"Carrying the weight of a broken system": Community Health Worker and Peer Recovery Specialist roles transformed

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ABSTRACT

The Problem: Recognizing the scale of challenges faced by the behavioral healthcare industry, there is a growing call to expand the utilization of community-based health workers (CBHWs). However, neglecting to fully understand the complex realities of working in these roles risks undermining the true costs and sacrifices made by CBHWs as we strive to reshape healthcare policies and systems. **Purpose of Article:** Drawing on 21 interviews we conducted with CBHWs in Rhode Island, we describe the evolving role of CBHWs within traditional healthcare settings and identify policy and practice implications. **Key Points:** CBHWs have been taking on the burden of a broken healthcare system while experiencing role transformation. **Conclusions:** CBHW roles were designed in terms of a desired vision of the healthcare system – rather than the fragmented, overburdened institutional landscape that presently exists. Efforts to support CBHWs, without addressing the scale of role transformation, will continue to push much of the day-to-day labor underground.

KEYWORDS: Community health research, Substance-Related Disorders, Mental Health Services, Health Care Reform, Health Care Quality, Access, and Evaluation

The Problem

The U.S. is grappling with a mental health and addiction crisis made worse by a lack of accessible resources. In the past year, nearly 58 million adults experienced mental health concerns, but only 47% received mental health services.[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) 2023-2026 strategic plan proposes an increase in the paraprofessional and peer support specialist workforce to help address the behavioral health crisis.[5] SAMHSA's plan states that the expansion of peer support can extend care, diversify the workforce, and "complement or, in some cases, replace clinical supports" (p. 51).

Today a professional role in healthcare and other services,[6,7] peer support and community health workers can be traced to the 18th century. In response to stigma, exclusion, and ineffective or destructive interventions, peer support arose through Indigenous movements, mutual-help groups, and community organizations in the 19th and 20th centuries.[6,8] Community health workers began to be recognized in the U.S. healthcare system in the 1960s. In contrast, it wasn't until the latter half of the 20th century that peer support became a recognized profession. Initiatives like the Affordable Care Act (ACA) in 2010 and the Department of Veterans Affairs' national effort to adopt peer support in 2012 expanded peer support.[6,9] Once sources of wisdom and mutual-aid in community spaces, professionalized peer support and community health workers became a "bridge" between institutionalized services and disenfranchised communities.

With the expansion of roles came the expansion of titles, such as peer recovery specialists, recovery coaches, outreach worker, harm reduction worker, and more. Regardless of title, peer-to-client relationships share common principles: equality, reciprocity, respect, honesty, mutual responsibility and power sharing.[6,8] Because of these similarities, and the complex, fluid, and intersecting functions of these roles, we describe these various roles as part of a larger, rapidly expanding workforce: 'Community-Based Health Workers' (CBHWs). CBHWs help clients access health care, substance use disorder

treatment, social services, and community networks. They assist in navigating bureaucracy, utilizing online portals, transport, and maintaining engagement in care. Identity is central to how peers support clients given that they "often have similar cultural beliefs, chronic health conditions, disability or life experiences as other people in the same community."[10]

CBHWs report feeling inspired by their work. However, they face numerous challenges.[12–14] There is a lack of consensus on core competencies, training, and certification requirements, resulting in variations in training programs and titles across states and organizations.[9] CBHWs working in substance use treatment encounter discrimination, role conflicts, and uncertainties about sharing their lived experiences.[2,15,16] In one survey, peer coaches reported that they often felt stigmatized and not respected by coworkers.[17] Pay also remains critical, as CBHWs historically receive low wages.[15,17–19] These factors contribute to burnout.[20–22] Adequate supervision may help,[14,16] however, in a recent survey, recovery-orientation of the workplace and clarity of the peer's role were the only factors significantly associated with job satisfaction and lower emotional exhaustion, respectively.[22] Substantial research, especially internationally, documents forms of gender discrimination that female-identified community health workers face.[23] Research on racism and the work experiences of CBHWs is less developed, but there are indications that this is a concern,[24] signaling that the workplace-based challenges that CBHWs confront should be analyzed through an intersectional lens.[25]

Purpose of Article

By delving into the experiences and perspectives of CBHWs, we aim to shed light on structural challenges CBHWs face within healthcare systems and make recommendations for public policy and practice. From September 2020 to April 2021, the authors conducted in-depth, semi-structured interviews with 21 community health workers (CHWs) and peer recovery specialists (PRSs) working in Rhode Island (RI) to gain insights into the evolving role of CBHWs within traditional healthcare settings. In an earlier publication, we present our main empirical findings and describe our method and sample in

detail.[24] In this article, we aim to describe in greater depth the context of our community partnerships leading to this work, and the CBHW role transformation described by those interviewed, to explore implications for public health policy and program construction.

In 2020, the Lifespan Transitions Clinic, which is part of a national network of clinics that employ community healthcare workers in providing primary care to formerly incarcerated individuals, began working with a student (SA) to research challenges that CBHWs were facing in traditional healthcare settings. This project[24] informed the implications described herein and reflects the obstacles that the clinic's own CBHWs experienced. The CBHWs working at the Lifespan Transitions Clinic played an important role in conceptualizing the study and piloting interview materials. As we began to analyze interviews, CBHWs from across the Lifespan hospital system came to discussions of the findings. From there, our partnership grew organically, reflecting the close networks that exist between CBHWs across local institutions and agencies. The beginning of this research was also during a period of increased activism among the CBHW community in Rhode Island. In September 2021, peer-led organizations held a "walk out" of the governor's task force on Opioids and Overdoses to protest funding cuts. In October 2021, two authors (JS and RV) publicly presented results of the interviews and CBHWs came from organizations across the state, two of which later played a recording of the presentation of findings in the staff meetings of peer-led community organizations. In September 2022, one of us (JS) drew on this research and the surrounding conversations to contribute to an open letter and presentation about CBWH work conditions to the Governor's Opioids and Overdose Taskforce by Project Weber/Renew and other organizations. After the appearance of our first article, the Community Health Worker Association of Rhode Island held a public forum to discuss our findings that was attended by people working in CBHW roles from across the state.

The level of public engagement in our research process reflects the fact that three of the authors have extensive experience working in peer roles (AM, SN, JS) and three authors identify as being in long-

term recovery from addiction (AG, AM, JS). But, the engagement also reflects the fact that our community-engaged research strategy gave members of the CBHW community a platform. In addressing how to better support CBHW positions, the focus has been on training, compensation, and supervision. Although raised repeatedly in these discussions, these suggestions miss something crucial that has become visible during the shutdowns of the COVID-19 pandemic. Both those interviewed and public interlocutors told us that the CBHW role itself has changed in ways that depart from the description in trainings, programs, and state guidelines. As researchers, the consistency of this message forced us to reevaluate our prior understanding. We initially saw discrepancies between the CBHW role definition and what CBHWs do in practice as implementation challenges or insufficient support. In contrast, we were being told that these differences reflected the inadequacy of training, supervision, and ethics *frameworks* built upon an incomplete understanding of the CBHW role, given what the CBHW role frequently requires in practice. This assertion that the field had collectively misunderstood important elements of the CBHW role, we have come to realize, has important normative policy implications.

Key Points

"Carrying the Weight of the Broken System"

Almost all of the CBHW's interviewed wrestled with the nature of the CBHW role when confronting the seeming intractability of social determinants of health. We heard multiple times that it was impossible to support client's self-determination or recovery goals when struggling to help them meet basic needs. In trainings and program descriptions, CBHWs are described as "systems navigators," but our participants frequently described healthcare, housing, social assistance, family services, and the behavioral health system to be fragmented, opaque, and sometimes hostile. CBHWs are meant to act as "resource brokers," yet were told repeatedly that resources are often not available during the critical window of help seeking and, in some cases, entail months or years of waiting. Our participants explained that they see their role as compensating for gaps in our existing health care and social safety net: *[Figure 1 - Quote 1]*

> *"there's no clear path to the work that we do 'cause the system's so messed up. We come to a standstill where we can only do so much to get people set up for housing, and then it's a big waiting game."*
> Quote 1

This "waiting game" threatens to redefine the dynamic between CBHWs and clients by intensifying the stakes of the relationship. Participants described building relationships of trust to maintain engagement while waiting for appointments, treatment, or social assistance that sometimes never materialized—and then attempting to re-engage clients after experiences of disappointment that seemed to confirm expectations of stigma, betrayal, or abandonment by "the system." Past a certain threshold, we heard repeatedly, trust often wears thin. The CBHW is no longer seen as an ally, but as "the system's" representative, and so assumes the burden of its broken promises. "What can you actually do for me?" is a rebuke that rings in many CBHW's ears, especially those working with the unhoused. On the CBHW side, this dynamic was experienced as working against time before the crucial thread of trust erodes. [Figure 2: Quote 2]

> As one participant stated, they *"hope during the weight of the broken system that they're [the client] gonna be okay and survive that weight 'cause eventually, they will get their help. It just takes too much time."*
> Quote 2

In some instances, participants believed that other mental health professionals referred clients to them when it was impossible to make further progress–"*washing their hands"* of intractable situations by handing clients and then claiming a successful *"referral."* These dynamics pose a question that is both deeply personal and strikes at the heart of the CBHW role: how do you promote trust in institutions and providers whom you have reasons not to trust yourself?

Abandonment During COVID-19

The COVID-19 pandemic intensified demands on the CBHW role.[14] Unplanned shutdowns coincided with an increased demand for mental health services driven by depression and anxiety, job loss, rising levels of substance use, and an intensifying overdose pandemic. In the midst of this upheaval, our participants expanded their responsibilities, in many cases acting as first responders.

[Figure 3 – Quote 3]

> According to one participant, *"we were actually some of the only ones that were visible while all these other places were closed, and people were confused and needed more help because it created that much more anxiety amongst the masses of people."*
> Quote 3

Some of our participants were given the option to work from home but decided to stay *"out on the streets"* because there was no one else to help their clients. Participants described the cumulative impact of losing clients, co-workers, friends and family members to a combination of overdose, coronavirus infection, and suicide.

[Figure 4 – Quote 4]

> *"It was a hard time,"* one of our participants recalled, *"I seen how it was affecting the peer recovery specialists. There were a lot who had to take some time off. It's tough. It's mental — not being able to provide support."*
> Quote 4

Some participants described this entire period in terms of holding on until help came for themselves and their clients—help that never seemed to appear.

Housing and Mental Health

While the first two years of the pandemic accelerated the CBHW role's transformation, our interviews suggest that it was underway before early 2020. Our participants emphasized housing and mental health as the areas where our current understanding of the CBHW role as resource

navigator/systems broker fails. No matter how competent the CBHWs are at filling out paperwork such as housing applications, picking up the phone, and making referrals, the barriers to accessing housing and mental health services run exceptionally deep. Several interviews made this point: [Figure 5 – Quote 5]

> *"there's not enough services for what these patients need. A lot of times, there's—I feel like that the system—it's a system thing and not so much our job thing."*
> Quote 5

Waiting for housing and therapist appointments was a context where role boundaries can become blurry. Lack of resources pushed participants to exert a great deal of emotional and physical labor to act creatively and improvise solutions on a client-by-client basis, at times acting outside of their defined role. The pressure to stand in for an unavailable therapist appeared to be particularly strong for CBHWs who work with clients who are not necessarily in acute *clinical* crisis—and therefore ineligible for a "higher level of care"—but still experience ongoing human crisis due to a combination of poverty, precarious housing, and substance use. Moreover, when these clients do face situations that rise to the level of "danger to self or others," acute services or inpatient treatment are frequently unavailable, or clients will not engage them due to past negative experiences. CBHWs regularly find themselves triaging, taking calls or addressing situations outside of work hours, and providing therapeutic support—sometimes in ways that lie outside their training or official roles. In turn, this has impacts on the CBHWs relationship with their supervisors, as CBHWs sometimes respond to well-intentioned efforts to enforce work-life balance and professional boundaries by dissimulating their level of involvement with clients.

Moral Injury

"*I wish we had the power because it's… but we just don't*," was a refrain throughout our interviews. Building a professional role around an individual's identity as members of a community, and then placing them in situations where it is impossible to fulfill that role, risks emotional harm, burnout, survivor's guilt, and moral injury. "Moral injury" describes trauma that arises from participating in,

failing to stop, or witnessing an act that violates a core tenet of one's moral worldview. Since the start of the COVID-19 pandemic, moral injury has become a general concern among health care and mental health providers.[28,29] In the case of CBHWs, the risk of moral injury is magnified by their responsibility for developing engagement in inadequate services and systems. The CBHW's participation in the client's betrayal can be experienced, in an unmediated way, as a betrayal of self, tied to "shared fate" with their community. This risk is particularly great for CBHWs who are in recovery from substance use disorder, who sometimes understand this work as "service" (a component of some recovery pathways) and integral to their own journey. The pain of perceived failure was searing across our interviews:

[Figure 6 – Quote 6]

> *"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."*
> Quote 6

A smaller number of interviews (n = 3) utilized a moralizing language that described clients as, *"not ready yet," "not really wanting it,"* or having a *"lack of gratitude."* Making attributions to assign responsibility or blame to the person experiencing harm can be a protective mechanism for the witnesser, especially when the witness shares some personal or situational similarity to the person being harmed.[30] In a protracted crisis with few solutions in sight, it is all-but inevitable that a need would emerge to psychologically protect oneself.

Conclusions

In response to this research, we have been asked what government agencies and providers can do to better support CBHWs. The September 2022 letter that we (JS) collaborated on with Project Weber/Renew and others flagged steps that should be taken immediately: increasing Medicaid

reimbursement rates and grant funding to support a living wage; more salaried or exempt peers; CBHW teams to facilitate peers taking take time off; minimum required supervision hours; improved supervisor training and wider uses of peers as supervisors;[13] addressing precarity created by dependence on short-term grant funding; increased possibilities for career advancement; and reciprocity agreements with other states so that CBHWs can seek inpatient support without encountering colleagues or clients.[31] Extension of mental health support for CBHWs is crucial–but this should be offered independently of employers, rather than as workplace-based resources, to ensure that CBHWs see these as confidential and independent rather than as a mandatory aspect of employment. There is a strong tradition of professional organization and activism among Community Health Workers, especially internationally (see e.g., Community Health Impact Coalition https://joinchic.org/about/). Peer Recovery Specialists could be included within this movement or develop their own organizations, such as unions, that represent their interests independently of employers, funders, and state agencies.

That being said, "the cat is out of the bag." It would be a mistake to address the gap between existing role definitions and emergent realities by doubling down on the existing role definition. We need a new, richer conceptualization. Efforts to support CBHWs, without addressing the scale of role transformation, will continue to push much of the day-to-day labor underground. In systems theory terms, the current approach to supporting CBHWs may be understood as a particular kind of policy error, which we call "the fallacy of the idealized system." This fallacy arises when a program or role is designed to address a systemic shortcoming, but its attributes and functioning are specified in terms of the desired outcome rather than the current context within which it is deployed. The context of actual deployment, however, determines the limits and scope of its real-world functioning. In other words, CBHW roles were designed to address gaps within existing services, but the functioning of the role was defined in terms of a desired vision of the healthcare and mental health systems – rather than the fragmented, overburdened institutional landscape that presently exists. We cannot expect the role to function as intended if the surrounding systems themselves are in protracted crisis. Without an unprecedented expansion of

affordable housing, mental health care, and substance use disorder treatment, CBHWs will continue to be placed in situations where they triage emergencies with insufficient resources and extemporize replacements for services that do not arrive in time. More supervision and support provided to peer workers will help, but they will not resolve this basic dilemma. The main request that most CBHWs make is for resources to properly help their clients.

CBHWs currently working in the field clearly cannot wait for this scale of investment. In order to support the existing workforce, we should begin with an understanding of the role as it exists in practice.[13] Two promising avenues are beginning to be explored. First, we could provide CBHWs more in-depth training in manualized mental health interventions. While we are not suggesting that CBHWs perform long-term psychotherapy, in practice they already provide extensive mental health support utilizing clinical tools such as motivational interviewing and cognitive-behavioral therapy-based skills training, drawing on formal training as well as their own experiences as clients. Recent research suggests that CBHWs can deliver manualized interventions such as Seeking Safety with equal effectiveness as licensed clinicians.[32] Second, we could recognize that many CBHWs, especially those who work at the frontlines of the mental health and overdose crisis, function as first responders and merit equivalent compensation and support as other emergency personnel. Currently, the CBHW role is sometimes conceived as an entry level position that allows people early in recovery or recently released from incarceration to find employment and develop professional competencies. In many cases, we argue, the role is demanding and requires highly developed skills of improvisation, code-switching, perspective taking, emergency crisis management, and case-by-case problem solving. These are skills that many (but certainly not all) CBHWs have acquired from life experience, but they can take years of work and training to integrate fully into their professional practice.

Despite the challenges highlighted in our interviews, participants made clear that they “love the work” and find it deeply fulfilling. Importantly, this “love” was interwoven with a sense of obligation, despite perceiving the role as financially and psychologically unsustainable. It is this sense of obligation

that requires us to understand the unintended consequences of asking CBHWs to (in the words of one of our participants) *"carry the weight of a broken system."* In a recent news article, one interviewee captured the consequences of role transformation: *[Figure7 – Quote 7]*

> *"Our job was not originally to manage the housing crisis. It was to provide overdose prevention, interventions, Narcan, talk to people who are in active drug use or living with people who are in active drug use so that we can make a dent there. Now we have been thrown into this tumble dry of the housing crisis and it is taking the wind out of all of our sails."* – She spoke anonymously out of fear of losing her job.[33]
> Quote 7

She spoke anonymously out of fear of losing her job.[33] If we continue to expand our reliance on the CBHW role without addressing its transformations, we risk scaling harm.

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