

Peers and Psychiatry in Dialogue

Meeting Summary

5600 Fishers Lane Rockville, MD

July 11-12, 2023

**Realizing Recovery: Policy and Practice Improvement Series
Substance Abuse and Mental Health Services Administration (SAMHSA)
Office of Recovery and the Office of the Chief Medical Officer
U.S. Department of Health & Human Services (HHS)**

This document was developed by Substance Abuse and Mental Health Services Administration’s (SAMHSA) Office of Recovery, while the content and themes outlined within were identified by participants—including technical experts and those with lived experience—during the Peers and Psychiatry in Dialogue meeting. Please note that the views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Office of Recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

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

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**U.S. Department of Health & Human Services (HHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Office of Recovery and the Office of the Chief Medical Officer**

Peers and Psychiatry in Dialogue Meeting

July 11-12, 2023

MEETING SUMMARY

The U.S. Department of Health and Human Services (HHS)/Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Recovery and the Office of the Chief Medical Officer convened subject matter experts to participate in a "Peers and Psychiatry in Dialogue Meeting" at SAMHSA Headquarters in Rockville, Maryland, on July 11-12, 2023. The purpose of the meeting was to facilitate a two-day in-person dialogue between psychiatrists and persons with lived experience to share perspectives on recovery from mental health and substance use problems and consider foremost topics related to systemic barriers and elements that foster recovery. The group was asked to identify areas and activities for peers and psychiatrists to work together to promote recovery-oriented systems of care and a society of caring.

This report captures the dialogue and the following guidance as collaboratively developed by the Peer Specialists and Psychiatrists in attendance:

Peers and Psychiatry in Dialogue: Guidance

- Human service system providers; as used in this document includes housing, employment, education, judicial, correctional, primary care, hospitals, social service agencies, and/or others, should consider examining and striving to incorporate peer support services in their respective practice, settings, and individual plans.
- Interpersonal contact and exposure with people and professionals of lived experience is needed to reduce prejudice, discrimination, and stigma to promote social inclusion, better health and person-centered outcomes.
- Develop educational programs specifically for healthcare and behavioral health providers centered on peer-developed materials, recovery-oriented service delivery, psychiatric advance directives, peer-provided services, and the intersection of roles between psychiatry and peer support services.
- Promote intentional collaboration between peer specialists and psychiatry to broaden the understanding of roles that contribute to optimal patient outcomes in service settings in clinical, systemic, operational, medical, and communities among other settings.
- Conduct education for the behavioral health community on collaborative person-centered care for recovery-centered solutions in behavioral health and substance use services/treatments and in the community at large.

- Develop and implement recovery-based outcome measures across behavioral health disciplines.
- Conduct research on peer specialists, psychiatric care delivery, and person-centered approaches to improve behavioral health and substance use outcomes.
- Increase equitable access to service delivery systems that are inclusive of a diverse peer and psychiatry workforce.

The dialogue that preceded and contributed to the above guidance is presented below, as well as in Appendix A, B, and C.

Day 1: July 11, 2023

Ted C. Bonar, PsyD, Chief Clinical Officer, A-G Associates, served as the meeting’s facilitator. Dr. Bonar welcomed the participants and emphasized that the structure of the meeting was intentionally designed to be a secure and safe space to encourage open and respectful dialogue. Dr. Bonar then invited Paolo del Vecchio, Director, Office of Recovery, SAMHSA, to give opening remarks. Mr. del Vecchio greeted the group and reiterated the sentiment that the meeting was designed to encourage open conversation on a wide variety of issues falling under two broad areas: 1) Recovery at the clinical level and how psychiatry and persons with lived experience can work together to improve outcomes; and 2) What types of system changes are needed in terms of improving outcomes. He continued to explain that the persons in the group were chosen as subject matter experts and asked to come together with both their personal and professional expertise for an open dialogue to further SAMHSA’s identified priorities of: 1) preventing overdose; 2) enhancing access to suicide prevention and crisis care; 3) promoting resilience and emotional health for children, youth, and families; 4) integrating behavioral and physical healthcare; and 5) strengthening the behavioral health workforce.

Next, Mr. Del Vecchio shared that the Office of Recovery has identified its overall mission as one to advance recovery across the nation—in partnership with people in recovery, family members, and other allies—to help promote recovery, build resilience, and achieve wellness. He stated the following as the goals for the Office of Recovery: 1) Inclusion of people with lived experience in all aspects of behavioral health, as well promote social inclusion by overcoming negative attitudes, barriers, prejudice, and discrimination; 2) Equity and the definitive need to improve recovery opportunities for under-resourced and underserved populations, specifically people of color, LGTBQI+, rural communities, veterans, and others; 3) Peer-operated services in every community across the nation; 4) Social determinants of health and the need to improve housing, employment, and education; and 5) Wellness, including addressing early mortality. In closing, Mr. Del Vecchio referenced the first such dialogue that was held in 1998, and he commented that it would be interesting to compare the outcomes of those discussions to the day’s dialogue. He then invited Dr. Neeraj Gandotra, Chief Medical Officer, to give opening remarks.

Dr. Gandotra echoed sentiments regarding the importance of the day’s meeting, and he reiterated the importance of including individuals with lived experience in their discussions. He said he could recall, during his medical training, being told, “You don’t understand what I’m going through.” He admitted that it took years of training and years of patient interaction for him to

begin to understand the experiences of his clients. To this end, to further practitioners' awareness, he said the goal of the day's dialogue was to gain further understanding from open discussion of personal journeys through lived experience—which enables a deeper connection than what simple knowledge of the surface problem can provide. Dr. Gandotra concluded by stating that, “Just as every person's journey is unique, and recovery is often not a straight line, this meeting does not have to go in a straight line either.” He also expressed his hope that the participants would speak openly and respectfully about their conditions, their disagreements, and most importantly their common ground, as he noted their shared goal of gaining a better understanding of how individuals with lived experience can benefit, influence, and actively participate in the recovery process.

Next, Steven Fry, Public Health Analyst, Office of Recovery, SAMHSA, briefly addressed the group. He thanked everyone for their participation, giving special thanks to HHS, SAMHSA leadership, and A-G Associates for their assistance in coordinating the meeting. Mr. Fry shared being hospitalized at age 15 for schizophrenia, possibly exacerbated by the trauma of bullying and physical assaults in middle school. When he turned 18, he signed himself out of services against medical advice, having been told he would need to be on disability and live in a group home for the rest of his life. He subsequently became heavily involved in alcohol and drug use, eventually achieving sobriety. He also lives with physical disabilities. He referenced a recent *New York Times* article featuring an essay about author Joan Didion and shared the quote, “We tell stories in order to live.” Recognizing that each participant had a different story, he said he looked forward to hearing everyone's story and how those stories influenced who each of them has become. He also commented that he was optimistic that those shared stories would result in everyone leaving with a better perspective on the group's shared goals. He then turned the meeting over to Dr. Bonar to begin participant introductions.

Dr. Bonar facilitated the participant introductions, allowing each member to freely share their background and how they came to be where they are today. The participant group consisted of a diverse pool of individuals, with occupations including policy administrators, psychiatrists, and other medical service providers, as well as peer support specialists, and others with professions outside of the medical arena. The members were diverse in racial and ethnic characteristics, gender identity, age and experienced different services environments and roles. Most peer attendees possessed advanced college degrees and some also had experience as licensed clinicians. In terms of lived experience, some participants, both peers and psychiatrists, spoke of direct, personal lived or witnessed experience with substance use, emotional abuse, childhood trauma, and mental health issues, while others described exposure to these areas because of familial connections. Additionally, family and socioeconomic backgrounds ranged from participants growing up in privileged, two-parent households, to those from single-parent families battling financial difficulties and parental incarcerations.

While it can be noted that there was some crossover in participants' backgrounds, by and large, each person brought a unique personal perspective and experience to the dialogue. Notwithstanding, they all realized the importance of “connecting” to those persons seeking services related to mental health issues and substance use to ensure more positive outcomes. On this point, they agreed that incorporating peer lived experience into treatment planning and delivery of care is invaluable in terms of reaching persons where they are and in understanding

best approaches to increase optimal outcomes. Other commonalities shared during introductions included the following:

- An innate desire to understand the “whys” of a situation (e.g., “what happened to you”), and not simply “what’s wrong with you,” to find a solution.
- Incorporating hope and optimism into care to reinforce the reality that recovery is real and possible.
- Understanding how titles (e.g., Doctor, Peer, Family Member) affect people’s perception/acceptance of one’s authority.
- Looking beyond how to assist an individual to focusing on the larger picture of determining what steps should be taken to leave a better system of care in place than what currently exists.

Participants took the balance of the day to discuss opportunities to improve patient outcomes, barriers to patient success, and common beliefs and practices that can advance the same as they related specifically to recovery at the clinical level. Participants’ feedback was captured under the broad categories of Barriers, Opportunities, and Common Ground. Summary points from the day’s discussion are provided in *Appendix A: Recovery at the Clinical Level – Barriers, Opportunities, and Common Ground*.

Before the first day ended, Tom Coderre, SAMHSA’s Principal Deputy Assistant Secretary for Mental Health and Substance Use, expressed his gratitude to the participants for lending their voices to this important work; and he assured the group that the outcomes of their dialogues would inform the agency’s agenda. Dr. Bonar closed the session by summarizing the themes and topics that resonated throughout the day:

- Trust: building trust-based relationships between peers and psychiatrists.
- Role Clarification: clarifying the specific roles and expectations that psychiatric and peer support practitioners bring to recovery and need for inter disciplinary education.
- Empathy: building mutual understanding and recognition of power dynamics.
- Equity: the importance of addressing disparities including racism in all service settings.
- Quality: addressing issues involved in diagnoses, person-centered planning, involuntary treatment, and coordinating with primary care providers. The need for more culturally appropriate services was frequently noted throughout the day.
- Willingness to support people in seeking complementary or alternative healing approaches.
- Stigma: how negative attitudes, stereotyping, prejudice, and discrimination impact people with lived experience as well as the psychiatric profession. Stigma is a driver of low public trust in behavioral health, help seeking, and workforce recruitment; and systemic failures such as delays in care or lack of empathy reinforce these beliefs.

Day 2: July 12, 2023

Dr. Bonar welcomed the participants back and outlined the goals for the second day, namely engaging in a discussion about how systems impact recovery and identifying action steps to

improve opportunities for recovery. He stated, based on the previous day’s discussion, that it had been suggested that the group first take time to define the roles of peer support and psychiatry to dispel misconceptions about what each group does and does not do. Summary points from this discussion are provided in *Appendix B: The Roles of Peer Support and Psychiatry*.

Dr. Bonar then moved the discussion to focus on the impact that systems have throughout the recovery process, examining how effective systems provide opportunities to advance recovery efforts, how system inadequacies can function as barriers hindering recovery efforts, and the underlying commonalities systems share. Summary points from this discussion are provided in *Appendix C: Recovery at the Systems Level – Barriers, Opportunities, and Common Ground*.

After lunch, Dr. Bonar summarized the themes that had emerged throughout the day’s discussion:

- Funding: need for adequate resources to provide quality care.
- Systemic integration: breaking down silos and promoting whole health approaches.
- Hiring/employment policies: improving practices to employ peer support workers and psychiatrists.
- Employer workforce education: improving workplace culture to integrate peer workforce, such as involving peers in unit rounding and clinical meetings.
- Workforce development: enhancing how both psychiatrists and peer workers can be trained – including re-implementing an updated version of the Recovery to Practice effort and including peers/people with lived experience of recovery part of medical school and residency trainings.
- Coalition building: developing collaborative efforts at local, state, and national levels to impact needed change.
- Equity: improving policies that expand outreach, engagement, access, and quality of care to people from diverse communities.
- Burnout: supporting both the peer support and psychiatric professions to address stress, moral injury, and more.
- Ethics: recognizing the imperative of ethical practices in both peer support and psychiatric professions.
- Technology: recognizing and evaluating the impact that technology (such as AI) has on the delivery of care; and examining quality issues of telehealth and self-help apps.

The group proceeded to discuss the parameters within which the recommendations should fall before working together to draft best practices as listed below.

Peer/Psychiatry Dialogue Best Practice Guidance

- Human service system providers should examine and strive to incorporate peer support services in their respective practice, settings, and treatment plans.
- Interpersonal contact and exposure with people and professionals of lived experience is needed to reduce prejudice, discrimination, and stigma to promote better health and person-centered outcomes.

- Develop educational programs for health and behavioral health providers centered on peer-developed materials, recovery-oriented service delivery, psychiatric advance directives, peer-provided services, and the intersection of roles between psychiatry and peer support services.
- Promote intentional collaboration between peer specialists and psychiatry to broaden the understanding of roles that contribute to optimal patient outcomes in service settings in clinical, systemic, operational, medical, and communities among other settings.
- Conduct community education on collaborative person-centered care for recovery-centered solutions in behavioral health and substance use services/treatments and in the healthcare community at large.
- Develop and implement recovery-based outcome measures across behavioral health disciplines.
- Conduct research on peer specialists, psychiatric care delivery, and person-centered approaches to improve behavioral health and substance use outcomes.
- Increase of equitable access to service delivery systems that are inclusive of a diverse peer and psychiatry workforce.

Supplemental Notes: Included below are specific priorities/guidance as identified by the group to support some of the best practice guidance noted above.

Clinical/Personal

- Address past criminal justice involvement as a barrier to employment in the context of addiction/recovery (recovery-friendly workplace).
- Develop guidance around what needs to be in peer recovery documentation and integrated into an Electronic Health Record.
- Update Treatment Improvement Protocol 64 to include mental health peer support practices (broadly).
- Identify and develop valid and reliable outcome recovery measures that are person-centered.

Systems

- Encourage the Centers for Medicare and Medicaid Services (CMS) to explore possible models to fund and replicate peer services in psychiatry settings, such as demonstration grants or activities within the Center for Medicare and Medicaid Innovation (CMMI).
- States should revisit their policy position for professional rehabilitation programs that are recovery-centered and align with ADA requirements.
- Expand technical assistance for how to promote/build peer services and expand the community usage of this.

Educational Campaign (for all accrediting bodies)

- Train peer specialists in the role of recovery.
- Replicate this dialogue at the local and state levels and provide continuing education credits.
- Convene a larger national conference to continue and expand this peer/psychiatrist dialogue.

- Training on psychiatric advanced directives should be required as part of the education of both professions.
- NIMH funded research is needed to identify the optimal psychiatrist/peer specialist dyad.
- Promote and disseminate materials and technical assistance to implement better person-centered thinking at the systemic level.

Financing

- Improve funding including reimbursement both for psychiatry and peer services (through CMS and States).
- Fund a national compensation survey for peers and psychiatrists.

In closing, Dr. Bonar and Mr. Fry thanked the participants for their time, patience, and passion for their work. Dr. Gandotra then echoed their sentiments, adding that he happily learned enough during the dialogue to be “a bit more humble.” The meeting ended with Mr. Del Vecchio emphasizing the importance of relationships in recovery and encouraging everyone to continue building those bridges.

Appendix A: Recovery at the Clinical Level – Barriers, Opportunities, and Common Ground

Barriers

- Uneven quality of care
- Lack of access to services
- Coercion (soft and hard)
- Evidence-Based Treatments (which can also be viewed as an opportunity)
- Mistrust*
- Power imbalance**
- Stigma
- Lack of resources for implementing recommendations
- Lack of awareness of peer support and recovery-based approaches
- Language
 - “*Professional*” is often only used to refer to clinicians and not to peer recovery specialists; “*help*” vs “*serve*” -- we *help* others when they are viewed as weak or broken vs. *servicing* others when they are seen as whole.
- Misconceptions about the roles of psychiatrists and peer specialists
- Differing perspectives of what “recovery” means.

Opportunities

- Increased peer support can be conceptualized as increased access to care.
- Advocacy to effect change
- Self-Directed Care
- Increased communication and education about basic mental health and substance use issues so the public has a better understanding of somatic and mental health issues.
- Determining how, within the boundaries of the clinician-client relationship, clinicians can share their lived experience to foster mutual understanding and respect.
- The developing model of medication optimization, which seeks to improve the use of medications in treatment plans.

Common Ground***

- Recovery from mental health disorders and substance use is possible.
- Personal Stories of Lived Experience help to build mutual understanding and positive change.
- Diagnoses
 - They can successfully inform treatment but can also result in labels of weakness and illness and have cultural implications that make them more or less beneficial inside of some cultures.
- Trauma – need to recognize the universality of traumatic experiences as precursors to mental health and addiction problems and need to implement trauma-informed practices.
- Finding purpose and meaning
- Family influencers (both positive and negative)
- Empathy

- Person-Centered approaches
 - Requires us to suspend our own biases and sense of certainty or assumptions about what a person needs, or their ability to make informed decisions, and that opens the necessary dialogue with the person seeking services. It also drives staff to think “outside the box” and engage with community assets.
- Cultural humility / community factors

***Additional Notes:** During the discussion on barriers to recovery, significant time was spent on the question of what drives mistrust between providers, clinicians, and peers and what can be done to alleviate that mistrust. Responses to this inquiry included the following:

- Mistrust is born from unfamiliarity, role confusion, and not spending time together.
- When considering how much exposure clinicians and peer specialists have to one another, the following should be evaluated: How many clinicians conduct rounds in peer-operated centers? How many clinicians have lived experience as part of their medical training? How many peer certification programs have a psychiatrist talk about what they do as part of the certification?
- The use of coercion and involuntary interventions and the trauma that results from their use.
- Fear of both psychiatry and peers and stigma in the professional environments.
- Clients often think medicine is an exact science; when treatment plans fail, mistrust is formed. Acknowledging medical limitations and historical faults can go a long way in establishing trust.

****Additional Notes:** During the discussion on barriers to patient success, significant time was spent addressing the topic of power imbalance as an element of mistrust and what can be done to address this concern. Comments included the following:

- Psychiatrists described noticeable disintegration of their power as many other providers are providing behavioral healthcare. These newer providers seem more likely to pursue a pharmacological treatment plan, thereby diminishing the psychiatrist’s role as an expert in psychodynamic approaches. This imbalance of power and perception of disrespect feeds into the mistrust between medical providers and clinicians.
- Imbalances in power and one’s paradigm feed into mistrust. The perceived power of a psychiatrist, coupled with his/her assertion of their paradigm without understanding of the client’s experience, can make the client feel pressured or coerced into accepting a diagnosis or treatment plan.
- There is an imbalance of power inherent in the clinician role as compared to being in the position of someone seeking services. The clinician is seen as the “expert” and can profoundly impact a person’s circumstances with their recommended course of treatment.
- Sharing backgrounds and approaches such as shared decision making are pathways to establishing trust.
- The “time demands” are always a factor and barrier to being able to fully engage in these practices.

*****Additional Notes:** During the discussion on common ground, significant time was spent addressing the following topics: 1) Developing better training on trauma-informed care approaches; 2) Clarifying elements of the peer support system; and 3) Needing a better understanding of the roles of peer support and psychiatry. Comments included the following:

Training

- In order to allow the person seeking services to choose what is best for them, clinicians and peers should be better trained to frame treatment plan discussions as presentations of options for consideration, rather than as definitive courses of action.
- SAMHSA's *Recovery to Practice* training curriculum, which was created in partnership with major mental health guilds and professional organizations, should be updated and made readily available and marketed to appropriate audiences.
- There is a wealth of free Person-Centered Planning training and implementation materials from the National Center Advancing Person-Centered Planning (NCAPPs) that should be used by health systems.
- This type of dialogue taking place should be replicated on local, state, and national levels.

Peer Support Systems

- Address the need for better understanding in terms of the difference between a person identifying as a peer solely because of their lived experience, as compared to a peer specialist who has been trained and certified.
- Clinics and organizations that use peer support specialists need to better understand the specific training the peer specialists have.
- Infrastructure needs to be in place for all human resources issues (e.g., recruitment, retention) working with peer specialists just like with any other employee.

Roles of Peer Support and Psychiatry

- Build better understanding between the peer/psychiatry dyad.
- Questions for consideration: Is there a proper assumption about psychiatry peer interaction? What is the role of the peer specialist to the psychiatrist and vice versa? Can psychiatry better express the critical role of peers in the recovery process of the individual? As a profession of clinicians and peers, do we recognize not only each other's strengths, but our collective limitations as well?

Appendix B: The Roles of Peer Support and Psychiatry

Self-Defined Role of Peer Support

- To advocate with (not for) people receiving services.
- To help frame issues for other health care professionals on behalf of the person being served.
- To help people explore their options and help them figure out (not decide for them) what information they need to pursue the path of recovery that they choose.
- To minimize the power differential by empowering the person served to be the expert on what they need, with the peer specialist coming alongside to offer support.
- To partner with and support other professionals who are also helping people who receive services.
- To work at the systems level to make systems more person-centered.
- To serve as a source of resource referrals.
- To coach people to wellness, not illness.
- To provide health education and care coaching.
- To be a source of community.
- To help people integrate the social aspects of their life.
- To ensure equity and cultural humility.
- To model recovery.

What Psychiatry Would Like from Peer Support

- Reassurance that all input and action from peer support is intended to enhance the recovery of the individual with whom they are interacting.
- A trauma-informed partnership.
- For peer support to engage in an open and healthy discussion with psychiatry when considering possible treatment options.
- A partnership through which the peer support helps psychiatry gain insight into what the person served is going through; connects with the person served and helps psychiatry to create a safe place in which the person served feels comfortable enough to open up; and uses lived experience to help the person served understand why a certain course of action is being recommended by psychiatry.

Self-Defined Role of Psychiatry

- To understand who a person is and acknowledge that there are different styles of assessment that can be used in reaching that understanding.
- To evaluate, diagnose, and treat illnesses of the brain.
- To conduct a complete assessment (including appropriate physical exams, tests, lab work; and obtaining patient history) and to formulate a collaborative treatment plan, including follow-up appointments.
- To partner with the patient and with other specialists in the system (social workers, peers, medicine, endocrinology) to increase optimal outcomes.
- To use psychological education without imparting personal views.
- To help the patient as much as possible through the least restrictive methods available.

- To be culturally sensitive.
- To abide by the Hippocratic Oath, informed consent, and mandated reporting regulations.
- To keep abreast of current practices.

What Peer Support Would Like from Psychiatry

- For psychiatry to ask the person served to identify their goals for treatment and for recovery.
- For psychiatry to reimagine the role of medication by: 1) following a more holistic approach to wellness and to recovery; 2) considering psycho-social interventions before encouraging a pharmaceutical solution; 3) understanding the limitations of medication and relaying that information to the person served; and 4) not offering false hope that medication will fix everything and acknowledging that the person served may need other supports for optimal outcomes.
- For psychiatry to assist with training and policy development.
- For psychiatry to listen to the person served and to peer support and not discount their input.
- Reassurance that all input and action from psychiatry is intended to enhance the recovery of the individual with whom they are interacting.
- A trauma-informed partnership.
- For psychiatry to engage in an open and healthy discussion with peer support specialists when considering possible treatment options, but with the understanding that it is not the role of peer support to necessarily agree with or endorse psychiatry's recommended course of action.
- For psychiatry to engage in co-treatment with peer support, whereby both professionals sit together with the person served to go over options, instead of holding separate meetings.
- For psychiatry to recognize peer support for their expertise.
- For psychiatry to respect boundaries established between peer support and the person served and understand that peer support may not be able to disclose something psychiatry has asked them to share.
- For psychiatry to better educate the person served on the effects of the prescribed treatment; and for psychiatry to be open to peer systems like WRAP [wellness recovery action plan] and psychiatric advance directives.
- For psychiatry to be aware of barriers (transportation challenges, financial restrictions, etc.) that the person served must overcome in their recovery journey.
- For psychiatry to conduct a thorough medical screening without discounting reported symptoms.
- For psychiatry to be an advocate for wellness with other medical professionals and especially with payors to ensure coverage is available and provided for the services needed.
- For psychiatry to work in partnership with peer support in ending coercion, restraint, and seclusion.

Appendix C: Recovery at the Systems Level – Barriers, Opportunities, and Common Ground

Barriers

- Technology - can be both positive and negative.
- Inability to translate good intentions into actions because systems have been created which result in more fragmentation of care, rather than integration.
- Stigma.
- Financial Feasibility
 - Including conflict in billing for different services provided on the same day.
 - Prior authorization.
 - Billing rules around providers and provider types.
- Hiring officials and administrators need more education on hiring peers to better understand what is reasonable and ethical for the peer position and how that position can best fit into the business.
- Understanding the peer vs therapist role at the individual care level.
- The need to facilitate the prevention of peer specialist burnout through hiring and employment policies that allow for, and understand, the peer workers' need for flexibility in dealing with their own challenges.
- Artificial intelligence (the removal of the human touch point and the selling of data).
- Micromanaged outcomes (i.e., value-based payment systems that define the outcome needed, which is acceptable, but then place too many requirements as to how that outcome is reached).
- Learning existing regulations and how to navigate the systems to help shape the regulatory bodies that tell us what we must do (e.g., Joint Commission and Commission on Accreditation of Rehabilitation Facilities).
- Lack of use of peer support networks or peer support professionals, due to:
 - Poor use of funding.
 - Poor understanding of return on investment.
 - The entire concept of workforce development for peers (education and credentialing; recruitment; growth and role development; equitable pay).
 - Disclosure requirements (including by psychiatrists) and the consequences for disclosure, whether explicit or implicit, e.g., what happens if you need support, and you work in a role where you are not allowed to be vulnerable?
 - Hiring policies that limit candidates with applicable lived experience, such as being unable to hire somebody with a felony, etc.

Opportunities

- Properly defining the role of a peer worker when developing job descriptions (i.e., do not include tasks such as overseeing breathalyzers or drug tests or anything where reporting is required where peer specialist role ethics will have to be violated).
- Defining outcomes and data collection processes in a way that is thoughtful and recovery-focused and person-centered, but still satisfies grant funding criteria.

- Funding and prevention at the community level (i.e., determining what a good community system looks like, i.e., considering the needs of children all the way up to the adults with the knowledge that if you start prevention efforts around kids then the adults will not end up in the system).
- Integration of peers in a broader array of behavioral health settings.
- Increase the ability of peers to be able to supervise other peers in more settings.
- Increase SAMHSA and peer/family-run organizational collaborations and utilization of resources that are available related to peer support, e.g., how to write a peer specialist job description, conduct an interview, etc.
- Increase use of peer support in somatic care settings, as well as in other systems, such as child welfare, juvenile justice, forensics.
- Integrated training/shadowing opportunities with CEs, CEUs, CMEs, which would allow for psychiatrists and other behavioral health service providers and peers to gain better understanding of roles, help dispel myths that sometimes hinder legislation and policy development and meet educational requirements.
- Creation of a regulatory advocacy coalitions to help navigate current systems to increase the likelihood of suggested changes being implemented.
- Ability for states to add a surcharge to telephone lines to help pay for 988 services.
- Focus efforts on developing community services to free up beds currently being held by people in transition with no other place to go, which in turn will free up beds to address the needs of Emergency Room boarding.

Common Ground

- Address Medicaid unwinding and insurance appeals.
- Collaborating on policy development.
- Addressing problems of stigma.
- Increasing the effectiveness of care related to trauma.
- Advocating for changes to barrier crime laws that exclude people from the workforce.
- Focusing on equitable focus on all social determinants of health, not just trauma.
- Creation of a Department of Labor Occupational Code for peer specialists that is separate from community health workers.
- Increasing the availability of non-restrictive options (i.e., less use of restraints in emergency rooms).
- Engaging a financial administrator to help develop accurate financial models for suggested programs and changes.

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—ranging from strengthening the general peer workforce to advancing recovery across tribal and justice-involved communities—aligns with a particular 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 that are part of 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.

Peer Support and Psychiatry Dialogue Participant List

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