CCBHC Living Experience Advisory Council

Recommendations Summary:

Centering Voices of Lived and Living Experience

NATIONAL COUNCIL
for Mental Wellbeing

Background

In March 2022, the National Council for Mental Wellbeing launched the CCBHC Living Experience Advisory Council. Through a vetted recommendation and application process, the National Council identified 10 individuals with lived and living experience working in peer support or peer support supervisory roles in Certified Community Behavioral Health Clinics (CCBHCs) across the country who were convened monthly to discuss and share best and promising practices to centering lived and living experience and recovery in practice, operations and governance.

At the onset of the project, primary objectives and key areas of exploration were established to guide focus during monthly meetings. These included:

Primary Objectives

- Amplify the experiences and perspectives of individuals with lived and living experience and those served by CCBHCs. Create dedicated space for those with lived and living experience to inform CCBHC implementation at a national level.
- Promote continuous improvement among CCBHCs. Identify promising or best practices in engaging individuals and families receiving care in shaping the future of service delivery. Translate learnings into practice tools and guidance for CCBHCs.
- Support current and emerging leaders as a voice for those receiving care.

Areas of Exploration

- What does the ideal client and family experience of care look like at a CCBHC?
- How have or how could CCBHCs successfully incorporate the voices of individuals with lived and living experience and their family members?
- What are common barriers or pitfalls individuals and families experience in engagement efforts?
- How can CCBHCs best leverage peer support specialists to improve the experience of individuals being served and their families?

Purpose of this Document

This document presents recommendations for the field based on monthly conversation and exploration of these areas. Although the participants of the advisory council were representatives from CCBHCs, we believe the findings and recommendations presented in this document have relevance and application for the field at large and encourage behavioral health and other community-based organizations to consider applying these recommendations where appropriate for their services and scope of practice.

Acknowledgements

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CCBHC Living Experience Advisory Council

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Recommendations for the Field

Recommendations from the Advisory Council were organized into two key areas: organizational shifts toward centering lived and living experience and building a strong workforce of lived and living experience.

Organizational Shifts Toward Centering Lived and Living Experience

These recommendations focus on uplifting, trusting and valuing the lived and living experiences of those you serve and working toward approaches where people with lived and living experience are part of leading, setting priorities, identifying solutions and shifting narrative.

Recommendations For Culture and Process Change

- Within each organization, create a shared understanding between all staff of the unique value of peer support – to be the "go-between," to advocate for and hold the voice of the person receiving services.
- Ensure that staff across the organization and at various levels represent people with lived and living experience, not just peer specialists.
- Include the peer voice as an equal seat at the table and critical voice during orientations, training and staff meetings. This includes:
  - Involve peer support representatives in all new staff orientation to describe the value and integration of peer support services and share experiences of success.
  - Whenever possible, add a peer as a co-trainer to staff training on interventions, working with people and other relevant areas of focus. This can improve accountability and demonstrate what partnering looks like.
  - Have peer specialists provide training and clarity on the peer role(s) to others at the organization to ensure all staff are aware of the breadth, depth and scope of peer services.
  - Advocate to include peer support staff in undergraduate and graduate training, especially for students of all levels doing internships at provider agencies. Peers should be actively involved in the education of these students/interns at whatever level, from bachelor's to residents in training.
- Engage staff to think about the ways lived and living experience could be centered in policy and practice throughout the organization. Consider design thinking exercises or other approaches where people from various disciplines could share their ideas on what culture shifts toward embracing the peer role could look like.
- Create career paths within the organization for peer staff and opportunities for career development and advancement within their areas of interest and skills.

"Person-centered is not a lofty aspiration. It is literally an action."

Recommendations to Improve Experiences in the Process of Care

Individuals entering supports for the first time, or re-engaging in care, are too often exposed to burdensome administrative processes and lengthy intakes before accessing any treatment supports at a time when they are experiencing crisis and extreme vulnerability.

These recommendations focus on improvements organizations can take to enhance positive experiences during engagement.

- **Orientation**: Use peer support staff to welcome new members and orient them to the intake process, including what to expect and how long the intake process will take.
- **Intake**: While recognizing that intake policies are, to some degree, dictated by state and federal guidelines, the impact of lengthy and detailed intake process for people coming for care can be counterproductive. Consider the following changes in process:
  - Organize the intake processes around what matters most to the person coming for care. Engage staff or individuals with lived and living experience in an assessment of your intake process to identify areas for improvement.
  - Recognize that people in crisis or who are coming for care are in pain and their immediate focus is getting relief from what they are experiencing. Goal setting is a process that takes time and can't be done when the person is in acute distress. As you evaluate your intake process consider: ***What would be the impact if we didn't do this/ask this on intake?***
  - Eliminate all redundancies in the process so that questions are only asked once.
  - Emphasize the importance of building trust and support at every contact, with every person in the organization.
    - » Embody the principle that "care begins in the parking lot." Each member of the team contributes to giving people this feeling.
    - » Provide help at first contact, this will build trust.
    - » Recognize that asking a person to share their trauma experiences during a first encounter may be re-traumatizing. Build rapport before introducing questions around trauma.
  - Be honest about what people can expect in this time of staffing shortage. If care cannot be provided in a 24-48 hour window, be clear about timelines. Once an intake is scheduled, communicate a realistic timeframe someone can expect (e.g., "This should take around one hour.").
- **Discharge:**
  - From the beginning of care, create the expectation that the time will come when care is no longer needed because the person has developed the skills and support they need to live a life in the community.
  - Clearly identify steps to discharge, focus on accomplishments routinely throughout care, not just at "treatment plan reviews."
  - Plan clear safety plans and identify supports several months before the actual discharge date, when possible.

Reflections from people with lived and living experience on experiences when engaging in care.

Involve peers from the beginning. "Intake was an hour-and-a-half-long thing of them asking me questions when I'm in crisis, asking about the trauma I've been through… I wish someone would have been like 'Hey (name), I'm going to help you through this.' It's so important to have peers involved at beginning of engagement."

"Clinical staff assume they know what's best. 'Goal' doesn't mean anything. Folks need to be asked 'What is important to you and how can I help you with this today?'"

"When my brain is already on fire, having you ask me question after question only heats it up more."

"They ask, 'What are your goals?' I don't have any goals… I just want to live."

"We don't have plans that fit that individual's immediate goals – we have people who think they know what's important for the person. But, 'If I don't have a place to sleep tonight, I don't care about anything else.'"

Building a Strong Workforce of Lived and Living Experience

Recommendations on the Role of Peers

- Create both full- and part-time roles for peer support staff with salary commensurate with case manager salaries.
- Pay a livable wage and recognize that the decision to work full-time and give up disability benefits comes with considerable risk that can be offset by salary and benefits at the organization employing them.
- Involve peer workers in all new staff orientation to describe role and share experiences of success.
- Identify success measures and outcomes specific to peer support with input from staff. Be clear on how the measures are set and used.
- Organizations should hire multiple peers, rather than expecting one person to carry out this critical work for the whole organization.
- When developing peer roles, consider:
    - Placing staff based on individual staff strengths, experiences, competencies and interests.
    - The specific roles, competencies and tasks needed in a specific setting (and writing specific job descriptions for that setting).

Recommendations on Training for the Peer Workforce

- Trainings on key topics MUST be provided by the organization to supplement the basic peer support training. These topics include group facilitation, suicide prevention, crisis intervention, etc. Content for these training courses should be developed in partnership with peer leadership.
- While training on the role of peer staff should include published writing and resources about peer support, the curriculum development should be led by the peer support staff leadership in the organization.
- Involve peer staff in group facilitation. Provide training on facilitation and include them in developing group curriculum.
- Provide training for specialty populations (e.g., forensic peer training, peer staff working in health care settings, helping people with physical health concerns).
- Develop career paths for peer staff to move in various roles: supervision, specialized peer support, advancement into leadership positions within the organization, etc.
- Combine peer support training with wellness support training.
    - Implement WRAP (Wellness Reflection Action Planning) training to develop skills within staff. This helps people identify their strengths, recovery tools, what will it look like when they're well, when they're starting to be well, who their supporters are, what crisis looks like, which medical professionals do they want and a post-crisis plan around when they're ready to take charge of their own life again.
- Provide organizational support for required and non-required continuing education opportunities.
- Offer leadership training to peers supporting their involvement at every level of the organization.
- Provide opportunities for those receiving services to be certified as peer staff by providing financial support for certification training and required hours.
- Advocate for states to align on expectations and credentialing and eliminate unfunded mandates (e.g., working as a volunteer for 500 hours before certification).

Recommendations on Supervision for the Peer Workforce

- The ideal supervisor for peer staff is a peer with supervisory training. When this isn't possible, training for supervisors should include principles of recovery and the clear and unique role that peer staff play.
- Firmly ground the supervision relationship in mutuality, safety, encouragement, balance, discipline, empathy and equity.
- Supervisors should be well-versed in the power of peer support and create boundaries to resolve any attempts to move peers into clerical functions or non-peer support roles. Their role as advocate is critical.
- Use motivational interviewing as a communication structure within supervision to support the employee in finding their own solutions.
- Train peer supervisors to understand they are not the therapist for peer staff, but a supervisor to support growth and development of the peer staff in their work and career.
- Address challenges and barriers as soon as observed to create a space for learning and growth.