Critical Time Intervention Advanced

Houston, Texas
June, 2014

HOUSING INNOVATIONS

Agenda

Background

Practices
- Housing First
- CTI
- Fidelity

How to CTI
- Structure
- Phases

Common Challenges

Discussion and Evaluations

Background

Goal to End Chronic Homelessness by 2016 and Veteran Homelessness by 2015

- Requires Best Use of all Homeless and Mainstream Resources

Housing First System

- Oriented to access to permanent housing as quickly as possible
  - Diversion, Market Rate, Rapid Re-Housing, Affordable Housing, Permanent Supportive Housing
  - No System Barriers to Housing Access
    - Plan for Sustainability including wrap around services

Background

Prioritize the families and individuals most in need of resources

- Reserving the most intensive housing and services resources for those most in need
- Use data to determine barriers to housing access and sustainability

Coordinate Resources

- Assessment, Eligibility, Priorities, and Referral
- What housing /service assistance best works for each household and quickly ends their homelessness permanently?
- Identify resources for Housing Access and Sustainability
- Match to Housing and Services

Practices

Housing First:

- System and Practice Approach
- Immediate access to housing with supports provided in the Housing for high need populations
- Can be ACT Model (Intensive Interdisciplinary Treatment Team)
- Can be Case Management Team (Team provides services and supports)

CTI:

- Transition focused practice
- Team or Individual CMs providing intensive time limited services and supports
- Transitional services and supports can be layered on other practices such as Housing First and PSH

Housing First

Housing First is an approach that centers on providing homeless people with housing quickly and *then* providing services as needed.

- Housing is not contingent on compliance with services – instead, participants must comply with a standard lease agreement and are provided with the services and supports that are necessary to help them follow the lease and maintain their housing
  - The lease provides the structure for housing stabilization
- Services are then wrapped around the individual to promote housing stability and well-being

Housing First Principles and Structure

- Choice/Affordability of Housing
- Housing is Integrated into the Community
- Separation of Housing and Treatment
- Service Philosophy and Service Array
  - Low Demand Approach (not no demand)
  - Access to Treatment Resources
  - Recovery Principles
- Team Structure, Supervision and Resources

CTI: Critical Time Intervention

Assists individuals and families to stabilize in housing by:

- Strengthening people's ties to community services, family, and friends
- The provision of a focused case management approach that is
- Connected to each participant's life goals.

- Time-limited (6-9 months)
- Three 3-month phases of *decreasing intensity* (transition to the community, try out, termination)-starts when moving into housing
- "Manualized" Intervention with Focused services (1-3 areas from 6 assessment areas) based on threat to long-term housing stability and access to support (mental health, housing, substance misuse, life skills, financial, and family and other social supports)

CTI Structure and Fidelity

- Focused on the transition point
- Time limited (usually 9 months)
- Designed for people/families with complicated clinical conditions
- Requires access to strong clinical resources for consultation and to provide access to treatment
- CTI is home and community based
- Dependent on each case manager to have adequate time and resources to accomplish tasks / first phase is most intensive
- Access and sustainability of resources for services and supports is critical
- Lease and landlord/property manager provide the expectations and structure
- Goal /Recovery based intervention / not crisis or problem based

Critical Time Intervention

IMPLEMENTATION

CTI: Critical Time Intervention

- Focused on Housing Retention and Life Goals
- Time-limited (6-9 months)
- Three 3-month phases of decreasing intensity that begin when the person is housed
  1. Transition to the community
  2. Try out
  3. Termination or transition to lower level of service

CTI

Focused Services

- 1-3 areas from 6 service areas
- Based on threat to long-term housing stability
  - Rent payment
  - Following rules re visitors, noise etc
  - Keeping unit healthy and safe
  - Only allowing those on lease to live there
  - Other lease requirements

AND

- Access to care and supports
  - Lots of focus on linkages and making them work
  - Think about natural supports

CTI

Areas of Focus for Assessment and Planning

1. Housing stability barriers
2. Income and financial literacy
3. Life skills
4. Family, friends and other supports
5. Psychiatric and substance abuse issues
6. Health and medical issues

Pre-CTI

- Housing Selection and Planning

Fidelity

CTI Fidelity Scale

Components

- Phases – worker steps back every 3 months
- Focused service plans – only 1-3 goals
- Engage, Outreach and Link Early – Pre CTI
- Contact with Links – accompany to appts, ensure link sticks, meet with links, maintain communications
- Time Limited – 7-9 months but may vary with population
- Families and youth may require additional time

CTI Fidelity (cont)

- Structure and Context
  - Caseload size – between 16 – 18 individuals per worker, varies by stage
  - Caseload size - Families between 12-14 families. Work very intensive in early phases
  - Team Meetings – weekly
  - Case Review – weekly by supervisory staff
  - Organizational Support – hiring and safety protocols and resources to assist clients

  - Fidelity scale

CTI Fidelity (cont)

Quality and Competencies

- Staff Role with Client –
  - Provides direct service as needed, works on ADL skills, probes about threats to housing, fosters autonomy while remaining available, use Motivational Interviewing
- Staff Role in Community –
  - Meets with clients and linkages, educates linkages about CTI, maintains communication
- Initial Assessment –
  - Focus on strengths and barriers in terms of community living skills and support network
- Phased Service Planning –
  - Based on client history, revised with community linkages

CTI Fidelity (cont)

Quality and Competencies (cont)

- Progress notes –
  - Content related to previous notes, specifies next steps
- Case Closing –
  - Final transfer of care meeting, identifies issues related to long-term housing stability
- Clinical Supervision –
  - Presentations of new, ending and particularly difficult cases
- Fieldwork coordination –
  - Ensures safety in the field, supervisor to model for new staff, monitors movement through phases by dates

Measures of Success

- Maintaining housing
- Increase income
- Network of supports
- Less emergency interventions: ER visits, hospitalization, incarceration, removal of children
- Structure and purpose in each persons life

Phases of CTI

Key Ingredients for Housing Access

- Orientation to the promise that everyone will access housing
- Information on all housing options including: eligibility, required documents, timeline and expectations for each option
- A predictable process to access housing
- Access to immediate services: a safe place to stay, critical treatment services, money to gather needed documents and/or meet immediate needs and time to develop a relationship
- A good sense of how each person structures their days and role
- Assistance to increase income

Goals for Pre-CTI

- Move into housing
- Plan is in place to maintain housing and role of CTI worker defined
- Person has at least two services and at least one support identified in the community
  - Appointment or plan is in place to meet with resources
  - Release of information complete
- Had meeting with landlord/managing agent and on-site team if applicable

Case Examples

Jack is sleeping on the streets. He is working with the outreach team. He usually is with a group of other guys. They seem to drink together, talk and protect each other; though sometimes they fight. Jack is not really interested when you approach him. He directs you to others nearby. He says they really need some help. He says he has lost more housing than you know; he is not going to do it again.

Debby has been living in a shelter for 3 months, before that she lived on the street. She has MH services but her attendance is irregular. She is not taking her medication and often hollers at night. She just want someplace safe. She wants a place to keep her stuff. She says she will go to the clinic and take all medication if she just gets housing.

Phase I: Transition to the Community

Assessment of new needs and resources

- Review assessment and revise based on current housing and lease compliance. Identify resources needed. Focus on community support, role and activity

Housing Planning revision

- Review plan and revise based on priority area, immediate needs and current resources.

Assistance in making linkages: meeting with the person and the resource if necessary

- Refine communication structures with landlord, services and other supports

Skill building for community resources

- Provide education about rights, responsibilities, and expectations; model negotiation skills

Housing Plan / Transition to the next phase

Key Ingredients for Housing Retention

- Landlords and property managers to establish tenancy obligations and enforce them. Set up communication structure.
- Focus on eviction prevention and use the structure of the lease to guide your interventions
- Provide services in the home and the community
- Ongoing assessments of housing barriers to prevent housing loss
- Connect with other mainstream and community-based services – benefits, services and treatment resources
- Connect with natural supports including spiritual
- Assist each person to develop structure and purpose in their lives

Key Ingredients

Focus on eviction prevention and use the structure of the lease to guide your interventions

Work with landlords and building managers

- Need Assertive approach
- Hold person to lease obligations
- Coordinate interventions
- May accept services if threatens housing

Changing Expectations

- Moving from crisis to planning
  - May be from immediate to 15 minutes from now
- Critical thinking
  - Using strategies and resources that work best for each person
- Structure and purpose
  - Developing a structure and purpose to days that are different from when homeless
- Developing new or changed roles
  - From homeless person to tenant, parent, worker, advocate

Goals for Phase One

- Less crisis
- Person has something to do during the day
- Connections in the community in place
  - Good communication with services, supports, housing
  - Person able to access the supports set up independently
  - Residents actively engaged in evaluating services, supports and housing
- At least half of support and services are happening in the community
- Crisis has decreased
- Supports are identified to address housing issues: rent, maintaining apartment and getting along with neighbors

Case Examples

June has recently moved into housing. You have helped her to set up her unit and met with her and the landlord. You have had regular contact with her when she was seeking housing. You visit June and she is not interested. She has her housing and would like to be left alone. The landlord lets you know he rarely sees her.

Bill has been in housing for 2 months. The landlord reports he Has not paid rent. Bill has complained to you and his worker at the clinic that he has been robbed. He says that people were waiting for him right at the bank. The outreach worker lets you know that he has complained of this before. With Bill it is always something.

Phase II: Practicing Phase

Solidifying Linkages to Community Resources

- This might include: legal assistance, schools for children, religious/spiritual, community treatment and support options

Promote independent living skills

- Ensure income in place, financial management, tenancy obligations, schedule and role

Ensure communication support systems

Regular meetings/communication to monitor progress and connections

Developing longer term plan

- Look at non-immediate needs such as education planning, career goals, long term housing plans

Key Elements

Focus on Recovery (as defined by participant)

- Goal Setting
- Connection to high quality sustainable services and supports and
- Empowerment

Focus on Long-Term Stability

- Use lease to structure the work
- Role and Expectations
- Not symptom or crisis based services
- Goal includes sustainability as opposed to acute interventions

Strong Expectation that Person becomes Integral Part of Community

- Considers purpose and activity as part of life in housing
- Role and life transition from “homeless” to “housed”

Goals for Phase Two

- Crisis stabilized and person has a plan for immediate needs
- Plan in place and resources to address barriers to housing retention as they come up
- Person gets at least 75% of direct services from community (can be on-site team, ICM etc) services and supports
- Regular communication with resources

Case Example

Judy had been doing really well in housing. Her rent is paid and her apartment a model. She goes to appointments and is very connected with her church. She has been drinking less. She has also recently reconnected with her children who were raised by her sister. Suddenly she is out of money. Her drinking seems to be increasing and she has missed her last clinic appointment.

Troy has struggled in housing. He had trouble with the rent and now has a rep payee. He is still often out of money by the middle of the month. Now it is by the second day. The landlord reports he has been having women in and out. When you see him, he tells you of his big plans. He is selling access to power and will no longer need SSI. His speech is pressured.

Phase III Step Down/Termination

Fine Tuning Linkages

Higher Level Skills training

- Focus on Negotiating Skills

Plan to address housing risks as they arise

Step down and let go- having other linkages take primary role

- Ensure needs are met, develop adjust linkages if needed
- Assess worker role going forward
- Develop formal plan with household and Linkages

Closing or Step Down

Final Meeting to document progress and plan for the future

- All sustainable services and supports should be included with the tenant
- Next Steps together be determined
- CTI workers continuing role, if any

Closing note

- Summarize Progress
- Document final/transition meeting
- Documents tenants feed back on CTI
- Documents strengths and challenges moving forward
- Next Steps

Goals for Phase Three

- Tenant has sound services in the community and initiates contact
- Tenant has at least 2 supports in the community and initiates contact
- Crisis has decreased and a plan is in place
- Tenant has identified more long term goals
- Tenant will step down or transition services

Case Examples

Anita has done well in housing with a couple of set backs. She has good connections for both services and supports. She has been in housing for 7 months. She has not been around for your home visits the last two times. She does call and say she is just too busy

Perry has also done well in housing with quite a few set backs. Crisis has decreased and services and supports are in place. The landlord is great with him and values him a tenant. However in the last month he seems to be in constant crisis. He has been in the ER twice, got arrested for loitering, and asked to pay half his rent. You think you might have to extend his time.

Common Challenges

Crisis

- Frontloading the most intensive services will decrease crisis
- Crisis can interrupt all working on goals identified and creates de-stabilization
- It could be a family crisis, financial, housing, psychiatric and many others
- Prepping for crisis and de-briefing after a crisis gives each person a chance to better manage their lives.
- Rewarding Planning behavior is key

Teaching Crisis Management Techniques

Most of the people we work with have spent their lives with scarce resources sand frequent crisis

Social Services often requires crisis to get assistance

Crisis is de-stabilizing

Teaching crisis management is key

Structure Purpose and Role

- Being homeless is busy: the days are filled
- Applying for Housing is busy with specific tasks and roles
- As people transition to housing the roles and structure can be lost
- They may have no idea what to do with the case manager
- The lack of structure can lead to behaviors that prevent stabilization

Structure and Purpose

- Important to clearly define all roles: landlord, case manager, tenant
- Ask what the person does in a day (homeless, applying for housing, in housing)
- What is does each person like to do
- Is this connected to the challenges in housing?
- Structure, purpose and role are connected to recovery and full community integration

Housing Link

Key Roles –

Landlord and Service Provider

Landlord has a key role in helping people understand their obligations and comply with them. (Assertive approach)

- Establish the **expectations** for the tenant

The social services staff provide and arrange for services needed to maintain housing and also function as advocates for the tenant.

- Assist the tenant to meet the **expectations of tenancy**

FAQs

- What happens if the landlord does not enforce the lease?
- The lease and the subsidy agreement remain contracts that each tenant agrees to. Not every rule is enforced consistently (like traffic rules) but they are enforceable and the result can be serious.
- The tenancy is linked to further goals such as a bigger apartment or a unit in a different neighborhood.
- If the unit provides a risk to health and safety:
  - Work with tenant and landlord to resolve
  - Does this behavior require hospitalization?
  - Adult Protective Services?
  - PHA involvement?
  - Buildings Department?
  - Eviction Proceeding?
  - Move to Project based?

Eviction Prevention

Eviction Prevention

Educating everyone on rights and responsibilities of tenancy

Regular communication with the landlord to catch any lease violations early

Agreement with the tenant and landlord about working together

Resources to address lease violations (back rent, clean up)

Knowledge of timelines for the eviction process

Policies on involvement

Eviction/Crisis planning to avoid eviction

FAQs: Moving to avoid eviction?

Will you be able to use the eviction process to address issues that interfere with tenancy?

- Look at agreements with tenant and landlord
- Look at court stipulations

To advocate for this option with a PHA:

- Look at issues that posed a threat to **tenancy**
- Develop a plan to address these issues
- Offer alternatives that may address these issues
  - Single Site vs Scatter Site
  - Neighborhood option
  - More assertive landlord

Changing Expectations

Full rights and responsibilities of tenancy

- Using structure of the lease to set expectations

Moving from crisis to planning

- May be from immediate to 15 minutes from now

Critical Thinking

- Using strategies and resources that work best for each person

Structure and purpose

- Developing a structure and purpose to days that are different from when homeless

Developing new or changed roles

- From homeless person to tenant, parent, worker, advocate

Resources

Resources

Resources will assist each person to sustain housing

The role of the case managers is not only access and sustainability but also communication with resources

Common challenge is getting the resources to do what they commit to and communicate

Systems may not have a CTI, HF or even Housing focus

Challenge is often also to teach each person to manage the services

Using Resources

Identifying sustainable resources with clear expectations

- Housing: landlord/property managers
- Financial: benefits and employment providers
- Health/Mental Health: treatment and support
- Substance Use: treatment and support
- Family and Relationships: support structure
- Life Skills: services for assistance/support

Building Skills

- Educating on rights and responsibilities
- **Modeling** for people to negotiate for services and enlisting the service's/support's help
- Trying it out and debrief
- Establishing regular check ins to see if it is working
- Review cost and benefits – **critical thinking**
- **Recognizing** strong partners and good skills
- Renegotiate the relationship as necessary
- Focus on longer term planning (non crisis based)

Support for the Practice

Use of Clinical Consultation

- People are presenting with complicated clinical pictures
- Often issues and behaviors emerge over time
- Having strong clinical expertise in the areas of: health, mental health and substance use, as part of the team is important to the practice
- Case conferences and clinical consultations with the tenants is a resource for the teams.
- Interdisciplinary teams allow case load distribution based on specialty skills and provide consults and modeling.

Support for the Practice: Supervision

Supervision:

- At least: weekly individual supervision, weekly team meetings with case conferencing

Case Conferencing:

- Highlight best practices, identifies themes around barriers, highlights resources, provides clinical consultation

Team Meetings:

- Team meetings have an informational, monitoring and support function, track where people are in the transition to and identify common barriers, share information and resources amongst team members, alert team to people in distress or crisis, identify best practices

Training

Remediation

The practice involves matching cognitive deficits with skill based computer training.

The practice also offers practical techniques to assist people to compensate for gaps and accomplish their goals

https://www.omh.ny.gov/omhweb/cogdys_manual/CogDysHndbk.pdf

http://journals.psychiatryonline.org/article.aspx?articleid=180705

Cognitive Remediation

Is an evidence based practice developed by Alice Medalia in NYC. The practice focuses on the remediation of cognitive functioning , specifically executive functioning

- Focusing skills
- Task Sequencing
- Task Prioritization
- Organizational skills
- Taking Verbal Directions

Additional Reading

Susser, E., Valencia, E., Conover, S., Felix, A., Tsai, W., & Wyatt, R. (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.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380803/pdf/amjph00501-0114.pdf

Herman, D., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., Susser, E. (2011). A randomized trial of critical time intervention in persons with severe mental illness following institutional discharge. *Psychiatric Services*. Jul;62(7):713-9.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3132151/

Permanent Supportive Housing Toolkit

http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510

Developing the Support in Supportive Housing

Http://www.csh.org/wp-content/uploads/2011/12/Tool_DevelopingSupport_Guide.pdf

CHHPS Study: http://www.vpi.org/files/ABendixen.pdf

Tenants Rights: http://www.houstontenants.org/TenantsRightsPamphlet2012.pdf

Discussion

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