Digital Recovery Support Innovations Technical Expert Panel

Executive Summary & Report

Virtual Convening
July 27th-28th, 2023

Realizing Recovery: *Policy & Practice Improvement Series*
Office of Recovery
Substance Abuse and Mental Health Services Administration
U.S Department of Health and Human Services

A special thanks to each participant for their time and dedication towards advancing the field of recovery.

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Executive Summary

Digital peer support is defined as live or automated peer support services delivered through technology media such as peer-to-peer networks on social media, peer-delivered interventions supported by smartphone apps, and asynchronous and synchronous technologies (asynchronous technology facilitates communication between peer support specialists and service users without the need for communication to happen in real time).[1] SAMHSA's Office of Recovery convened digital recovery support service (D-RSS) subject matter experts to review various topics related to D-RSS to assist in identifying priority areas in need of additional examination. The concept and utilization of D-RSS is not a new one, however, the advances in technology, the shift to a more digital world brought on by the COVID-19 pandemic, and the increased use of peer support in addressing mental health and substance use disorder conditions have prompted rapid growth in D-RSS's[2]. The goal of the Digital Recovery Innovations Technical Expert Panel (TEP) was to assist the Office of Recovery in developing a list of the top priority areas facing the digital peer recovery support field. At the conclusion of the TEP, the panelists agreed on three priority areas needing additional examination:

- Identifying risk and benefits of digital opportunities for under resourced and underserved populations,
- Discussing role clarity for the peer workforce in a digital setting,
- Understanding regulatory oversight of D-RSS, including patient privacy and data protection laws,
- Research to ensure delivery of quality services, and a common language that multiple sectors impacted by D-RSS can use to easily collaborate.

The following is the summary of the virtual TEP meeting that was convened July 27-28, 2023.

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[1] Fortuna, K. L., Venegas, M., Umucu, E., Mois, G., Walker, R., & Brooks, J. M. (2019). The future of peer support in digital psychiatry: promise, progress, and opportunities. *Current treatment options in psychiatry*, *6*, 221-231.
[2] Bergman BG, Kelly JF. Online digital recovery support services: An overview of the science and their potential to help individuals with substance use disorder during COVID-19 and beyond. J Subst Abuse Treat. 2021 Jan;120:108152. doi: 10.1016/j.jsat.2020.108152. Epub 2020 Oct 4. PMID: 33129636; PMCID: PMC7532989.

Day One Welcome and Introductions

Kristen Harper, Public Health Advisor within SAMHSA's Office of Recovery, welcomed the meeting participants, and reviewed the purpose of the meeting: to advance recovery from mental health and SUDs across the nation by:

- Discussing the current landscape and status of digital recovery support services (D-RSS) including the benefits, challenges, and opportunities of these approaches.
- Revealing innovations – particularly to engage underserved and under resourced populations; and
- Identifying activities and efforts that SAMHSA's Office of Recovery and/or others could initiate to address identified challenges.

It was noted that SAMHSA has published an Advisory on using technology-based therapeutic tools in behavioral health services but this document did not include recommendations for digital recovery support services, specifically.

> **"Digital Recovery Support Services is new and exciting but also needs further exploration."**
>
> Ms. Tarino

She then introduced Danielle Tarino with Code X as the meeting moderator. Ms. Tarino is an expert in bioethics, specific to privacy, confidentiality, and health information technology development.

Ms. Tarino shared some community standards for the meeting which were derived from the Rules of the Road developed at Harvard Medical School's' Center for Bioethics.

Paolo del Vecchio, Director of SAMHSA's Office of Recovery, then welcomed participants and shared that information from the meeting will help SAMHSA in generating guidance on the use of D-RSS.

As an ice breaker, participants were requested to introduce themselves and share current technology they are exploring. A few technology tools mentioned included Insight Timer, Ellipsis Health, Spotify, the Domino's app, Facetime (to speak with grandchildren), and "any app that my clients benefit from."

Overview of the Current State of Digital Recovery Supports
Karen L. Fortuna, Ph.D., LICSW Geisel School of Medicine, Dartmouth

Dr. Fortuna's presentation focused on four key aspects:

- **Defining D-RSS** – Simply put, this is any technology that is a means for human connection. It can include live real-time services or automated approaches. She shared a survey that showed the array of ways individuals access digital support. They ranged from video conferencing to smart-phone communications and apps and even video game approaches. D-RSS helps to expand access and allow for addressing "micro interventions." But it also can create digital fatigue.

> **"Technology should support human connection. We don't want to amplify isolation."**
>
> Dr. Fortuna

- **Assessing D-RSS** – Dr. Fortuna noted that typically data has been segregated between mental health and SUD (e.g., not co-occurring). With mental health digital services, assessments show enhanced hope and functioning; reductions in symptoms; and increased engagement in services. Similarly, assessments with SUD digital services show reductions in risky substance use; more engagement services; and high levels of satisfaction and perceived benefit.
- **Quality Assurance Measures** – Dr. Fortuna shared the following resources related to quality assurance measures:
    - A peer-journal article about core competences for digital peer support.
    - A video to guide peers on how to make informed decisions about digital use and offer their clients voice and choice in these services.
    - The website Digital Peer Support which provides information on certification, research, and technology projects.
- **Diversity, Equity, and Inclusion (DEIA) Concerns** – Dr. Fortuna also shared a short video on equity issues related to mobile health (mhealth) services.

Lived Experience with Digital Recovery Supports
Dan Lionett, President of Students for Recovery

Mr. Lionett is in long-term recovery and describes himself as a "vintage" (e.g., 50 year-old) college student. He is in college to help him realize his entrepreneurial aspirations.

> **"During the pandemic, technology saved those of us in recovery."**
>
> Mr. Lionett

Those in recovery were particularly at risk during the pandemic because of triggers from fear, politics, and isolation. However, being able to participate in meetings virtually helped, though there were admittingly drawbacks to this type of engagement.

Mr. Lionett recently participated in the Safe Project's Collegiate Recovery Leadership Academy which exposed him to other alternatives to recovery besides the traditional 12-Step Program.

He now tries to promote a more inclusive and safe approach to recovery support using an All Addiction Recovery Meeting format on his campus. He included the following examples of this:

- **Acceptance of medication for addiction treatment (MAT) –** This evidence-based approach has been a miracle to many.
- **Process Addictions –** Those who have these conditions (gambling, eating, love, sex, social media) can also benefit from recovery services.
- **Family Members –** Parents and siblings are welcome at his meetings.
- **Non-Religious –** There is not a requirement to accept a higher power to be part of the program.

In essence, the prevailing approach is to have services that make participants feel safe and included rather than have them first fit a "checkbox."

Follow up Comments and Chat

Following are some additional insights shared by participants:

- **Co-Occurring –** Courtney Pence noted that SUD is often a symptom, and the root cause is based in a psychological stressor. She stated that to provide holistic recovery the full spectrum of factors and experiences also need to be addressed. Digital apps may oversimplify the complexity of need.
- **One Size Doesn't Fits All –** A collaborative and person-centered digital ecosystem is needed.

Breakout Session Discussion 1

Participants met in four breakout groups to discuss the current state of digital support. Areas of focus included issues that impact DEIA, social determinants of recovery, wellness, training/certification, recruitment, retention, diversification, supervision, and career pathways in the digital space.

Following are the report outs from the group.

<u>Breakout Group 1 Report</u>

- **Accessibility/Readiness Issues** – Some individuals may not have access to broadband or digital readiness to access these services, especially in rural communities. This is a DEIA concern.
- **Peers** – Are peers trained on how to effectively use D-RSS services? Organizations should also protect peers from burnout associated with the potential 24-7 access that digital approaches can offer.
- **Data** – This can be an asset but also a barrier across the different steps of the process. It also is challenging because funding often requires data but a person in recovery may not want to provide it and thus it may cause attrition.
- **Defining Virtual versus Digital Support** –virtual services more closely mirror in-person level engagement.

<u>Breakout Group 2 Report</u>

- **Digital Peer Support Core Competencies** – Dr. Fortuna's information was new to many in this group, and they felt it was important to share it more broadly.
- **Accessibility** – Similar to feedback from Breakout Group 1, access to broadband is an equity and disability rights issue. Older generations may also have digital literacy issues. The group advocated that non-broadband options like phone and text need to remain as service delivery options.
- **Provide a Menu of Options** – There is no "right way to recover" so there should be no "right way" to access services.
- **Humility** – It is important to continuously ask people for what they want rather than thinking that we know better.
- **Incentivize Collaboration** – With funding, SAMHSA can incentivize opportunities to build collaborations across entities which can reduce competitiveness.
- **Pre-recorded Materials** – This can be another access channel for individuals.

<u>Breakout Group 3 Report</u>

- **Biases in Algorithms** – Efforts should focus on reducing this as they impact marginalized communities.
- **Asynchronous Resources** – There should be more discussions about text options.

- **Guidance on Consent** – Consent should have various options for the individual in terms of the storing and sharing of data. Also how is consent guidance developed and administered?
- **"Preliminary Evidence Suggests" Statement** – How do we get to the statement "evidence shows?"
  - Ethically, how do we get data into a repository to demonstrate efficacy?
  - How do we inform people about how the data is used and what value it can have?
- **Positive Data** – In addition to collecting data on the absence of something (e.g., interaction with law enforcement), data should also show positive impacts in an individual's life ("metrics of a meaningful life.")
- **Moving in the Right Direction** – DEIA discussions as well as person-centered approaches are positive beginnings that the field should lean more into.
- **Access Concerns** – This includes both equipment and providing education to improve literacy.
- **Quality Assurance** –It is important to connect the developers with the users to create meaningful measures.

Breakout Group 4 Report

- **Human-Centered Design** – Developers need to include the end user in the development of these products to ensure that they meet the needs and are user-friendly. This is important because some tech companies may not have lived-experience input.
- **Barriers to "Building for Everyone"** – While this is standard in the medical field, there currently isn't enough investment to allow for this. And private companies will focus on the communities that can pay. Advocacy is needed to get Federal investment into digital services just as is now done with telehealth services.
- **Successes in Accessing** – D-RSS has expanded access to individuals who could not obtain in-person services (e.g., recovery desert areas). This is a success to celebrate. But more work is needed.
- **Digital Literacy** – What is the role of peers in terms of helping their clients in selecting and then using D-RSS services?
- **A New Frontier** – D-RSS should be the right tool to do the right job at the right time.

Privacy Protection, Data Sharing, and Participant Consent

Robert Ashford, Ph.D., Founder, CEO, Unity Recovery, Recovery Link; David Whitesock, Founder, CEO, Commonly Well; Lisa Marsch, Director, Center for Technology and Behavioral Health, Dartmouth College

Using a series of guided questions, Ms. Tarino moderated this discussion on privacy protection, data sharing and participant consent.

What are the major protection concerns and data sharing issues that you see? And what vulnerabilities are there for those who are still in active SUD but are trying to stop?

Dr. Ashford noted the following concerns related to consent:

- **A Limited Training Protocol** – The environment of consent regulations is changing and there is also the issue of whether an individual with SUD in active use has the cognition to give consent. Peers have only limited training in any of these issues.

> **"Confidentiality, informed consent, and mandatory reporting are discussed in ethics trainings. But in some senses, it is still like the Wild West."**
>
> Dr. Robert Ashford

- **Applicability to Peers** – Peers are in a variety of settings and aren't clinical providers. So, there is the question of whether the Health Insurance Portability and Accountability Act (HIPAA) and/or 42 Code of Federal Regulations Part 2 (Confidentiality of Substance Use Disorder Patient Records)(42 CFR Part 2) apply. For example, most information collected is not protected health information (under HIPAA) so may not be covered under HIPAA.
- **Helping Educate Providers** – More needs to be done to educate providers. Just having a webinar or a handout on the issue isn't enough to provide support to the frontline providers, especially peers.
- **User Autonomy Should Include Data Control** – Recovery values the individual's autonomy and ownership of their care. In that regard, individuals should be the sole data owner and have the opportunity to direct not just their initial consent of data use, but also be allowed to opt out entirely later or choose segments of the data that they want to withhold.
- **The New Reality of Technology** – With the proliferation of social media access and D-RSS, new standard protocols are needed.

Are there lessons learned and takeaways from past and existing data sharing/privacy protection activities?

Mr. Whitesock noted most of the data collected is through self-report. It can be viewed in one way as personal health information or PHI and in another way as non-health related data. He was engaged in a project that reviewed guidance on data collection and noted that in terms of recovery data it is a "no-man's land" with a dearth of guidance.

He noted one valuable resource –Stanford Digital Economy Lab – which could serve as a model.

It specifically focuses on data protection for marginalized communities and is framed on the principles of permission, privacy, openness, and pluralism.

Mr. Whitesock note that his organization, Commonly Well, has provided [guidance on data ownership and privacy](). Some key points are:

- Participants own the data and organizations/peers are stewards of what is provided.
- It is never sold (a "hard rule").

Their approach is to rely on a public-benefit company which puts the principle of data protection into their charter. Mr. Whitesock also noted that while laws are helpful, there has been a wave of deregulation which has created a less protective environment for digital data.

What are the issues that you are tracking in terms data, privacy, and consent?

Dr. Marsch noted that Dartmouth's Center for Technology and Behavioral Health has been focused on digital therapeutics. These are apps that take clinical-grade interventions through the functionality of software. These have been shown to provide quality complementary support to individuals and improve clinical outcomes.

She noted that relevant considerations include the following:

- **Privacy –** How are privacy concerns communicated with individuals in a simple way? And can individuals compartmentalize the consent (e.g., share their daily diaries but not their geolocation)?
- **Data Sharing –** How do you enable data to flow according to a participant's preference? For example, an end user may want to have access to their own aggregate information or shared details with their provider/support person.
- **Food and Drug Administration (FDA) Approved Prescription Digital Therapeutics –** These are digital therapeutics that can be prescribed. The benefit of these is that they will be subject to FDA's regulatory oversight.
- **Data Harmonization –** While there is a lot of advocacy on this, standards are still lacking.

Can you speak to the distinction between end user and patient since an end user may not be covered by HIPAA and 42 CFR Part 2 protections?
While there is a Consumer Financial Protection Bureau (CFPB) which offers limited protections, there is not much protection for end users. He noted that apps can have complicated terms and conditions which people don't read and, if they did, might be unpleasantly surprised about what is stated.

He encouraged advocacy towards developing a framework to give end users additional privacy protections. He noted that the European Union has some model approaches that can be replicated.

We know that data has been sold. What are issues with monetization of data?

Mr. Whitesock noted that monetization of data is tempting for startup companies so they can finance their work. They need to have choices and other opportunities to raise capital in order to disincentivize this trend. He stressed leveraging blockchain technology so that individuals can manage their own data. And perhaps an option could be a capital market where the end user financially benefits from the monetization (e.g., gets a percentage of the revenue).

Can you discuss the issue of an individual's capacity to consent while in active use (e.g., under the influence)?

Dr. Marsch noted that there is a lot of variability among digital therapeutics. For example, some reside on the user's device and never share any data. So they are low risk. There is also interactive digital therapeutics where the user engages with others and is able to decide in real time what information they want to share.

Thus far, data have not identified any contraindications of approved digital therapeutics. This speaks not just to consent but how the therapeutics are developed (e.g., easily understandable for the targeted audience).

Dr. Marsch recommended two resources that address best practices regarding digital therapeutics:

- The [Digital Therapeutics Alliance](#)
- The [Division of Digital Psychiatry at BIDMC](#) run by John Torous

Lastly, Dr. Marsch highlighted equity as an issue in that digital therapeutics can increase access to care but also may have barriers (e.g., not covered by Medicaid, internet access). Dartmouth is conducting a scoping review to explore cultural issues related to digital therapeutics.

What about hacking concerns? Since 2009, there were at least 160 million health records compromised.

Dr. Ashford noted that insurers need to be included at this table because they will demand those cybersecurity protections be put in place. However, the issue is that some of the startups may not prioritize this because they don't engage with insurance entities and thus have no financial gain (and in fact would incur costs) by addressing this.

He added that there needs to be meaningful regulations with enforcement so that cybersecurity is not a "nice to have" but something that will have repercussions if it is overlooked.

Breakout Discussion 2

Participants met in four breakout groups to discuss privacy protection, data sharing and participant consent. Particular focus included issues that impact DEIA, social determinants of recovery, wellness, training/certification, recruitment, retention, diversification, supervision, and career pathways in the digital space.

Following are the report outs from the group.

Breakout Group 1 Report

- **Guidance** – There is already agreement on system types and protections as well as some guidance on how data information systems should be developed. This needs to be documented and resourced. SAMHSA is well positioned to do this.
- **Informed Consent** – In addition to providing different levels of consent, it is also important to train those who explain the consent parameters.
- **Not Conditioning Service with Consent** – Systems need to ensure that opting out of data sharing doesn't result in someone being blocked from services.

> **"There has to be a mechanism for consent that "hopes for the yes but honors the no."**
>
> Chris Hart

- **Focus on the Should rather than the What's Required** – Specifically, the focus should be on the higher intent rather than on meeting the minimal regulation requirements.
- **Lack of Diversity Today** – It was noted that participants in this meeting are not reflective of the diversity of the recovery community and more work is needed to improve representation of underserved communities.

Breakout Group 2 Report

- **Privacy Needs Have Evolved**[3] – 42 CFR Part 2 was inspired because individuals were not seeking treatment out of fear of arrest, loss of job, or child custody risks. The environment (technical access and opportunities) has changed considerably but the risks/fears remain.
- **Literacy** – Terms and conditions should be written at a third-grade level.

Breakout Group 3 Report

- **Empowerment** – This was the theme of discussions and focused on empowerment of both the individual as well as the organization.
- **Adopt the Strongest Regulation Approach** – The prevailing approach has been to adhere to the strongest regulation as a best practice. However, this might conversely deter smaller recovery organizations from participating.
- **Goodwill of Data Sharing** – It was noted that a suicide prevention initiative requested personal Facebook data to identify data. Many voluntarily agreed to do so for the greater good of saving lives.

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[3] Some of this background was shared by Ms. Tarino, the moderator.

- **Opt Out Options** – This should always be an option throughout the service period.
- **Measurement-Based Care** – How does data flow back to inform care decisions?
- **Grant Expiration** – A question was raised about the status of data after an organization's grant has expired and data is no longer required.
- **The Risk of Inaction** – While there has been a lot of discussion of risks in collecting data, there are also risks of not collecting data (missed opportunities in understanding).

Breakout Group 4 Report

- **Framework for Security/Privacy/Confidentiality** – Leadership is needed to build the framework for how community-based organizations should address consent and data sharing.
- **The Social Media Pandora Box** – Due to social media, information is already out there. Are there ways to manage/mitigate existing data from being sold and/or shared?
- **Simplifying Legalese** – Most people no longer read end user agreements. This needs to be simplified.
- **Capacity to Sunset/Delete Information** – Users need to have an option to delete information or have the reconfirm consent option after 60-90 days for example.
- **Consent While Under the Influence** – Can an individual give "informed consent" while actively using a substance (e.g., under the influence)?
- **Research** – How do organizations ensure that data used for research doesn't harm anyone in the future.

Follow up Comments and Chat

Following are some additional insights shared by participants:

- **Government Performance and Results Act (GPRA)** – The data collected by community based organizations in the field is reported to be cumbersome and may not be meaningful to their work.
- **Focus on Wellness** – This data is more meaningful than asking what drugs a person is using.
- **Mining Existing Data** – There is already a lot of existing data. There needs to be research and funding to build the tools that can help make sense of this data in a way that can support storytelling regarding recovery.
- **Near Term Policy Recommendations** – The Meadows Institute has developed policy recommendations that can accelerate the adoption of digital technologies. It includes discussions related to privacy and consent.

Day One Wrap Up

Ms. Tarino asked participants to provide one word describing today's meeting which is listed in the word cloud.

Day Two Welcome

To begin Day Two, Ms. Tarino asked participants to share any thoughts either of ideas that they would think need to be amplified, or ideas that were not mentioned during Day One. Participants noted the following:

- **Layers of Complexity** – Ms. Harper noted that there are many layers in recovery (peer, harm reduction, workforce) and the digital options add another layer of complication. She emphasized the need for strong management and guidance.
- **Artificial Intelligence** – This wasn't discussed yesterday but will be referenced during the technical panel today.
- **Harm Reduction Lens** – Jon Picard, IT Manager at Faces & Voices of Recovery, noted that harm reduction needs to be discussed in any recovery work, including with digital applications. He noted that since there could be harm or perceived harm in shared digital information, it is important to always have options so that an individual can choose what aspects of recovery services and information they want to participate in at all levels.
- **Barriers due to Criminal Justice Involvement** – Those in recovery often find employment barriers if they have previously been involved in criminal justice systems, even if they are seeking to be a peer. MJ Clausen noted that a complication is that there are multiple entities involved. There is the certifying entity, the employer, and even CMS which authorizes Medicaid reimbursement. If just one of these entities doesn't accept CJ-involved peers, it impacts hiring.
- **Training Individuals Currently Incarcerated** – Melissa Dittberner, Founder and CEO of Straight Up Care, shared that she is engaged in training peers while they are still

incarcerated. South Dakota has no regulations, so the barriers are low for this kind of work.
- **Marketing of Digital Products** – Participants shared several ways that they do marketing. This includes social media but most often in-person direct engagement opportunities (ads at malls and events). Others use word-of-mouth and have a high organic presence in online searches.
- **Entrepreneurship** – Dr. Dittberner had a grant that focused on peer entrepreneurship. She noted that this created greater buy-in into recovery programming.
- **Terminology** –Dr. Ashford raised the issue of the definition of digital (e.g., different from virtual, etc.). Others had varying definitions, but it was agreed that development of a common terminology was needed.

Peer Support Specialist/Recovery Coaching Workforce

Panel: David Awadalla, SAMHSA Public Policy Advisor; Holly Dixon, Clinical Director, Marigold Health; Jennifer Clarke, Certified Recovery Coach, Marigold Health; Melissa Dittberner, Ph.D. 'Dr. Mo', Founder, CEO, Straight Up Care

Using a series of guided questions, Ms. Tarino moderated this discussion on workforce issues.

Why did SAMHSA prioritize the development of [SAMHSA's Model Standards for Peer Certification](#) and how was that developed?

Mr. Awadalla noted that this was expressly referenced in President Biden's 2022 Unity Agenda. The development spanned over five phases and included:

- **Developing an environmental scan** of State SUD and mental health peer certification requirements.
- **Convening an expert panel** which included tech personnel, peers, supervisors, and State leadership.
- **Building a draft/framework of standards**.
- **Soliciting public comment**.
- **Analyzing comments** to develop a final public document.

Mr. Awadalla noted that the national model standard aims to promote quality of and consistency across peer services; limit barriers to expanding the peer workforce; relies on guidance from the peer workforce: and is based upon existing practices utilized by state certification entities. He noted that there are 11 standards/domains incorporated into the document:

Authenticity/Lived Experience	Work Experience	Ethics
Training	Background Checks	Cost and Fees
Examinations	Recovery	Peer Supervision
Formal Education	DEIA and accessibility	

The document also has a discussion of reciprocity strategies and definitions of common terminologies.

As an employer, what are the major workforce issues?

Ms. Dixon noted that because of the increased demand for peer specialists' standards have been lowered to allow for an influx of new workers. However, this also impacted the quality and in Delaware she noted that it has impacted on the level of trust and, unfortunately, also created stigma.

With regard to digital services, she noted that peers need to be trained on the technology. She also highlighted that there is a noticeable lack of diversity in the workforce with most peers being Caucasian females.

As a peer, how do you connect and build relationships using digital tools?

Ms. Clark acknowledged that it is harder to develop those intimate relationships with individuals through a virtual format. However, she also noted that virtual formats allow her to connect with an individual "in the moment" which is important as recovery can be a day-to-day struggle. Also, some individuals may find barriers to participating in an in-person session.

What more is needed to build a strong workforce. What's missing and what's next?

Dr. Mo noted that she has done some quantitative and qualitative (e.g., story timelines) research on what is missing/makes the difference in individuals staying with their recovery journey. Peers are a key ingredient for success.

Dr. Mo was a winner of the National Institutes of Health's (NIH's) SUD Challenge Grant for an app she developed and noted that it served as a slingshot for the development of her product. In terms of outreach, she has worked to "wiggle" into every system that touches individuals with SUD. Specifically, her app is comparable to a dating site in matching individuals with appropriate peers. As an example, those in the military prefer a peer who understands that experience.

She also stressed the importance of peers being supported by their employers. They are interested in being better educated but need to have the tools. She added that burnout is a barrier/concern and goes beyond self-care. It includes setting boundaries and guardrails for keeping safe.

With regard to peer training, it needs to go beyond multiple choice tests. It needs to incorporate critical thought and hands on work related to addressing implicit biases and development of a crisis plan. It also needs to be available online and allow for asynchronous access.

Share some thoughts on general peer support versus a Certified Peer Specialists.

Mr. Awadalla noted that what makes peers so invaluable is the lived experience and authenticity. However, it is important to be very general and allow the person to self-reveal what they choose. For example, a peer should not be required to reveal their diagnosis. In other words, there needs to be a balance between authenticity and privacy for the peer.

While there are three main certifications (SUD, mental health, and family), there are specializations that individuals value in their recovery journey. These include peers specific to the military, criminal-justice involvement, HIV diagnosis, and others. He noted that those veterans who were engaged in combat have indicated that this experience is important and a peer with non-combat military experience may not understand their concerns.

What are strategies for recruiting, retaining, and incentivizing the peer workforce?

Ms. Clark shared that Marigold has a vigorous recruitment and hiring process which includes interviews and role-playing, both by phone and on a digital platform. With regard to retention, there are a number of recovery-oriented activities including game breaks, hump day huddles, and opportunities for side chats. They work to have appropriate supervision and provide a competitive package. Lastly, they aim to support development opportunities through education and career advancement. Career advancement is just not peer-related but also in other department needs (e.g., IT, accounting).

As a peer, can you share what opportunities and career advancement you look for?

Ms. Clark shared that her goal is to remain as a peer, even though there is sometimes external pressure to be more clinical (e.g., become a counselor). However, she would welcome an opportunity to train other peers and share her experience.

The one concern that she has about digital options is that it erases boundaries, in that a person can contact a peer at any time. As a peer, she doesn't want to refuse a person in need. But peers also need to have a balance and find ways to set boundaries so that they can maintain care for themselves.

What keeps you up at night? Are there "wicked problems" in this work?

Dr. Mo noted that the resources are only helpful if people know about them. There is a need to increase awareness and incorporate peer support in all work. She stated that there is a need to educate other providers to reduce the stigma and ensure that peers are used appropriately. That they are partners and should not be viewed as competition to other professions (e.g., case managers and counselors).

Breakout Discussion 3

Participants met in four breakout groups to discuss the peer support/recovery coaching workforce. Particular focus included issues that impact DEIA, social determinants of recovery,

wellness, training/certification, recruitment, retention, diversification, supervision, and career pathways in the digital space.

Following are the report outs from the group.

<u>Breakout Group 1 Report</u>

- **Overregulation Concerns** – This can reduce authenticity and also keep a peer from being person-centered. Also, someone who has been involved in the justice system or not abstinent would be precluded from this role even though they have experience that could be beneficial.
- **Care for Workforce** – Peer support is about relationships which can be intensive and frontline work. They are also themselves in recovery. Intentional efforts are needed to keep them safe and healthy.
- **Harm Reduction** – There are a lot of nuances and complexities that need to be understood/addressed.
- **Employers** –They need support in understanding peers and how to best supervise this workforce. They also have regulations that might create barriers for hiring.
- **Digital Apps in Prisons** – Inmates tend to have the greatest need but the least access. Digital options may help.
- **Facilitation** – Peers need to be taught how to do group and one-to-one facilitation strategies.

> **"Peers have a wealth of resiliency and ability to connect with people and have empathy. This resource can benefit not just those in recovery but anyone struggling with the human experience."**
>
> Group 1 Report

<u>Breakout Group 2 Report</u>

- **Certification Standards** – There needs to be a low barrier to be more inclusive. However, the curriculum should be expanded to improve skills and tools as technology changes. Some curriculum needs are harm reduction/alternative modalities; inclusiveness; and understanding/addressing individual biases based on a peer's personal journey to recovery.
- **Career Ladder** –There should also be a BA program to allow peers to advance up the career ladder.
- **Supervision** – There needs to be training provided, particularly for clinical staff. The supervisors are those that get the grant. Poor supervision leads to misaligning the peer role (e.g., serving as an administrative assistant or case manager); burnout; and having worse data outcomes.
- **Reciprocity** – National leadership is needed for this.

> **"The opposite of addiction is not abstinence. It is connection."**
>
> Dr. Mo

<u>Breakout Group 3 Report</u>

- **Consistent Training** – This should be both for peers and supervisors. Breakout participants appreciated the bold step of SAMHSA's model standards, particularly in not requiring abstinence as a requirement for recovery.
- **Career Ladder** – This needs to be more intentional and national guidance can help.
- **Risk and Benefits of Digital Opportunities** – Digital opportunities can help peers in skill building and measuring progress. However, it can also create burnout because it opens the door for 24-7 connection with individuals.
- **Integration with Workforce** – Other workforce professionals need to better understand the role of peers. In some instances, peers are not valued and don't have a place at the decision-making table.

Breakout Group 4 Report

- **Balancing Fidelity with Authenticity** – It is important to measure and test fidelity. But in order to maintain authenticity there is a need to recognize that one-size doesn't fit all and services are consultative not prescriptive.
- **Peer Supervision** – This is truly lacking nationally. In addition to work support, supervisors should have mechanisms to provide emotional support and maintain boundaries (e.g., work in off-hours) which is even more difficult with digital access.
- **Clinical Trials** – Clinical trials can help assess the value of various online trainings.
- **Unions** – Other professions have benefitted from establishing a union to advocate for work conditions and career advancement.
- **Representation of Underserved Communities** – This may be a problem in that communities of color may have more systematic barriers (e.g., racism) that hinder their recovery. They thus never enter the peer workforce.
- **Mutual Aid** – There are many untapped spaces where individuals in need can be found. We need to reach out to these non-traditional spaces, particularly if we want to reach out to underserved communities.

Following are some additional insights shared during the chat or after the breakout reports:

- **Peer Supervision Resources** – The National Association of Peer Supporters has [resources](#) to develop effective peer supervision skills.
- **Barrier of Formal Testing** – Digital innovations may be able to improve testing and ways to measure knowledge as some of the more formal approaches may be a barrier for peers becoming certified.

Horizon for Digital Peer Supports

Vincent F. Caimano, Ph.D, Founder & CEO, HeyPeers; Chris Hart, Chief Data and Analytics Officer, Third Horizon Strategies; Kacie Kelly, Chief Innovation Officer, Meadows Mental Health Policy Institute

Using a series of guided questions, Ms. Tarino moderated this discussion on digital peer supports:

How has digital peer support changed and impacted services? Have you seen a diversification of providers?

Dr. Caimano noted the considerable changes in technology saying that back in 2009, the term "zoom" was associated with a Mazda commercial. One of the challenges to address is that most people (up to 60%) use their mobile phones for internet access and the small screens can make it difficult for engagement.

Another aspect of the increase in digital options is that connections are now able to be global. This is an opportunity to learn from those in other countries. But it also increases the need for DEIA approaches.

In terms of future opportunities, he cited the following:

- **Telehealth Modality** –There was slow adoption of telehealth across the medical field until the pandemic but now it is here to stay. The American Medical Association projects that utilization will reach 70% of services. For peer support, telehealth may increase complexity but also offer benefits.
- **Intersectionality with Other Needs** – Dr. Caimano cited a group that addressed narcolepsy and noted they had leveraged peers as co-facilitators as many individuals with narcolepsy face depression because of their condition. He noted that there are many other conditions that might benefit from having a behavioral health peer playing a co-facilitated or supporting role
- **AI-Powered "Sherpas"** – These can help navigate and guide an individual to a peer that best meets their needs/aspirations.

What are some ethical questions to consider with machine learning and artificial intelligence?

Mr. Hart explained that machine learning entails gathering statistical models and then deploying them to make inferences of likely patterns. These types of machine learning are:

- **Supervised Machine Learning** which provides classifications (e.g., high, medium, and low options) as well as regression analysis (e.g., understanding the relationship between independent and dependent variables).
- **Unsupervised Machine Learning** incorporates a variety of methods including clustering, associations (affinity analysis) and outlier testing. Amazon's product suggestions is based on affinity analysis. Another example is grocery store's identifying clustered purchases (e.g., diapers and alcohol) and designing their layout to allow for close placement of those products. With recovery, this might be used to identify what a person might need given their certain demographics (e.g., a female with two or more dependents needs an employment setting with a daycare nearby).
- **Artificial Intelligence (AI)** is unsupervised learning with greater amounts of diverse data sources. As a result, the associations and clustering is not only identified, but resources provided.

Mr. Hart noted that to fully tap machine learning and artificial intelligence in an effective way, the recovery field needs to answer the following questions:

- **Data Resources and Models** – What type of data, practices and models can be leveraged to help peers do their jobs to their highest level?
- **Biases** – What are the biases that are built into an AI system? This could be due to the bias of the individual (excluding questions about the number of dependents) or the bias of the database (only capturing data from affluent Caucasians).
- **Interpretation and Training** – The training of the machine (interpretation) can impact the results and create a false premise. This is what most people fear.

Mr. Hart noted that there has been a lot of advancements in this field over the last few years, so it is important to keep abreast as there may be even more in the near horizon. One example he noted was that CMS now requires all commercial insurance companies to publish monthly their rates for all procedures. Work is still being done to convert this into a digestible format. But once available, it could be an invaluable resource, not just for SUD and mental health services, but a variety of other applications.

What kinds of standards and processes have been put in place for digital innovations?

Ms. Kelly reaffirmed the importance of standards and processes but added that these guardrails need to still allow for flexibility and person-centered care. To that end, she recommended approaching standards/processes iteratively so that feedback loops can be used to improve and learn.

Another key suggestion that she offered was to be precise in defining "digital services" and then categorize the types. This will allow for stratifying the guidance. As an example, the FDA has indicated that many types of digital apps are low risk and therefore do not need to be regulated.

She noted the Centers for Medicare and Medicaid Services (CMS) is providing guidance on how to get reimbursement for some digital services and that some States (Louisiana, Washington, and Massachusetts) have already approved reimbursement. Sharing this with other States can accelerate this effort.

She also stated that the process related to privacy and solutions is long so there is a need to begin those efforts now.

What considerations are needed to ensure that underserved communities have access (e.g., broadband limits/language barriers)?

Dr. Caimano shared that many poorer countries have found ways to overcome the digital divide and are locations where phones are used more than other electronics (e.g., tablets/computers). He recommended that SAMHSA and other funders allow funds to be used to provide devices. This has been done on a limited basis and has been successful in expanding access to services.

What are strategies to work more collaboratively with people who offer lived experience?

Mr. Hart recommended that having an inventory and taxonomy of resources is invaluable. And those with lived experience are the best source for identifying these resources. He cited an example of a project where students at USC were tasked to help develop an inventory of resources. The students mapped out the traditional resources identified on the list but included others that they were aware of. For example, there was a café near campus run by a man in recovery. It was a place that many others in recovery would go to for respite and as a safe supportive location. This is just one example of why co-design is so important.

> **"Resource Mapping is important. We are bound by what we understand."**
>
> Chris Hart

What is on your dream list to better support adoption of digital services?

Ms. Kelly stated that digital services can help to improve measurements of peer support programs. She would like to see these services receive better financial support. She also advocated for leaning into a risk-benefit discussion related to AI, as she sees inaction being one of the biggest risks related to addressing SUD and mental health needs.

> **"There is a lot of discussion about the risk of using AI. However, there should also be discussions on the risk of not using AI. We must find creative ways to impact the trajectory of the opioid epidemic"**
>
> Kacie Kelly

Breakout Discussion 4

Participants met in four breakout groups to discuss the horizon of digital support for recovery issues. Particular focus included issues that impact diversity, equity, inclusion, social determinants of recovery, wellness, training/certification, recruitment, retention, diversification, supervision, and career pathways in the digital space.

Following are the report outs from the group.

Breakout Group 1 Report

- **Data Needed** – Having "recovery vital signs" can help measure efficacy.
- **Technology is an Added Complexity** – There is already a lot of complexity with recovery, particularly addressing the workforce and education/credentialing concerns. The intersection with technology adds an extra layer of complication.
- **Need to Increase Educational Opportunities for Minorities** – There are already some minority fellowship and mentoring opportunities but these need to be expanded. Including this work in STEM for minorities could be an opportunity.

Breakout Group 2 Report

- **Keep it Simple** – While one approach might be to navigate and address complexity, another might be just to work to simplify efforts. Early recovery is a stressful time in a person's journey, and they are struggling. Giving them small wins and "one-day-at-a-time" approaches are important for sustaining a recovery journey.
- **Text Options** – Apps aren't for everyone. Having a text option would improve equity.
- **Recovery Capital** – There are many services that build recovery capital but never use the word "recovery" so they may not be included in resources. Many social determinants of health programs are an example. There is a need to be able to connect these dots.
- **Mapping the Various Models** – It will be helpful to communicate and translate the various models (e.g., 8 dimensions of wellness, recovery capital, etc.) and map how they relate to each other.

Breakout Group 3 Report

- **Complexity** – Because there are so many different entities, data management is needed to coordinate information and dissemination in a meaningful and useful way.
- **Privacy and Accessibility** – These concerns need to be a prerequisite discussion before moving on with implementation.
- **Adverse issues with AI** – This group identified an adverse use where a national eating disorder association used both a staff person and a chatbot for support and then decided to get rid of the live chat option. They then realized that the bot had limitations/issues.
- **Accessibility** – As society moves digitally, it is important to maintain accessibility to those who have visual or auditory impairments as well as those who have a neurodiversity issue or even older generations who may prefer simpler technologies.

- **Fear of Being Tracked** – Most individuals use their phones and may be afraid of being tracked (e.g., previously justice involved) or losing their phone with sensitive information on it.
- **Helping Smaller Organizations** – Smaller organizations may be able to reach different (even more underserved) populations but may struggle to pay for digital service plans. It would be helpful to have a tiered payment system.
- **Self-Reporting** – Individuals in recovery may prefer to input their own data as a way of control. This would also ease the burden of peers having to capture all the information.

Breakout Group 4 Report

- **Advantages of AI** – Recovery is complex, and AI can expand the possibilities of connection and digesting the many components involved.
- **Cover Hardware Costs** – Allowing grants to purchase tablets and phones increase access and particularly for underserved communities.
- **Co-Design is Important** – Everyone needs to have a voice at the table, and most particularly those that are underserved. It is important to be mindful of language used and to ensure that there is multi-directional communication among the varied stakeholders.

Top Issues and Next Steps

Ms. Tarino asked participants to identify the top issue for them based on this meeting's discussion. These are listed below:

- Language that conveys a unified purpose but also flexible to convey complexity and variations of this work.
- Remote work and interstate compacts options.
- Professional growth opportunities for peers.
- Flexibility to cover infrastructure and technological purposes (e.g., phones, license fees).
- More money for contingency management costs ($75 is too low).
- Leadership guidance on what consent means and how to put it into practice.
- Repository of data and recommendations on how to standardize.
- Expansion of Medicaid reimbursement beyond fee-for-service (e.g., including asynchronous peer support).
- Leadership and perhaps a taskforce related to ethical use of AI.
- Better approaches for interoperability across Federal systems. Shouldn't have to upload GPRA info in a CSV file.
- More engagement with SAMHSA beyond a once-a-year meeting.
- National standards for curriculum and certification which will help with reciprocity issues.
- Standards for peer supervision.

Ms. Harper then thanked participants, speakers, and staff for their contribution to this meeting. She noted that SAMHSA will be generating a summary of this meeting and perhaps a white paper based on the key findings/recommendations identified.

A list of resources identified during the meeting are listed in Appendix B.

About the Realizing Recovery Series

To advance recovery across the nation, the Office of Recovery (OR) forges partnerships to support all people, families, and communities impacted by mental health and/or substance use conditions to pursue recovery, build resilience, and achieve wellness. With this goal in mind, the OR initiated a series of (in-person, virtual, or hybrid) dialogue, technical expert panel, and summit-style convenings, beginning in February of 2023 with SAMHSA's Technical Expert Panel on Peer Support Certification.

The themes across these convenings, which range from strengthening the peer workforce to advancing recovery across tribal and justice-involved communities, each align with an objective, strategy, or priority within SAMHSA's National Recovery Agenda. All convenings, both past and present, reinforce efforts to forge new partnerships while strengthening old. Further, each convening and associated report serves not only as a foundation and guiding light for the Office of Recovery moving into 2024, 2025, and beyond; but also provides SAMHSA, the OR, and our federal, state, local, tribal, and territorial partners with the information that is needed to advance recovery across the nation.

To access materials and publications related to recovery—including other reports within the Realizing Recovery Series, please visit https://www.samhsa.gov/find-help/recovery.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

Appendix A – Participants

<u>SAMHSA</u>

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Appendix B – Resources Identified

(In order of mention during meeting)

- [SAMHSA Advisory: Using Technology-Based Therapeutic Tools in Behavioral Health Services](#)
- [SAMHSA National Model Standards for Peer Support Certification](#)
- Journal Article: [Core Competencies to Promote Consistency and Standardization of Best Practices for Digital Peer Support: Focus Group Study](#)
- Video: [How Do I Select Technologies That Align With My Values and Principles](#)
- Website: [Digital Peer Support](#)
- Video: [Designing an mHealth Ecosystem for Equity](#)
- Safe Project's [Collegiate Recovery Leadership Academy](#)
- The Lived Experience Power Research Network
- [Stanford Digital Economy Lab](#)
- Audio by Commonly Well: [Data Ownership and Privacy](#)
- [Dartmouth's Center for Technology and Behavioral Health](#)
- The [Digital Therapeutics Alliance](#)
- The [Division of Digital Psychiatry at BIDMC](#) run by John Torous
- [The Apple Research app](#)
- Policy Paper by Meadows Mental Health Policy Institute: [Near-Term Policy Solutions to Bolster Youth Mental Health Workforce through Digital Technology](#)
- [Anthropic](#) (working on an AI Constitution)
- Supervision resources from the [National Association of Peer Supporters](#)