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

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Welcome to *Progress in Community Health Partnerships'* latest episode of our Beyond the Manuscript podcast. In each issue of the Journal, the editors select one article for our Beyond the Manuscript post-study interview with the authors. Beyond the Manuscript provides the authors the opportunity to tell listeners what they would want to know about the project beyond what went into the final manuscript.

In this episode of Beyond the Manuscript, Editor-in-Chief, Hal Strelnick, interviews Arryn Guy, John Soske, and Anthony Thigpen, three of the authors of, ""Carrying the weight of a broken system": Community Health Worker and Peer Recovery Specialist roles transformed."

Hal Strelnick: Good morning. This is Beyond the Manuscript, a production of Progress in Community Health Partnerships, and today we're going to be speaking with a team based in Rhode Island. Before we get into that discussion, I want to just highlight that the focus on community health workers and peer support and peer educators also appears in two other manuscripts being published in the same issue of the journal. The first by Nguyen, is entitled *Program of a Peer Support Group by and for Formerly Incarcerated Women*, and it's in our Work in Progress in that section. In our Education and Training section, a manuscript by Lapidos, et al., is called *Employing Community-Engaged Approaches to Develop and Implement E-Learning for Community Health Workers and Peer Specialists*.

The manuscript we'll be discussing today is entitled *Carrying the Weight of a Broken System: Community Health Worker and Peer Recovery Specialist Roles Transformed*. With us today are three of the authors—Arryn Guy, Anthony Thigpen, and Jon Soske—and I'm going to ask them to introduce themselves and give us a sense of what role they've played in the work they're going to be discussing. Let me start with Arryn, and then you can pass the microphone around.

Arryn Guy: Sure. Thanks, Hal. Hi, I'm Dr. Arryn Guy. I'm a clinical psychologist. I'm actually currently an assistant professor in the psychology department at Illinois Institute of Technology, but I worked on this with Jon and Anthony and others when I was a postdoctoral fellow at Brown University. I am in long-term recovery from alcohol addiction, and a lot of my research focuses on developing peer support interventions, focused on health disparities among LGBTQ individuals. Jon really invited me in on this project, I think, for my perspective as a clinical psychologist and someone who has worked in HIV clinics with peer recovery support specialists, and also thinking about the broader landscape of peer support, and what supervision can look like, how do we envision this as it starts to scale up in future years. I will turn this over to Jon.

Jon Soske: Hi, I'm Jon Soske. I am also a person in long-term recovery from alcohol and drug addiction, and a researcher currently based at the Center for Complexity at the Rhode Island School of Design. I have

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also worked as a peer recovery specialist in different spaces over the last five years. Right before we started working on this article, I was at an organization called RICARES—Rhode Island Communities for Addiction Recovery Efforts—where I worked as a peer recovery specialist, an outreach worker, and a trainer. I've been involved in the peer world for the last five years, providing peer support, training peers, as a consultant helping to develop and build peer programs, and now as a researcher of peer and CHWs.

Anthony Thigpen: Hello. My name is Anthony Thigpen. I am a community health worker, peer recovery specialist here at Brown Health. I am also a program coordinator for another program called Connect for Health. Here in Providence, we help disenfranchised families and members of the community. We support and help them with different barriers that they face on the social determinants of health wheel. As a community health worker, because of my lived experience and formerly being incarcerated, I have acted as the bridge, not just for the patients and the community, but also for the healthcare providers. I view myself as a healthcare provider, and, again, like I said, my past experience, my lived experience with formerly being incarcerated, I was one of the first community health workers that Lifespan hired with lived experience and formerly incarcerated. Again, I act as the bridge for the patient and also the provider.

Hal Strelnick: Thank you. Would you describe the partnership that you all created and were involved in that led to the work that you've been doing and publishing? Jon?

Jon Soske: I'm probably the best person to start us off, and then Anthony can pick it up. This article has multiple origins and really came out of multiple partnerships. About a year into COVID-19, I took a job at the Transition and Recovery Clinic at what is now Brown University Health. The Transitions Clinic is part of a national network of clinics serving formerly-incarcerated patients, organized around teams of formerly-incarcerated community healthcare workers. It is a powerful, and now increasingly well-studied model. I came into the clinic on a SAMHSA educational grant, but started to play something of a kind of role of an informal director of research, and there were a set of projects already underway, one of which was a student project looking at experiences of community healthcare workers and peer recovery specialists working in more traditional healthcare settings: hospitals, clinics, substance use disorder treatment facilities.

This project was inspired by, but also became part of, a set of conversations about how the CHWs on the Transitions Clinic team were being treated by the healthcare entity that they were working in. Anthony can speak to some of this even better than I, but the clinic was running into repeated experiences of direct racism against CHWs, CHWs not being admitted to see patients, CHWs being asked to leave hospitals even though they were wearing their badges, a whole litany. We could spend the podcast talking about some of the harassment and backlash CHWs faced. Also, what became clear in the midst of COVID is everything shut down, of course, and when everything shut down, by and large, the people who were there to take up the slack were community healthcare workers and peer recovery specialists.

I joke with my wife—she sometimes talks about the lockdowns and social isolating—I was working as a peer, and didn't isolate for a day the entire pandemic, except when I had COVID. Peers and CHWs were out on the streets, and they were filling these holes left by the fact that providers had closed doors, and, in some cases, community-level institutions had just collapsed. It was really striking to me that CHWs and peers already knew how to do this. Part of the reason why is that they had been,

for years, operating in relationship to hostile systems, in contexts where they did not have enough resources, and, often, kind of working against systems and institutions to fulfill the function that they claimed they were fulfilling, like providing healthcare to marginalized people, but in fact were failing to do in practice.

Both of these currents, I would say, started to come to inform our research into the work conditions of CHWs and peers, the kind of institutional backlash and harassment they faced entering into clinical spaces, but also this really critical work that they were doing, really compensating for systems crises. When we began to do our interviews with the CHWs and peer recovery specialists, it was clear that this didn't start with COVID-19. It might have intensified under COVID-19, but peers and CHWs for a long time had been filling these gaps where systems were failing, or, in some cases, systems just didn't really exist, that what appeared to exist on paper, in fact, wasn't there, particularly for people who are poor or from racialized communities. I think, Anthony, you could take over the conversation from here.

Anthony Thigpen: Yes. To what Jon was saying about the things that the community health workers faced, the level of racism and discrimination we faced, it was thankful that we had people like Jon and other members of the team that were able to support us, and start this conversation to where we're like, "Hey, the community health workers need to get treated better. We need to start looking into this. They are the ones who actually are doing pretty much most of the work." That started happening, and then we fast-forward to COVID, where, again, another point that Jon made, it was only us out there working. I only took time off when I was affected by COVID, when I was sick, I had COVID. But, other than that, I was in the field. I believe the other community health workers, we all realized that the work we do, we can't do from home, we couldn't do on a Zoom, we couldn't do on a phone call, such as picking a person up from the ACI, getting them to a shelter, getting them to be able to stay in a shelter after "misbehaving", taking them to register, and finding out and navigating that whole system with probation, parole.

There were many things that the community health worker took on the responsibility of. The team and the partnership that we have with our whole team, we supported each other, and higher-ups gave us the tools that we needed so that we can go out and do the work on a high level. But that was our team, who understood, the administration in our team who understood our challenges, our barriers, and what we were facing. I'm hoping that kind of gave you a good answer to your question.

Hal Strelnick: This is a follow-up to what you just said. It sounds like the team formulated a way of convincing the leadership in the organization to be more responsive and aware of the issues you were facing on the ground.

Anthony Thigpen: No, just our team, like the administration is actually where we ran into a lot of our problems and our barriers, but it was the general, immediate team of the three physicians that we had, Jon, and the community health workers. The physicians, the providers, the primary care physicians, they were the ones who understood how important it was. Even they were calling us to come back out of the street because they wanted to protect us, but it was the community health workers who understood that we'll be all right, but the people out there that are homeless, and being released from prison or trying to get into treatment, they are the ones that are going to need us more. They understood, they gave us what we need so we can do it, and they were our eyes, ears, and our mouthpieces for the administration if the administration felt like we were a liability or this can be a hazard to us, so it wasn't the administration, it was our team.

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Hal Strelnick: Thank you. I'm glad you clarified that.

Jon Soske: Hal, if I can—

Hal Strelnick: Please, Jon.

Jon Soske: —take his thought forward. You asked about the partnership around the article, and what Anthony and I are describing is the partnership started in the structure of the clinic, the Transitions Clinic model that was physicians, researchers, and CHWs working together. But as soon as we started raising some of these issues, it had much broader resonance, both broader resonance among the CHWs working at the hospital that we were affiliated with, but also these discussions were happening around the state in different corners as people were increasingly frustrated about being paid barely a living wage, while doing this kind of essential work that Anthony talked about, about clinical supervisors who often didn't understand the peer role, but having tremendous power over how peers and CHWs were doing their work. But, also, COVID showed a lot of internal, you could say, cultural and structural weaknesses to community-based and health organizations, so kinds of exploitation that existed before the COVID-19 pandemic.

There was something of a grassroots movement that started to cohere amongst community healthcare workers and peer recovery specialists across the state. As we were working on this research, I would put snippets up that we were writing or sometimes interviews, onto social media, and then acquaintances or friends at other healthcare organizations would pick up the discussion and then develop the argument. In some ways, this article was written in public in dialogue with CHWs and peers across the state. Then, about a year and a half into doing the work, Rahul Vanjani—who at that point in time was the lead clinician at the Transitions Clinic—and I gave a public talk on the peer workforce, really directed at the State of Rhode Island, BHDDH, but also to kind of puncture some silence in the field.

It's like we've spent so much time making the case for these roles that we've not really talked honestly about the impact that these roles have on the people doing the work. I think people from a variety of peer organizations came to Rahul's and my talk, that the recording of the talk got played in staff meetings in community-based peer organizations, and so it just managed to tap into a conversation that had already been developing, in part, I think, because the people involved in the article were in recovery, in part because the origins of the article were already in this partnership model. But, also, because we were willing to think publicly and talk through this work with our community as we were trying to write this up.

Hal Strelnick: That's very helpful to understand. One of the choices in writing the article you made was to describe community-based health workers, but the vocabulary includes things like community health workers, peer educators, peer coaches, patient navigators, systems brokers, peer recovery specialists, as in the title of the other manuscript. I wonder if you would help me parse any real difference there is among those different categories.

Anthony Thigpen: Well, I think that in regard to whatever organization that a peer recovery specialist works in, that's where they would probably be able to identify the hats that they wear. For myself, I'm pretty much all of the above, and that's because of the lectures that I participate in, the discussion panels, some of my appearances at some classes to where I've had students change their major; I have been part of thesis projects. I think whatever organization that the community health worker or peer recovery specialist

is part of, I think that's where they pretty much identify themselves and say, "I'm a peer educator," or "I'm a peer navigator." I have trained a lot of the peer recovery specialists and community health workers in the state of Rhode Island, so I think that it all depends on the organization. Me, personally, I believe we all wear many hats out here in the field because we get things done that no one else can do without the red tape.

Hal Strelnick: A question about Rhode Island. Some states have well-defined terminology and requirements for certifications. How does Rhode Island handle that?

Anthony Thigpen: Well, I think it's pretty much the same model, where you have to be certified. I want to say I think it's easy here to be certified. I think the training, personally, has become watered down and more policy-based versus trauma-informed. But Rhode Island's model for community health workers, I think, is growing the same way it is around the country.

Jon Soske: I think it's really normal for people to be trained, like people are trained as CHWs and peers, but they're also passing through these jobs, so the same person will work across organizations doing very similar work with a different job category. People who are trained as peers and trained as CHWs will be on the same team, and they'll learn from each other, kind of swapping skillsets and approaches and frameworks. There is, at a certification level, a peer recovery specialist certification and a community healthcare worker certification, and some push for people to be co-certified. In practice, I think, a lot of people take bits and pieces of multiple roles. I mean, I certainly know of contexts where people are classic CHWs, and contexts where people are classic recovery coaches.

But, by and large, I encounter more people who are, as Anthony said, wearing multiple hats at once. The other thing that has become clear about this workforce as we've done more research into it is the majority of people working in these roles aren't certified, for a variety of reasons. Part of the reason we chose this broader terminology, community-based health worker, is to make both clear this mobility across the roles, and how people were inventively combining the roles in different contexts, but also that there were these invisible layers to this workforce that I think may well be the majority of this workforce that are people working in these roles without certification, or sometimes even training.

I think that's probably more from both political economy and the sociology, looking at the workforce much more broadly is probably more accurate even though, for different reasons, people have a lot of investment in particular job titles and in descriptions. I think this is a perfect example of the state sees and organizes things in one way, and actually how things function on the ground is radically different.

Hal Strelnick: I wanted to ask you about the manuscript that you published before this one, and the work that was involved, before we focus on the title of your manuscript again. Who would like to take that?

Jon Soske: Arryn, you have been pretty quiet.

Arryn Guy: Okay. Well, Jon, please feel free to fill in anything that I miss. Yeah, so I think the other article, it comes from the same interviews that Jon and his team conducted with peer recovery specialists and community health workers, and that other article does a better job of sort of highlighting the breadth of themes that we heard from those folks that we interviewed, including some of the joys and reciprocity that comes with working in a peer recovery specialist or community health worker role, that there is a lot of meaning that people draw on these roles. But it also really highlights some of the

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issues with compensation, and Anthony, I think, highlighted this a lot, with how community health workers and peer recovery specialists were really on the ground almost like first responders during the COVID-19 pandemic, and compensation doesn't reflect that, necessarily.

Some of the other themes that came up specifically, which I think is really something interesting, and perhaps a blind spot for a lot of systems or administrators that might not notice these aspects, are community health workers or peer recovery specialists, maybe before having that position, would benefit from things like SNAP or other benefits from being low-income. Then, once getting to the level of pay for a peer recovery specialist or community health worker, they no longer qualify for some of those benefits, but don't get paid enough to actually have a living wage. They're sort of in this ironic in-between of having a full-time job, no longer having time to sit in lines and advocate for themselves for getting some of these things, like one of our interviewees said, "It takes time to be poor; it's time-consuming."

So, no longer having that time, and then, also, having health insurance, where co-pays are more expensive now, and so there is more negotiating of, "Do I go to the doctor because I have this $25.00 co-pay that I used to not have?" We really kind of emphasized some of those other themes, and then, in this paper, I think we try to highlight some of the more policy implications, and specifically this theme of moral injury, which we can talk about more.

Hal Strelnick: Well, let's answer the question about what you each thought about the title in terms of carrying the weight of a broken system, and how each of you have a perspective on that that I would like you to share.

Anthony Thigpen: Well, I think, for me, that the title was in real time for us community health workers. It's still a broken system. Us, community healthcare workers, came in and did the best we could with what we were working with, and our work has caused these conversations, and things like these podcasts and these discussions about the way a community health worker is treated, and how much work they have done. Again, I say that we're the bridge because, in this broken system, a lot of the providers don't even think twice about the way they care for a person. The same way with the whole system, the administration is far removed from what actually happens on the ground, the way a patient is getting taken care of and treated, and how their workers are actually getting treated. At the time of this article, we were the ones that were carrying the weight of a broken system, and still is.

Arryn Guy: Yeah, I think to add to that, what we see is that community health workers, in this idealized role, they're someone who can help someone access resources, or know which resources to ask, and then feel comfortable accessing those or get some assistance with that. But, when the resources aren't available, or the waiting lists are so long, then community health workers are sort of trying to make up for those lack of resources, or having to find these creative solutions to sort of fill in the gaps. From a mental health perspective, particularly what I'm interested in is how community health workers are then serving as crisis counselors, needing to determine on their own what rises to the level of, say, a higher level of care versus, "Is this something that I can handle in my own sphere?" I don't think that that's necessarily acknowledged, how much mental health care that community health workers are providing in the moment, and how much kind of triaging and decision-making they're needing to do on a day-to-day basis and outside of sort of the 40-hour workweek.

Jon Soske: I feel like we could talk for hours about this title. I'll just add two points, which is, one, I think we really wanted to throw some cold-water realism on how people think about this role. In all of the versions of this role, people talk about community healthcare workers or peers as resource brokers and systems navigators. Don't get me wrong, peers and CHWs definitely do that work. They help people navigate systems, and they find resources for people. They're very good at it and inventive, and do it in inventive ways. But, often, the system itself is hostile, especially to people of color, but also people who use drugs, and, often, the system itself is highly incoherent. We're working on another article called *The Myth of the System*.

We call things systems where they actually don't necessarily have the kind of coherence that we imbue them with, so how do you help people systems-navigate a system that is, in many respects, hostile to them, and is often not a coherent system itself, like the mental healthcare system. Also, resource brokering assumes that the resources exist, and we heard time and time again they don't exist for mental healthcare, and they don't exist for housing. Yes, people are systems-navigating on resource brokering but they're doing something in addition to that that's far more difficult, demanding, and inventive, which is they're stepping into these places where the system has really collapsed, has stopped functioning, and finding ways to support people's survival in these spaces.

That's what we wanted to point to, that this really was not an accidental element of the role, it's what the role has evolved into given the depth of crises in American healthcare, and in the American mental health system. The other thing I think we're trying to underline, and Arryn already spoke partially to this, is this moment, this gap between where you as a CHW or peer have started to build a relationship of trust with somebody, and when resources like housing or mental healthcare arrive. This can be a gap of days or hours, but it can also be a gap of months and years. That gap is a gap that people are finding ways to fill, often by acting, really, as ad hoc therapists, counselors, even kind of family support.

But it's also a gap that puts enormous pressure on this relationship, because if you keep telling people, "Engage, engage. We'll get there, trust me," and the resources don't arrive, then you, as a CHW or peer, are starting to become the face of the system that's betrayed people time and time again. So, we have to talk seriously about this gap as a key part of the role, and how we're training and supporting CHWs and peers as they're trying to fill this impossible gap of waiting, which really has risked transforming the nature of the relationship between them and their clients.

Hal Strelnick: I think Arryn referred to this before, this is beginning to examine the issues of moral injury. How do you view that, and, also, how do you see corrective change happening?

Arryn Guy: In a kind of traditional sense, we think about moral injury as something that happens for maybe soldiers when they're in war and they're asked to do things that are sort of against their core values in service of another task that they're being asked to do, or we think about this a lot during the COVID-19 pandemic and with frontline healthcare workers, needing to make tough decisions in the moment that might be against kind of core values. We think about applying this in the case of community health workers and peer recovery specialists with this gap that Jon described, where you are asking someone to step into this role based on an identity and lived experience, to build more trust with folks who have been mistreated and had many negative experiences from the healthcare system, and kind of broker or use that trust-building to re-engage folks. But then what happens, when you are,

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as the community healthcare worker, saying, "Okay, trust me. Yes, keep re-engaging, the resource will come," and it never comes?

I think another aspect that we haven't talked about enough as a field is how do we provide supervision and support to community health workers and peer recovery specialists who are inherently in a multiple relationship with their clients? I think from a psychologist or a counselor perspective, we often talk about our ethical code to try to minimize multiple relationships because it can help with some of these ethical dilemmas. We don't want to be providing therapy to someone that I also have a close relationship with in my community because then, when really challenging things happen, it's easier to have a boundary. But, in this case, inherently, the role is a multiple or dual relationship, so then what are we asking peer recovery specialists and community health workers to do when we say, "Well, just don't answer your phone after a certain time"?

In our other article, one of the interviewees talked about, "Do I not answer my phone and hear that one of my clients OD'd the next morning, or do I pick up the phone at 10:00 PM?" It also puts community health workers in this position to feel like maybe they shouldn't be telling their supervisors how much work that they're actually doing in outside hours, because the supervisor would say, "Well, you're being maybe unprofessional if you're picking up the phone." But they really need to pick up the phone to feel okay with the role that they're in and the closeness that they have with the community.

Hal Strelnick: That's sort of a prescription for burnout.

Arryn Guy: Absolutely.

Hal Strelnick: Jon, go ahead.

Jon Soske: Another thing I would add to this is CHWs and peers carry a double burden of stigma and discrimination. They are members of marginalized communities helping other members of marginalized communities navigate spaces that are often discriminatory toward both of them, and we have a kind of strange disconnect about this. We understand, for example, that people who use drugs and people of color are often treated quite poorly in emergency departments, so we ask peer recovery specialists or CHWs of color to work with and advocate for these patients in emergency departments without recognizing that that means the CHWs and the peers will face the exact same kinds of discrimination that their patients do. In fact, in a way, we face it in a double form, because we face the stigma or discrimination ourselves, and we witness the stigma and discrimination our patients experience, which lands doubly on us.

This isn't accidental to the role. This really is an intrinsic part of the role, and it raises all of these ethical questions about what does it mean to ask people to confront racism and stigma in this manner, and if we're going to do so, what kind of institutional support do we throw behind them to minimize these experiences, and make sure when they do happen, they're corrected promptly and transparently, and forcefully. It's like we've done a classic psychological splitting in terms of this role, right? We designed this role because the healthcare system is failing certain groups of people. Yet, then we're asking people from those same groups to enter those same spaces to advocate for the people who we're failing, yet we're not drawing the consequences of this, that we are putting people in situations of structural discrimination and stigma, and asking them to bear the weight of that stigma as part of trying to correct the situation. Yeah, I'll stop there.

Hal Strelnick: Anthony, would you like to respond to the issue, as well?

Anthony Thigpen: I think Jon and Arryn hit that nail right on the head.

Hal Strelnick: The next question was really if you were developing genuine corrections, improvements, what would they look like short of a total transformation of the capitalistic, mixed-economy healthcare system that we have inherited, which is a huge business, as well as a huge employer and important service? What would be the approaches you take to correcting at least this level, the issue of the on-the-ground peer educator, peer specialist, community health worker to improve things, short of a total transformation of the system?

Anthony Thigpen: Well, I think there are numerous things that could change, and they could be very small. I think the way we approach people can be something that's done over the next couple of months. The reason why I say that is that from my experience, I don't see an approach of, "How do we make this work?" or "How can we make this work?" The approach is always, "You broke the rules, this is the policy, and there is nothing else I can do about it." Language. I think the language that we use in these spaces—these are all small things that we know that we would want for our own family members, our own friends when they walk in these spaces. The mission statement is for a person to leave out of these spaces feeling better than they came in, and so there are things that we could start off, little, and start to change the system brick by brick, but we have to acknowledge that these little things are taking place.

A lot of times, there is zero accountability because of things like unions, and stuff like that. I think we have to re-write a lot of this stuff, but we can start with little things of showing the patients that they are heard. There is a thing where—how can you say I can't be 15 minutes late to an appointment because life has happened to me, but want me to be okay and understand that I've been sitting in here waiting for an hour to be seen, and you want me to understand that life happened to one of your staff this morning? It's just those little things that we can get back to taking care of our people, not just our patients, but of our workers. Our workers face many challenges and toxic workplaces, as well, so it's a whole wraparound that we can start in any one of those topics and spaces with just something small to change.

I mean, the lighting in these hospitals looks like a prison. When you're walking up to some of these hospitals, it's very dull, the walls look the same as a cell, and so these are little things that we could change, small things. When you talk about changing a system, everybody thinks about the big thing and the cost. It doesn't cost nothing to treat a person with respect and dignity, or the way we would want our family member to be treated, period.

Hal Strelnick: That's very elegant and true.

Anthony Thigpen: Thank you.

Jon Soske: It's always hard to top anything Anthony says. I love being on panels with him and I hate being on panels with him. For me, one thing is to recognize just how highly skilled these roles are. They're often seen as roles which people early in recovery, or just released from incarceration, can enter into as entry-level roles, and supported correctly, they definitely can be that. But that gives the sense that they're not highly skilled and not highly demanding roles. But the roles, to do well, require things

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like code-switching, case-based problem solving, improvisation, crisis management, de-escalation, a kind of multiculturalism, a kind of institutional literacy—*[Jon lost connection]*

Hal Strelnick: Well, let me ask one last question, which is Rhode Island is a small state, and different, certainly, than California, or New York, or Washington State. Thoughts on some of what this might be unique to Rhode Island?

Anthony Thigpen: I'm from Boston, Massachusetts, and I live here in Rhode Island now. Just the fact that Rhode Island is recognizing that community health workers haven't been taken care of, haven't been given the recognition that they deserve, and how much they mean to this work. Again, having people like Arryn, Jon to come along and start these conversations, and start to get people to look at the broader work that a community health worker or peer recovery specialist has done. Rhode Island, from what I see, is one of the states leading the charge on getting this thing out there where people understand what it really takes to be a community health worker and the many hats we wear, the vulnerability that we have, and just a bunch of things. I'm thankful that I'm actually a part of this movement, to be able to help out community health workers coming behind me, and coming behind them, so we're leading the charge in some ways.

Arryn Guy: I'll just add that I think something that's unique with Rhode Island, especially Providence, Rhode Island, which is the big city in Rhode Island, is very close to the Massachusetts border. It could be a suburb of Boston, almost. It's about 50 miles away from Boston, and so community health workers and peer recovery specialists, I think, are often navigating the state differences in legislation about certification across Massachusetts and Rhode Island, and are probably getting certified in both states to be able to do work across those states as they are just so close together. I mean, when I lived in Providence, I went to the Target in Massachusetts because that was the closest Target. Yeah, even though they're separate states, it really feels like one place in some ways.

Anthony Thigpen: You might want to repeat the question for Jon. Jon is back.

Hal Strelnick: Jon, we saw that you lost the connection momentarily. We've been just talking about what is unique about Rhode Island related to this issue, and perhaps you have some thoughts since you do mention in the article about some of the activism of your group.

Jon Soske: Yeah, Rhode Island, I mean, it's the smallest state in the country, and you definitely feel it here. You have the closely-knit, tight communities, and many people who are just deep Rhode Islanders, like no matter how long you've lived in Rhode Island, if you weren't born in Rhode Island, you will never truly be a Rhode Islander. That creates bonds of really strong trust. People have intergenerational knowledge of each other's families, of communities. Community feels a lot less abstract when we talk about it here sometimes, like people mean the neighborhood they grew up with in South Providence, a particular swimming pool, a particular set of streets.

All of that I think really fed the discussions around this article, it tapped into really strong relationships of trust that had been strengthened during COVID-19 in the way that we had to look out for each other. I mean, COVID-19 was also this period of time where we were losing people every week from overdoses, from COVID, from suicide, so this article was also written during a moment of real trauma for the peer and CHW community, and I think that intensified some of the activism around the article. I think another element to the Rhode Island landscape is you have fewer funders,

so that means more intense competition over funding at an agency and program level, and sometimes that can lead to people not wanting to rock the boat.

If you talk about the fact that peers in your program are really struggling, it might sound like you're saying you're really struggling, which might sound like you're saying you don't deserve to continue to be funded. I do think there are positive ways that the smallness of Rhode Island contributed to these discussions, but it might have also led to a reluctance to talk publicly about just how much this workforce struggled, and just how much pressure it faced during COVID-19, so benefits and drawbacks.

Hal Strelnick: Well, I'm glad that you all shared your experience in this manuscript, and that you've shared more with us on this call and with this podcast. I want to thank you. You're doing groundbreaking work, and I think you're right, Anthony, that Rhode Island is being a leader in this space, and you should be proud of your work, and we're proud to be publishing. Thank you for this much longer discussion than we originally planned, but that's because of its richness, so thank you.

[End of Audio]