in the morning, and it wakes me up. Yeah, I'm a little frustrated, but I don't wanna see that person do any harm to themselves or anyone else. I wanna help support them and be there for them, but I don't work 24 hours, and I need to work on self-care, too, which I've done. Over the past year-and-a-half, I've done work on because I have answered the phone in the middle of the night for people and talked 'em through a crisis." –Interview #17, PRS, Male

" . . . just recently, my wife has experienced a few deaths in her family. The team rallied around me to be able to spend time with my wife and be there for my wife by makin' sure my patients was okay and tooken care of because they knew it would be hard for me to take time off because our patients are pretty much in crisis a lot." –Interview #2, CHW, Male

" . . . in my own personal experience, sometimes, when we start to share our lived experience with individuals, it's hard for them to view you as a professional, especially – I have a work cellphone. It's hard to have them view me as a professional. It's a peer-based relationship. Although it's professional, it becomes a friendship in their eyes. When it comes time to draw the boundaries like, "Hey, I can't answer your phone call at 3:00 in the morning," or "I can't be there for you when you're struggling at that time because that's not my work hours." I have, and that's where, again, the boundaries get crossed, and the lines get blurred. I think that that's the biggest struggle with being a peer is when you're effective at it in building a peer-based relationship, it's hard to – especially having so much compassion and empathy for people that are strugglin.'" –Interview #17, PRS, Male

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Working hours

The majority of participants explained that their roles were organized around a traditional 40-hour work week. However, few participants believed that they were able to fulfill their responsibilities within this framework (See Box 5). For CBHWs working with people who are insecurely housed and/or homeless, people who are formerly incarcerated, people with severe mental illness, and people with SUDs or people who use substances, there is a high frequency of client crisis. Many clients live within chaotic circumstances which, while not rising to the need for acute intervention such as hospitalization, nevertheless produced frequent situations of risk. Moreover, the line between clinically defined crisis (the client poses a danger to self or others) and emergency situations (as defined by the client) can be difficult to evaluate in real time. CBHWs understand that, in theory, they should refer clients in crisis to a higher level of care, such as management by a clinician, in-patient SUD treatment, or hospitalization. In practice, clinical referrals or SUD treatment are often not available in the necessary window and clients will not engage other emergency services like EDs or walk-in behavioral health centers because of previous negative experiences.

As a result, CBHWs find themselves improvising to support clients through crisis situations – or they are confronted with either informing their clients that services are not available or referring clients to providers who are seen as having failed them previously. These crises are not limited to the standard workday. Almost all of our participants describe triaging texts or phone calls after hours and on weekends to determine which clients' needs are sufficiently urgent for off-hours engagement. These realities lead some participants to feel as if they must always be available. This is complicated by the fact that shared lived experience or community are founding principles of CBHW work. Some participants reported that sharing their personal histories with clients encouraged the blurring of important boundaries: the closeness of these relationships could make it more difficult to limit client-engagement to working hours.

In turn, participants described supervisors responding by advising them to turn off their phones on the weekends or reestablish boundaries, placing the responsibility of navigating client crises solely on the individual and (however unintentionally) questioning the CBHWs professionalism. As one CBHW said in a discussion of these findings, "What do you think will contribute more to burnout, taking a call after ten pm or opening up a text in the morning that says that my client died of an OD?" In practice, many of our participants choose not to tell their supervisors the extent to which they work on weekends and evenings, settling for uncompensated and unsupported work over "failing" their clients. Especially pervasive among CBHWs in recovery from SUD was the belief that failing their clients was in some sense "failing themselves" – an identification based on the "shared fate" of having been in similar situations and the risk of returning to crisis someday.

Some participants noted that being on a team with other CBHWs helped ameliorate these demands. One example of this team approach included others stepping in to assist with regularly scheduled clients when another CBHW had to shift their schedule to address an emergency. Across interviews, team members were cited as sources of emotional support for work-related stresses, an audience to troubleshoot especially difficult situations, and a key source of resource-sharing. Participants who were most satisfied with their role reported working with strong, supportive teams of peers where team members had the day-to-day flexibility to reallocate responsibilities and client care.

Duality of lived experience

Personal connections versus emotional boundaries. Participants emphasized the importance of lived experience (also expressed as "coming from the same community") in facilitating the connection built between CBHWs and clients. Shared experience provides a point of relatability, helps reduce stigma and fear of judgment, and facilitates honesty. The CBHW can serve as an example that gives clients hope for greater stability and wellbeing. Participants experienced tension between the close relationships with clients and the expectation by some coworkers that they respond "professionally" to traumatic events like client death (see Box 6). This tension highlights a double bind inherent to the role:

Box 6 – Duality of Lived Experience: *Personal Connections versus Emotional Boundaries*

"That leaves me to go home feelin' bummed 'cause I don't know what kinda phone call I'm a get tomorrow sayin' that he died when he was just on my phone beggin' for help, and then I couldn't give him none. I got patients sleepin' in a storage unit dead smack in the winter. You know what I mean? Those are low points for me. Sometimes I don't even wanna go home because I know what I'm goin' home to, and I know what they're not." –Interview #2, CHW, Male

"As long as you're human, and if you do not lie to yourself, you will never fully separate that. You will never. Because as long as you can relate to it, there's always something that's gonna come back up . . . In this profession, there's also a lot of loss. There's a lot of loss of life. When you get to know a lot of people, and you put yourself out there, it's like you naturally – you can't just make your brain forget and say, 'I didn't know that person. I didn't work with them,' but they passed away, and then act like it doesn't affect you." –Interview #3, Case Manager, Female

"Yeah, we lost a patient last week. You have to stay neutral, if you will. Maybe there's a better word [for what] I'm thinking of. You have to remain professional when you're working as a Community Health Worker and not get too attached because these people are not your family. At the same time, you have to treat them like human beings that were just like your family. They need. They care. They hurt." – Interview #13, CHW, Female

"Because I have to utilize public transportation, it's like I'm always working because I know so many people, people will naturally start coming up to me. It doesn't matter if it's a Saturday, a Sunday. I'm like a public figure, and it's almost like, when people see you, you're always working. I don't have that ability to break off from that as much as I would because I have to utilize the same systems that the same people do, if that makes sense." –Interview #3, Case Manager, Female

CBHWs are expected to build mutual trust, care, and connection with clients, but they are not always supported in addressing the emotional realities of having close connections that often involve extreme distress and loss of life.

Identification with the client meant that professional frustrations, such as the inability to secure resources inside a critical window, can be perceived as failure to support one's community or failure toward one's own recovery. While most participants report benefiting from emotional support from a supervisor, several interviewees felt that clinically trained supervisors inadequately understood this dimension of the role because they were able to separate and "turn off" at the end of the day. Some participants also described the difficulty separating their work from the rest of their lives given that they live in the same neighborhoods, share public transportation, shop at the same markets, and use the same services or recovery community spaces as clients. In this context, participants saw supervisors' advice to emotionally detach or "set boundaries" as divorced from reality.

Professional relationships

Supervisor and team support. Many participants commended supervisors who treated lived experience as an asset as opposed to a burden. In contrast, some participants expressed fears of being seen as incapable, unprofessional, or fragile by team members and supervisors if they spoke about experiencing poor mental health or recurrences of substance use, especially when these struggles were somehow related to their employment (see Box 7). These concerns take a unique form for CBHWs because highly sensitive elements of their personal history are public knowledge in their workplace. While CBHWs are often encour-

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Box 7 – Professional Relationships: *Supervisor and Team Support*

"I think peer recovery specialist needs to be hired in pods or groups, two or three at minimum, so that you can have that collegial experience and to be able to support each other because our perspective is different, and our ethical boundaries are different. They're not clinical. Even if someone is very respectful of who we are and what we do, they still might not get it. Continuing to have that connection with other peer recovery specialists, I think, is extremely important." –Interview #20, PRS, Male

"She's flexible, but she always told me like, 'I want you to take your days off off.' She's big on that. I was talking to one of my coworkers, and he says he leaves his phone on too and that one day, he texted our supervisor because he got – it was an emergency text, and he was like, 'What should I do?' She was like, 'Why do you have it on?' He was like, 'I heard it, and I just looked, and something bad, and now I cannot ignore it.' She's very big on making sure that we have time to ourselves." –Interview #1, CHW, Female

"In this world you wanna hide that you're an alcoholic or that you had issues, whereas this was – it's almost an asset. It is an asset that you have experience with substance abuse. Right from that interview, my boss, he – and it's not – it's genuine. He made me feel like that's an asset for this job, and the more honest you are, the more appreciated you'll be. That was exactly what I was looking for. That's exactly what I need in order to feel safe at a job. My supervisor is just awesome. He's like, 'I'm one of you.'" –Interview #6, PRS, Female

"I wondered if or thought that if I'm upfront about how I'm feeling, right now, emotionally, am I gonna be viewed differently because I'm the peer because I think that can be an issue? I've not seen it much here at the agency that I'm at now. I've seen it a little bit, where people will talk about self-care is really important for peer specialists, and I'm like, 'Yeah, because it's important for everybody. That's why.' I understand where that assumption comes from, but – yeah, there have been times where I was concerned if I'm upfront with what's going on with me now, will I be viewed differently than if it was the social worker or the case manager saying the same thing?" –Interview #8, Male, PRS

aged to ask for additional support when struggling with burnout or secondary and/or vicarious trauma, participants expressed that accepting this support could be seen as an admission that they were less able than colleagues. This pressure was compounded by the burden of feeling, as a person from a marginalized and stigmatized group, that part of their role was demonstrating in practice that people from their community were capable of positively contributing to the organization as professionals. Another fear participants shared was that mental health or addiction history could be used against them in the context of workplace disagreements with supervisors or while advocating for better work conditions.

Doctors' and nurses' attitudes. Participants shred a wide range of experiences, both positive and negative, of working with doctors and nurses. Most participants described multiple and regular experiences of stigma (see Box 8). They felt disparaged by medical professionals who negatively reacted to their appearances (such as wearing more casual clothes as part of their role – a theme especially present among African American participants) and their education levels (especially as evidenced by speaking in working class vernaculars, African-American Vernacular English (AAVE), or a primary language other than English). Interviewees shared that their understanding of patients' needs were devalued relative to the judgments of medical professionals.

Interviewees also described participating in consults or case meetings where doctors or nurses used stigmatizing terms like "frequent flyers" or spoke disparagingly of "addicts" in their presence, seemingly unaware that the CBHW would experience these remarks as directed against themselves as well. We heard numerous stories of medical professionals

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Box 8 – Professional Relationships: *Doctors' and Nurses' Attitudes*

"People go for years, decades in school and they put in a lot of time and a lot of classes and a lot of papers. I feel like sometimes I walk in and this person is like who are you? What is your qualifications? Because you're not talking like we do, how come you are here when I'm the smarter one? That's literally how I get the little looks or the little huh or the *[laughter]* right?" –Interview #9, CHW and PRS, Female

"There were a couple of times that we 'certed' people at <Health Facility>, and it was the clinician and nurses call. They're the ones with the license and that are credentialed to do that, but at the same time, sometimes I felt like they were maybe overstepping the need for hospitalization. If you gave this person a little bit more time just to talk and to destress and come down, maybe they wouldn't need to be hospitalized. There were definitely times that I questioned whether someone really needed to go to the hospital against their will." –Interview #8, PRS, Male

"I think having the whole organization being a recovery-oriented system of care, where people are using person-centered language, avoiding stigmatizing language – calling someone by their diagnoses label rather than referring to them by their name or just as a human. That is something I think is really important, that if you're gonna bring a peer recovery specialist in – I think it should be happening across the board no matter what, but I really think if you're gonna bring peer recovery specialists in – and it's hard to sit in on a meeting and your providers talk about patients in a derogatory way with the talking about things that you've experienced." –Interview #20, PRS, Male

"I had to teach every single person that I met, every single member of the team what a peer specialist was because they never had one at this particular location before. They had them at the agency but not here. They were using peer specialists in a very inappropriate way. They were basically using peer specialists as basically the grunt work that case managers didn't have time to do and transport. We do all of the – we do do transport, but that is – we're not Uber. They were treated like Uber." –Interview #21, PRS, Female

questioning the presence of CBHWs in clinical spaces, preventing their access to clients, reporting them to security, or requesting administrative services that fall outside of their role descriptions. CBHWs from communities of color experienced these kinds of aggressions regularly at their workplace, a fact that points to the intersection of racism and class hierarchy that is operationalized by the (more) elite and protected classes of professionals in treatment and medical settings.

In comparison, some participants spoke highly of doctors and nurses who expressed gratitude for their work and for their ability to provide insights into patients' situations that would have otherwise escaped the care team. Several participants expressed their respect for doctors who collaborated in addressing patients' non-medical needs, such as keeping a patient in the hospital until space in a shelter could be secured or writing letters to judges on behalf of clients to help prevent reincarceration.

Defining appropriate metrics

In addition to concerns of funding and stability, participants also discussed grants in the context of defining metrics. Several participants described grants requiring metrics such as number of calls or frequency of client contact, which did not always align with clients' stated needs (see Box 9). In other cases, the nature of the client population made keeping in consistent contact nearly impossible due to clients' lack of access to phones or stable housing. Many participants noted that these metrics did not align with their own understandings of the purpose or function of their roles. For example, one CBHW saw the expectation that clients should attain full independence, and therefore cease contact after the conclusion of services, to be in opposition to genuine connection.

The majority of participants did not believe grant metrics captured the often messy and non-linear progress made by clients or the most valuable work that they performed.

Box 9 – Defining Appropriate Metrics: *Different Goals from Different Stakeholders*

"I have a couple people that are highly addicted to methamphetamine and it's like their homeless, there is really, literally no way for me to get ahold of them except for when they come into the emergency department. If I miss an opportunity and I do not get contacted it's just – that's difficult." –Interview #10, PRS, Female

"Well, the goal is to actually have them to be able to do some of the stuff that I've done for them on their own and move on. Now, that don't really align with me because I just know that it doesn't work like that. When you help somebody, and someone trusts you, and they comin' to a crisis, and you've been there when everybody else has given up on them, judged them, and you've been through, pretty much, just about everything they been through, they're not gonna not call you." –Interview #2, CHW, Male

"Well, he passed away. He lasted a lot longer than he would've if he wasn't part of the <Clinic>. That's first and foremost. The second part is the victory, to me, was that he died at home with his family. His family didn't get a call sayin,' "We found him." Now, they got a bunch of questions. They could never be at peace 'cause they think that somebody give him some bad drugs. Who was he with? Who left him? He died sober in his family's home surrounded by his family. They all are at peace . . . They can all not just move on with their life and forget about him, but actually let him rest in peace." –Interview #2, CHW, Male

"As learned here, what I define [as] success was nothing of what I've learned here. I think that what I've learned success to me is through this role is, if he has six goals and we accomplish one, I feel successful because that was one less thing that he has to worry about, she has to worry about. This has taught me that success is not measured in how fast you run and how much you achieve, but that what you achieve, you achieve. That it's solid and that they're able to say I mastered this. I think that that's – to me, that's success." –Interview #15, CHW, Female

Participants discussed their understanding of success as being tied to individual clients' stated goals, which vary wildly and – especially during the first year of the COVID-19 pandemic – were tied to immediate needs rather than goals required by funding organizations or grants. The notion of small successes arose frequently, as participants spoke of the importance of celebrating incremental progress based on the understanding that all markers of wellbeing are valuable. One particularly salient example of this divergence involved a participant's client who died after a period of time working together. The participant explained that though the loss of a client would be considered a failure by traditional metrics, the CBHW recognized the immense value of having reconnected the client with their family prior to their passing. This framing is demonstrative of the complexity that is lost in strictly defined grant metrics.

A further difficulty in defining metrics of success within grant frameworks was attributed to the unmeasurable nature of the personal relationships that defined success for many participants. In addition to general expressions of closeness with clients, these successes manifested as the knowledge that a client will call the CBHW instead of engaging in harmful behavior, feeling trusted by clients, humanizing clients to coworkers or outside providers who failed to understand their situation, and clients looking to CBHWs for hope that their own lives can improve. These types of interactions sat at the heart of the role for the majority of participants, indicating the importance of recognizing (and rewarding) these types of successes despite the difficulty of quantifying them.

Unrecognized aspects of the role

Participants described validating clients' experiences while navigating healthcare or mental health treatment as a key component of the CBHW role. Because CBHWs hold both identities shared with clients as well as their professional roles within treatment contexts, they are able to independently verify the realities of clients' experiences of racism, discrimination, stigma, and not being heard by providers. This aspect of the role is particularly important because internalized hierarchies and stigma often lead clients to doubt their own experiences with providers.

Existing literature emphasizes that CBHWs are "missing links" or "bridges" between services and communities. This label generally refers to CBHWs' role in connecting clients to resources. Participants in this study also highlighted a linkage in the other direction: CBHWs provide clinicians with information about patients that they would not otherwise be able to attain (see Box 10). This information often includes the concrete realities of patients' socioeconomic conditions and overall life circumstances. In effect, CBHWs lessen the information gap that may arise due to lack of access (both physical and sociocultural) to the physical spaces that patients inhabit outside of the clinic. A bridge of a third sort can also be formed within the care team, as many participants described how sharing their own experience with the clinical team subsequently allowed for a more thoughtful and empathetic approach to patient care, including by shaping the outlook and approach of younger providers.

Box 10 – Unrecognized Aspects of the Role

"We also can give information that the nurse care manager never sees. She doesn't see inside the home. She didn't see how the person lives. She doesn't smell the person when they're not coming to the doctor's. There's so many factors that, when somebody goes into a medical appointment versus going to somebody's home, that are different. I think it – once again, is that we're that bridge between community and medical health." –Interview #13, CHW, Female

"The clients say it that, 'Yes, my case manager helps me get housing. My therapist helps me with this or that. My prescriber does another thing for me, but you're the only one who hears me and sees me without stigma, without judgment.'" –Interview #13, CHW, Female

"I feel like I'm given the opportunity to help shape some of our doctors' futures that's gonna be in these emergency departments practicin' medicine, whether it's gonna be around the world. Bein' a community health worker and given the opportunity to share my story and lecture classes or have these medical students follow me around, I'm shapin' the difference where they're gonna look at people with social determinants of health differently." –Interview #2, CHW, Male

" . . . we accept that it's appropriate [to] share my own experience with my team, my colleagues on my team, so they have some understanding of what it's like from the perspective of someone that's been through some of these things . . . " –Interview #8, PRS, Male

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Discussion

This study highlights the importance of understanding the experiences of CBHWs themselves in evaluating how this role functions in practice. These experiences have a complex relationship to delineations of CBHW roles that exist in training materials, grant outcome statements, and Federal government publications. Most CBHWs that we interviewed see their responsibilities as substantially exceeding written job descriptions and sometimes perceive the formal framework of their employment as misaligned, if not conflicting, with their actual responsibilities. Additionally, they reported widespread misunderstanding of their role by both supervisors and coworkers in traditional health care, SUD treatment, and mental health settings (see also Felton et al., 2023). As the Federal Government, state agencies, researchers, and providers advocate for the expansion of these roles, the evaluation of their effectiveness, as well as impact on CBHWs themselves, must start with an empirical understanding of actual work conditions and functions, rather than existing (and largely prescriptive) role descriptions. The same caution should hold for research based on metrics and datasets that reify existing role descriptions.

At the time of our interviews, almost all of our participants reported staying in their current job despite insufficient compensation and because they "love the work." Without minimizing the benefit that this emotional connection provides (especially to members of groups devalued through stigma), it is important to observe that the contradiction between emotional satisfaction and financial viability represents a widespread potential for the exploitation of a vulnerable workforce. Given that the emotional value of the work derives from the CBHW's shared identity with the community served and, in some cases, their recovery identity, the danger exists that employers can exploit "loving the work" in exchange for increased work responsibilities or forgoing tangible benefits such as upward economic mobility. Along similar lines, some CBHWs reported staying in underpaid and under-resourced positions because they worried that they would not be able to find other equally meaningful work due to their incarceration history, lack of formal education, public

history of addiction, and other stigmatized life experiences. More attention needs to be given to the structural conditions, including "War on Drugs"-era policies that disqualify formerly incarcerated CBHWs from other areas of employment, that maintain CBHWs as a "low cost" workforce and the consequences of this status for the CBHWs, their families, and their communities (Dower et al., 2006; Pallas et al., 2013; Rodriguez, 2022).

The majority of our participants report struggling to balance a standardized workday with the demands of working with clients who regularly experience some level of crisis. While this dilemma preexisted the COVID-19 pandemic, it appears to have been exacerbated by the simultaneous reduction and increased demand for social and psychological services. One response of supervisors, asserting that CBHWs should develop "better boundaries," misunderstands the nature of the emotional connections between CBHW and clients. By generating a conflict between institutional expectations and the responsibilities felt by the CBHW, this approach creates the conditions for "moral injury:" a profound injury to self created by the perception of betraying or violating one's moral obligations. At the same time, this dilemma appears to be a false dichotomy created by an inflexible structure. Future research should explore a variety of options for defining CBHW roles in relation to crisis response, including options such as alternative working hours, increasing the CBHW to patient ratio, teams of CBHWs working with individual clients, additional training of CBHWs in crisis planning and response, and more salaried CBHW positions.

This study deepens the understanding of "shared experience" that defines the CBHW's role. Participants commonly used the language of "missing link" and "bridge" in relation to their work in broadening medical and behavioral health professionals' understanding of their patients' experiences. Alongside the work of bridging clients to care (the widely recognized "systems navigation" aspect of their role), CBHWs underscored the work of translating the realities of their clients' lives into terms that were accessible to providers with no comparable experiences of stigma, poverty, racism, and other forms of disenfranchisement. As Pérez and Martinez describe, CBHWs are "'natural researchers" – they can observe and relay community realities to outsiders.' (2008) Without the CBHW's knowledge of patient circumstances, many of the impacts of social risk factors would remain invisible even within the most thorough clinical history. These avenues of non-clinical knowledge are of similar consequence for public health more broadly. The "practical role" of CBHWs and the information to which they have access "can improve system structures and inform how resources are allocated" (Pérez and Martinez 2008).

Another novel aspect of the CBHW role that emerged across interviews was the extent that patients use the CBHW to "reality test" their experience of discrimination in the face of their own self-doubt. Given her position as a professional employed by the institution and a person with lived experience, the CBHW is able to affirm the client's reality, discuss the consequences of different possible reactions (complaint, compliance, confrontation), and motivate the benefits of accessing resources or care even in those cases where the experience is negative. The sense of allyship-from-validation can also allow the CBHW place negative events within a larger context, helping an individual to weigh the costs of disengagement for the client and others in their lives. There may also be an emotional cost for the CBHW, who can experience this work of reframing challenging situations as normalizing abusive institutional dynamics that they themselves have experienced.

Themes concerning the main challenges of working with clients were consistent regardless of the particular nature of lived experience and shared community of the CBHW/client. This suggests that core facets of the CBHW's role may relate less to the specifics of addiction, mental health, homelessness, or incarceration and instead are a response to forms of racism, stigma, and especially poverty experienced by members of these groups. In particular, the poverty of clients was a shared theme across interviews although it is not necessarily a defining characteristic of the populations or communities in question. This raises the question of whether health conditions like SUDs or mental illness are, in practice, being used euphemistically, obscuring the main problem that CBHWs confront each day: the daunting range of systemic obstacles that impoverished and economically precarious clients face accessing physical health care, mental health treatment, and social services. The risk here is that mischaracterizing problems faced by these clients leaves critical aspects of the CBHW roles unrecognized and CBHWs under-supported in confronting structural issues that, at the level of patient advocacy and systems navigation, are intractable more often than not.

Limitations

These interviews occurred in the wake of the COVID-19 shutdowns and the severe curtailment of social services, especially housing and mental health care, during a period of time when the demand on these same resources was magnified. This context heavily influenced our interviews. Participants reported a number of pandemic related impacts, including struggling with isolation, the challenges of working with clients remotely, inadequate personal protective equipment, assuming the responsibilities of closed agencies, and a lack of hazard pay, among others. At the same time, the main themes that emerged in our analysis related to structural and role definition issues that preceded COVID 19, even if the pandemic appears to have intensified their impact. Nor do these issues seem to have abated in the time since we finished our analysis. In the words of a CBHW quoted in a recent article on burnout among harm reduction and substance use disorder treatment workers: "The new normal has become a nonstop crisis" (Unachukwu et al., 2023).

Many CBHWs see advocating for the importance of the role as a core component of the role itself. Additionally, the public knowledge of CBHWs lived experience among coworkers often leads them to perceive that their competency, both as an individual and a member of a stigmatized community, is continuously on trial. While there is no question that our participants were sincere in praising the benefits of the role, this larger context may have informed how participants framed the position's challenges, potentially leading them to understate its personal costs. Similarly, CBHWs in recovery from addiction often participate in cultures, such as 12-step fellowships, that stress gratitude, hope, and service as core recovery values. In some interviews, this culture may have shaped how participants narrated their experiences as CBHWs, likewise leading to an accentuation of the benefits of the role at the expense of personal costs and challenges.

Finally, it is important to note that Rhode Island is a small state with tightly linked communities. These shared networks may be reflected in the frequency that certain themes appear in our interviews. While we endeavorer to interview CBHWs working in a variety of settings, many of our interviewees attend trainings together, participate in the same Facebook discussion groups, or know each other from community contexts such as recovery meetings.

Our interviews therefore captured one moment within a larger discussion among CBHWs as well as the individual experiences of the participants. Because of our community-engaged methodology, the research process itself came to participate in the development of advocacy surrounding the role. Project Weber/Renew, a peer-led Harm Reduction organization, utilized an earlier presentation of our findings, combined with an online survey informed by this research, to write an open letter to the State of Rhode Island on CBHW work conditions. This letter resulted in a working group attended by a number of peer-led organizations and a presentation to the Governor's Overdose Task Force. As a result of this presentation and an earlier walk out held by peer organizations, several changes occurred in state policy, including an increase in funding for organizations conducting outreach and a minimum wage for peer outreach workers in some state contracts. Self-reflexively accounting for this type of feedback will be important for future qualitative research with these communities, especially as more CBHWs themselves come to participate in research through community advisory boards, acting as research assistants, authoring articles, and other avenues.

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