

Critical Time Intervention Overview

VCEH Conference
August 2015

Suzanne Wagner

swagner@housinginnovations.us



Agenda

Introduction

Core Components of Critical Time Intervention

Keys to Successful Implementation

Supports for the Practice



Principals: Suzanne Wagner, Howard Burchman, Andrea White, Lauren Pareti

- Founded in 2009

Principals previously at CUCS (formerly Columbia Univ. Comm. Svces) for 20+ years

Extensive experience in:

- CoC and Homeless Systems Support and Transformation
- Developing, Operating and Evaluating Housing and Service Programs
- Staff Training
- Coordinated Entry/Access Processes
- Program and Systems Planning and Needs Assessments
- Implementing Evidence-Based and Best Practices – Critical Time Intervention, Housing Stabilization, Continuous Quality Improvement, Motivational Interviewing, Rapid Rehousing and Permanent Supportive Housing

What is Critical Time Intervention (CTI)?

Evidence-based practice (EBP) designed to:

- Support people through TRANSITIONS
- Build skills and networks of support

Helps people with high needs live successfully in

the community and reduce returns to homelessness, use of institutions

Incorporates “Supporting EBP’s”

- Harm Reduction, Person Centered Planning, Family Psychoeducation, Motivational Interviewing, Stages of Change
- Assumes staff have basic engagement, assessment and counseling skills



Transitions



Core Components of CTI

Focused on housing stability and achieving life goals

- Person-centered recovery orientation

Time-limited (6-9 months)

- Although other services may continue post 9 months

Three 3-month phases of decreasing intensity

- Phase 1: Transition to the community
- Phase 2: Try out
- Phase 3: Transfer of care or termination

Pre-CTI

- Planning and preparing for the transition
- Important phase





Core Components of CTI – 2

Limited Focus

- 1-3 goals in identified assessment domains

Interventions focused on preventing and addressing threats to housing stability and achieving personal goals

- Meeting obligations such as rent and bill payment and maintaining housing
- Following standard community norms and expectations
- Having sufficient money for basic needs
- Relief from disturbing symptoms and connecting to effective treatment

Establishes Linkages to Community Resources

- Develop network of supports/linkages and adjust
- Connect to natural supports



Assessment and Planning Domains

Areas of Focus for Assessment and Planning

- Housing and homelessness history and barriers to stability
- Income and financial literacy, education/training and employment
- Life skills
- Family, friends, and other supports
- Psychiatric and substance abuse issues
- Health and medical issues



Assessment reviews history, current, strengths, barriers and GOALS by domain

Assessments/service plans conducted monthly during Pre-CTI and updated during each phase



Focused Service Planning

Limit the areas of intervention

Focus on the most pressing needs that impact stability

Relate all interventions to long term goals

Usually not a linear process

Help people move away from crisis-driven lives

Focus Areas for Service Plan

Focus on Self Sufficiency

- Goal setting by person in partnership with the worker
- Connection to high quality sustainable services and supports
- Shared-Decision Making (SDM) model and Harm Reduction approach

Focus on Long-Term Stability

- Use person's goals and housing stability focus
- Help assume role and meet expectations of tenancy and community
- Movement away from symptom or crisis-based services
- Teach rather than do

Strong Expectation that Person becomes Integral Part of Community

- Considers purpose and activity
- Transition and recovery of valued life roles



Case Management and CTI



www.shutterstock.com · 160578266

“Case management makes continuity of care possible.

- Although definitions of case management vary widely, most would agree that it consists of some combination of:
 - Linking, which involves connecting clients to available resources, and
 - Direct clinical care

Case management focuses on treating the individual and his or her environment.

This occurs both through the clinical relationship, and through the case manager’s intervening in the client’s external world, in order to create a more responsive care environment (Swayze, 1990)”

Case Management and CTI - 2



Case managers must have adequate time and resources



Access and sustainability of services and supports is critical



Lease and landlord provide the expectations and structure



Goal /Recovery based intervention / not crisis or problem based

Housing Perspective



The expectations of a lease or the community do not change and apply to everyone



Conditions of the lease must be made clear and consistently enforced



Lease violation issues will often be a reason to seek services



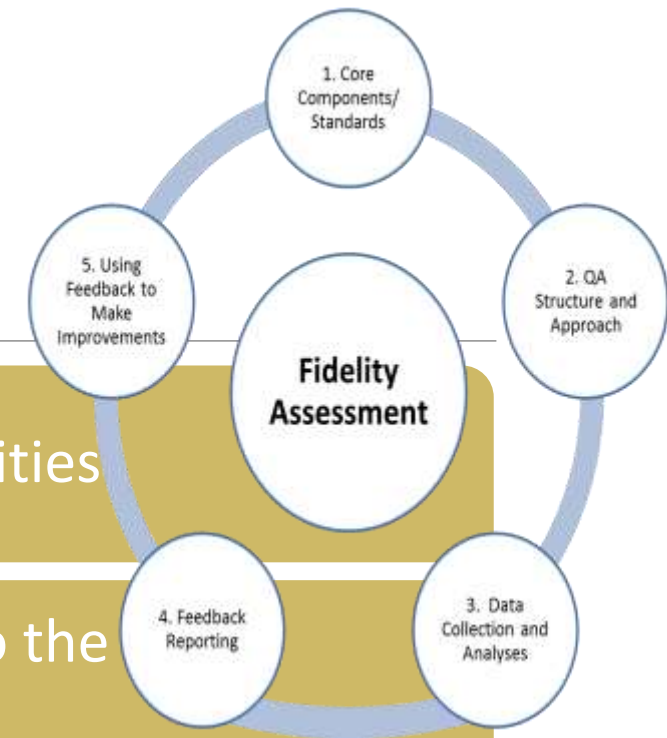
Workers focus on BEHAVIORS that interfere with functioning as a tenant and as a member of the community

The Evidence and Resources for CTI

- Recognized an Evidence-Based Practice (EBP) by the Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov
- Based on the original research at Columbia University on work with homeless single adults with serious mental illness
- Applied and researched in a variety of setting and with different populations
- Center for the Advancement of CTI: www.criticaltime.org
- CTI Global Network: <http://sssw.hunter.cuny.edu/cti/global-network/join/>
- CTI Implementation Manual: <http://sssw.hunter.cuny.edu/cti/wp-content/uploads/2014/05/CTI-Manual.pdf>



Fidelity to the CTI Model



Fidelity Scale provides guidance for program design and activities

Assess the level of consistency (fidelity) that a program has to the model as designed and researched

Full Fidelity Scale Review is usually done by researchers

The “CTI Implementation Self-Assessment” is a simpler tool to assess adherence to the model

CTI Fidelity Scale

Maximum 100 Points, Minimum of 20, 5 Points/Domain

- Components Compliance – 40 points
- Structure and Context – 20 points
- Quality and Competencies – 40 points

Higher Score – most consistent implementation of fidelity scale

Embedded Document:



CTI Implementation Self-Assessment

- Tool to assess progress on implementing core practices
- Scored on scale of 1 to 5
- 30 domains
- Score is an average w/max 5
- Conduct post-implementation as check in
- Embedded Document:



**CTI
Implementation Assessi**

Reviews the following Areas:

- Main Components
- Engagement
- Initial Assessment
- Linking Process
- CTI Worker Role
- Clinical Supervision
- Fieldwork Coordination
- Documentation

How is CTI Different?

- Structured and time limited intervention
- Goal focused - not symptom based
- Transition is the focus of the work
- Depends on community connections to services and supports for sustainability
- Community and home-based service
- Staff must step back and adjust their roles with each phase
- Adjust documentation to reflect areas of assessment and no more than 3 goals in service plan



CTI Implementation

INTEGRATING CTI

Applying CTI to Different Program Models



Options:

- In Rapid Rehousing programs to assist with and focus the transition to community based services
- In Permanent Supportive Housing to assist with adjustment to new setting and warm hand off to on site team or community based services
- Transition from incarceration to community living
- Transition from institution to community living
- Transition from one location to another
- Moving on from PSH

Pre-CTI/Housing Planning:

- Before moving into new housing – must make provision for this in shelters and other crisis response programs

Keys to Successful Implementation

Team-based: team meetings at least weekly

Individual supervision at least weekly

Access to clinical consultation

Providing services in the home and community

- Travel can be time consuming and is a shift for facility-based services

Persistent engagement

- Process not an event
- Based on person's expressed needs and aspirations
- Offers services and defines worker role



Keys to Successful Implementation - 2



Ongoing assessments of threats to housing stability



Crisis prevention orientation - research shows that the most intensive period of need is the first 6 months; plan accordingly



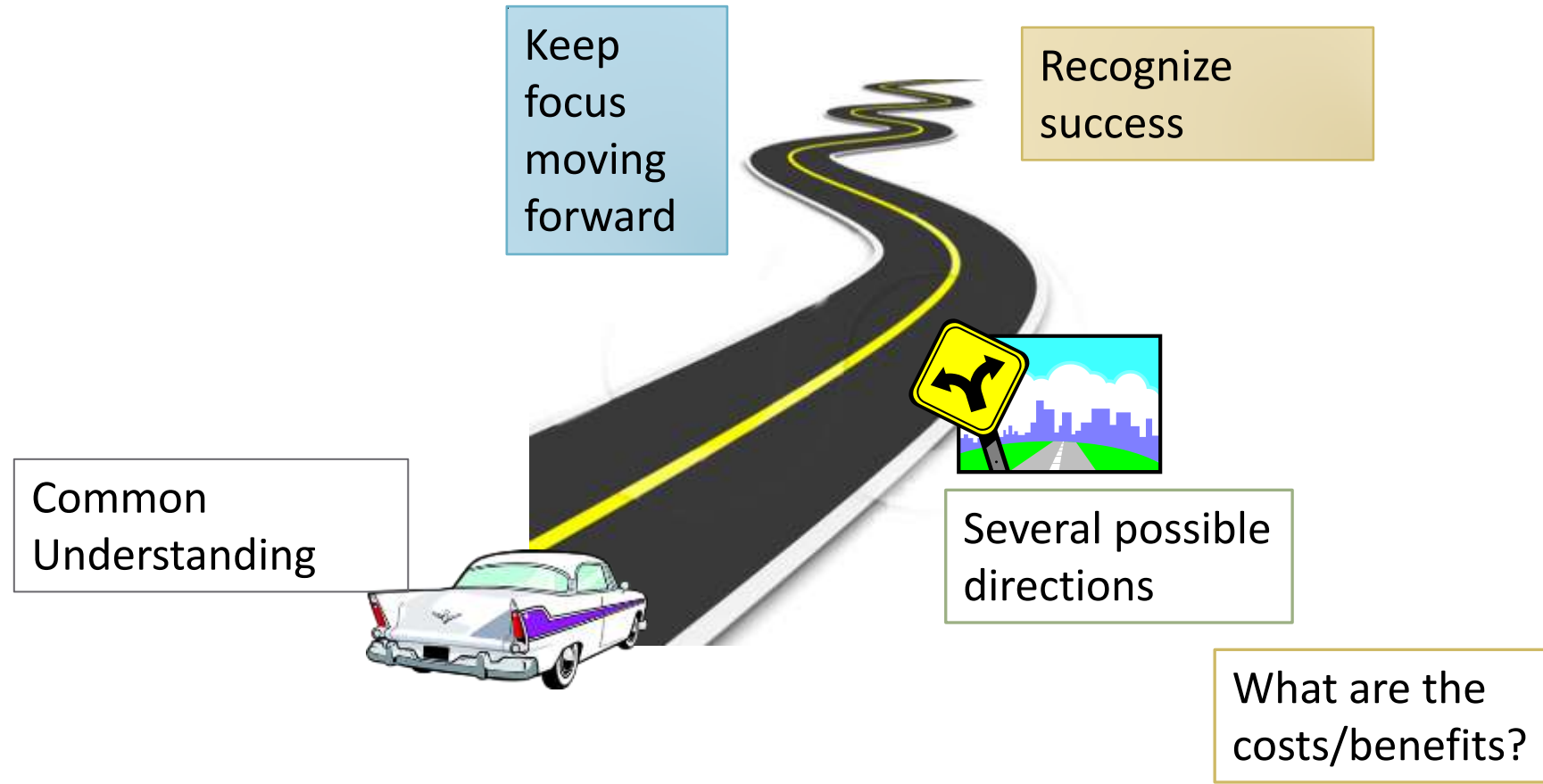
Connect with natural supports (including spiritual)



Use supporting practices and ensure core competencies

Harm Reduction, Stages of Change, Motivational Interviewing, Person-Centered Planning, Housing First

Motivating Change





Maintaining Engagement

- Connect staff role to the consumer's goals
- People may believe that once housed there is no need for services
- Staff may prioritize other consumers in crisis
- Services may shift to office-based check ins
- Staying connected is critical
- Home and community visits present opportunities to assess and teach skills
- If a consumer has expressed an interest in ending early, establish a process and review

Home Visits and Field Work



Teaching the skills to be in a person's space, structuring the visit and addressing safety concerns

- Home visits challenge boundaries
- First home visit modeled by the supervisor or seasoned colleague
- Must have P+P for safety in the field

Supervisor can periodically accompany staff on home or field work to observe and assess competencies

Working with Community Resources



- Core to the practice
- Part of worker's job is to ensure resources are working for consumers, frequent check-ins with the service.
- Staff new to community services will need training on community resource options, application and enrollment processes.
- Staff should visit community programs to get a feel for them.
- Sometimes meetings with senior staff to negotiate roles and responsibilities and an MOU (Memorandum of Understanding)

Working with Housing Providers

- Clarify expectation about roles
- Education of staff on:
 - Using the Coordinated Entry system to identify options and manage the applications
 - Working with community landlords, family and significant others
 - Role and transition process when people move into supported housing or other options that provide ongoing support
 - Tenants rights, housing subsidy process and rules, reasonable accommodations, fair housing, eviction process



Stepping Back

- Identify services and supports needed to maintain community living and achieve personal goals
- Focus on connecting to community resources and building skills
- The worker remains involved but must step back and allow person to try on their own
- This can be difficult for staff
- Give permission for extra time to teach skills
- Monitor movement through phases





CTI Phase-Date Tracking Form

Adjustments to Documentation



- Paperwork can help guide practice
- Adapt forms currently in use to include CTI
- Ensure housing stabilization goal is central
- Ensure tracking for assessments and plans
- Limit goals to two or three
- Use areas of focus for assessments
- Assessments connect to service plan
- Provide sample chart notes and review in supervision
- Sign off by supervisor on notes and plans

Effective CTI Teams

- Strong Team Leader (supervisor) with good clinical skills
- Interdisciplinary practitioners, including Peer Support and Housing Specialists
- Experience with hands-on, community-based services
- Committed to the model
 - Monitor fidelity to prevent practice drift
- Use outcome data to evaluate services and identify adjustments to improve service quality



Caseloads

Caseload size

- 16–18 individuals per worker
- 12–15 families per worker

Varies by stage (Standard Caseload Equivalents – SCE's)

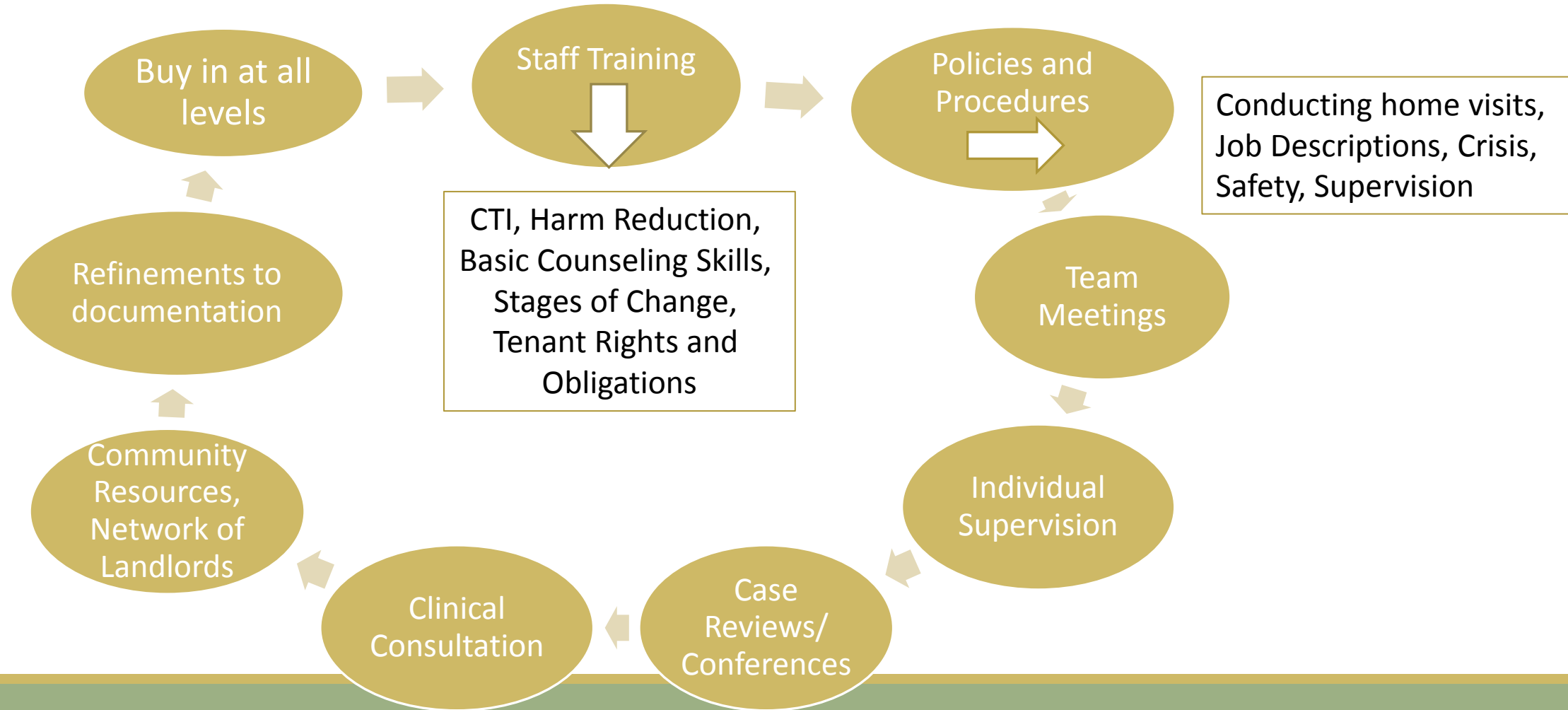
- Phase 1 – each person/family counts as 2
- Phase 2 – each person/family counts as 1
- Phase 3 – each person/family counts as $\frac{1}{2}$

Example

- 10 people in Phase 1 = 20 cases
- 10 people in Phase 2 = 10 cases
- 10 people in Phase 3 = 5 cases



Supports for the Practice



CTI Measures of Success

Maintaining housing in the community

Increasing income

Developing a network of supports

Less emergency interventions: ER visit, hospitalization, shelter stay, incarceration, removal of children, school truancy

Structure and purpose in each person's life



Summary

CTI creates partnerships between participants and staff

CTI helps people through transitions by focusing on housing and community stability, the shift from a crisis orientation and providing opportunities for success

CTI assists people to develop a network of supports and achieve their own goals

CTI provides a structure for staff interventions and a framework where participants have opportunities for success

CTI requires shifts in practice and organizational supports to be effective

Questions and Discussion
