Housing Transitions

QUERI

Critical Time Intervention

MANUAL FOR CTI WORKERS AND SUPERVISORS IN VA GRANT AND PER DIEM'S CASE MANAGEMENT GRANT PROGRAM

SUPPORTED BY
VA QUERI PII 21-132
IMPLEMENTING CRITICAL TIME INTERVENTION TO ENHANCE CARE COORDINATION FOR HOMELESS-EXPERIENCED VETERANS

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Acknowledgments

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Manual for CTI Workers and Supervisors
in VA Grant Per Diem's Case Management Grant Program

Daniel Herman
Carolyn Hanesworth
Ben Cattell Noll

Center for the Advancement of Critical Time Intervention
Silberman School of Social Work
Hunter College of the City University of New York

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Implementing Critical Time Intervention to Enhance Care
Coordination for Homeless-experienced Veterans

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I. Background

Adapting Critical Time Intervention (CTI) for VA Grant and Per Diem Case Management (GPD-CM) Grantees

Created over twenty years ago, the original Critical Time Intervention (CTI) model was an intensive, nine-month case management approach designed to reduce the risk of recurrent homelessness among single adults making a transition from shelters to housing. In a set of three timed phases, CTI aimed to connect these vulnerable individuals to crucial services and supports and assisted them in navigating complex systems of care during the transition period. The goal was to create deep, lasting connections to supports that would remain in place after the intervention ended, so that its impact would endure well beyond the end of the active intervention period.

The main differences between the original CTI model and CTI for VA Grant and Per Diem's Case Management Grant Program (CTI GPD-CM) are the target population, the duration of services (six-months instead of nine-months), and the interface with the financial assistance for housing resources. CTI GPD-CM delivers short-term, targeted services designed to increase economic resources and connect Veterans to community supports that will help them retain housing after the financial assistance and case management period end.

Like all case management or care coordination models, CTI GPD-CM relies primarily on mobilizing and effectively coordinating existing services and informal supports. It does not create additional housing, income, treatment or other resources on its own, but seeks to maximize access to and the impact of existing resources. Since communities differ significantly on the availability of such resources, its form and impact may vary in different communities.

A successful CTI GPD-CM implementation depends on the resources available to deliver the model. In order to achieve fidelity, programs must have infrastructure that includes:

- Staffing consistent with the guidelines for caseload size
- Basic resources for fieldwork, including reimbursement for travel and technology
- Supervisors with professional credentials and additional training in CTI
- Senior staff that are prepared to serve as advocates for the models with funders and other community providers

II. CTI GPD-CM

This manual describes CTI for VA's Grant and Per Diem's Case Management (GPD-CM) Grantees. Prior to entering the GPD-CM program, Veterans were often engaged in VA's Grant Per Diem (GPD) programs or Contract Residential Services (CRS) in the Health Care for Homeless Veterans (HCHV) program. Veterans in the GPD-CM program receive a variety of financial subsidies for housing, including short term (6 months) subsidies from the VA's Rapid Rehousing Program, Supportive Services for Veteran Families (SSVF), or longer term housing on GPD campuses. A portion of Veterans in this program are permanently housed without financial subsidies.

Additionally, at some VA facilities with limited case management resources, CTI GPD- CM provides an uninterrupted continuum of care for Veterans engaged in the U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program, which provides financial subsidies and supportive services using a Housing First approach. These Veterans will ultimately be transitioned to traditional and long-term HUD-VASH case management. This is referred to as the "HUD-VASH GPD Collaborative Case Management Program." The majority of Veterans in HUD-VASH already have case management and are not enrolled in the CTI GPD-CM program.

Grant Per Diem (GPD) programs provide up to 24 months of housing and supportive services, with the goal of facilitating residential stability, increased skills and income, and greater self-determination for successful independent living. The Health Care for Homeless Veterans (HCVC) program Contract Residential Services (CRS) provides short term (approximately 6 months) of residential services and treatment for Veterans who need immediate housing placement as they for wait for permanent housing and/or additional care and services.

Although most Veterans in the GPD case management ("aftercare") program come from GPD, HCHV, or are in the HUD-VASH GPD Collaborative Case Management Program, some come from community shelters, transitional housing, or a variety of other settings; all have experienced homelessness and are transitioning to permanent housing.

Language Used to Describe CTI

Although some Veterans served by CTI GPD-CM receive long-term subsidies for housing

placements through HUD-VASH or other programs, some receive short-term subsidies for housing. Hence, an adaptation of CTI for Rapid Rehousing, which was designed for temporary financial subsidies, is the foundation of the model described here.

The title “case manager” or “housing case manager” is used here to identify the worker who serves Veterans in their originating transitional housing programs. The title “CTI worker” will be used in this manual to identify the individual who subsequently provides CTI services to the Veteran following housing placement, in an agency who receives a GPD-CM grant, with the understanding that the title can be adapted based on the preference of each service setting.

III. Goals of CTI GPD-CM

The primary goal of CTI GPD-CM is to improve the Veteran’s capacity to remain housed during program participation and beyond by effectively connecting them with crucial community supports and helping them to attain greater economic stability.

CTI GPD-CM aims to support a successful transition to permanent housing by maximizing available resources and supports. **In order to achieve this, the intervention focuses on activities that directly influence housing stability, including:**

- Obtaining and coordinating financial benefits
- Accessing health care, child care (if necessary), employment and education services
- Budgeting and management of financial resources
- Connecting Veterans to effective social and community supports that address barriers to stable housing

CTI GPD-CM is not designed to resolve poverty, and in many cases Veterans’ housing will remain precarious, although most are expected not to return to homelessness.

IV. Model Description

CTI GPD-CM is a care management model composed of a Pre-CTI period of varying duration that ends at the point of transition to stable housing, followed by three distinct phases; each approximately two months long. The amount of contact between the CTI worker and Veterans should decrease as Veterans move through the phases of CTI GPD-CM, promoting a gradual transition to community supports.

Core Principles

While CTI GPD-CM shares a number of characteristics with traditional case management, the following core principles distinguish it from many other similar interventions:

- **The intervention is focused on a transition period** — CTI GPD-CM is aimed at assisting individuals to adjust to a difficult transition in their lives. This transition can be a physical shift (e.g., the transition from a shelter to housing in the community) or a lifestyle transition (e.g., the transition from a sobriety model to a harm reduction approach to addressing substance use). Often, but not always, the transitions are into community housing from an institutional setting, such as a residential treatment program, transitional housing program, hospital, shelter, or jail.

- **It is divided into four phases** — Pre-CTI takes place before the transition period, and Phases 1-3, which are of equal duration, take place during the first six months of the transition period.

- **It is time limited** — Once Phase 1 begins, the intervention lasts no longer than six months.

- **The number of CTI worker contacts decrease over time** — The CTI worker has fewer face-to-face meetings, phone calls and other types of interaction with Veterans and resources as the intervention progresses.

- **It is highly focused** — One to three priority areas are selected for each phase from the program's list of CTI GPD-CM focus areas. The focus areas selected depend on the type of long-term support the Veteran needs from providers, friends, family and/or other resources in order to maintain stability. We recognize that the Veterans served by CTI GPD-CM programs have many unmet needs and priorities. However, in contrast to

traditional case managers, CTI GPD-CM workers are not responsible for helping Veterans achieve their 'treatment goals'. Instead, CTI workers use information about Veterans' needs, strengths and aspirations to assist in identifying appropriate community services and informal resources that will continue to help them achieve long-term stability and continuity of care.

- **Modest caseload size is essential** — All caseloads are limited to 20 "weighted cases" (in CTI, Veterans are assigned a different weight depending on which phase they are in, since the amount of work required is typically greater in early phases).
- **The work is community-based** — Assessments and interventions with Veterans and their resource network ideally take place in the home and community where the Veteran lives.
- **Supervision is done in team meetings** — CTI GPD-CM team members attend weekly team supervision meetings. Some programs also provide individual supervision, but this is not required.

Core Values

A set of core values guides the approach taken by CTI GPD-CM teams:

- **Strengths-Based**
  The approach is grounded in a strengths-based assessment of the person in their environment, and CTI workers leverage these inner resources to connect Veterans to external resources that support long-term stability.

> ***Example:***
>
> A 50-year-old Veteran with chronic mental illness no longer interacts with his parents, who are supportive of him, but only when he takes his medication. He has started taking his medication but it has been years since he has spoken to his parents and he fears the relationship is beyond repair. The CTI worker points out the strengths inherent in his former relationship, and his continued sense of hope to reconcile. Because the CTI worker explored the strengths of the former relationship and praised the Veteran's eagerness to repair it, the focus turned to creating a solution. The Veteran agreed to work on a plan to reunite with his parents.

- **Shared Decision Making**
  The CTI worker and Veteran take a collaborative approach to ensure that plans are aligned with Veteran preferences, honoring the Veteran's right to self-determination.

> ***Example:***
> During a discussion about the Phase I plan with a Veteran who struggles with addiction, the CTI worker learns that he is already connected to VA and community resources that provide him with enough support for this problem. Therefore, the CTI worker and the Veteran turn their attention to other focus areas. The CTI worker did not automatically assume that the "substance use treatment" area should be a focus area simply because the Veteran is still using substances.

- **Individualized**
  CTI is not prescriptive, rather it responds to the diverse needs of each individual Veteran. Their strengths and needs vary across a broad continuum and change over time. Similarly, the availability of resources for providing needed support is different for each Veteran.

> ***Example:***
> A Veteran wants to return to work, but does not know how to search for a job. In the beginning, the CTI worker helps her to address this barrier. However, when the Veteran's psychiatrist switches her medication, it becomes apparent that it is making it hard for the Veteran to get up in the morning. The CTI worker and Veteran must now address this new concern.

- **Recovery-Oriented**
  We assume that Veterans have the capacity to progress toward greater stability and social integration, and to obtain enhanced meaning in their lives. Some Veterans need help rebuilding a sense of hope that will enable them to continue to grow and to reconstruct a stable sense of themselves. In a recovery-oriented approach, CTI workers must also believe in their own ability to influence the Veteran's recovery. They should go at the

Veteran's pace, taking a harm-reduction approach to encouraging positive behavioral change. This approach includes helping Veterans to:

- Take on life roles (e.g., being a good neighbor, or a responsible tenant) that will contribute to a sense of self, in which illness is only one aspect
- Draw on their current coping strategies and develop new ones
- Develop links to self-help and peer support groups
- Identify things they enjoy doing and ways they can keep themselves healthy

> ***Example:***
>
> A Veteran says he painted his walls, adding that while painting used to give his life meaning, he hasn't painted in the past few years while he has been struggling with depression. The CTI worker takes a recovery-oriented approach that goes beyond his illness, by encouraging him to take up painting again as a means of improving the quality of his life as a whole.

- **Culturally Sensitive**

  CTI workers should respect the different worldviews and beliefs that Veterans might hold and be aware that the Veteran's experiences and views will inform their decisions. To the extent possible, CTI workers should strive to balance the goal of supporting stability and continuity of care while respecting that the choices Veterans make are based on their personal values and priorities.

> ***Example:***
>
> Experiences with landlords who discriminate based on race have had a negative impact on a Veteran's belief that he will be able to secure a safe and stable home. When his CTI worker tells him about an apartment for rent, he hesitates to submit the application because he believes he will be subject to discrimination in this area of town. Aware of the Veteran's experiences and concerns, the CTI worker is able to discuss with the Veteran how race-based discrimination might or might not affect the opportunity, and how to address it.

- **Transparent**

  Veterans have the right to get accurate information about the nature, aims and limits of the CTI intervention and the CTI worker's role. When the CTI worker introduces themselves to the Veteran, the description of the intervention and worker role should be clear.

  Transparency maximizes the likelihood of developing an open and productive relationship with the Veteran and can encourage them to share important information. Transparency about a Veteran's strengths and needs is also important in their communications with their family, providers and other potential sources of support.

  > ***Example:***
  >
  > A CTI worker has a Veteran who rarely shows up for scheduled meetings and does not share much about himself when they do meet. During one meeting, the Veteran explains that in previous experiences with caseworkers, decisions were forced on him and many were unhelpful. The CTI worker realizes that the Veteran does not understand the purpose of CTI. Once the worker explains that CTI is time-limited and that they will collaborate on connecting him to resources that will ensure his long-term stability, the Veteran begins to engage more.

- **Trauma Informed**

  The vulnerable individuals served by CTI programs have often been exposed to one or more severe traumatic stressors during childhood, adulthood or both. For Veterans, the trauma may be service related (e.g., combat exposure or military sexual trauma), or may have occurred outside their service role. For example, many people in the shelter system struggle with mental illness and/or addiction; for some this was what initially led to their housing loss. CTI takes place during a major transition, which could in itself trigger earlier life trauma. Trauma-informed care reflects an understanding of trauma by emphasizing emotional and physical safety, establishing trust, and promoting opportunities for Veterans to rebuild a sense of control and empowerment. It encourages the development of positive relationships in their social network, which promotes successful navigation through transition. Trauma-informed care therefore minimizes the chances that Veterans will be re-traumatized and limits their exposure to further trauma.

Example:

A Veteran has transitioned from a shelter to a supportive apartment, far from the healthcare providers at the VA facility where he has received care from trusted providers for years. However, as he refuses to take the bus, he has not used these critical resources since moving out of the shelter. The CTI worker, taking a trauma-informed approach, does not assume the Veteran is simply being "resistant" by refusing to take the bus, but rather opens a conversation with him. After learning that the Veteran has a fear of buses due to previous traumatic experiences while waiting at bus stops, the CTI worker discusses alternative options with him, including telehealth, accessibility rides, or trying out new providers closer to home.

V. The Role of the CTI Worker

Ensuring Continuity of Care, Stability and Social Integration

Working collaboratively with Veterans, the CTI worker links Veterans with VA and community resources that will ensure: (1) continuity of care, (2) stability and (3) social integration. The CTI worker assists Veterans in these areas until they are linked with VA and community resources that are able to take over the provision of uninterrupted and coordinated support. Some Veterans in the GPD-CM program are not eligible for healthcare from the VA; these Veterans will need to be linked entirely to community resources.

During the six-month transition period, the CTI worker makes assessments in the Veteran's community, removes potential barriers and identifies resources that enable Veterans to successfully adjust to the transition and maintain long-term stability. These resource networks will assist Veterans in coping with new demands, as well as in anticipating and responding to crises. Crises often mirror the types of challenges Veterans have experienced before, and which put them at risk of homelessness, incarceration, hospitalization, and addiction relapse. CTI workers focus mainly on the specific areas that place the Veteran at risk for housing instability, which will be unique to each individual.

Example:

Focus areas selected for each Veteran must relate to reducing their risk of recurring homelessness, given their particular history, strengths and vulnerabilities. Selection of the areas is based on assessments of how the Veteran became homeless in the past and what skills and resources they have that could help them retain housing. For example, money management was one of the focus areas selected for a Veteran whose past evictions were precipitated by rental arrears. The CTI worker should focus on ways to support the Veteran in making rent payments. This may include increasing income (e.g., by applying for service connected disability or engaging in VA vocational services), budgeting, or reducing the rent (e.g., by sharing a space or moving in with family). Each of these requires a different set of resources, for instance, job training or a financial literacy workshop. In addition, if the Veteran is moving in with family, the CTI worker might need to focus on the area of social relationships to resolve barriers arising from friction between the Veteran and her family.

Key Characteristics of the CTI Worker

The required experience, training and personal strengths for CTI workers are:

- A firm understanding of the personal challenges and systemic barriers experienced by vulnerable people during significant life transitions
- An open, flexible and optimistic approach to the work that does not make unwarranted assumptions or judgments about the Veterans' situation, identity, behavior, appearance or beliefs
- Adeptness at interdisciplinary teamwork
- Experience with community work
- Experience with engaging and building alliances with other providers
- A strong ethical sense and respect for the dignity and worth of all Veterans
- Willingness to step back and monitor how well Veterans and resources are managing routine activity and crisis events. This stance fosters personal autonomy and prepares Veterans for the end of the CTI relationship.

The CTI Supervisor

The CTI supervisor oversees services delivered by the team's CTI workers and demonstrates proficiency in guiding the workers' activities during all phases of the intervention. He or she:

- Ensures that CTI workers' practice is consistent with the phase-specific activities and foci of the CTI GPD-CM model
- Carefully monitors the CTI worker to ensure that phase transition dates are observed
- Ensures that model-specific case planning and recording documents are being completed correctly and are up to date for all CTI workers
- Encourages open communication and demonstrates a willingness to support, as well as instruct, supervisees
- Monitors and manages the caseload to ensure there is reasonable time to provide services as intended
- Works to create relationships with key providers in the community

The CTI supervisor should be a master's level social worker or other human service professional with experience working with people experiencing homelessness.

Housing Placement in the VA's GPD-CM Program

Successful implementation of CTI GPD-CM relies on linking the Veteran to critical resources at the VA and in the community. In the context of the GPD Case Management grant, the key resource is long term, stable housing. The case managers in these programs identify housing for Veterans; though some Veterans may be placed on site at a GPD campus, others may be placed in neighborhoods that are geographically distant from the transitional housing programs that they are exiting. During the Pre-CTI phase (described in the following section), the case manager will connect the Veteran to the CTI worker to promote a smooth transition, or a "warm hand off" to services once they leave transitional housing. The CTI worker is ideally located geographically close to the Veteran, but in cases where this is not possible, adjustments should be made to provide technology for CTI worker and Veteran that support the intensity and nature of contacts required in each phase.

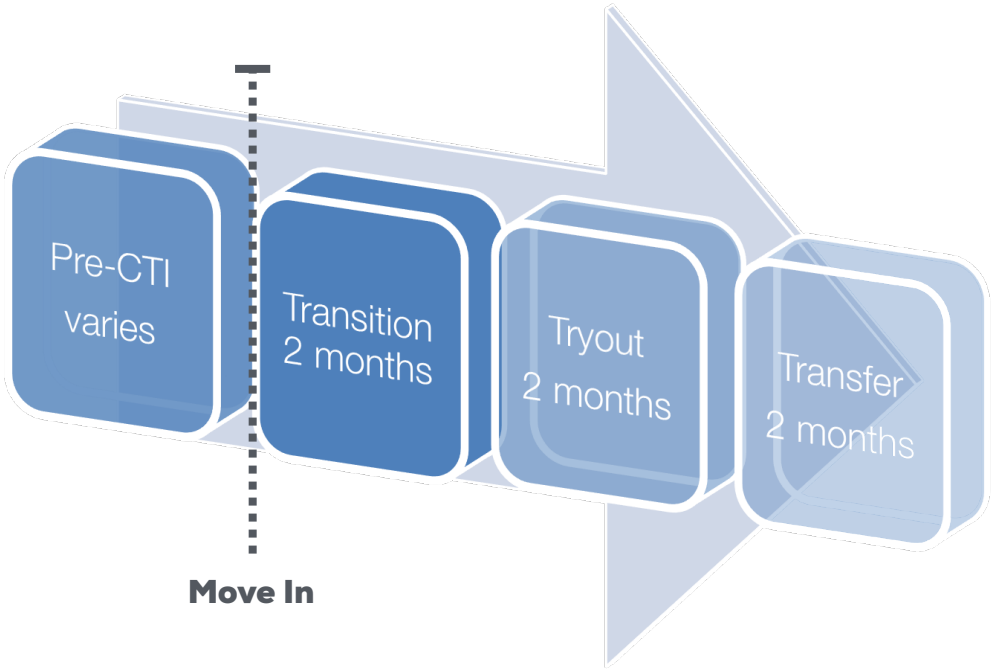
The duration of CTI GPD-CM is not dependent on the length of financial assistance. Financial assistance for housing may conclude before, or extend beyond, the termination of CTI.

What about Veterans who need more than six months of CTI?

The CTI GPD-CM model is guided by the assumption that the majority of Veterans can succeed within the six-month timeframe. However, we recognize that some Veterans may not be stably housed or successfully linked to needed supports by the end of this period. For such persons, programs should have explicit procedures in place that authorize extended or enhanced assistance. However, these exceptions should be rare, carefully justified and require approval by supervisory staff. Examples of circumstances that may require extensions include: pending benefits, employment, relocation in which some important status change is imminent; a hospitalization or other health-related crisis experienced by the Veteran or a family member; or other situations in which a short extension of services is clearly indicated.

VI. The Phases of CTI GPD-CM

The Phases of CTI GPM-CM



A. Pre-CTI GPD-CM

Housing Search & Placement

Time Frame: Flexible. Unlike CTI GPD-CM phases I, II and III, which each have a fixed duration, Pre-CTI GPD-CM may vary in duration as the housing identification process is unpredictable. In keeping with the goal of exiting Veterans quickly to housing, Pre-CTI GPD-CM should conclude as quickly as possible. For Veterans in the GPD case management grant program, Pre-CTI GPD-CM generally occurs prior to program enrollment (e.g, when the Veteran is in a GPD program or another transitional housing program).

Intensity: Moderate. The CTI worker should be coordinating activities with the case manager doing housing placement, but he/she is not the primary service provider during this phase.

Objective: For the housing case manager, the objective is to locate housing that meets Veteran needs and is accessible to familiar services and supports. The CTI worker's objective is to engage with the Veteran and begin to develop a trusting relationship. Ideally, the CTI worker can begin the process of assessment and connection to VA and community resources, although this may not be feasible in all cases. In most cases, this process will not complete until the end of Phase I, because typically the Veteran's new housing location will influence both Veteran needs and access to services and supports.

Action Steps:
The housing case manager should engage the Veteran in a collaborative process by involving the Veteran in the search, in communications with the landlord, and in lease negotiation. This will promote the Veteran's sense of ownership for their new home and transfer valuable skills. The housing case manager should assess the Veteran's understanding of tenant rights and responsibilities, and aim to educate Veterans in these areas as appropriate. The CTI worker should communicate with the case manager about this effort and be prepared to continue the work in Phase I. The CTI worker should meet with the Veteran regularly in order to start building a trusting relationship and identifying key goals. The CTI worker and Veteran may also initiate some aspects of the housing plan, particularly in areas that might require longer amounts of time such as applying for service connection or Social Security benefits or searching for employment.

Potential Barriers:
Barriers to successful housing placement may include landlord discrimination, lack of affordability, a limited housing stock, or difficulty locating housing nearby a Veteran's workplace, their medical providers (inside or outside VA), or family and friends. Families or individuals who settle for poorly located housing may lack access to important supports and services. These circumstances reduce overall housing stability and increase the risk that Veterans will become homelessness again.

A key barrier for the CTI worker to be aware of is the challenge of negotiating the time and schedule of Veteran meetings with the housing case manager. Some Veterans may feel confused and overwhelmed when offered services through a two-worker team.

Strategies:
Success will depend on the housing case manager's ability to secure relationships with

landlords prior to housing search and to advocate effectively. Case managers and CTI workers should be sensitive to vulnerable populations, such as those who may need accommodations for a disability. Survivors of intimate partner violence may need extra consideration in the housing location process to ensure they are safely relocated.

In order to minimize Veteran confusion, the housing case manager and the CTI worker should clarify their roles for the Veteran. The housing case manager should be the primary service provider until the Veteran has successfully moved into their new home. However, the CTI worker should aim to meet the Veteran immediately after they have been identified as a future CTI GPD-CM recipient, to begin the process of assessment and resource connection. This will promote effective engagement and help the CTI worker develop a preliminary picture of the Veteran's strengths, challenges and priorities. Early engagement will also ensure that no time is lost in acquiring important resources during the housing placement process.

The transition of primary responsibility from the housing case manager to the CTI worker should follow in a carefully planned manner. This may include a conversation between the Veteran, the housing case manager and the CTI worker to discuss what was learned during the housing placement phase, along with the passing of information related to the Veteran's needs and strengths that can be valuable to the CTI worker in moving forward to Phase I of CTI GPD-CM. Once the Veteran is housed, there is no need for the housing case manager to continue meeting regularly with the Veteran. From this point, the CTI worker will aid in negotiations with landlords should challenges emerge related to rent payment, housing conditions, or other concerns that may lead to the need or desire for a Veteran to transfer to another housing unit.

B. Phase I: Transition

Time Frame: Two months.

Intensity: High. In-person visits should occur at least weekly, preferably in the Veteran's residence or in the community.

Objective: While continuing to establish a strong working relationship, the CTI worker and Veteran will complete an initial assessment, develop the Phase Plan and make the connection to resources.

Action Steps:
At the beginning of each phase, the CTI worker and Veteran develop a **Phase Plan** that identifies a short list of **Focus Areas** to be addressed during the upcoming phase and that will guide efforts to establish effective links to services and supports. The selected focus areas should address needs that are directly tied to the maintenance of stable housing by the family or individual being served and should be selected from a "menu" of areas identified by the program.

Areas of focus may include (but are not limited to):

- Income generation (non-employment sources)
- Income generation (employment sources)
- Budgeting and financial management
- Survival needs (food, clothing, furniture, etc.)
- Physical and mental health
- Child care
- Transportation
- Education (child/adult)

The CTI worker will conduct a brief bio-psycho-social assessment related to housing loss and barriers to stability. The assessment should determine causes for previous housing loss, and identify current stressors, challenges and strengths that inform future housing stability. Areas to explore should include financial history and current status, health (physical and mental), education, and employment. Health and access to education/child care should be assessed for each child in a family.

The CTI worker and Veteran will work collaboratively on a housing plan that is specific, goal-oriented and measurable. One to two goals for each phase should be identified. In Phase I, the CTI worker will attempt to ensure the Veteran is connected to the resources necessary to complete goals.

Potential Barriers:
Veterans may be weary of services at this point and hesitant to engage. Some communities may lack adequate resources necessary for Veterans to achieve their goals, particularly for Veterans who reside in regions with limited VA resources.

Strategies:
CTI workers should strive to present themselves as advocates and allies to their Veterans, and not as people in positions of authority who are checking in on or disciplining the Veteran. CTI GPD-CM should never be imposed on a Veteran and will be most successful if the Veteran feels they have some control over the nature and extent of services.

Programs should work to establish resource networks at their local VA facilities and in their communities. Ideally, CTI workers should visit the VA and local organizations regularly and get to know key personnel who can aid in the referral process; VA GPD case management grant liaisons can be an important resources in connecting to VA care. This is an ongoing endeavor, since resources and personnel change frequently. Supervisors should inform leadership about gaps in VA and community services as a means to advocate at the macro level for additional community services.

C. Phase II: Try-Out

Time Frame: Two months.

Intensity: Moderate. In-person visits should occur at least bi-weekly, preferably in the Veteran's residence or in the community.

Objective: To monitor the impact of resources on goal attainment and make adjustments as necessary. To begin empowering Veterans to maintain resources independently of the CTI worker.

Action Steps:
The Veteran and CTI worker should assess progress made in Phase I, and identify Phase II specific goals. The CTI worker and Veteran should assess the strength and value of current resources and make adjustments as necessary. The CTI worker should decrease engagement in cases where resource linkage is successful and increase engagement in situations where resources are weak or ineffective.

Potential Barriers:
In some cases, the leveraging of community resources, welfare benefits and work will not be sufficient to support the payment of monthly rent without additional financial assistance.

Additionally, having sufficient financial resources to cover rental costs does not necessarily mean Veterans will always pay their rent in full or on time. Veterans may have multiple economic pressures on them that aren't readily visible or that aren't shared. This may include family members in need or unexpected expenses for children.

Strategies:
The CTI worker should provide the minimum amount of assistance needed for the Veteran to progress. In this phase, the CTI worker may need to advocate on the Veteran's behalf, but should aim to model and/or teach the Veteran how to self-advocate. In cases where resources and benefits do not adequately address financial needs to support the housing plan, CTI workers and Veterans should work together to re-assess the long-term viability of the housing plan and think creatively about other means of increasing resources, such as apartment-sharing or reuniting with family members who can assist.

When sufficient resources seem to be in place to meet the goals of the Phase Plan but Veterans are not engaging with them, CTI workers should not assume Veterans are behaving irresponsibly. Veterans may be prioritizing other needs and obligations separate from housing that may seem like a low priority to CTI workers, but may be an opportunity for an individual to give back to someone who has helped them or to feel competent as a provider for their family. Phase II is a good time to assist Veterans with negotiating these challenges by discussing how to prioritize competing interests and what other resources might be necessary to ensure all obligations are addressed to promote housing stability. A strong working relationship, if established during Phase I, will help the CTI worker to initiate conversation around potentially challenging and sensitive topics such as this.

D. Phase III: Transfer

Time Frame: Two months.

Intensity: Low. In-person visits should occur at least monthly. The number of direct contacts with the Veteran should be few during this phase as the CTI worker ideally functions as a consultant more so than in a direct helping role.

Objective: The final phase of CTI GPD-CM focuses on completing the transfer of primary CTI care management responsibility to the VA and community resources that will provide long- term support to the Veteran. For many Veterans, this may be their Patient Aligned Care Teams (PACTs, VA's brand of patient-centered medical homes); some VA facilities have Homeless-PACTs (H-PACTs), which are tailored for homeless Veterans. Other Veterans, (e.g., those with serious mental illness), may receive long term support from other VA resources (e.g., the Mental Health Intensive Case Management (MHICM) teams, which provide Assertive Community Treatment).

Action Steps:
The main task in the final phase is to ensure that significant members of the support system meet together and, along with the Veteran, reach a consensus about the components of the ongoing system of support. Ideally, this occurs at least one month before the end of the intervention.

The CTI worker and Veteran should review and reflect on the work that has been done over the course of the intervention. CTI workers should have a strengths-based conversation with the Veteran about the progress they have made and why they feel they are ready to move on independently. The CTI worker should ensure the Veteran is aware of steps they can take in maintaining secure housing should unexpected challenges arise. These steps may include legal assistance or housing loss prevention services. The CTI worker should also discuss with the Veteran whom they will call in case they have questions or need further assistance, especially if the CTI worker will no longer be available as an ongoing support.

Potential Barriers:
As Veterans begin to operate effectively with greater independence, the CTI worker may be tempted to terminate services too early or forego final visits, especially when new cases

in the early phases are demanding attention. This is a common mistake and one that can cause CTI workers to overlook important issues in Phase III. At this point, the Veteran has had an opportunity to utilize existing resources, and yet only begun to practice accessing them independently. Phase III is the time to assess whether the Veteran is successfully maintaining housing on his or her own, and if not, what supports need to be in place to avoid repeated housing loss.

Veterans may have anxiety about making ends meet and express doubt in their ability to manage. CTI workers may have similar worries about how a Veteran will do without their support. These anxieties may be legitimate in the face of ongoing financial strain, and termination may be equally difficult for both CTI worker and Veteran.

Strategies:
Throughout the intervention, the CTI worker should gradually reduce his or her role. This gradual process ensures that termination of CTI GPD-CM is not perceived by the Veteran as a sudden, potentially traumatic, loss. It also helps the CTI worker to be more confident that terminating the relationship will not lead to abrupt housing loss when the Veteran confronts future challenges.

VII. Supervision

It is essential that CTI programs provide regular ongoing supervision conducted by human service professionals who are experienced working with persons who have experienced homelessness. This supervision should include the follow elements.

To ensure program quality and encourage fidelity to the CTI GPD-CM model, it is critical that organizations provide regular ongoing supervision of CTI workers delivering CTI in GPD-CM grant programs. Supervisors should be social workers, psychologists, mental health counselors or other human service professionals.

Weekly team supervision sessions are the recommended format, but individual supervision should also be provided, if possible. Team supervision is seen as a critical complement to individual supervision because it encourages sharing of important VA and community resource information between team members as well as providing a forum for joint problem-solving and support. Furthermore, it facilitates CTI worker collaboration in unusual situations in which a worker may not be available to respond to a pressing Veteran emergency in a time-sensitive manner. Supervisors should also put in place procedures to ensure that case planning and recording forms are completed and updated regularly. Although not all are done every week, team meetings include the following elements listed below and are explained further in the following section:

- Case presentation of each new Veteran
- Review of cases that will end intervention within the coming month
- Review of cases that are facing major crisis or cannot be located
- Review of cases that have experienced major success or positive change
- Brief review of entire caseload every two weeks to ensure that phase changes are on schedule and that cases are not overlooked

The Weekly Team Meeting

The CTI supervisor leads a weekly team meeting that provides a forum for joint problem solving and support. The CTI workers learn from each other and, over time, develop into CTI experts. Through feedback they get from the supervisor and the other CTI workers, they are able to ensure fidelity to the model. They discuss their activities from the previous week,

review the status of Veterans on their caseload and plan for the next step they will take with each. In addition to encouraging accountability, this enables CTI workers to substitute for one another when a worker may not be available to respond to a Veteran's pressing need in a timely way.

Require Regular Case Presentations

Early in Phase I, as soon as the CTI worker has met with a Veteran and is familiar with the Veterans' history, they give a full, yet concise, case presentation about the Veteran to the team. This is especially important for CTI teams whose workers have had little formal human service training, because they can draw on the collective experience of the team and supervisor.

Ensuring Continuity Between Fieldwork and Meetings

The supervisor begins the meeting by asking the CTI workers to update the team on any items needing follow up from the last meeting. Then at the end of the meeting, the note-taker or supervisor emails the team a list of the planned tasks for the coming week. Through this process, the supervisor makes sure that CTI workers follow up on decisions made in the team meetings.

Review of Entire Caseload

The team briefly reviews the entire caseload every two weeks, if possible, or at least once a month to ensure that phase transitions are on schedule and that no Veterans are overlooked. Team supervision meetings can run into the problem of focusing exclusively on a few Veterans who are in constant crisis, while devoting little or no time for discussing others. Several different strategies have been employed by teams to prevent this from happening. Some teams use one of their weekly meetings each month to quickly go through every Veteran; other teams use the weekly meetings to give brief updates on all their Veterans and hold a second meeting each week for in-depth discussions about particular problems that have arisen.

Ensuring Continuity Between Fieldwork and Meetings

Adhering to the integrity of the model will increase the likelihood of achieving successful outcomes using CTI. In the Documentation section, we described the Implementation Self-Assessment Form, which allows CTI workers to evaluate their work across key dimensions

of the model. This self-assessment can be shared during team supervision as a way to both highlight areas of strength and identify challenges to be addressed.

Supervisors should require the use of CTI forms described in the previous section. Programs that use these forms demonstrate greater success in implementing CTI with fidelity than those who continue to use their own forms. The forms were designed to help keep CTI workers on track by having them record all CTI-appropriate information, and no additional information that is outside the focused approach of CTI.

Each CTI worker briefly updates the team on their Veterans, providing information about: the phase they are in; whether a transition is due in the next two weeks; or whether they are due to end CTI in a month. If a phase transition is coming up soon, they give the date when they will meet with the Veteran to complete the Phase Plan. If the end of CTI is coming up in a month, the CTI worker gives the date when they will hold the final transfer of support calls or meetings with the Veteran and resource network, the final meeting with the Veteran alone, and the graduation or ending celebration. Everyone provides feedback that reinforces that good CTI practices are being adhered to and that calls attention to whenever a worker is veering from CTI. The weekly team meeting is a crucial tool for monitoring the team's fidelity to the CTI model. The supervisor can initially keep a list of CTI principles and practices to guide feedback. The Implementation Self Assessment Form can be used to strengthen this process.

Monitor Quality of Documentation

Supervisors implement procedures to ensure that all forms are completed regularly. They give each CTI worker feedback on their documentation, as well as extra help with any area they are having trouble with.

Update Resource Lists

Team supervision enables team members to share important VA and community resource information. In the past, a list of VA and community resources would be kept in a binder, but now it can be made available online to all CTI workers. During the team meeting, the supervisor draws the team's attention to any new resource that has been added since the previous meeting. The CTI workers talk about experiences they have had with resources, including any personal relationships they have developed and ways in which these have been helpful.

Monitor Phase Dates

The supervisor updates the Phase-Date Form before the weekly meeting. This form is used as a guide to Veterans' phases as they are discussed. CTI workers also refer to it when they go into the field to make sure their activities for a Veteran are consistent with that phase.

Manage the Weighted Caseload

The recommended caseload size for CTI is 20, with cases weighted differently depending on which phase they are in. This reflects the greater amount of CTI worker time needed during the early phases. Weights are applied as follows:

Pre-CTI	Phase 1	Phase 2	Phase 3
1.5	2	1	0.5

For example, the amount of work for a Veteran in Phase I is equivalent to twice that of a Veteran in Phase II. The table below illustrates how a caseload of 16 individual Veterans in various phases would be converted into a weighed caseload of 20.

Converting Veterans to Weighted Cases					
Per Caseload	**Pre-CTI**	**Phase 1**	**Phase 2**	**Phase 3**	**Total**
# Veterans	4	4	4	4	16
	x 1.5	x 2	x 1	x .5	
# Weighted Cases	**6**	**8**	**4**	**2**	**20**

Using CTI with families requires more work, and therefore the calculations add more weight. At the discretion of the supervisor, up to 50% more weight can be added as follows:

Pre-CTI	Phase 1	Phase 2	Phase 3
2.25	3.0	1.5	0.75

VIII. Preparing for Program Implementation

Before a new CTI program is launched, the organization's leadership must understand and support adaptations that need to be made to their usual practice, and make a commitment to remove existing barriers to successful implementation. The organization must be able to ensure the following conditions are feasible:

- **Workers should complete basic CTI training by a certified CTI trainer**
- **Each CTI worker should carry no more than 20 weighted cases at a time**
- **Weekly team supervision should be led by a master's-level clinician**
  Supervisors should have completed basic CTI training and a CTI Train-the-Trainer course, which certifies them to train new staff as needed. They should not supervise more than 10 CTI workers.
- **Organizations should provide resources needed for VA and community-based work**
  CTI workers should be provided with the tools needed to adequately serve their Veterans in the field, including access to agency vehicles or reimbursement for other forms of transportation, and internet enabled smartphones or tablets.

An evidence-based practice like CTI is only effective when it is faithfully implemented. Conducting an impartial fidelity review reveals the extent to which a CTI team is adhering to the model as it was originally developed and tested. Adhering to the integrity of the model will increase the likelihood of achieving successful outcomes using CTI. Fidelity review findings are invaluable in helping agencies adapt their approach, adjust resources, improve model delivery and, ultimately, increase successful outcomes. The Center for the Advancement of CTI provides fidelity review training to personnel who can carry out such a review. In the Documentation section, we describe the Implementation Self-Assessment Form which allows CTI workers to prepare for a fidelity review by evaluating their work across key dimensions of the model. Self-assessments can be shared during team supervision as a way to both highlight areas of strength and identify challenges to be addressed.

IX. Documentation

Documentation for CTI falls into two categories — Veteran forms and team forms. See the Appendix for the forms described below.

Veteran Forms

- **Veteran Resource List**

  The Veteran Resource List is an essential tool for maintaining continuity of care. It contains the addresses, phone numbers and e-mail addresses for the Veteran and their friends, family members and other resources (housing providers; financial contacts; and health care providers). It provides as many ways as possible for the CTI worker to locate the Veteran. In addition, it provides space to list the presence (and location) or absence of important documents, such as insurance cards, medication lists, military service records, and advance directives. The Veteran Resource List is first filled out during Pre-CTI and then is updated at each subsequent interaction with the Veteran and their network of support.

- **Phase Plan**

  The Phase Plan serves as the working contract between the Veteran and CTI worker. The Veteran and worker complete an updated plan for each phase. It indicates one to three areas selected from the list to be the focus of their work during the current phase. Below each area is an explanation of the reason this area needs to be addressed, (i.e., how the area potentially puts the Veteran at risk of repeated housing loss). The plan also lists as the area's objectives which kinds of resources and/or Veteran skills are needed. The Phase I Plan is completed within two weeks before to two weeks after the start of Phase I and is updated at the start of the following phase. In the Phase II Plan and Phase III Plan, the CTI worker should include information on progress made during the previous phase towards objectives of each area in that phase's plan. This will inform the choice of areas for the current phase. Note that lack of progress towards an objective does not preclude a CTI worker from transitioning the Veteran into the next phase. Phase transitions should occur every two months and are not delayed for any reason, with very few exceptions (see Phase III barriers).

- **Progress Note**

  A separate progress note is filled out for each Veteran interaction or attempt at interaction. This is in contrast to traditional progress notes, in which case managers list

everything that was done during that day for or with the Veteran. The types of interactions include a face-to-face meeting, phone call, text message and email. On the progress note, the CTI worker documents the phase number the Veteran is in, the type of interaction, what took place during the interaction, and, for a meeting, where it took place. The CTI worker describes what happened during the interaction and how it was linked to the CTI intervention. For instance, they might document that they organized a meeting between the landlord, the Veteran and the Veteran's social worker in order to make a plan to prevent the Veteran from being evicted. Knowing that the worker had arranged the meeting clarifies the ways in which the CTI intervention is addressing the focus areas in the Phase Plan.

- **Closing Note**
  The CTI worker fills out the closing note at the end of CTI, or as soon as the final transfer-of-support meeting, and the final Veteran meeting have taken place. The closing note provides a summary of what occurred over the nine months of the intervention and during the final meetings with the Veteran and resource network. The summary includes the issues identified through the initial and ongoing assessments, resources to which the Veteran was linked, barriers encountered and how they were overcome. It provides the CTI worker's assessment of the durability and efficacy of those resources, as well as the Veteran's feedback about CTI and expectations for life after CTI.

Team Forms

- **Phase-Date Tracking Form**
  The Phase-Date Tracking Form is a record of when each Veteran starts Pre-CTI (i.e., the date they were enrolled in the program) and when they start Phase I (i.e., the date they move into the transition period). Based on the date that Phase I starts, dates are entered for when Phase II and Phase III are due to start and when CTI is due to end. Later, the CTI worker records the actual dates for these transitions, which should be no more than two weeks before and up to two weeks after the due dates. The Phase-Date Tracking Form also includes a place for noting whether Veterans end CTI early or late, and a code for the reason they ended when they did.

- **Weighted Caseload Tracker Form**
  The Weighted Caseload Tracker Form is a tool that converts each CTI worker's caseload to

a weighted caseload. The supervisor uses this tool to keep track of the size of caseloads in order to determine which worker will be assigned the next new Veteran without exceeding the size limit of any caseload.

- **Team Supervision Form**
  The supervisor completes the Team Supervision form every week during the team supervision meeting. The supervisor records the date of the meeting and lists all attendees. At the beginning of the meeting, CTI workers identify a few of their Veterans who are 'priority Veterans' requiring longer discussion and indicate why these Veterans were identified. The supervisor places a check mark next to the name of each Veteran after they are discussed.

- **CTI Caseload Review Form**
  The CTI Caseload Review form can be used by CTI supervisors to track case consultation and supervision; it provided a template to track supervision provided on all Veterans who are on the caseloads of CTI workers being supervised.

- **Assessment Domains (CTI-Informed)**
  This document highlights core assessment domains that are relevant to the CTI GPD-CM model. It provides an outline for CTI workers to collect biopsychosocial histories on Veterans entering the GPD-CM program, including housing and homelessness history; employment history; income, benefits, and entitlements; debts; legal history; education history; family/dependent children; physical and behavioral health; and independent living skills and supports. While this form is not required for CTI GPD-CM, it can be a helpful tool to summarize Veterans' strengths and barriers. Completing this form can also spark discussion about Veterans' recovery goals.

- **CTI Implementation Self-Assessment Form**
  The CTI Implementation Self-Assessment Form serves as a brief internal program audit. The CTI workers and supervisor can complete this and use it to monitor how closely they are following CTI guidelines. During the team meetings, the supervisor tracks progress made on any items that received a poor rating. Some programs include this quality assessment as part of their quarterly reports.

- **Harm Reduction Plan for Housing Stability**
  This tool can be used to discuss Veterans' options when he/she experiences a risk to his/her housing instability. It provides a framework to discuss options to address the risk

factor, including pros and cons of each option, and to identify preferences that are non-negotiable for the Veteran.

Other Forms

- **CTI GPD-CM Providers' Frequently Asked Questions**
  This frequently asked questions guide answers queries commonly posed by CTI workers and supervisors about the CTI model. Questions are categorized into case planning, extending beyond the GPD-CM time frame, the CTI Philosophy, and Ending Services.

- **Explaining Critical Time Intervention - Sample Talking Points**
  This document provides sample talking points you can use to explain CTI to colleagues and Veterans. As you start to learn and use the CTI model, these talking points can be useful to help you explain the model and its goals to other case managers (within and outside your agency) and Veterans in the GPD-CM program.

X. Case Examples

Example One: Don

Pre-CTI

Empowering the Veteran, Establishing Rapport, Transparency

Don is a 45-year-old male Veteran who has been staying in a transitional housing program for the past 8 months. This is his first time experiencing homelessness. He has been diagnosed with PTSD, but has declined any formal mental health services. He prefers to talk to fellow Veterans, but not service providers, when he feels the need. Don injured his back while working several years ago and has been experiencing chronic pain making his work as a mechanic too difficult. He receives about $1300 each month in SSI/SSDI payments.

You meet Don and the housing case manager to begin getting to know him and identifying the supports he may need once CTI begins. Don is hesitant to engage in a discussion with you, and says once he is housed he will be happy to be on his own, free of the need for "help." He appears to be proud of his ability to take care of himself. After the initial meeting, Don does not return any of your emails or calls to meet again. The housing case manager has a good rapport with Don and encourages him to meet with you again. This time you spend more time clearly explaining what CTI is, and how it may benefit him. You clarify that you will not be "managing" him or checking in to make sure he is following rules, but will serve as person who can connect him to resources he may need in his new living situation. He wants to know what these "resources" may be, and you explain it could be helping him find community activities to engage in, navigating local public transportation, or finding a new primary care physician. You also reassure him that no resources will be mandatory- he can decline to engage at any time. Upon hearing this, Don decides he will give CTI a try, and shares that his main concern was that he does not want to be forced to receive therapy.

Comments

This example illustrates the importance of working together with the housing case manager in transitioning the Veteran from their care to a CTI intervention. At this point, Veterans may be wary of additional services and these feelings should be acknowledged. CTI is unique in that it does not impose an "agenda" on the Veteran or force participation, but Veterans will not understand this until it is clearly explained. It is critical that the intervention is described to the Veteran in the Pre-CTI phase to avoid misunderstanding.

Example Two: Ophelia

Phase I: Transition

Identifying Informal and Formal Supports and Prioritizing Goals

Ophelia is a 35-year-old Veteran and single mother with a 6-year-old son and a 4- year-old daughter. She became homeless after fleeing from intimate partner violence from the father of her youngest child. While staying in a transitional housing program, she was able to complete a home health aide certification and has been working Monday through Friday from 8am-4pm providing care to an elderly woman in the community. Ophelia's son is in school every day and the transitional program provides childcare for her daughter, which will end when she moves into her own apartment.

When you develop a housing plan with Ophelia, she explains that she enjoys providing care as a home health aide and that her goal is to return to school to obtain her LPN license. Her greatest concern is how she will pay for childcare for her 4-year-old while she is working. Additionally, she tells you she recently received information that the father of her daughter wants to seek custody.

The top priority for working with Ophelia is to secure childcare for her daughter. Ophelia was able to identify a temporary replacement to care for her patient while she gets moved in and adjusted, but she cannot afford to miss any more work and still cover her living costs, and she does not know how she will pay for childcare. While researching available options in the area, you come across a Head Start program that serves low-income families with children 5 and under. This seems like a perfect fit for Ophelia's daughter. You provide her with the information and she is able to enroll her in a full-day program. Ophelia drops her son off at the school's breakfast program at 7:30 each morning and re-arranges her work schedule to arrive at 8:15 so she can drop her daughter off at her program at 8:00.

When Ophelia receives court papers for a custody hearing two months into working with you, you provide her with contact information for a legal aid program in the area. The program office is a long distance from Ophelia's home in an unfamiliar area and so you agree to travel with her for the first meeting. They agree to take on her case and plan to conduct business over the phone and at the courthouse, which is much closer to Ophelia's apartment, moving forward. As you prepare to conclude CTI services with Ophelia, you

discuss her desire to increase her education to better provide for her family. Ophelia is not certain how she will be able to balance school with working to pay the bills and providing care and supervision for her kids. Through the process of exiting homelessness and getting back into housing, however, Ophelia was able to reconnect and start to repair a troubled relationship with her mother. Ophelia's mother has been looking after her kids one evening a week for the past month to give Ophelia a chance to relax, and they have started to discuss more frequent childcare arrangement in the future that could allow Ophelia to take some classes. You leave Ophelia with brochures about VA vocational services and educational benefits, which can facilitate her educational goals, and information about how to apply for financial aid and loans if she needs them. You also familiarize her with services offered at the VA Women's PACT, which offers resources tailored to women Veterans and their families.

Comments

This case demonstrates the importance of setting and prioritizing goals. Managing multiple major life changes at once--such as a move into housing, a new job, and education--can be difficult to impossible. Goals must be prioritized based on what is the most essential to meet current needs and what can reasonably be attained within the scope of the program. In this instance, identifying childcare for the daughter was the most critical goal as it allowed the Veteran to work and provide income necessary for housing stability. The custody and educational goals, while important to the Veteran and necessary for long-term stability, were outside the initial scope of the program. Still, the CTI worker assists the Veteran with identifying and taking small steps towards achieving these larger goals by connecting with VA and community providers who can support the Veteran in achieving the goals after the conclusion of the CTI GPD-CM period. Here, the VA Women's PACT will be an important source of care for this Veteran after CTI is complete.

It also shows the importance of exploring both formal and informal supports. While knowing about Head Start and legal aid resources in the area was crucial for helping the Veteran achieve two of her goals, identifying the Veteran's mother as a key informal support and resource will allow her to take steps towards achieving future goals in ways the formal supports could not.

Example Three: Stuart

Phase I and into Phase II: Transition to Try-Out

Rapport Building, Goal Identification and Resource Connection

Stuart is a 58-year-old Gulf War Veteran who has been living in a shelter on-and-off for the past 4 years before entering a VA GPD program. Stuart's housing case manager found a studio apartment in a complex he really liked and was accepted for move-in, but you were concerned that the rental amount- $850- was too much given his income once his short-term rental assistance ends.

Stuart's back problems were a result of work he did with heavy machinery while serving in the Army, therefore he qualified for income due to a service-related disability. The housing case manager has already helped him to apply for service connection but his claim is still pending when the CTI worker takes over the case. Stuart also expressed the desire to increase his income through employment that didn't require heavy physical labor.

Stuart was thrilled to move in, proud to show off his new apartment, and quick to make friends with neighbors in the complex. Stuart did not start looking for work right away. After several visits, and you providing him job leads, VA vocational services, and encouragement, he still had not begun the process. When he did, he experienced a few rejections and gave up. He reported that he was not feeling well and did not feel ready to work yet. After a couple weeks, Stuart brought up the idea of working again and even attended a job fair, but became discouraged when an employer reported that in order to drive a truck for his company Stuart would need to pass a background check. He revealed to you that he would not be eligible due to a previous felony conviction.

You continue to assist Stuart in following up with his service disability claim at the VA. He is eventually approved for a 40% service connection, which increases his income by an additional $590 each month. Through meeting with the Veterans' benefits organization, Stuart also learns about a job development program that works specifically with employers who have a preference for hiring Veterans, even if they have a criminal background. Stuart enrolls in the job program and continues to look for suitable employment to supplement his disability income. Knowing money is still tight, you help connect Stuart with a subsidized

phone service, utility assistance, and a local food bank so that he can continue to meet his basic needs and prepare to pay rent once his subsidy ends.

Comments

This case study highlights the importance of fully and creatively exploring goals with participants. While Stuart reported that he wanted to work, what was most important to achieve and maintain housing stability was to increase his income, which can be done in a variety of ways. There were benefits available to Stuart that he was not aware of and/or needed help to pursue that could make the difference between him making ends meet or falling short. The current short term housing subsidy that Stuart has will likely not solve all of his financial instability, however, and his rent burden will remain high, so his CTI worker works to connect him to other community resources, as well, that can help alleviate some of the burdens of paying for living costs like food and utilities.

This also highlights the importance of getting to know VA and community providers. One of the foundational principles of the CTI model is connecting to supports in the community, and if providers are unaware of the services that exist they cannot adequately connect participants. Participants may also be hesitant to engage with providers for a variety of reasons and may need some coaching and assistance from a CTI GPD-CM worker to build the relationship with these critical supports.

Example Four: Terrance

Phase II: Try-Out

Mediating, Testing Resources, Empowering the Veteran

Terrance is a 48-year-old Veteran experiencing homelessness for the third time. He slept in his car for 5 months before reconnecting with housing through your program. Terrance reports that finding full-time employment is his top priority and that he is primarily interested in jobs in the security field.

Much of your work with Terrance is over the phone because it is difficult to find times to meet with him. Terrance is doing construction work for a friend, which requires him to be away from home from 6 am to 9pm. He reports that he still wants to find full-time work and you offer to accompany him to the local job center. Terrance insists he does not have the time to do this, because he will lose critical income and may not be able to pay for his cell phone and other basic needs if he misses work.

Throughout Phases I and II you find times to meet with Terrance outside of normal business hours and help him develop his resume and apply for some jobs online. Thus far, he has not yet received any responses. You continue to encourage Terrance to take a day to connect with the job center, but he declines.

A few weeks before he is scheduled to complete the CTI GPD-CM program you receive a call from Terrance that he is worried about paying his bills because his friend has not had work for him for the past two weeks. You and Terrance agree to go to a community job center together on the following day so that he can connect with an employment specialist and start applying for jobs. He meets with a specialist who explains how they develop partnerships with employers to get people hired quickly. He and Terrance exchange numbers and set up a meeting for the following week to complete applications. You also connect Terrance with VA vocational rehabilitation, who can help him apply for federal employment (on USAJOBS) and also connect him with resources for compensated work therapy at the VA.

Comments

This example highlights the challenge of experiencing a setback in Phase II of CTI GPD- CM.

While you may try and anticipate problems and address challenges throughout all phases, things do not always work out that way and you may have to navigate how to help a Veteran manage a crisis before their services end. One of the primary ways this can be navigated is through effective community partnerships. The more a Veteran is able to tap into resources at the VA and in their own community, the better they will address a similar crisis in the future when they are not connected to your services. In this instance, the CTI GPD-CM worker was able to successfully connect the Veteran to a local employment program and VA vocational services, which will be responsible for helping him address his ongoing employment goals. It is also worth reflecting on strategies in this case (i.e.- Motivational Interviewing skills). The CTI worker may have been able to engage Terrance earlier in the process, if he had addressed his ambivalence about utilizing employment support services. This may have prevented this last-minute setback.

Example Five: Roger

Phase III: Transfer

Dealing with a Last-Minute Set-Back, Justifying an Extension

Roger is a 54-year-old Veteran who received housing assistance through the VA two years ago but has become homeless again and is in need of housing assistance. He has been working as a security guard at a nearby mall for the past three years but recently lost his job due to the COVID-19 pandemic.

Days after moving into his new housing, Roger begins voicing complaints about the new apartment, including a broken lock on the bathroom door, a leaky faucet, and roaches in the kitchen. Roger says he has reported the problems numerous times to the landlord and she does not respond. You inform the landlord about Roger's concerns and she promises to address them, but says that there have been numerous complaints about Roger making noise, and hoarding items that are now taking up space outside his door.

Your initial assessment revealed that conflicts with a landlord have previously led to episodes of homelessness. Roger is also beginning to exhibit signs of depression, and he has begun drinking alcohol again after being sober for several years. Whereas previous Phase Plan goals addressed employment and income, you decide to discuss with Roger the need to access mental health care and a return to AA meetings that have helped him in the past.

Comments

This case study illustrates how a Veteran's situation can deteriorate substantially at any time, and in this case, in Phase III of the CTI intervention. The CTI worker should be prepared to pivot immediately to address whatever issue arises as a threat to the Veteran's overall wellbeing. In this case, tensions with neighbors and the landlord revealed that Roger's mental health was deteriorating. Although intervening with the landlord to attempt to remedy the situation is indicated, the first priority is to address Roger's mental health needs by connecting him to services and ensuring he can continue them after the end of CTI. Since this happened in Phase III, it may warrant a rare approval of an extension of services, to ensure Roger is connected to mental health care and that some progress is made in the housing situation to prevent eviction.

XI. Appendix

Veteran Resource List

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Veteran's Name

Family Member Names

Address

Telephone

Email

Emergency Resources:

If there is a risk to safety, please call 911. Have this sheet with you for contacts.

Veterans Crisis Line: 1-800-273-8255 (Press 1) VA 24/7 Line: _____

Contact	Telephone	Address
Trusted Neighbor or Friend:		
Friend with Phone:		
Social Services Support:		
Permission to Enter Home / Relationship:		
Care for Children & Relationship:		
Care for Pet & Relationship:		
Treatment Provider:		
Legal Assistance		

Housing:

Contact	Telephone	Address
Landlord Name:		
Subsidy Administrator:		
Support Services:		
Legal Services:		

Housing Documents:

Document(s)	Yes, No, Not Available	Location
Lease	Yes No	
House Rules:	Yes No Not Available	
Notice(s) from Landlord:	Yes No Not Available	
Rent Receipts:	Yes No	
Inspection Schedule:	Yes No	
Inspection Form:	Yes No	
Utility Bills:	Yes No Not Available	
Housing Plan:	Yes No	

Financial:

Contact	Telephone	Address
Social Security Office:		
Person Assisting w/ Application/Appeal:		
Public Assistance / FS:		
Medical Assistance:		
Banks:		
Emergency Assistance: Rent & Utilities:		
Food Banks:		
Employer:		
Person who helps with Financial:		
Representative Payee:		

Financial Documents:

Document(s)	Yes, No, Not Available	Location
VA SC or NSC Award Letter/Application :		
SS Award Letter:		

Financial Documents (Continued):

Document(s)	Yes, No, Not Available	Location
PA Award Card:	Yes No Not Available	
Medical Assistance Card:	Yes No Not Available	
Bank Statement:	Yes No Not Available	
Rent Receipts:	Yes No	
Utility Bills:	Yes No Not Available	
Tax Records:	Yes No Not Available	
Pay Stubs:	Yes No Not Available	
Identification:	Yes No	
Tax Forms, W2:	Yes No Not Available	
DD214:	Yes No	

Medical:

Contact	Telephone	Address
Primary Care Provider:		
Speciality Care Provider:		
Dentist:		
Emergency Room:		
Transportation:		
Homecare Provider:		
Pharmacy:		
Friend to call for support:		

Medical Documents:

Document(s)	Yes, No, Not Available	Location
Medical Insurance Card:	Yes No	
Appointment Calendar:	Yes No Not Available	
List of Medications:	Yes No Not Available	
Medical Proxy:	Yes No	

Medical Documents (Continued):

Document(s)	Yes, No, Not Available	Location
Crisis Plan:	Yes No	
Advance Care Directive:	Yes No	
Utility Bills:	Yes No Not Available	
Housing Plan:	Yes No	

Mental Health:

Contact	Telephone	Address
Psychiatrist:		
Clinic:		
Case Manager / ACT:		
Pharmacy:		
Life Coach:		
Club Houses / Peer Support:		
Hot Lines:		
Warm Lines:		
Friend to call for support:		

Mental Health Documents:

Document(s)	Yes, No, Not Available	Location
Insurance Card:	Yes No Not Available	
Appointment Calendar:	Yes No Not Available	
List of Medications:	Yes No Not Available	
Crisis Plan:	Yes No Not Available	
Advanced Care Directive:	Yes No Not Available	

Substance Recovery:

Contact	Telephone	Address
Counselor:		
Program:		
Peer Support / Sponsor:		
Friend for support:		
AA / NA Home Meeting:		

Substance Recovery Resources:

Resource	Yes, No, Not Available	Location
Recovery Plan:	Yes No Not Available	
Crisis / Relapse Prevention Plan:	Yes No Not Available	
Insurance Card:	Yes No Not Available	
Meeting Book:	Yes No Not Available	

Education & Employment:

Contact	Telephone	Address
Employer:		
School: HoH & Children		
Teachers:		
Employment Program:		
Counselor:		
Education Advisor:		
Tutor:		
Peer / Colleague:		

Education & Employment Documents:

Document(s)	Yes, No, Not Available	Location
Pay Stubs:	Yes No Not Available	
Insurance Card:	Yes No Not Available	
Social Security Card:	Yes No Not Available	
GI Bill Award Letter / Documentation:	Yes No Not Available	

Education & Employment Documents:

Document(s)	Yes, No, Not Available	Location
Voc Rehab Letter / DocumentationL	Yes No Not Available	
Schedule: for HoH and each child	Yes No Not Available	
School Documents for Children: Vaccination Cert., transcripts, report cards, evaluations, plans for special needs	Yes No Not Available	

Community Connections:

Contact	Telephone	Address
Faith Community:		
Family:		
Friends for every family member:		
Camp / Afterschool:		
Child Care:		
Sports Team:		
Community Center:		
Clubs:		

CTI Phase Plan

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Phase #: Phase One: Transition ☐ Phase Two: Try-Out ☐ Phase Three: Transfer ☐

Today's Date: ☐☐ Month ☐☐ Day ☐☐ Year Veteran's Name: _____

Date Phase Starts: ☐☐ Month ☐☐ Day ☐☐ Year Due Date for End of Phase: ☐☐ Month ☐☐ Day ☐☐ Year

Check the focus areas for this Phase: (Choose 1 to 3 areas)

- ☐ Benefits
- ☐ Employment
- ☐ Survival Needs (food, clothing, furniture, etc.)
- ☐ Child Care
- ☐ Transportation
- ☐ Education (child/adult)
- ☐ Natural Supports
- ☐ Budget Management
- ☐ Health and Mental Health
- ☐ Children's Health and Mental Health
- ☐ House
- ☐ Legal Concerns

Area #1 _____

Reason for choosing this area:

Overall goal for this area:

Area #2 _____

Reason for choosing this area:

Overall goal for this area:

Phase #: | **Phase Plan Date:** | **Veteran's Name:**

Area #3 _____

Reason for choosing this area:

Overall goal for this area:

Summary of Achievement in Each Area

Complete this section at the end of **Phase One** and **Phase Two only.** Use this information to plan for the next phase. At the end of **Phase Three**, write the *Closing Progress Note* instead.

Area #1 _____

Area #2 _____

Phase #: | **Phase Plan Date:** | **Client's Name:**

Area #3 _____

CTI Worker Signature: _____ Today's Date: _____

Supervisor Signature: _____ Today's Date: _____

CTI Progress Note

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Phase #: Phase One: Transition ☐ Phase Two: Try-Out ☐ Phase Three: Transfer ☐

Date of phone call, meeting, or other: ☐☐ Month ☐☐ Day ☐☐ Year

Veteran's Name: _____

Check One Box Only.

- ☐ Received call
- ☐ Office-based meeting
- ☐ Received fax/e-mail/letter
- ☐ Made call
- ☐ Field-based meeting
- ☐ Sent fax/e-mail/letter
- ☐ Attempted call
- ☐ Attempted meeting

Can record multiple attempts on this note if to same person, same day:

List Persons: _____ **Location:** _____

Name and position/agency or relationship

Notes:

Next Steps:

CTI Worker Signature: _____ Today's Date: _____

Supervisor Signature: _____ Today's Date: _____

CTI Closing Note

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Veteran's Name: _____ _____
Last Name First Name

CTI Worker Initials: _____
Initials

Today's Date: __ __ __ __ __ __ __ __
Month Day Year

Date Closed: __ __ __ __ __ __ __ __
Month Day Year

Final Meeting with Veteran

Final Meeting Date: __ __ __ __ __ __ __ __
Month Day Year

What was discussed at this meeting? Check all items that apply.

- ☐ Ongoing challenges to housing stability
- ☐ Review of Veteran's progress since beginning of CTI intervention
- ☐ Veteran feedback about CTI intervention
- ☐ Review of linkages to resources
- ☐ Other, please specify:

Notes:

Long-Term Plan

What are potential threats to long-term housing stability, and community adjustment?
(These are barriers that existed during CTI and continued throughout. Check all items that apply.)

- ☐ Not enough income to pay rent
- ☐ Conflict with family members
- ☐ Conflict with friends
- ☐ Unstable child care/lack of child care
- ☐ Dissatisfaction with apartment unit
- ☐ Mental health
- ☐ Physical Health

Notes:

What resources are available to help support long-term housing stability?

Family

Name	Relationship	Contact

Friends

Name	Relationship	Contact

Community Organization For example: Employment, Child Care, Public Assistance

Name	Relationship	Contact

Providers For example: Primary Care Providers and/or Mental Health Care Provider

Name	Relationship	Contact

What is the CTI Worker's Role after closing date?

Role:

Worker's Contact Info:

Is the CTI Worker available for follow-up visit? ☐ No ☐ Yes

CTI Worker Signature: _____ Today's Date: _____

Veteran Signature: _____ Today's Date: _____

Supervisor Signature: _____ Today's Date: _____

CTI Phase-Date Tracking Form

For CTI Workers and Supervisors*

VA | U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Program Name:					**Supervisor Name:**		
CTI Worker	Veteran Name	Date Enrolled in GPD-CM Grant	**Phase 1 Start Date** Date of Move In	**Phase 2 Start Date** Planned / Actual	**Phase 3 Start Date** Planned / Actual	**Date Closed** Planned / Actual	Date of Supervisory Review
EXAMPLE J.Jones	EXAMPLE Mr. Smith	EXAMPLE 4/10/20	EXAMPLE 5/8/20	7/15/20	9/15/20	11/15/20	4/13, 4/21, 4/28, 5/5, 5/9, 6/2, 6/9, 6/16, etc.
				7/17/20	9/10/20	11/5/20	

*This form tracks participant progress through the phases of CTI, supervisory reviews and can be used for fidelity review.
It is not required, but rather strongly recommended to use this or something similar to assist in supporting movement through the phases of CTI.

Weighted Caseload Tracker*

U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

CTI Worker Name:							Date:		
	PRE-CTI		PHASE 1		PHASE 2		PHASE 3		
Client Initials	Start Date	"1" if Veteran is in Pre-CTI	Start Date	"1" if Veteran is in Phase 1	Start Date	"1" if Veteran is in Phase 2	Start Date	"1" if Veteran is in Phase 3	End CTI Date
J.J.	2/1/20	1	3/1/20	1	5/1/20	1	7/1/20	1	9/1/20
C.S.	3/1/20	1	3/15/20	1	5/15/20	1	7/15/20	1	9/15/20
CATEGORY TOTAL :									TOTAL WEIGHT:
MULTIPLIER :		x 1.5		x 2		x 1		x 0.5	
TOTAL :			+		+		+		

** See page 28 in the CTI Manual for further explanation about how to calculate the weighted caseload.*

CTI Team Supervision Form

U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Present

Absent

Today's Date: Month Day Year

Instructions:

1. This form is filled out every week during the team supervision meeting to document in-depth discussions about the highest priority Veterans (use reasons listed below as a guide).
2. Before the meeting, the CTI Worker fills in the names of Veterans with highest priority, based on past week's fieldwork and any change to Veteran status and records explanation and one reason code.
3. The supervisor places a √ mark in the far right column next to each Veteran who has been discussed.
4. If the entire caseload is discussed during supervision, fill out the CTI Caseload Review form.

Veterans's Name	CTI Worker's Initials	**Explain why it is important to discuss this Veteran at today's meeting.** Record the **reason code** in the box. 1= Ready To Give New Case Presentation 2= Veteran Faced With a Crisis or Big Change 3= Cannot Be Located 4= Discuss Whether Refusal Is Permanent 5= Time To Prepare for a New Phase 6= Time To Prepare for End of Intervention 7= Difficult Problem With Support Network 8= Positive Occurrence To Share With Team	Place √ mark in box when team discusses Veteran

CTI Caseload Review Form

U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

CTI Workers Present

CTI Workers Absent

Date of Meeting:

Month Day Year

Instructions:

1. This form is filled out by the CTI supervisor every two weeks during his/her meeting with CTI workers to quickly go over all active CTI Veterans.
2. Before the meeting, the supervisor lists all the currently active Veterans.
3. The supervisor places a √ mark in the far right column next to each Veteran who has been discussed.
4. If meeting discussion does not cover all active Veterans, the supervisor may finish collecting information by phone to fill out this form within the two-week period (e.g., if not enough time or a worker couldn't attend.

Veterans's Name	**CTI Worker's Name**	Place √ mark in box after Veteran is discussed
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

CTI Caseload Review Form *Continued*

U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Date of Meeting: ☐☐ ☐☐ ☐☐☐☐
Month Day Year

Veterans's Name	CTI Worker's Name	Place √ mark in box after Veteran is discussed
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

Assessment Domains
CTI Informed *

U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Veteran's Name and **Date** of Enrollment in Pre-CTI:		/ /
Basic Demographics Age, Ethnicity, Household Composition, Current Location, etc.		

Housing & Homelessness History — Last 5 Years

Name/ Location	Type	Start Date	End Date	Lease-holder	Reason Leaving
				Yes No	
				Yes No	
				Yes No	
				Yes No	
				Yes No	

Every evicted from housing?	Yes	No	**Reason:**	
Ever in foster care?	Yes	No		
Barriers to Housing Stability? 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:				

**This document highlights the cores assessment domains for CTI and is "CTI-Informed". This is not a required or official CTI form.*

Employment History — Last 5 Years

Employer	Position / Title	Wage	Start Date	End Date	Reason Leaving

Employment Goals:	
Services Currently Receiving:	
Services Needed to Access or Maintain Employment:	
Motivation to Obtain Employment:	

Income, Benefits & Entitlements

Income Sources	Status	Plan
Unemployment Income	Yes No	
Supplemental Security Income (SSI)	Yes No	
Social Security Disability Income (SSDI)	Yes No	
Veteran's Disability Payment	Yes No	
Private Disability Insurance	Yes No	
Workers Compensation	Yes No	
General Assistance	Yes No	

Income, Benefits & Entitlements (Continued...)

Income Sources	Status	Plan
Other (List:)	Yes No	
Alimony of other spousal support	Yes No	
Unemployment Insurance	Yes No	
Veteran's Pension	Yes No	

Plan to Apply For or Maintain Income Benefits			
Task:		Responsible Party:	
Does this person have a representative payee?		☐ Yes ☐ No	
If 'Yes', Name:		Relationship, Phone Number:	

Other Sources/Benfits	Status	Other Sources/Benfits	Status
Non-cash Benefits	Yes No	Private Health Insurnace	Yes No
Food Stamps	Yes No	VA Medical Serives	Yes No
Medicaid	Yes No	Other (List):	Yes No
Medicare	Yes No	Other (List):	Yes No

Goals and Plan to Apply For or Maintain Non-cash Benefits			
Task:		Responsible Party:	
Barriers to Obtaining/ Maintaining Benefits & Entitlements:			

Debts

Current Debts?	Yes No	**If Yes, List Total Below**
Debts	**Status**	**Amount Owed**
Utilities	Yes No	$
Rent	Yes No	$
Credit Card	Yes No	$
Mortgage	Yes No	$
Medical Bills	Yes No	$
Car	Yes No	$
Overdue Child Support	Yes No	$
Gambling	Yes No	$
IRS	Yes No	$
Other (Include Informal Debts):	Yes No	$
Credit Status / Score:		
Play to Pay Off Debts:		
Services Needed:		
Motivations to Resolve Credit / Debt Issues:		
Financial Goals:		

Legal

Legal Resident?		☐ Yes ☐ No	
Probation / Parole Status:			
Name of PO:		Date Supervision Ends:	

Felony History — Last 5 Years

Date	Charge / Crime

Incarceration History — 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:	
Motivations to Resolve Legal Issues:	

Education History

Highest Grade Completed or Current Enrollment:		
☐ Grade in School, if Enrolled:_____	☐ Some High School	☐ H.S. Diploma or GED
☐ Technical Certification, Field:_____	☐ Some College	☐ Associate's Degree
☐ Bachelor's Degree	☐ Other:_____	

Current Education Status:	☐ In School	☐ Applying for School		
Name of School:				
Current Progress:				
Has IEP or Section 504 Plan?	☐ Yes	☐ No	**If 'Yes', check all that apply below:**	
☐	Austism	☐	Multiple Disabilities	
☐	Deafness	☐	Orthopedic Impairment	
☐	Deaf-Blindness	☐	Other Health Impairment	
☐	Emotional Disturbance	☐	Speech or Lange Impairment	
☐	Hearing Impairment	☐	Traumatic Brain Injust	
☐	Intellectual Disability	☐	Visual Impairment	
☐	Leaning Disability	☐	Other:	

Comment on Academic Functioning e.g., attendance, grades, learning ability, behavioral issues etc.	
Education Goals:	
Services Needed:	

Family / Dependent Children

Family:	**Notes:**	
Household Status & Composition:		
Names & Ages of Children:		
Names & Relationships of Supportive Family Members:		
Has children in foster or kinship care?	Yes No	
If Children's Services Involvement: *Status, Worker Name, and Contact*		
Domestic Violence History?	Yes No	
Services Needed:		
Goals Regarding Family:		
Motivation to Use Services:		

Physical & Behavioral Health

List Any Diagnosis *Mental Health, Substance Abuse, Mental Retardation, etc.*	**Severity of Illness**	**Treatment History**
Current Treatment / Service Providers: Name, Organization, Phone Number		
Previous Treatment Providers: Last 3-5 Years, Agency/Hospital, Dates		

Physical & Behavioral Health

How health issues impact community stability (check all that apply):					
	Pay Rent		Disruptive Behavior		Hoarding
	Noise		Visitors		Other:

Current Medications:	
Adherence to Medication Regiment:	☐ 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 a Week		Once A Week		Less than A Week

Hospitalization in Last 3-5 Years	Reason	Hospital
Date:		
Date:		
Date:		
Detox in last 3 years: Number of inpatient detox stays		
Services Needed:		
Motivation to Use Services: Pre-contemplation, contemplation, preparation, action, 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 *Circle the number which applies:*	1	Mostly Independent
	2	Needs Help Sometimes
	3	Needs Help Most of the Time
	4	Always Needs Assistance
	NA	Not Applicable

Independent Living Skills *Score 1-4 in Right Column*	1. Pay Bills	*Score 1-4:*	
	2. Budgeting and Managing Money	*Score 1-4:*	
	3. Maintaining Entitlements and Other Paperwork	*Score 1-4:*	
	4. Maintaining a Home	*Score 1-4:*	
	5. Preparing / Obtaining Meals	*Score 1-4:*	
	6. Traveling		
	7. Personal care / Hygiene		
	8. English Proficiency		
	9. Literacy		
	10. Awareness of Needs and Knowledge When to See Help		
	11. Able to Access Help When Needed		
	12. Managing Health / Behavioral Health Need and Services		
	13. Taking Medications		
	14. Keeping Appointments		
	15. Discriminating Danger / Asserting and Protecting Self		
	TOTAL SCORE on Independent Living Skills (Max Score = 60 Points)		

Goals, Ability, and Motivation to Improve Skills:	

Barriers Summary

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

Strengths Summary

Income and Financial:	
Employment:	
Housing:	
Health:	
Mental Health & Substance	
Family & Supports	
Skills:	
Education:	
Other:	

Name of CTI Worker *who filled out form:*		**Date:**	/ /

CTI Implementation Self-Assessment Form

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Score Scale

Never or Rarely	Sometimes	About half of 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	**Score:**
During Pre-CTI 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	**Score:**
During Phase 1 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.	
Linking Process	**Score:**
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*.	
During Phase 2 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.	
During Phase 3 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)*	

Linking Process *(continued...)*	**Score:**
In Phase 3, before a case is closed: 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	**Score:**
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	**Score:**
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	**Score:**
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.	
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*.	

Documentation *(continued...)*	**Score:**
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)	

Score Results

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

Harm Reduction Plan for Housing Stabilization

U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

Housing Risk	Options	Factors in Favor	Factors Against	Non-Negotiable

CTI GPD-CM Providers' Frequently Asked Questions

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VA Greater Los Angeles Healthcare System

Case Planning

1. CTI GPD-CM training indicated that visits with Veterans should be at least weekly in Phase 1, bi- weekly in Phase 2, monthly in Phase 3 and more as needed in any given phase. Do all of those visits need to be face-to-face visits or visits in their homes?

In Phase 1, visits should be face-to-face (in person or via video technology) whenever possible, but don't have to be in the Veteran's home. After Phase 1, telephone contacts can take the place of some face-to-face visits.

2. What are the guidelines for how many supports should be set up in each phase?

There are no specific guidelines for the number of linkages, as they will vary case to case. The test of whether the linkages are adequate is how well the system is operating, and whether or not the Veteran is achieving his/her goals.

3. What is the best method for identifying goals for the Phase Plan?

The purpose of CTI GPD-CM is to connect Veterans to supports and resources that increase the likelihood for long-term housing stability.

Therefore, the goals in each phase should be directly related to this outcome. A good first step is to thoroughly explore what caused the Veteran to lose their housing and to make goals that directly address these issues. For example, if a Veteran lost a job due to symptoms of depression, an appropriate goal for Phase 1 would be to connect the person to mental health services. If a Veteran lost their housing due to intimate partner violence, appropriate goals would be family counseling, linkages to social supports and legal assistance. If the Veteran has already been connected to these supports before entering the GPD-CM program, a good Phase 1 goal may be ensuring these supports are maintained throughout their transition to their new community.

4. The main purpose of CTI in the GPD-CM program is to link Veterans to a support network that will reduce his/her likelihood of repeated housing loss. What if your Veteran doesn't want to be linked to other services, or isn't comfortable with case managers contacting their existing or potential supports? Do we discharge after six months, or should we request an extension in their duration of case management?

Yes, discharge is indicated. This would not be a case where extending the GPD-CM time frame is likely to be appropriate. However, the case manager should explore the Veteran's reasons for declining the connection to services and take steps to address their concerns.

5. A Veteran loses their housing while in the GPD-CM program but still needs services. Does he/she have to re-enter GPD or another VA residential program and connect with other case management, or should we work with him/her until something else is found, or until the 6 months is up?

The answer to this question differs depending on the referral processes in your agency. If the Veteran becomes homeless again and your agency allows for such, it makes sense to try and rapidly re-house them again with the support of the GPD-CM team that knows the Veteran.

Extending Beyond GPD-CM Time Frame

6. Veterans in our program may receive financial assistance of variable duration (to help with housing and other needs), but the GPD-CM program is only for 6 months. What do we do with Veterans who are still receiving financial assistance, but no longer receiving CTI?

Remember, the six-month time frame does not begin until the Veteran is housed. If your time working with the Veteran in the GPD-CM program ends, and financial assistance continues, VA and community linkages should be providing support to the Veteran. Establishing linkages to these VA and community linkages is a major part of CTI while Veterans are enrolled in GPD-CM.

7. What if there is a lack of supportive services in the area to help Veterans achieve their goals? Do we still discharge the Veteran after 6 months? Should or can the time frame be extended?

Yes, you should discharge the Veteran, unless a critical resource is forthcoming that indicates that an extension is vital (after a waiting period, childcare becoming available, for example).

A lack of resources for Veterans should be noted and shared with your agency and GPD-CM liaison, so that they can work with the VA and local community leaders to add critical services.

8. A Veteran disengages with the CTI Worker for a significant amount of time due to relapse, incarceration, hospitalization, residential treatment or other reasons. Later, this Veteran re-engages. Can the clock for the 6-month time frame be extended in these circumstances by holding them in their current phase during the disengagement, or starting them over fresh in Phase 1?

Dependent on the Veteran's circumstances, it is acceptable to resume where the Veteran left off or to re-start. Re-start would be indicated if the Veteran's situation changes significantly so that essentially a "new" transition process is underway (e.g., lengthy hospital stay, incarceration, etc.).

9. A Veteran contacts a CTI worker after discharge from the GPD-CM program requesting help dealing with a crisis or other reason. Do we tell them that we are no longer providing GPD-CM and refer them back to their supports and linkages, or do we help them?

Some limited advice and contact are acceptable, but Veterans should be re-directed to new supports and sources of help. The CTI worker should not assume the role of a primary, long-term contact for crisis intervention.

The CTI Philosophy

10. Some agencies we work with in the community do not embrace the CTI approach and collaborating with them can be difficult. Traditional case management strategies seem to prevail and there is a lot of disagreement about how to work with Veterans. How do we best collaborate with and educate other agencies about CTI and maintain these important partner agency relationships?

CTI agencies should work with their GPD-CM liaison and consider convening meetings with partner agencies to educate them about the model and discuss potential concerns and conflicts.

11. Some agencies that agree to use CTI do not engage in proper utilization of it. Common phrases/concerns from Case Workers: "CTI doesn't work, this Veteran needs permanent case management." Or, "this client is not appropriate for CTI. He needs a higher level of care. This household is waiting for HUD-VASH, so why bother with CTI?" How do we check ourselves with this kind of thinking? How do we prepare our teams to change their way of thinking from traditional case management to CTI?

For some, implementing CTI requires a shift in thinking, which can be supported through additional training and supervision. It may be helpful to meet with other workers who have successfully employed the model with similar clients. CTI is not meant to be a substitute for long-term case management if that is what the Veteran needs; the GPD-CM program employs CTI to transition Veterans to appropriate community supports, including permanent case management (through the VA or community agencies) when indicated and available.

Many Veterans can exit homelessness with short-term case management and/or financial subsidies; in fact, current nationwide data suggests that rapid-rehousing and other short term models are successful interventions for many people experiencing homelessness.

It is often challenging – if not impossible – to identify which Veterans need HUD-VASH or other permanent supportive housing and which Veterans only need a lighter touch, like CTI implemented in the GPD-CM program. Sometimes Veterans who appear to need HUD-VASH are able to resolve their situations with temporary help and sometimes the opposite is true. Helping staff to recognize and believe in Veterans' strengths and resilience can be discussed in supervision. In case conferencing, a review of successful CTI examples can also help reinforce this.

Ending Services

12. If a Veteran has completely disengaged from CTI of their own free will (e.g. after multiple attempted visits to their home, phone calls, texts, emails, letters, collateral contacts, etc.), at what point can we discharge them early from the program and still maintain CTI fidelity? These disengaged Veterans hold valuable spots in a CTI caseload when other Veterans could be served.

If Veterans make clear after multiple attempts at engagement that they are not interested in receiving GPD-CM services (with adequate documentation), discharge may be appropriate if this plan is approved by your supervisor and/or GPD-CM liaison.

13. A Veteran is doing very well and does not need services but has not reached the 6-month time frame. Can we discharge the Veteran early to make more space in the caseload for Veterans who need the services and just do a brief check in monthly?

Yes, you can do a brief check in monthly. Monthly visits are simply “Phase 3” and there is no need to discharge the Veteran from your caseload. By using the weighted caseload, you will be able to add more Veterans because Veterans in Phase III require less of your time.

Explaining Critical Time Intervention (CTI)
Sample Talking Points

U.S. Department of Veterans Affairs
VA Greater Los Angeles Healthcare System

1. To individuals and groups in the community with no prior experience with CTI:

- CTI is a time-limited social service approach that provides people undergoing housing transitions with assistance getting the resources they need for long-term housing stability.
- The intervention was created to address the problem of people cycling back into shelters too quickly after becoming housed, and too often.
- Research on CTI found that if people were given extra assistance in their transition to housing, they were more likely not to return to homelessness and they continued to do well even after the intervention ended.
- CTI workers in the VA Grant and Per Diem Case Management (GPD-CM) program use an array of skills to help Veterans transition, including supportive counseling, education and advocacy. However, CTI is not a mental health intervention, job training, or educational program. The purpose of CTI in the GPD-CM program is to actively link Veterans to these types of services, and others if they need them, in a systematic and meaningful way.
- The GPD-CM provides 6-months of case management for Veterans who have experienced homelessness undergoing housing transitions. CTI is currently being implemented as a preferred service model in the GPD-CM program.

2. To other social service providers:

- Critical Time Intervention (CTI) is an evidence-based practice used to help client's transition from homelessness to housing.
- Research on this intervention has shown that CTI increases the likelihood of long-term housing stability.
- CTI includes a set of phases that begins with intense services and tapers off over time. In the GPD-CM program, Veterans are provided a CTI Worker who meets with Veterans

frequently at first, and then works to actively link Veterans to formal and informal supports that can meet their needs over the long term.

- A CTI worker may educate Veterans, offer supportive counseling, or help Veterans prepare for job searches. However, CTI is not a substitute for long-term case management, nor is it a mental health intervention. CTI was adapted as a 6-month intervention to support Veterans engaging in VA's Grant and Per Diem Case Management (GPD-CM) program.

3. To the Veteran who has just enrolled in the GPD-CM program. This is sample language that should be adjusted based on the needs of each Veteran:

- Hello, my name is _____ and I will be your CTI Worker. I'd like to explain what CTI is and what my role will be.
- CTI stands for Critical Time Intervention, and it is a service I can offer you as you adjust to your new housing situation. The words "Critical" and "Time" refer to the fact that the first few months in your new housing arrangement are an important time. The more we can do to ensure you have a smooth transition, the more likely we can help you avoid losing your housing again.
- My role is to get an idea of what you (or you and your family) need to be comfortable and stable in your new home well into the future. I will then work with you to locate needed resources and help link you up with them.
- Over time we will check to see if these resources are helpful and might make some changes. This might include making sure you are getting all the benefits you are entitled to, or finding work, or re-connecting with friends and family. What we do will depend on your situation and your goals. CTI works best if you take an active role in our work together.
- Do you have any questions about CTI or our work together? Does this sound like it would be helpful to you?

The following is suggested language for explaining more about the process of CTI to Veterans in the GPD-CM program. Some of the

language is appropriate for Veterans in Pre-CTI GPD-CM (before they are housed and enter the 6-month GPD-CM program):

- Until you get housed, I will meet with you here in (the GPD program, the shelter, etc.) to get a sense of what resources we need to start looking for housing. Once you are in housing, I will want to meet once a week at first to offer my support as you settle in.
- We can meet in your home, or in my office, or by video, whichever is most preferable to you. After two months, we will begin to meet less frequently, and six months after you are housed, my work with you will end.
- By the time our work together ends, I am hopeful you will have what you need, or will know how to access help if a need arises. For example, if you have difficulty paying your rent you will know what steps to take to avoid losing your housing. If you need medical care, you will know where to go to access it.

If the Veteran seems hesitant or resistant…

- You seem a bit hesitant. Before I go further, I am wondering — have you had case managers in the past, and what was your experience?
- Do you have any concerns about participating in CTI?