Digital peer support as an approach to TechQuity in mental health

Harpreet Nagra, Christina Beck and Elizabeth Shabazian

Abstract

Purpose – *This opinion piece aims to argue that digital peer support (DPS) services can meet unmet mental health needs by offering scalable, anonymous and affordable alternatives to typical mental health care.*

Design/methodology/approach – *This paper applies the 5A's of TechQuity: Availability, Accessibility, Accommodation, Affordability and Acceptability, analyzing how DPS can offer greater health equity in digital settings.*

Findings – *DPS may be especially beneficial for individuals that experience social isolation, stigma, subclinical symptoms, and barriers like cost and transportation. When such digital tools are designed with attention to safety, moderation, digital inclusion and referral pathways, they can support social connectedness, promote emotional well-being, and bridge to in-person services when needed.*

Originality/value – *This paper approaches DPS as a social inclusion model, rather than only a digital health tool. DPS's promising roles in bridging subclinical support and in-person mental health care are emphasized.*

Keywords *Digital peer support, Social inclusion, Mental health equity, TechQuity, Peer support, Digital mental health*

Paper type *Viewpoint*

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Abbreviations

BIPOC = Black, Indigenous, and People of Color;
DPS = Digital Peer Support; and
PHI = Protected Health Information.

Introduction

Public awareness and demand for mental health care continue to grow, yet unmet emotional health needs remain a public health challenge in the USA. Less than half of adults with mental health conditions receive treatment, due to barriers such as high costs, limited provider availability, stigma or cultural incompatibility between the provider and individuals (*Stress in America, 2023*, 2023). The care gap extends beyond clinical settings, affecting subclinical yet widespread challenges such as stress, loneliness and disconnection (U.S. Surgeon General, 2021). This is particularly apparent in underserved populations including rural communities, low-income individuals, and other marginalized groups due to their racial or cultural backgrounds (Morales *et al.*, 2020).

Digital mental health tools offer scalable and accessible solutions, however they may fall short for marginalized populations. Engagement challenges include early attrition, low inclusivity or clinical gatekeeping that decrease their effectiveness and reach to a wider population (Torous and Roberts, 2017). In this opinion piece, we propose that digital peer support (DPS), an online approach grounded in lived experience and cultural

Conflict of interest statement: This article examined DPS services and was supported by Supportiv, a DPS service. All authors were Supportiv employees, contractors, or were otherwise affiliated with Supportiv and may have financial or professional interests related to this service.

responsiveness, represents a promising alternative or complement to formal mental health care services. Using the TechQuity framework's 5A's (Availability, Accessibility, Accommodation, Affordability and Acceptability) (Nagra *et al.*, 2025; Penchansky and Thomas, 1981; Rodriguez *et al.*, 2021), we examine the impact of DPS on addressing equity gaps in emotional healthcare and providing greater social inclusion.

Why mental health access remains a social inclusion issue

Mental health challenges are escalating, especially among young adults and socioeconomically marginalized groups. Although there is a rising need for mental health care, formal services often require time, money, insurance, transportation and official diagnoses. These barriers can exclude people that have subclinical symptoms but do not fit in formal clinical pathways of receiving mental health care. One in four adults report that they cannot afford to see a healthcare provider due to cost, and nearly 40% of those with unmet mental health needs cite cost as the primary obstacle (Young *et al.*, 2001). Geographic limitations further contribute to inequitable access to mental health care. Approximately 122 million Americans live in areas where in-person, professional mental health services are scarce (Health Resources and Services Administration, 2023). Currently, the mental health provider to population ratio is approximately 1:340, which makes receiving support even more difficult (National Council for Mental Wellbeing, 2022). Access is particularly limited in low-income and rural communities, where community-based services are unavailable or underfunded (Health Resources and Services Administration, 2023; Mechanic, 2007). Individuals from rural areas may face longer wait times to see a mental health provider, travel longer distances, and face increased stigma around seeking support (Graves *et al.*, 2024; Negaro *et al.*, 2023). Racial, ethnic and cultural inequities are also deeply embedded in the mental healthcare system. Only 14% of US psychologists identify as BIPOC, limiting opportunities for clients to find providers with shared lived experiences or cultural understanding (*Demographics of U.S. Psychology Workforce*, 2022).

Loneliness, social isolation, stress and psychological distress are serious public health concerns. These concerns can seriously affect well-being, but they often fall between formal and informal symptoms. The U.S. Surgeon General's A*dvisory on the Healing Effects of Social Connection and Community* cautions that the hidden consequences of social disconnection are comparable to those associated with substance use and depression (U.S. Surgeon General, 2021). According to the Centers for Disease Control and Preventions (CDC) Behavioral Risk Factor Surveillance System Survey (2022), social isolation, loneliness and low levels of perceived social support are the most adverse nonmedical determinants of health (Behavioral Risk Factor Surveillance System Survey, 2022; Hawkley and Cacioppo, 2010). Low social support has consistently been associated with increased anxiety and depression (Cacioppo *et al.*, 2010; Depression and Other Common Mental Disorders: Global Health Estimates, World Health Organization, 2017). Many individuals that experience subclinical symptoms, like stress, depression and anxiety, are not effectively treated by typical mental health care, indicating gaps in support. Additional tools are needed beyond clinical care that support individuals in everyday life.

Digital peer support as a low-barrier social inclusion model

DPS may help address this gap in care by offering a low-barrier space between informal social support and formal clinical care. By connecting peers experiencing similar struggles, it can provide a timely support system, validation, social connection and coping strategies without a need for formal diagnoses, insurance, transportation or any sharing of personal information. Unlike self-directed services or AI chatbots, moderated DPS can promote social connection, while reducing access barriers. When user accessibility is considered in designing DPS tools, it may serve as a social inclusion tool in mental health care.

In peer support, peers engage in dialogues based on shared experiences to reframe their thoughts about their circumstances or troubling events, promoting social connection and well-being (Solomon, 2004). This type of care usually involves lower barriers to entry compared to typical therapy, as well as lower or no costs to individuals. Peer support interventions can improve hope, sense of control and self-efficacy (Repper and Carter, 2011). Studies show that those who receive peer support were also found to engage in more self-care, and experience a higher sense of belonging, improved life satisfaction, decreased depression, anxiety and loneliness (Richard *et al.*, 2022). These emotional benefits are especially important for individuals that face barriers to typical care due to stigma, cost or cultural differences.

While subclinical, DPS can serve as a more equitable and accessible avenue to peer support as users benefit from DPS at comparable levels and often empower each other to seek out additional mental healthcare (Greenglass *et al.*, 1998; Ma *et al.*, 2022). Research shows that guided peer-based chats can increase mindfulness, resilience and emotional regulation, lower depression and anxiety while being more cost-effective (Tomasino *et al.*, 2017; Yeo *et al.*, 2023).

While access to DPS requires having an internet-enabled device and a reliable internet connection, this poses a smaller barrier than in-person care. For example, 96% of American adults use the internet, compared to only 14.4% of adults with disabilities who lack reliable transportation for in-person care (Internet, Broadband Fact Sheet, 2024; "QuickStats," MMWR, 2024). Furthermore, DPS can offer anonymity that can reduce stigma and accommodate cultural attitudes toward emotional experiences. These characteristics of DPS present it as an equitable tool to expand emotional care access. However, DPS is not a replacement for clinical care. Instead, it may function as a social inclusion tool that helps individuals receive accessible social and emotional support when they need, and bridge to formal care when necessary.

TechQuity: the 5 A's of access

To expand emotional care access, barriers present within formal mental health care pathways should be examined by the feasibility of use, affordability and fit into everyday life. *TechQuity* refers to "the strategic development and deployment of technology to achieve health equity" (Nagra *et al.*, 2025). Adapting Penchansky and Thomas's Five A's of access (Availability, Accessibility, Accommodation, Affordability and Acceptability) (Penchansky and Thomas, 1981) to DPS gives an opportunity to reduce barriers that typical mental health care systems embody and promote social inclusion in care (Table 1).

Availability

Availability defines the extent to which services meet the needs of individuals. Formal mental health services often have waitlists, limited business hours, and insurance coverage restrictions (Andrade *et al.*, 2014). By contrast, DPS is available on-demand and does not require an appointment. The continuous availability of DPS services makes them suitable for users that seek immediate and subclinical support, especially for individuals that have barriers to accessing mental health care, such as shortage of providers, or geographical distance, particularly important for individuals from low-income or rural backgrounds.

Accessibility

Accessibility refers to the relationship between users' digital skills, literacy and effort required to use a service. Many portals and telehealth systems require complicated intake forms and processes with diagnostic assessments before individuals can access care (Graham *et al.*, 2020). DPS models reduce this bureaucracy and prioritize self-identification

Table 1 Applying the five A's of TechQuity to digital peer support as a social inclusion model

Dimension	*Common access barrier*	*DPS Design*	*Social Inclusion Relevance*
Availability	■ Waitlists ■ Limited to business hours ■ Insurance requirements or high costs ■ Session length and number limits	■ No waitlist ■ Available 24/7 ■ No insurance requirement ■ Immediate access ■ Unlimited sessions	■ Allows people who may be isolated, overwhelmed, or unable to schedule formal care to receive timely support around-the-clock
Accessibility	■ Finding a provider ■ Intake forms ■ Formal assessments and diagnosis ■ Hierarchy of symptoms to receive care	■ No diagnoses required ■ Streamlined intake ■ Immediate access ■ Supports low-acuity symptoms	■ Reduces entry barriers to receive mental health support, especially for people with limited health or care system literacy, or discomfort with formal care services
Accommodation	■ Transportation to services ■ Individual, private and quiet setting, away from dependants (caretakers may be necessary)	■ User-friendly digital interface ■ Text-based support allows discreet use anywhere	■ Allows people to seek support in ways that fit their daily lives, schedules and limitations
Affordability	■ High-speed internet access to receive telehealth video or audio support ■ Open schedule and reliable transportation to receive in-person care ■ High copays or out-of-pocket costs	■ Low-speed internet is adequate for text-based chats ■ No co-pay through participating health plans or employee assistance programs	■ Decreases direct or indirect cost-relevant exclusion for people that may not be able to afford formal care, copays, transportation or time away from work
Acceptability	■ Stigma may keep clients from accessing and accepting formal therapy ■ Mismatch between demographics of client and therapist	■ Anonymous support reduces stigma and promotes free sharing of experiences ■ Synchronous moderation ensures psychological safety and encourages mutual respect among participants	■ Reduces stigma and increases comfort by offering anonymous, peer-based support that may be more culturally relevant

to allow for immediate mental health support. Services use easy to understand language and interfaces to allow recipients to access services rapidly within minutes. Especially for individuals with limited mental health literacy or who are stigmatized by typical care due to being from underserved regions or populations, DPS services offer accessible support.

Accommodation

Accommodation refers to whether a service fits users' daily lives, preferences and needs. Typical mental health services require transportation, scheduling of appointments, and private spaces. Text-based DPS is discreet and flexible, and accessible via web services. This makes participation possible among individuals with restrictions for scheduled in-person sessions and disclosures of private health information (PHI). This service model also enables seeking support while managing other duties, such as work, school or caregiving, and overcomes limitations regarding mobility or living arrangements. The flexibility that DPS provides can promote participation from individuals that otherwise may be excluded from formal clinic-based support services.

Affordability

Affordability is the relationship between the direct and indirect costs associated with obtaining care and the participant's ability to pay for them. Formal mental health services often require copays, out-of-pocket fees, transportation costs and unpaid time from work. These costs may accumulate over time, burdening low-income populations

disproportionately (2024 Employer Health Benefits Survey, 2024). By contrast, DPS services are low-cost or are employee-sponsored through Employee Assistance Programs, and do not require insurance (Nagra *et al.*, 2025). By limiting both direct and indirect costs, DPS provides low-cost entry to mental health care. However, access to digital services still requires an internet-connected device.

Acceptability

Acceptability is the relationship between a digital health tool's workflow and the participant's attitude and comfort. Typical mental health services may require participants to overcome stigma associated with seeking services before accessing them (Clement *et al.*, 2015). DPS offers anonymity and social connection, without sharing any personal information throughout the entire service. Human moderation in DPS promotes psychologically safe spaces that increase user trust and in turn increase user engagement, especially among individuals from marginalized populations such as rural communities, who experience stigma, mistrust or cultural mismatch that can interfere with seeking support.

Together, the five A's demonstrate what makes DPS equitable is not merely its digital platform, but the application of a TechQuity lens to design support that is socially meaningful. DPS may address the "missing middle" gap in mental health care, which refers to individuals experiencing mild to moderate psychological distress who do not meet criteria for high-level clinical services and often fall through the cracks of typical mental health systems (Menssink *et al.*, 2025). This is particularly important for individuals from marginalized populations, such as low-income households and rural communities. DPS models offer a potential bridge for this group by providing a low-barrier, accessible and anonymous space for emotional expression. Through moderated peer chats, individuals can receive real-time support and coping skills while remaining outside of diagnostic and insurance systems. These interventions assist individuals in recognizing their emotional experiences, developing self-efficacy and if needed, transitioning to formal mental health care.

Digital peer support in practice

DPS services vary in structure and format, ranging from asynchronous to synchronous moderated peer chats. Some examples include Supportiv, TalkLife, 7 Cups, Wisdo, among others. As a synchronously moderated, web-based DPS service, Supportiv anonymously connects users to small peer groups based on shared concerns. Trained subclinical human moderators facilitate these chats to promote engagement, validation and safety. This model also integrates AI-supported monitoring tools to identify suicidality risk and trigger swift crisis referrals. This multilayered approach enables identification and appropriate referral of individuals facing acute crises, including suicidal ideation, thereby complementing existing clinical care pathways. From a TechQuity perspective, this model shows how DPS can integrate availability, accessibility, accommodation, affordability and acceptability, and refer users to formal higher-acuity care when necessary.

Limitations

While the existing literature suggests that 24/7, real-time, anonymous, DPS services offer promising avenues for more equitable mental health access, a few limitations must be considered. DPS can reduce barriers like cost, stigma and scheduling, but it can also reinforce inequity for individuals with limited digital literacy or internet access. Digital literacy training is essential to increase access to digital health tools. Studies frequently include participants who are already engaged with or open to peer-based support, potentially overstating the generalizability of findings. Many individuals, especially older adults, still prefer in-person psychological services, suggesting that DPS may not appeal to all

demographics (Woerner *et al.*, 2022). In addition, there is a relative lack of longitudinal or comparative studies assessing DPS outcomes versus typical mental health services. Most studies examine cross-sectional data to assess emotional outcomes without attention to long-term improvements. Finally, as previously noted, DPS services offer subclinical support and should be perceived as a complement to formal care when it is needed, instead of a replacement. Integrating DPS within multi-step care and ensuring transition to professional services for higher-acuity needs would be essential for improving user outcomes and safety.

Conclusion

Addressing the burgeoning emotional health crisis necessitates innovative, equitable solutions that go beyond the limitations of typical emotional health services. DPS represents a promising approach to bridging gaps in access. By leveraging technology to provide 24/7 anonymous and synchronous support, DPS can effectively meet the emotional health needs of underserved populations, empowering individuals to seek immediate help in a stigma-free environment. Furthermore, the integration of peer support fosters a sense of belonging and shared understanding, which can enhance emotional resilience and promote mental well-being. As emotional health challenges continue to rise, adopting and refining DPS within a TechQuity framework offers a scalable, inclusive pathway to reducing barriers and achieving meaningful, equitable emotional health care for all.

Acknowledgements

No additional funding was sought for this paper. Generative AI was not used in writing this paper.

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