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Peer Support Provisions of Helping Families in Mental Health Crisis Act (HR 2646)

Talking to someone who has been what you have been through ("peer-support") can sometimes make people feel better. Peer support is generously funded by states and SAMHSA, but research does not show it improves meaningful outcomes in people with serious mental illness. ((Dixon, Perkins and Calmes September 2009) (Cochrane Collaborative 2013) (Lloyd-Evans, Mayo-Wilson and Harrison 2014) (Landers and Zhou 2014) (SAMHSA-BRSS 2012).

While peer-support may be enjoyable to give and receive, the organizations that receive peer support funds often use the funds to promote an anti-medication, anti-psychiatry philosophy, and lobby against treatments (hospitals, AOT, ECT, etc.) that can help the most seriously ill. Ex. the National Coalition for Mental Health Recovery (NCMHR) believes diagnosis is not of value in helping people recover, and works to replace medical model with a talk model they helped to invent.

The Helping Families in Mental Health Crisis Act attempts to reign in the excesses of peer support by setting up what will essentially become a credentialing mechanism that requires those engaged in the practice to understand science, the utility of medications and other aspects. Some think this is a good idea. Others are worried that the bill essentially credentials an intervention without evidence it is effective. They would prefer to see a two-step process. Government should first determine if peer support is effective at improving meaningful outcomes like reducing homelessness, arrest, incarceration, hospitalization and suicide; and if so, after that, establish best practices. It is hard to argue against determining if an intervention is effective before taking steps to spread its usage.

Following is the important section of Helping Families in Mental Health Crisis Act related to peer support.

SEC. 103. REPORTS.

(b) REPORT ON BEST PRACTICES FOR PEER-SUPPORT SPECIALIST PROGRAMS, TRAINING, AND CERTIFICATION.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, and biannually thereafter, the Assistant Secretary shall submit to the Congress and make publicly available a report on best practices and professional standards in States for—

(A) establishing and operating health care programs using peer-support specialists; and

(B) training and certifying peer-support specialists.

(2) PEER-SUPPORT SPECIALIST DEFINED.—In this subsection, the term

"peer-support specialist" means an individual who—

(A) uses his or her lived experience of recovery from mental illness or substance abuse, plus skills learned in formal training, to facilitate support groups, and to work on a one-on-one basis, with individuals with a serious mental illness or a substance use disorder, in consultation with and under the supervision of a licensed mental health or substance use treatment professional;

(B) has been an active participant in mental health or substance use treatment for at least the preceding 2 years;

does not provide direct medical services; and

(C) does not perform services outside of his or her area of training, expertise, competence, or scope of practice.

(3) CONTENTS.—Each report under this subsection shall include information on best practices and standards with regard to the following:

(A) Hours of formal work or volunteer experience related to mental health and substance use issues.

(B) Types of peer specialist exams required.

(C) Code of ethics.

(D) Additional training required prior to certification, including in areas such as—

(i) psychopharmacology;

(ii) integrating physical medicine and mental health supportive services;

(iii) ethics;

(iv) cope of practice;

(v)) crisis intervention;

(vi) identification and treatment of mental health disorders;

(vii) State confidentiality laws;

(viii) Federal privacy protections, including under the Health Insurance Portability and Accountability Act of 1996; and

(ix) Other areas as determined by the Assistant Secretary.

(E) Requirements to explains what, where, when, and how to accurately complete all required documentation activities.

(F) Required or recommended skill sets, including—

(i) identifying consumer risk indicators, including individual stressors, triggers, and indicators of escalating symptoms;

(ii) explaining basic de-escalation techniques;

(iii) explaining basic suicide prevention concepts and techniques;

(iv) identifying indicators that the consumer may be experiencing abuse or neglect;

(v) identifying and responding appropriately to personal stressors, triggers, and indicators;

(vi) identifying the consumer's current stage of change or recovery;

(vii) explaining the typical process that should be followed to access or participate in community mental health and related services; and

(viii) identifying circumstances when it is appropriate to request assistance from other professionals to help meet the consumer's recovery goals.

(G)) Requirements for continuing education credits annually

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