Recording Link: https://youtu.be/dr9bK861SJ0

Critical Time Intervention
Rapid Re-Housing Programs
Contra Costa County
Health, Housing and Homeless Services

Session 1

August 24, 2022

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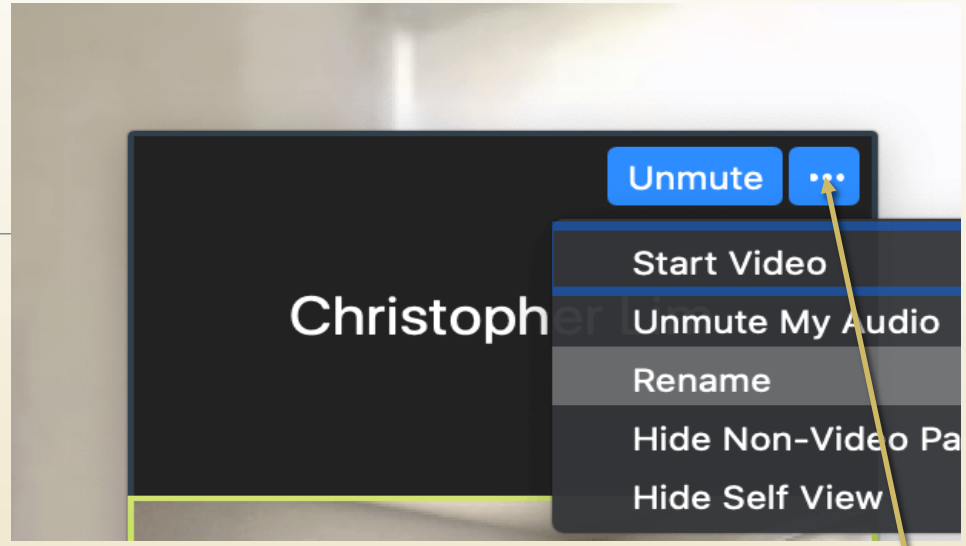
Welcome



- Housing Innovations
  - Suzanne Wagner
  - Andrea White
- Goals for the Training Series
- Housekeeping
  - **PLEASE TURN YOUR CAMERAS ON AS MUCH AS YOU CAN**
  - **Please put your name as you would like to be addressed as your screen name**
  - **We will upload the slides to the chat box momentarily**
  - **We love interaction – please raise hand, use emojis, type comments in the chat box or just unmute and talk!**
  - **This session is being recorded…….**

Agenda

- Introductions
- Overview of the CTI Model
- CTI and Housing Stability
- Assessment Domains for CTI and Risk Factors for Housing Instability
- Wrap-up and Questions

Introductions

- TURN ON YOUR CAMERAS PLEASE
- Type in the Chat box
  - Preferred Name
  - Agency/Program
  - Role/Title
  - How long working with people who have experienced homelessness?
  - Favorite ice cream flavor?

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

Transitions

New start

Opportunity for change

Involve both loss and gain

Often stressful

Can increase symptoms

Unknown/uncertainty increases anxiety

Require a new daily schedule

Trigger fears of failure

Require support

Core Components of CTI

Focused on housing stability and achieving life goals	• Person-centered recovery orientation
Pre-CTI Phase	• Planning and preparing for the transition • Important phase before move-in
Three 3-month phases of decreasing intensity starting at move in	• Phase 1: Transition to the community • Phase 2: Try out • Phase 3: Transfer of care or termination
Time-limited (6-9 months post move-in to housing)	• Although other services may continue post CTI intervention

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

Poll: CTI Experience

Case Management and CTI

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 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 and connect housing stability to personal goals.

Collaboration for Long Term Community Stability

CTI promotes collaborations based on:

- Common goals
- Common understanding of eligibility, needs and resources
- Commitment to achieving participant goals
- Effective outreach to high need people on behalf of the system, identifying the right resource for each person
- Clear roles and responsibilities for staff
- Clear expectations for participants
- Good communication and ensuring all experience with participants within the system is shared
- Cross team collaboration and warm handoffs to ensure the continuity of care

CTI Measures of Success

- Maintaining a base in the community
- Increase income
- Network of supports
- Less emergency interventions
- Structure, purpose and valued role(s)

POLL: CTI Implementation

Discussion Breakouts

- PLEASE TURN ON YOUR CAMERAS AND "JOIN" YOUR GROUP
- Introduce yourselves to each other
- Discuss:
  - Reactions to the CTI model
  - Previous or current experience with CTI
  - Elements of CTI you are already implementing in your work

Evidence for CTI

Original research at Columbia University on work with homeless single adults with serious mental illness in a large shelter in NYC. Based on housing focused clinical case management approach. Developed from the “ground up”.

Applied and researched in a variety of settings with different populations. Reduces returns to homelessness, use of emergency interventions and institutions. See www.criticaltime.org

Outcomes of critical time intervention case management on homeless veterans after psychiatric hospitalization.

- Using nonrandomized pre-post cohort design with a one-year quarterly follow-up, evaluated CTI for homeless Veterans leaving VA inpatient care.
- CTI cohort had 19% more days housed, 14% fewer days in institutional settings, and reported lower alcohol use, drug use, and psychiatric problems.
  - 19% lower Addiction Severity Index (ASI) alcohol use scores.
  - 14% lower ASI drug use scores.
  - 8% lower ASI psychiatric problem scores.

How is CTI Different?

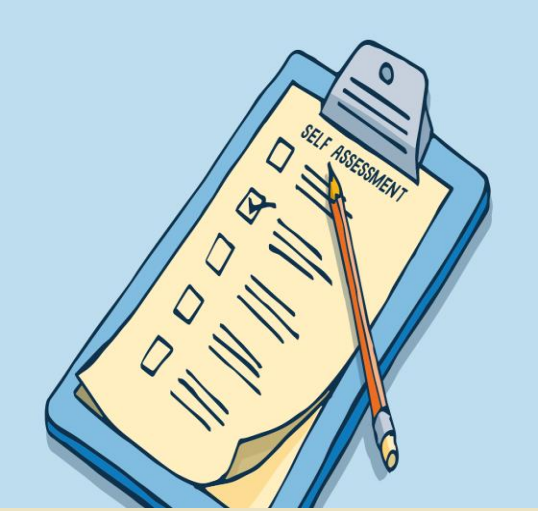
- Structured and time limited intervention
- Goal focused - not symptom based
- Transition is the focus of the work
- Depends on community connections to services and supports for sustainability (including landlord)
- Community and home-based service
- Staff must step back and adjust their roles with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

CTI Requires Organizational Supports

- Buy-in at all levels of the organization
- Hiring the Right People
- Structured Supports: Supervision, Team Meetings, Case Reviews/Conferencing
- Clinical Consultation
- Workload Management
- Staff Education and Training – ongoing
- Resources
- Policies and Procedures esp. for home visits, confidentiality
- Program Design/Modification process

CTI Implementation Self-Assessment Tool

- Tool to assess progress on implementing CTI practices
- 40 domains scored on scale of 1 to 5
- Score is an average w/max 5
- Conduct post-implementation as check in



Reviews the following Areas:

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

Why Focus on Housing Stabilization

- Housing is the base for people to stabilize in the community
- Housing provides a structure and expectations
- Housing provides a vehicle to move to pro-active role: Tenant
- Housing requires an assertive landlord that will flag any lease violations and give an opportunity to correct the violations
- Housing requires the support of workers to maintain tenancy
- Housing provides an early warning system and can be a trigger to accept services
- POLL: Experience as Leaseholders

The Assessment and Plan Forms

Documentation can help guide and structure staff's work

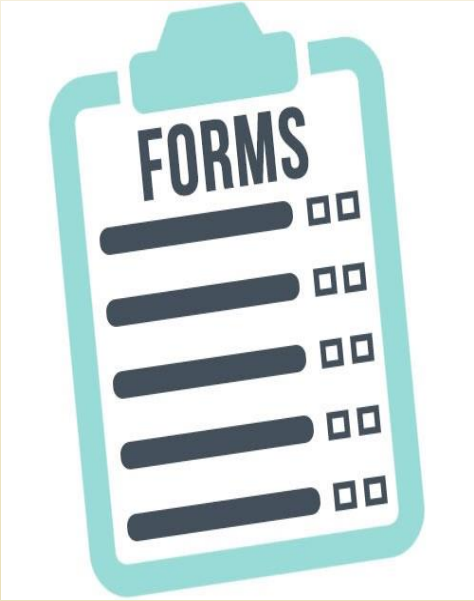
Examples are "CTI Informed" Assessment and Plan

Can adapt forms currently in use

- Modify to incorporate CTI-informed domains and elements

Recommended Frequency

- Update assessment and plans within a couple of weeks after move-in and at each new phase
- See: CTI Informed Service Plan and Assessment Forms



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 looks at history, current, strengths, barriers, motivation and GOALS

Service plans reflect the participant's goals and connect housing success to personal goals

Understand Housing and Homeless History and **Goals**

Housing History –
- Places lived, with whom (last 5 years)
- Experience as a leaseholder
- Roles and responsibilities
- What worked/what didn't
- Satisfaction with current housing
- Housing goal(s)

Homelessness History -
- Cause of initial episode
- Length of time homeless
- Places stayed
- Routine
- Supports

CTI Assessment Domains

Go to: CTI-Informed Assessment Domains Form

Discussion Breakouts

- PLEASE TURN ON YOUR CAMERAS
- Introduce yourselves to each other.
- Discuss:
  - What kind of housing and homelessness histories are you seeing?
  - Are the people you are working with happy in their housing and motivated to maintain it?
  - How is housing success connected to people's personal goals?

Closing

- CTI RRH Case Management is focused on the transition to housing stabilization
  - Longer term goals require connections to sustainable resources
- Focus is on establishing and maintaining a base in the community
  - Attention to immediate needs that affect housing retention
  - Assist people to increase income
- Assess barriers and strengths to maintaining housing
  - Get info from previous workers and the person you are serving
  - Transfer engagement
- Work the plan
  - Use the plan to create structure and expectation
- Establish a resource list
    - Ensure resources are sustainable and committed
- PLEASE TURN ON YOUR CAMERAS TO WAVE GOOD BYE. See you next week!

Citations

de Vet, R., Beijersbergen, M., Jonker, I., Lako, D., van Hemert, A., Herman, D., and Wolf, J. (2017). Critical Time Intervention for Homeless People Making the Transition to Community Living: A Randomized Controlled Trial. American Journal of Community Psychology, 60(1-2), 175–186

Herman, D., Opler, L., Felix, A., Valencia, E., Wyatt, R.J., & Susser, E. (2000). A critical time intervention with mentally ill homeless men: impact on psychiatric symptoms. Journal of Mental and Nervous Disorders, 188(3), 135-140.

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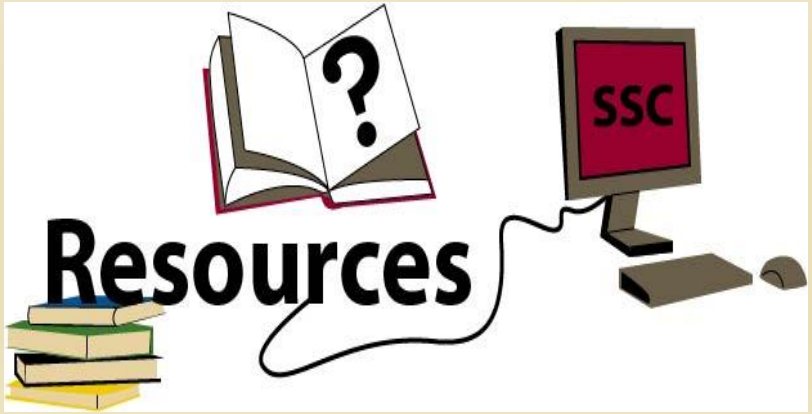
Susser, E., Valencia, E., Conover, S., Felix, A., Tsai, W.Y., & Wyatt, R.J. (1997). Preventing recurrent homelessness among mentally ill men: a “critical time” intervention after discharge from a shelter. American Journal of Public Health, 87(2), 256-262.

Resources for CTI

- Center for the Advancement of CTI: www.criticaltime.org
- CTI Global Network: https://www.criticaltime.org/global-network/join/
- CTI Implementation Manual
- Facebook : Critical Time Intervention (CTI) Global Network



Assessment Domains (CTI-Informed)*

Name and Date of Enrollment in Pre-CTI:

Basic Demographics: age, ethnicity, household composition, current location etc.

Housing and Homelessness History – Last 5 years

Name/Location	Type	Start	End Date	Leaseholder	Reason Leaving
				Yes or No	

- Ever evicted from housing? Y or N Reason:
- Ever in foster care? Y or N
- Barriers to Housing Stability e.g., Disruptive behaviors, trouble budgeting, visitors create problems, involved in illegal activity, no experience as lease holder, noncompliance with rules
- Housing Plan – short and long-term
- Housing Goals
- Motivation to Maintain Housing:

Employment History – Last 5 Years

Employer	Position/Title	Wage	Start	End	Reason for Leaving

- Employment Goals
- Services currently receiving
- Services Needed to Access or Maintain Employment
- Motivation to obtain employment

Income, Benefits and Entitlements

Income Sources	Status	Plan	Income Source	Status	Plan
Unemployment Income			General Assistance		
Supplemental Security Income (SSI)			Retirement from Social Security		
Social Security Disability Income (SSDI)			Other (list):		
Veteran's Disability Payment			Alimony or other spousal support		
Private Disability Insurance			Unemployment Insurance		
Worker's Compensation			Veteran's Pension		

Plan to apply for or maintain income benefits

• Task	• Responsible Party

Does person have a representative payee? ☐ Yes ☐ No
If yes, Name: _____ Relationship: _____ Phone number: _____

Noncash Benefits	Y or N		Y or N
Food Stamps	Y or N	Private Health Insurance	
Medicaid	Y or N	VA Medical Services	
Medicare	Y or N	Other: (list)	

Goals and Plan to apply for or maintain noncash benefits

• Task/Goal	• Responsible Party

- Barriers to Obtaining/Maintaining Benefits and Entitlements:

***This document highlights the core assessment domains for CTI and is "CTI-Informed". <u>This is not a required or official CTI form</u>.**

Assessment Domains (CTI-Informed)*

Debts

Current debts? ☐Yes ☐No - If yes, list totals
Utilities $_____ Credit Card $_____ Medical Bills $_____ Car $_____Overdue Child Support $_____
Rent $ _____ Mortgage $ _____ Gambling $_____IRS $_____ Other: (Include informal debts) $_____
Are wages being garnished? ☐Yes ☐No If yes, what amount? _____
If you pay child support, monthly amount? _____ Back payment amount? _____ Total Monthly debts $_____

- Credit Status/Score
- Plan to pay off debts
- Services Needed
- Motivation to resolve credit/debt issues
- Financial Goals

Legal

- Legal Resident Y or N
- Probation/Parole Status Name of PO: _____ Date Supervision Ends _____
- Felony history for last 5 years:

Date	Charge/Crime

- Incarceration history for last 5 years:

Start Date	End Date	Facility	Reason/Charge

- Current involvement – e.g., engaging in criminal activity, current legal proceedings, outstanding warrants, subject to order of protection, etc.
- Services Needed
- Goals
- Motivation to resolve legal issues

Education History

- Highest Grade Completed or Current Enrollment:
  ☐ Grade in School if Enrolled: _____☐ Some HS ☐HS Diploma or GED ☐Some College ☐ Associate's Degree ☐Bachelor Degree ☐ Technical Certification - Field: _____☐Other_____
- Name of School:
- Current status ☐ In school ☐ Applying
- Current progress
- Has IEP or Section 504 Plan? Y or N. If Yes, check all that apply below

☐ *Autism*	☐ *Multiple disabilities*
☐ *Deafness*	☐ *Orthopedic Impairment*
☐ *Deaf-Blindness*	☐ *Other Health Impairment*
☐ *Emotional Disturbance*	☐ *Speech or language Impairment*
☐ *Hearing Impairment*	☐ *Traumatic Brain Injury*
☐ *Intellectual disability*	☐ *Visual Impairment*
☐ *Learning disability*	

- Comments on Academic Functioning (attendance, grades, learning ability, behavioral issues etc.)
- Education Goals
- Services Needed

Assessment Domains (CTI-Informed)*

Family/Dependent Children

- Household status and composition
- Name and ages of children
- Names and relationships of supportive family members
- Child custody and child support status
- Has children in foster or kinship care - Y or N
- If Children's Services Involvement – status, worker name and contact
- Domestic Violence history
- Services Needed
- Goals regarding family
- Motivation to use services

Physical and Behavioral Health

- Diagnosis: Mental Health, Medical, Substance Abuse, Mental Retardation, etc
- Severity of Each Illness
- Treatment history for each diagnosis
- Current Treatment/Service Providers - Name, Organization and Phone Number
- Previous Treatment Providers (last 3-5 years) – Agency/Hospital, Dates of service
- How health issues impact community stability
  ☐paying rent ☐disruptive behavior ☐hoarding ☐noise ☐visitors Other: _____
- Current medications
- Adherence to medication regimen ☐ Almost Always ☐ Sometimes ☐ Never
- If substance abuse diagnosis, current status and impact on functioning
  ☐ Actively using, not a problem ☐ Actively using & a problem ☐Reducing use ☐ Abstinent: Sobriety Date__
- Frequency of Use: ☐ Daily ☐ Several Times Per Week ☐ Once a Week ☐ Less than 1X a Week
- Hospitalizations in last 3-5 years - Dates, Reasons, Hospital Names
- Detox in last 3 years – Number of inpatient detox stays
- Services Needed
- Motivation to use services: Pre-contemplation, Contemplation, Preparation, Action, or Maintenance
- Narrative explanation
- Goals

Independent Living Skills/ Supports

- Nature of social relationships – identify supports and significant others, also identify negative influences and relationships
- History of seeking and using help/assistance
- **Independent Living Skills Checklist**

1 - Mostly Independent 2 - Needs Help Sometimes
3 - Needs Help Most of the Time 4 - Always Needs Assistance NA – Not Applicable

1. Paying bills	1-4
2. Budgeting and managing money	1-4
3. Maintaining entitlements and other paper work	1-4
4. Maintaining a home	1-4
5. Preparing/obtaining meals	1-4
6. Travelling	1-4

Assessment Domains (CTI-Informed)*

- **Independent Living Skills Checklist (cont.)**

7. Personal care/hygiene	1-4
8. English proficiency	1-4
9. Literacy	1-4
10. Awareness of needs and knowing when to seek help	1-4
11. Able to access help when needed	1-4
12. Managing health/behavioral health needs and services, etc	1-4
13. Taking medications	1-4
14. Keeping appointments	1-4
15. Discriminating danger/asserting and protecting self	1-4
Total Score on Independent Living Skills (Maximum score = 60 points)	

- Goals and ability and motivation to improve skills:

Barriers Summary	
Income ☐ No income ☐ Recent decrease in income ☐ Receiving unemployment or other income that is time-limited ☐ Sanctioned or timed out on benefits	**Debts/Expenses** ☐ Monthly obligations exceed monthly income ☐ Poor credit history ☐ Currently in bankruptcy ☐ Subject to Child Support Enforcement – e.g., "garnish wages"
Education and Employment ☐ Not enrolled in school (and should be) ☐ Awaiting IEP ☐ No High School Diploma or GED ☐ Unemployed ☐ Currently in temporary or seasonal job ☐ Inconsistent work history – gaps in employment or frequent changes in jobs	**Legal Issues** ☐ On parole ☐ On probation ☐ Felony in last 5 years ☐ History of violence ☐ Current legal involvement ☐ Undocumented immigrant
Housing History ☐ Multiple episodes of homelessness ☐ One or two legal evictions ☐ More than 2 evictions ☐ Never had own lease ☐ Evicted from subsidized housing ☐ History of institutional care – e.g., state hospital, foster care, prison	**Family Status** ☐ Current or past involvement with foster care system ☐ Has children in foster care ☐ Domestic violence survivor ☐ Current involvement with batterer ☐ Subject to Order of Protection
Health/Disability ☐ Chronic physical illness ☐ Health crisis, detox or hospitalization in the past year ☐ Multiple hospitalizations in past year. #: ___ ☐ Ongoing medical needs and no health insurance ☐ Multiple disabling conditions ☐ Disabling condition has negatively affected community stability ☐ Not in treatment for ongoing issues	**Supports/Independent Living Skills** ☐ No ID ☐ No or limited support networks ☐ History of being unable or unwilling to seek help ☐ Engaged in abusive relationship ☐ Limited English proficiency ☐ Literacy problems ☐ Gaps in Independent Living Skills ☐ History of problem visitors ☐ Hoarding problems ☐ Inadequate financial management skills
Strengths Summary	
Income and Financial:	**Mental Health and Substance Use:**
Employment:	**Family and Supports:**
Housing:	**Skills:**
Health:	**Education:**
Other:	

Center for the Advancement of Critical Time Intervention

CTI Implementation Self-Assessment

Never or Rarely	Sometimes	About half the time	Most of the time	Always
1	2	3	4	5

MAIN COMPONENTS	Score
Time-limited *(financial assistance may extend beyond end of CTI)*	
1. CTI workers provide no more than six months of CTI after the date a client starts Phase 1.	
Three Phases	
2. Beginning after Pre-CTI, the intervention takes place in three phases, each phase lasting two months.	
Focused	
3. Using the *Phase Plan*, CTI workers select 1-3 focus areas for each phase.	
4. All focus areas on the *Phase Plan* must be selected from the list of predetermined CTI areas.	
Small caseload size	
5. Each FTE CTI worker has no more than 20 weighted cases (using the *Weighted Caseload Tracker).*	
Weekly team supervision meetings	
6. Supervision takes place as a team, consisting of the supervisor and more than one CTI worker. *For agencies with only one CTI worker, supervision is between the supervisor and CTI worker.*	
7. Team supervision meetings are led by the supervisor, who is a clinician and has been trained in CTI.	
8. Team supervision meetings take place weekly.	
Decreasing contact over three phases	
9. As clients become connected to community supports, CTI workers decrease frequency of contact and shift their role to mediator/monitor.	
No early termination *(financial assistance may conclude before end of CTI)*	
10. The CTI program does not end the intervention for a client before six months.	
INITIAL ENGAGEMENT & ASSESSMENT	
<u>During Pre-CTI:</u>	
11. CTI workers contact client (meetings or calls) at least twice a month to build trust as early as possible.	
12. CTI workers assess basic resource needs to establish where early linkages should be made.	
13. CTI workers act quickly to begin securing early linkages.	
14. CTI workers attend lease signing and establish connection with the landlord.	
COMMUNITY-BASED	
<u>During Phase 1:</u>	
15. CTI workers gather client information to enable a best fit between client and community resources *(e.g., client's interests, skills, strengths, vulnerabilities, aspirations; and client's history, such as education, jobs, housing, treatment).*	
16. CTI workers explore neighborhood with client in order to foster new community-based relationships and skills.	

Never or rarely	Sometimes	About half the time	Most of the time	Always
1	2	3	4	5

	Score
LINKING PROCESS	
<u>During Phase 1:</u>	
17. CTI workers have at least one weekly contact (meeting or call) with the client.	
18. Building on work done during Pre-CTI, CTI workers continue to connect client to community supports where needed and to strengthen relationships with existing supports.	
19. CTI workers and client complete the *Client/Family Personal Resource List*.	
<u>During Phase 2:</u>	
20. CTI workers contact client once every two weeks (meeting or call).	
21. CTI workers mediate between a client and his/her support network, including informal supports such as family, friends and spiritual communities.	
22. CTI workers assess the strength of linkages by observing and recording client's interaction with providers and other supports.	
<u>During Phase 3:</u>	
23. CTI workers contact client once a month (meeting or call).	
24. CTI workers ensure direct communication between different members of a client's support network *(e.g., a family member and a provider, as well as between client and his/her providers and informal supports)*	
<u>In Phase 3, before a case is closed:</u>	
25. CTI workers have a transfer-of-care meeting or call with those providers and informal supports with whom it is necessary to meet. *(e.g., maybe not with daycare provider)*	
26. CTI workers have a final meeting with each client. *(They discuss client's experience with CTI and relationship with CTI worker; client's expectations for the future; long-term support network's contact information.)*	
CTI WORKER ROLE	
27. CTI workers use a strengths-based, person-centered approach that incorporates shared decision-making in their interactions with clients. *(e.g., they relate to clients in a genuine way; ask about topics not related to treatment; share their own experiences as a way to normalize client's feelings)*.	
28. CTI workers take a harm-reduction approach to planning with clients, when applicable.	
TEAM SUPERVISION	
29. The team uses supervision to reinforce practices that are consistent with the CTI model and to correct practices that are not.	
30. CTI workers give a case presentation at the supervision meeting for each new client.	
31. Team continuously updates community resource list and shares latest information during supervision meetings.	
SUPERVISOR ROLE	
32. Some (~6-8) high priority clients are selected prior to each supervision meeting for in-depth discussion by the team.	
33. Supervisor monitors CTI workers' documentation regularly to ensure high quality and timeliness.	
34. Supervisor identifies community resource deficits to inform advocacy efforts at the system level.	

Never or rarely	Sometimes	About half the time	Most of the time	Always
1	2	3	4	5

DOCUMENTATION	Score
Phase Plan form	
35. CTI workers complete a *Phase Plan* form close to the start of each phase. *(~2 weeks before to ~2 weeks after the due date for the phase to start)*	
36. Selected focus areas are based on their relevance to long-term housing stability, which is reflected in the "Reasons" section of the *Phase Plan*.	
Progress Notes form	
37. A progress note is completed for each meeting or phone call (the form is up to discretion of agency)	
Phase-Date form	
38. At weekly supervision meetings, team members discuss clients in context of clients' current phase.	
Team Supervision form	
39. The clinical supervisor completes a *Team Supervision* form for each weekly team meeting.	
Caseload Review form	
40. The supervisor completes a *Caseload Review* form for each monthly caseload review meeting.	

A	Total of scores for items 1 through 40	
B	AVERAGE CTI IMPLEMENTATION SCORE (A divided by 40)	

Not implemented	Poorly implemented	Adequately implemented	Well implemented	Ideally implemented
1.0–1.4	1.5-2.4	2.5-3.4	3.5-4.4	4.5-5.0