Implementing Critical Time Intervention (CTI) to Enhance Care Coordination for Homeless-Experienced Veterans

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Agenda

- Introductions
- Overview of the CTI Model
- CTI and Housing Stability
- Assessment Domains for CTI and Risk Factors for Housing Instability
- Housing Stabilization/Service Planning
- Linking to Community Resources and Developing an Individual Resource Guide
- Wrap-up and Questions

Introductions

- Housing Innovations
  - Suzanne Wagner
  - Andrea White
- Goals for the Training Series
- Housekeeping
  - **Please sign in to the chat box, with your first and last name and agency name**
  - **We will upload the slides, handouts and the evaluation to the chat box momentarily**
  - **We love interaction – please raise hand, indicate in chat box that you would like to comment or just unmute and talk!**
  - **Turning your camera on**
  - **We are recording this so….**

Introductions (2)

- TURN ON YOUR CAMERAS PLEASE
- Name
- Agency
- Role
- How long working with Veterans and people who have experienced homelessness
- Where are the Veterans coming from before you start your case management services?
- Favorite ice cream flavor?

What is Critical Time Intervention (CTI)?

Evidence-based practice (EBP) designed to:

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

Helps people with high needs live successfully in the community and reduce returns to homelessness, use of institutions

Incorporates “Supporting EBP’s”

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

Transitions

New start

Opportunity for change

Involve both loss and gain

Often stressful

Can increase symptoms

Unknown/uncertainty increases anxiety

Require a new daily schedule

Trigger fears of failure

Require support

Core Components of CTI

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

Core Components of CTI – 2

Limited Focus	• 1-3 goals in identified assessment domains
Interventions focused on preventing and addressing threats to housing stability and achieving personal goals	• Meeting obligations such as rent and bill payment and maintaining housing • Following standard community norms and expectations • Having sufficient money for basic needs • Relief from disturbing symptoms and connecting to effective treatment
Establishes Linkages to Community Resources	• Develop network of supports/linkages and adjust • Connect to natural supports

Case Management and CTI

Case managers must have adequate time and resources

Access and sustainability of services and supports is critical

Lease and landlord provide the expectations and structure

Goal/Recovery based intervention / not crisis or problem based

Housing Perspective

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

Conditions of the lease must be clear and consistently enforced

Lease violation issues will often be a reason to seek services

Workers focus on BEHAVIORS that interfere with functioning as a tenant and as a member of the community and connect housing stability to personal goals.

Collaboration for Long Term Community Stability

CTI promotes collaborations based on:

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

CTI Measures of Success

Maintaining a base in the community

- Could be housing, residential program, family

Increase income

Network of supports

Less emergency interventions:

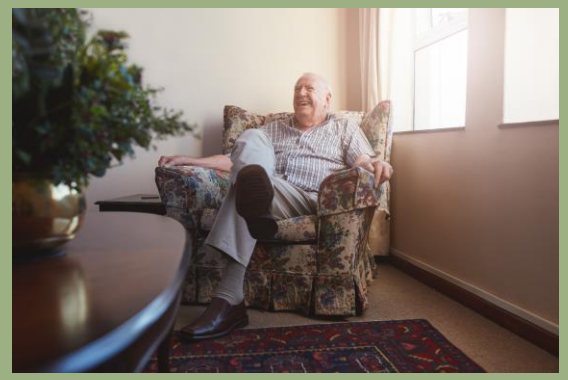
- Shelter, outreach team, ER visits, hospitalization, incarceration

Structure and purpose in each person's life

Discussion

- PLEASE TURN ON YOUR CAMERAS
- Reactions to the CTI model
- Previous or current experience with CTI
- Elements of CTI you are already implementing
- Questions or comments

Evidence for CTI



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

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

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

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

How is CTI Different?

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

CTI Requires Organizational Supports

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

CTI Implementation Self-Assessment Tool

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

Reviews the following Areas:

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

Why Focus on Housing Stabilization

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

The Assessment and Plan Forms

Documentation can help guide and structure staff's work

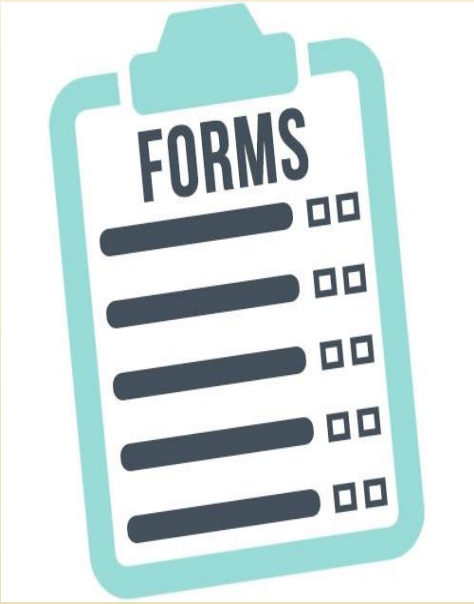
Examples are "CTI Informed"

Can adapt forms currently in use

- Modify to incorporate CTI-informed domains and elements

Recommended Frequency

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



Assessment and Planning Domains

Areas of Focus for Assessment and Planning

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

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

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

Understand Housing and Homeless History

Housing History –

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

Homelessness History -

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

Use Stages of Change to Assess Motivation for Housing

Stage	Relationship to Problem	Staff Tasks
Pre-Contemplation	No awareness/interest in addressing problem/housing issue	Ask q's/ raise awareness of obstacles to goals
Contemplation	Aware of problem & considering housing	Pros & cons of changing/not
Preparation	Making plans for how/when to change	Options: strategies, supports & services
Action	Changing behavior (pursuing housing)	Support/eviction prevention
Maintenance	Change sustained for 3-6 months	New goals/continue eviction prevention
Relapse	Return to problem behavior/ homelessness	Assess stage and intervene accordingly

Discussion

- PLEASE TURN ON YOUR CAMERAS
- What kind of housing and homelessness histories are you seeing?
- Do the Veterans you work with have experience as leaseholders before?
- Are the Veterans you are working with happy in their housing and motivated to maintain it?
- How is housing success connected to people's personal goals?

Focused Service Planning

Limit the areas of intervention – no more than 3 goals

Focus on the most pressing needs that impact housing

Relate all interventions to long term goals

Be aware this may not be a linear process

Be mindful about moving from crisis

Focus Areas for Service Plan

Focus on greater Self Sufficiency

- Goals setting by Veteran in partnership with the worker
- Connection to high quality sustainable services and supports
- Shared-Decision Making (SDM) model and Harm Reduction approach
- Use success on service plan goals to build confidence for making other changes

Focus on Long-Term Stability

- Use Veteran's goals and housing stability focus
- Help assume role and meet expectations of tenancy and community
- Teach rather than do

Strong Expectation that Person becomes Integral Part of Community

- Work on structure purpose and activity
- Transition and recovery of valued life roles

Components of the CTI Plan - Goals

- Goals set as a team of client and worker
- “So that” principle
- Focus on the issues that affect stability in the community – base on the current crisis and previous episodes of homelessness/ housing instability
- Immediate and longer-term goals clear
  - Focus by phase
  - Use the plan for the intervention

- Steps to reach goal clearly defined and measurable
- Longer term needs require connections to other resources.

Components of the CTI Plan - Roles

Participant and Worker Role

- Designs plans for two-month intervals
- Reflects areas of the assessment
- Prioritizes areas for work
- Sets time frames for work to be accomplished

Components of the CTI Plan - Resources

Resource Identification

- Clearly defines resources needed to access and/or maintain stability including:
- **Income**, credit repair, legal services, employment assistance/support, financial planning and management, access to medical services, educational support, natural supports, community based treatment services such a mental health, substance abuse, socialization and recreation etc.

Evaluating the Plan

Measure Success

- Use documented steps to reach goal and benchmarks set
- Use service plan as an opportunity for succss
- Uses phases to gauge expectations and progress
- Identify need to renegotiate goals and resources
- Reframe setbacks as learning opportunities

Goals Discussion

- PLEASE TURN ON YOUR CAMERAS
- Share examples of goals Veterans are setting.
- What are the reasons behind these goals? "So that" what?
- In other words, I want to ……. so that …….

Engagement Tips

Developing Relationships

- The first step is to engage and establish a working relationship
- Key to this is to identify what each person wants and tune into what they are feeling
- Once even small goals are established, engagement and the work begins
- As people achieve small things, confidence and trust grows and they can take on bigger things
- Building motivation for a home and connecting it to the person's goals is the worker's focus during engagement

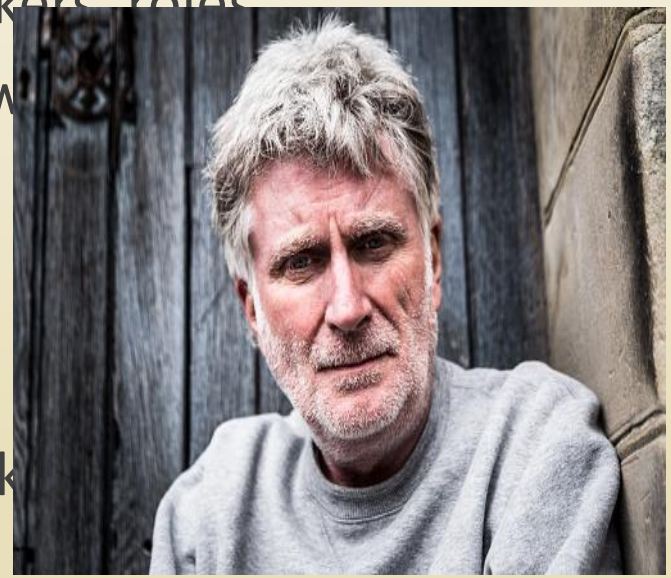
Hand Off to Program

‘Warm’ handoffs are recommended and a standard CTI practice

Each person will know their rights and responsibilities for housing

Each will know the expectations of each service and workers’ roles

- What can persons expect from the first worker – how w
  follow up be handled?
- Teams can set up weekly meetings to discuss new
  persons and persons transferring between programs.
- Ensure all information is communicated
- Be available to meet with the person and the new work
- Agreement to a series of visits
- Agreement to consult when needed

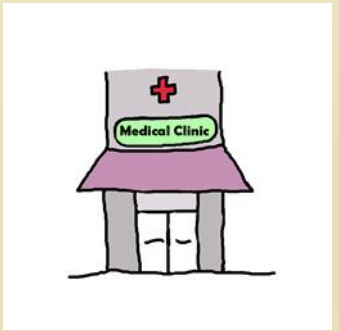


Focus on Resources

In order to fully integrate in the community, each person needs a range of services and supports

CTI helps each person or family to connect with and begin to manage each support as a full partner

Connections to resources is core to CTI practice

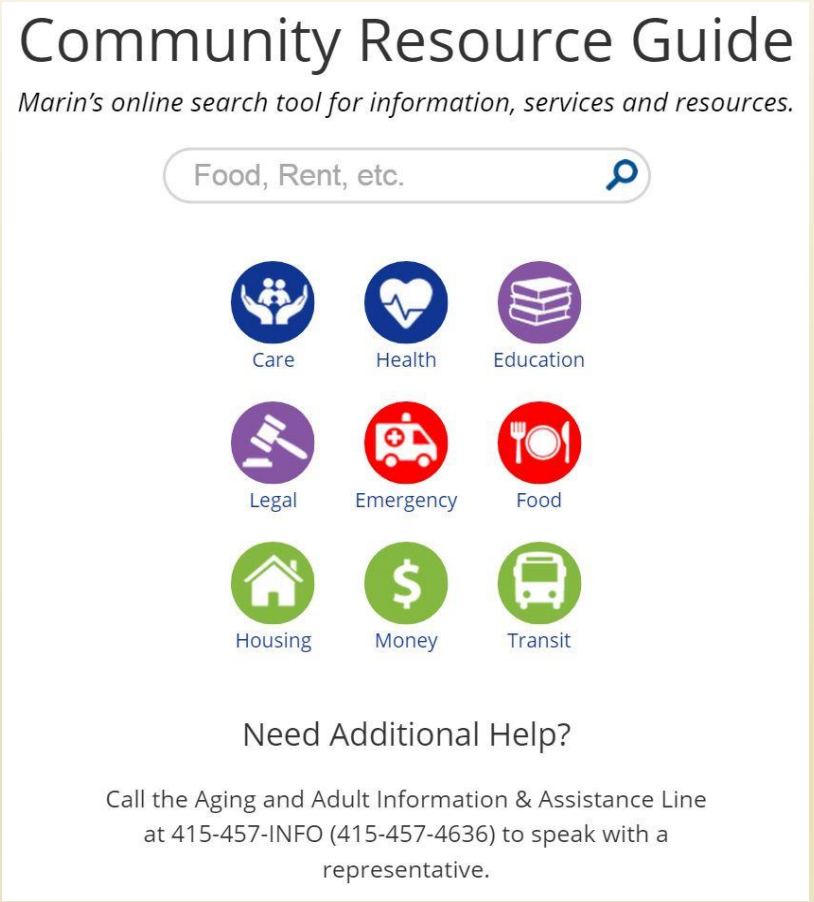


Community Resources

- Develop a person focused resource list
- See: RESOURCE GUIDE HANDOUT
- Identify resources by CTI focus areas tasks
  - Emergency Resources and contacts, Housing, Financial, Employment, Education, Medical, Mental Health, Substance Use, Recreation and Socialization
- Review resources in current use
- Add resources developed through work with other consumers
- Identify needed connections
- Formal and informal (natural) supports

Using the Resource Guide

- May take multiple conversations
- Will and should be built over time and throughout the phases
- Standard domains prompts conversations about resources person may not have considered
- Shows areas of strong support as well as gaps
- Opportunity for evaluative conversation about usefulness of resources



Links to Resources

- Ensure knowledge of them – directory, visits to programs, ask users of the service for feedback, know goals of the service and what they provide
- Introduce yourself and your service, especially if there will be a lot of referrals and identify how you can help them meet their goals
- Explain your role and what they can expect
- Gather and share history (with consent) and attempt coordinated planning
- Accompany person to assist with engagement with new service
- Maintain regular contact to see how things are going
- Keep your promises

Closing

- CTI and GPD Case Management are focused on the transition to housing
  - Longer term goals require connections to sustainable resources
- Focus is on establishing and maintaining a base in the community
  - Attention to immediate needs that affect housing retention
  - Assist people to increase income
- Assess barriers and strengths to maintaining housing

  Get info from previous workers and Veteran

  Transfer engagement
- Work the plan

  Use the plan to create structure and expectation
- Establish a resource list

  Ensure resources are sustainable and committed
- PLEASE TURN ON YOUR CAMERAS TO WAVE GOOD BYE. See you next week!

Citations

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Kasprow, W. J., & Rosenheck, R. A. (2007). Outcomes of critical time intervention case management of homeless veterans after psychiatric hospitalization. Psychiatric Services, 58(7), 929-935.

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

Resources for CTI

- Center for the Advancement of CTI: www.criticaltime.org
- CTI Global Network: http://sssw.hunter.cuny.edu/cti/global-network/join/
- CTI Implementation Manual: http://sssw.hunter.cuny.edu/cti/wp-content/uploads/2014/05/CTI-Manual.pdf
- Facebook : Critical Time Intervention (CTI) Global Network