Community Support Training 101
September/October 2013

Key service functions with examples from training:

1. Providing holistic, person-centered care with emphasis on personal strengths, skill acquisition and harm reduction, while using stage-wise and motivational approaches that promote active participation by the individual in decision making and self-advocacy in all aspects of services and recovery/resiliency.

For example: Bill has co-occurring mental health and substance use disorders. Bill indicates that his Probation Officer made him come to treatment. He really doesn't think he has that much of a problem and thinks he could control the amount he drinks. He mentioned during his assessment that he would like a different place to live and half-heartedly agrees that it might be better to not be around people that drink and party a lot. From this example we know Bill is in the pre-contemplative stage of change readiness related to his alcohol use and not ready to quit drinking. Interventions for this stage would include spending time building rapport with Bill, learning what his life goals are, what motivates him and helping him to meet his basic needs. Then while helping Bill check into alternative housing you would begin motivational interventions to help him develop discrepancy between his drinking behaviors and his life goals. While helping Bill in meeting his basic needs you could explore why the probation officer might have recommended he go to treatment.

2. Using interventions, based on individual strengths and needs, to develop interpersonal/social, family, community and independent living functional skills including adaptation to home, school, family and work environments when the natural acquisition of those skills is negatively impacted by the individual's mental illness and /or substance use disorder.

Let's take the example of Katelyn, age 8. Katelyn has difficulties with following directions and behaving appropriately in public. The CSS could work with the family to develop a reward system, such as stickers, for good behavior at home or help the family know how to work on appropriate behavior around other children at the park. Both of these examples are reasonable and affordable activities that can be carried out in their normal life as a family.

Another example is Betty - Betty has few social opportunities because, due to depression and anxiety, she tends to isolate within her home. One thing Betty enjoys doing is cooking and she is pretty good at it. So, you could find a way to utilize Betty's interest or strength of cooking and

incorporate cooking into the goal to develop more social activities such as encouraging Betty to cook a meal and inviting her neighbor or a new acquaintance over for a meal. You could also role play conversation starters and talk about common topics for conversations with people you are establishing new friendships with.

3. Facilitating and supporting recovery/resiliency through activities including: defining recovery/resiliency concepts in order to develop and attain recovery/resiliency goals; identifying needs, strengths, skills, resources and supports and teaching how to use them; and identifying barriers to recovery/resiliency and finding ways to overcome them.

For example, Tom has a diagnosis of panic attacks and anxiety. Tom has recently come to live with his grandmother. Tom has worked in the past and has skills as a waiter. He is personable and is motivated to work. His new community has employment resources, a public bus system (though he has never ridden a bus before) and his grandmother is very supportive. Tom's recovery might mean to him that he has a job, more money and a date on Saturday night. A CSS might teach Tom how to use his strengths and skills as well as the resources and supports he has available to him. The CSS will help Tom identify what barriers he may encounter in his quest to be employed and help him overcome these barriers. Barriers for Tom could be his unfamiliarity with the community including the employment resources and potential job sites as well as unfamiliarity with the public bus system and his hesitancy to use the bus. A CSS could assist Tom in accessing the job center and in learning about possible employers who hire waiters. As far as getting a date, Tom may need help with where to meet people, conversation skills, or pointers on hygiene or dress.

4. Developing, implementing, updating, and revising as needed, a treatment plan that identifies specific, measurable and individualized interventions to reduce and manage symptoms, improve functioning and develop stability and independence. This plan is developed by a team consisting of the following as appropriate: the individual, family, community support specialist, community support supervisor, therapist, medication providers, schools, child welfare, courts and other supports.

So to continue on with the example in #3, Tom has a stated goal of finding a job so he can have more money and eventually move out of his grandmother's home into his own apartment. But because he is new to the community he needs help learning how to get around and where things are located. One possible step toward his goal could be to learn the bus route so he could get to work. The first intervention could be to go to the bus station with Tom or go online with Tom to get a bus schedule. (check, this is measurable and you know when you've accomplished this step). [It's time to do the happy dance]. The next step is to determine the route, times, and bus stops. The third step might be to ride the bus with Tom, if needed. A next step might be to go with Tom to the bus stop, let him ride the route alone and meet him at the destination, checking with him to see how it went. The last step could be to let Tom to ride the

bus on his own and call to follow up. Different people need different levels of intervention. Tom may just need information or to know where the resource is. Or Tom may need you to ride with him several times if he has problems with fears or anxiety.

5. Providing services that result in positive outcomes including but not limited to the following areas: employment/education, housing, social connectedness, abstinence/harm reduction, decreased criminality/legal involvement, family involvement, decreased psychiatric hospitalizations, and improved physical health.

Let's take the example of Mary which relates to social connectedness. Mary has isolated for several years and as part of her recovery has decided she wants to make more friends. A CSS could work with Mary on how to connect with people in order to make more friends. Steps could include exploring where to meet new people and how to meet new people. The CSS could help Mary learn how to start and have conversations with people, what some typical topics might be for first conversations, how much to share or not share with people you meet for the first time, the importance of non-verbal communication, learning what personal space means, learning that it's ok to have differing opinions, etc. A CSS could role play a conversation with Mary, modeling first for Mary how to start a conversation with a new person she may meet, then letting Mary lead the role play and practice starting the conversation and you provide feedback on how she did.

6. Working collaboratively with the individual on treatment goals and services including the use of collaborative documentation as a tool to ensure that individuals are active in their treatment.

It might go something like this - Ok Harry let's summarize what we accomplished today and what we want to put in the note. We worked on your goal of being physically healthy today. We went to the store and looked at nutrition labels to learn which types of food have less sugar or carbohydrates because eating fewer carbohydrates helps your blood sugar to stay lower. I think you did a good job of identifying which foods would make your blood sugar higher. What do you think? [Harry agrees and says she didn't realize potatoes had so many carbohydrates because she thinks of them as a vegetable]. CSS says to Harry Do you want to continue learning about foods that will help you manage your diabetes? [Sally says yes], so you plan an intervention related to further education about how foods effect blood sugar.

7. Documenting services that clearly describes the need for the service, the intervention provided, the relationship to the treatment plan, the provider of the service, the date, actual time and setting of the service, and the individual's response to the service.

Some agencies choose to utilize note formats such as SIRP, SOAP or PIRP to help ensure all elements of the notes are included. [For example PIRP means purpose, intervention, response, and plan] Example:

Purpose: Met with Mary today to work on social connectedness (Goal 1, Obj. 3)

Intervention: Worked with Mary today on learning how to develop new friends. We listed together potential places she could consider for where to practice her conversation starter skills. We then role played how to start a conversation with a new acquaintance. I modeled a conversation starter, prompted her to try a conversation starter with me and gave her feedback on how she did.

Response: Mary was nervous and moved very quickly into a lot of very personal information during the role play. She also said that she was a bit uncomfortable role playing because it felt fake. She said she would be willing to try it again because she knows it can help her learn how to be better at talking to people.

Plan: Meet with Mary again to work on social connectedness. We will try role playing again next week.

8. Developing a discharge and aftercare/continuing recovery plan to include, if applicable, securing a successful transition to continued services.

No example given for this key service function.

9. Contacting individuals and/or referral sources following missed appointments in order to re-engage and promote recovery/resiliency efforts.

Let's look at an example: You and Mary had an appointment scheduled for today to complete an application for housing assistance. However; Mary did not show up and did not contact you to cancel or reschedule as she has done in the past. You are also aware that Mary was expecting to have a conversation with her ex-husband prior to your scheduled appointment. Mary revealed to you that she was anxious about this encounter and dreading it. Given this situation and your concern for Mary, you begin calling the phone numbers that Mary has provided to try to locate her. You are unable to make contact, so you travel to her home and find her there having car trouble. She had forgotten to contact you to tell you about her situation and the need to reschedule your appointment. You and Mary set another time to

pursue housing assistance. You are assured that Mary is ok.

10. Supporting individuals in crisis situations including locating and coordinating resources to resolve a crisis.

Let's take the scenario with Mary again. Only this time, when you arrive at her home, you find her crying and reporting that all her efforts to get her children back are worthless, that she is worthless like her ex-husband says and that she might as well end it all. You are concerned for her well-being and safety, so you contact your supervisor to assess her, provide crisis intervention services and make plans to provide for her safety.

11. Maintaining contact with individuals who are hospitalized for medical or psychiatric reasons and participate in and facilitate discharge planning for psychiatric hospitalization and for medical hospitalization as appropriate.

Using Mary's example again, as a result of assessment from the QMHP and evaluation by a physician/psychiatrist, Mary agreed to be hospitalized for further evaluation of her crisis situation. During her inpatient hospitalization, the CSS makes contact with Mary at the hospital and inquires how she is doing and if she knows of her discharge date. Mary indicates that she has been started on a medication to help with her anxiety and will be meeting with her doctor to discuss her discharge. Mary voiced concerns about not being able to remember to take her medications as prescribed because this one is taken at different times than her other medications. The CSS agreed to assist her at discharge in getting the medication and a medication organizer and developing a method to help Mary remember to take her medications. CSS also reminds hospital staff that she will assist Mary upon discharge and would like to be aware of and part of the discharge planning process.

Another example: After Tonya is discharged from acute hospitalization, she leaves the hospital with a change in medication. A CSS could provide education to Tonya and Tonya's family on any new prescribed medications. The CSS could educate not only Tonya, but also the family on what the medication is treating in regards to Tonya's illness and potential side effects to look for as a result.

12. Provide information and education in order to learn about and manage mental illness/serious emotional disturbance and/or substance use disorders including symptoms, triggers and cravings, and reinforce the importance of taking medications as prescribed, while facilitating the persons' served communication with prescribers as needed.

For example: A CSS could educate Cindy and her family (go to slide 50) members on skills to tolerate distress that can be used in situations when Cindy becomes escalated. The CSS could facilitate a role play and discuss particular situations when skills would be beneficial to better cope with stress. By including family, the family could also learn ways to help Cindy cope and reinforce more adaptive behavior.

13. Reinforce the importance of taking medications as prescribed and assist the individual to make medication concerns regarding side effects or lack of efficacy known to the prescriber.

For example Tammy was just recently prescribed metformin for her diagnosis of diabetes. The CSS has printed some basic information to take to Tammy and review with her. The CSS asks if Tammy is remembering to take the medication as prescribed. Tammy says she is remembering. CSS asks if Tammy has been taking her blood sugar. Tammy says she is and they are still high that the medicine isn't working. The CSS discusses with Tammy the importance of contacting her doctor to let him know her blood sugars are still high. The CSS can role play with Tammy how to have this conversation with her doctor if needed.

14. Building skills for effective illness self-management including psycho-education, behavioral tailoring for medication adherence, wellness/recovery planning, coping skills training, and social skills training.

For example, if Tammy says she is having problems remembering to take her medications, a CSS could help Tammy develop a way to remember to take her medications (this is often referred to as behavior tailoring). Some ways might include sticky notes on the refrigerator to connect morning medications with breakfast time, rubber-banding the medication box to her toothbrush since she brushes her teeth morning and evening, putting the bedtime pill box on the night stand, set reminders/alarms, etc.

15. In conjunction with the individual, family, significant others and referral sources, identifying risk factors related to relapse in mental illness and/or substance use disorders and develop a plan with strategies to support recovery and prevent relapse.

For example a CSS may help Joe to identify situations, people or places that act as triggers for his substance use behaviors and help him identify alternatives to these triggers. Or a CSS could help Jim develop and understand his wellness recovery action plan which includes identifying triggers, recognizing when things are getting worse, making a plan for crisis and reviewing how to use the plan.

16. Make efforts to ensure that individuals gain and maintain access to necessary rehabilitative services, general entitlement benefits, employment, housing, schools, legal services, wellness or other services; by actively assisting individuals to apply and follow up on applications; and to gain skills in independently accessing needed services.

As an example - A CSS could help Lucy learn how to apply for food stamps while modeling how to communicate with the benefit specialist, complete paperwork, demonstrate patience while waiting; then lessening the level of intervention and supports with successive visits to benefit offices while providing encouragement and guidance to Lucy so she can learn to independently access these benefits and services. It is recognized that people have differing abilities and will need different levels and amounts of intervention.

17. Ensuring communication and coordination with and between other interested parties such as service providers, medical professionals, referral sources, employers, schools, child welfare, courts, probation/parole, landlords, and natural supports.

For example Phillip recently got his Shelter Plus housing assistance and moved into his apartment. He tells his CSS that his faucet isn't working and he's not sure what to do. The CSS helps Phillip understand that the lease says the landlord will make needed repairs to the apartment. The CSS can either role play with Phillip what to say to the landlord when he calls or can model the conversation by calling the landlord with Phillip.

18. Ensuring follow through with recommended medical care, to include scheduling appointments, finding financial resources and arranging transportation when individuals are unable to perform these tasks independently.

For example, Betty may only need reminders or assistance developing a calendar system that works for her. Others may require much more assistance such as going to an appointment with Linda to help her communicate with her doctor and understand changes in medication orders. It's ok to transport a person to the doctor when a CSS intervention is needed and identified on the treatment plan. If the person is capable of attending the medical appointment independently and can communicate effectively on their own, it may be that a CSS would work on helping the person find a means to get to the appointment on their own. Or if Linda can get to the appointment on her own, but needs assistance during the appointment, a CSS may meet Linda at the doctor's office. Remember it is not ok to provide a CSS service that is only simple transportation such as a taxi would provide, with no treatment interventions provided.

19. Developing and supporting wellness and recovery goals in collaboration with the individual, family and/or medical professionals, including healthy lifestyle changes such as healthy eating, physical activity and tobacco prevention and cessation; and coordination and monitoring of physical health and chronic disease management.

For example, Eddie may have a goal to eat healthy and lose weight. CSS interventions could include, assisting him in meal planning, inventory of foods he has in his home, developing a healthy shopping list, learning to compare foods at the grocery store, learning how to read food labels, and/or learning how to prepare healthy meals. Again, it is based on Eddie's needs and abilities and the skills that Eddie needs to learn. These interventions would not continue on indefinitely, rather, the CSS would again follow the rehab model with teaching, modeling, coaching and fading interventions to allow Eddie to complete the tasks that he has learned. For some individuals, this process may take longer than with other individuals. There may also be a need to change your interventions if they are not effective. The key to success is breaking the goal into small manageable steps that are achievable in a shorter amount of time. And once again, to recognize and celebrate progress and goal achievement.

20. Assisting to develop natural supports including identification of existing and new natural supports in relevant life domains.

No example given for this key service function.

21. In coordination with the treatment team, improving skills in communication, interpersonal relationships, problem solving, conflict resolution; stress management; and identifying risky social situations and triggers that could jeopardize recovery.

For example, a CSS may help Susie learn what causes her stress, identify the signs of stress, and help develop ways to prevent and cope with stress. It's important to be aware of what has caused Susie stress in the past. Some strategies for managing stress include the use of positive self-talk, journaling feelings, exercise, and relaxation techniques such as slow even breathing.

22. Providing family education, training and support to develop the family as a positive support system to the individual. Such activities must be directed toward the primary well-being and benefit of the individual.

For example a CSS working with a youth and their family could assist with finding a potential respite option for a youth in situations where the behaviors of the youth are creating a great deal of stress for the entire household. This could include helping the family to identify family

members, neighbors, friends or other supports that could be a place for the youth to go when everyone needs a break. This could be a protective factor to prevent out of home placement for the youth. Or a CSS could provide education regarding guardianship to the family to assure that the individual's medical and behavioral needs are being met as they transition into adulthood.

23. Helping individuals develop skills and resources to address symptoms that interfere with seeking or successfully maintaining a job, including but not limited to, communication, personal hygiene and dress, time management, capacity to follow directions, planning transportation, managing symptoms/cravings, learning appropriate work habits, and identifying behaviors that interfere with work performance.

One example from the employment guidelines issued by the division is as follows: The person you are working with begins hearing voices on the job, walks off the job site, and calls to tell you he does not want to work. You discuss with him that there are ways to manage increased symptoms at work, and you are willing to coordinate with his psychiatrist and/or licensed Mental Health Clinician to develop a plan that would include ways to deal with symptoms on the job site. You spend time with him planning and practicing which strategies to try when symptoms occur at work. You meet with him and his work supervisor to discuss any reasonable accommodations that need to be made, discuss recent problems at work, and develop a plan. Then you touch base with him and his supervisor several times over the next few days to see if the plan is working.

24. Building skills associated with obtaining and maintaining success in school such as communication with teachers, personal hygiene and dress, age appropriate time management, capacity to follow directions and carry out school assignments, appropriate study habits, and identification of behaviors that interfere with school performance.

For example, a CSS may help the family develop healthy time management strategies such as making a schedule for their child that includes getting up on their own using an alarm clock set for a specific wake up time, setting aside a time for breakfast, arriving at school on time, having time set aside after school for homework and working toward a set bedtime.

25. Building personal self care and home management skills associated with achieving and maintaining housing in the least restrictive setting by addressing issues like nutrition, meal preparation; household maintenance including house cleaning and laundry; money management and budgeting; personal hygiene and grooming; identification and use of social and recreational skills; use of available transportation; and personal responsibility.

For example, maybe Fred has been evicted in the past as a result of very poor housekeeping. A CSS can help ensure Fred keeps his housing by working on housekeeping skills. Steps may include ensuring Fred has appropriate cleaning supplies and tools and demonstrating how to use them and coaching Fred through a practice session. You may need to provide education on what needs to occur daily such as doing dishes after you eat, picking up after yourself and throwing trash away. You may help Fred develop a cleaning schedule, such as which days to do laundry, take out the trash, or vacuum, then follow up to see if he's sticking to his schedule. When a person has been evicted in the past for poor housekeeping, motivational intervention comes in handy to develop the discrepancy between their behaviors and their goal of having a nice place to live.