

# Critical Time Intervention

Sponsored by the Sisters of Charity Foundation,  
Cuyahoga County Office of Homeless Services, MHS  
and Saint Luke's Foundation  
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# Agenda

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- ▶ Overview of CTI and Supporting Practices
- ▶ Pre-CTI Planning Stage
- ▶ Assessment
- ▶ Goal Setting
- ▶ Developing the CTI Plan
- ▶ Interventions by Phase
- ▶ Transitioning Services
- ▶ Wrap -up





# Overview

# Intro: A step toward transformative change

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Re-orientes planning efforts – away from managing homelessness to ending and solving it for homeless people. Focused on helping people and their families access and maintain housing.

Collaboration with systems, resources and expertise to reach the goal of ending homelessness for people.

Process is data-driven and oriented toward achieving 100% reduction in homelessness amongst people

Initiative prioritizes people who are chronically homeless

Housing focused customized services emphasizing evidence based practices that have demonstrated effectiveness

- Critical Time Intervention
- Motivational Interviewing and Stages of Change
- Rapid Re-housing for Individuals and Families
- Suicide Prevention
- SOAR

# CTI: Critical Time Intervention

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Assists people to stabilize in housing by strengthening each individual's long-term ties to community services, family, and friends through the provision of a focused case management approach 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 and termination or lower level of service)*
- ▶ Focused services (1-3 areas from 6 treatment areas) based on threat to long-term housing stability and access to care and support (psychiatric treatment, housing, substance abuse treatment, life skills training, financial literacy, and family intervention)
- ▶ Connections to Mainstream Resources and Supports

<http://criticaltime.org/>

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# CTI is an Evidence Based Practice

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- CTI has been recognized an Evidence-Based Practice by both the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the President's New Freedom Commission on Mental Health
- <http://nrepp.samhsa.gov/index.htm>
- [www.criticaltime.org](http://www.criticaltime.org)
- CTI is based on the research of Columbia University's (Columbia Center for Homelessness Prevention Studies) work with the homeless individuals



# Core Elements: Housing Stabilization Support Services

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- ▶ **Assessment**
  - ▶ Goals
  - ▶ Understanding barriers to housing
- ▶ **Engagement on Common Goals**
- ▶ **Services:**
  - ▶ Using treatment as a link
  - ▶ Using CTI as a tool
- ▶ **Education**
  - ▶ Expectations of Tenancy and Housing Options
  - ▶ Available Resources for Support
- ▶ **Housing Stabilization Plan**
- ▶ **Linkages**
  - ▶ Community, Services, Treatment Resources
- ▶ **Evaluate progress**



# CTI Fidelity

- ▶ **Components**
  - ▶ Phases
  - ▶ Focused
  - ▶ Engage early
  - ▶ Outreach
  - ▶ Link Early
  - ▶ Contact with Links
  - ▶ Follow up
  - ▶ Time Limited

# Fidelity

- ▶ **Structure**
  - ▶ Caseload size
  - ▶ Team Meetings
  - ▶ Supervision
  - ▶ Case Review
  - ▶ Organizational Support

# Fidelity

- ▶ **Quality**
  - ▶ Role with Client
  - ▶ Role in Community
  - ▶ Initial Assessment
  - ▶ Phased Planning
  - ▶ Progress notes
  - ▶ Case Closing
  - ▶ Supervision
  - ▶ Fieldwork coordination

# CTI

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- ▶ Focused on housing stabilization with intensive services
- ▶ Transition to less intensive level of care at 6-9 months
- ▶ Focused on self sufficiency through goal setting, connection to high quality sustainable treatment and supports, and empowerment
- ▶ Goal focused instead of symptom or crisis based services
- ▶ Goal includes sustainability as opposed to acute interventions
- ▶ Strong expectation that each tenant becomes integral part of community
- ▶ Considers purpose and activity as part of life in housing



# Key Ingredients for Housing Stabilization

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- ▶ Landlords and property managers to establish tenancy obligations and enforce them
- ▶ Focus on eviction prevention and use the structure of the lease to guide your interventions
- ▶ Coordinate Property Management and Social Services interventions
- ▶ Use Evidence-Based Practices EBP's
  - ▶ Critical Time Intervention
  - ▶ Motivational Interviewing

# Key Ingredients for Housing Stabilization

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- ▶ 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 and services
- ▶ Connect with natural supports including spiritual

# Housing Stabilization Services: Measures of Success

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Maintaining housing

Increase/stabilization of income (earned and benefits)

Connections with services and supports to prevent becoming homeless again



# Building the Practice

# Focused Housing Stabilization Services Planning

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Limit the areas of intervention based on housing barriers assessment

Focus on the most pressing needs that impact housing

Relate all interventions to keeping housing + long term goals

Be aware this may not be a linear process

Be mindful about moving from crisis

# Focus Areas of Assessment

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1. Housing Stabilization and Lease Compliance
2. Income and Financial Management
3. Family & Other Relationships
4. Mental Health and Medical
5. Substance Use and Misuse
6. Life Skills
7. Strengths and Potential for Change – how has person managed in the past?

# Components of the Housing Plan - Tenants' Goals

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- ▶ A safe place to live
- ▶ Work
- ▶ Enough money to live on
- ▶ Friends
- ▶ Valued status and a role in the community – purpose and structure
- ▶ Move from crisis
- ▶ Community
- ▶ A chance for their children
- ▶ “Dignity of Risk”
- ▶ 5 Years from now?



# Goal Based Assessment Strategies

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Explore what each family's choice means

- ▶ History (i.e. housing, employment, safety)
- ▶ How this family became homeless: what worked what didn't
- ▶ **How each family has managed in the past**
- ▶ Preferences: what does the parent/family want
- ▶ Financial Issues
- ▶ Implications of disabilities or service needs and how this relates to goal
- ▶ Long term goals: how do they see their future?



# Components of the Housing Plan -- Goals

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- Goals set as a team of clients and worker
- **Focus on the issues that affect housing retention – base on what caused the current crisis and previous episodes of housing instability**
- Immediate and longer term goals clear
- The Plan determines your interventions
- Steps to reach goal clearly defined and measurable
- Longer term needs require connections to other resources.

# Expectations of Tenancy

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## Paying Rent

- Income
- Financial Management
- Subsidy Administration
- Logistics: check or money order, timeliness

## Maintaining Apartment

- Understanding and Meeting Cleanliness Standard
- Inspections
- Safety
- Managing Repairs

## Quiet Enjoyment

- Getting along with neighbors
- Visitors
- Following project rules and norms

## Occupancy

- Only people on the lease live there

# Using the Lease to Structure the Work- Rationale

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- ▶ One of the goals is for families to be stably housed and in order to do so, they need to learn how to manage their tenancy obligations.
- ▶ One of the keys to achieving this goal is the active coordination between property management and support services staff, while maintaining the functional separation of these two staffs.
- ▶ Having separation of functions helps tenants learn by being treated no differently from any other tenant by the property management. (Don't want to create alternate reality)
- ▶ Problems that threaten tenancy may motivate tenants to use services in order to keep their housing.



# Key Roles – Landlord and Service Provider

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- ▶ 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



# Coordinating Social Services with Landlords/Property Managers

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Provide written program information

Explain role of CM as resource

- Provide contact information
- Means to resolve issue so that tenant can remain in housing

Engage in proactive coordination/communication

- Check in on some regular basis, preferably meet regularly

There is some “natural” tension in the work

# Assertive Landlord/Property Management

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- ▶ Hold tenant to the obligations of the lease
- ▶ Respond to problems in a timely way
- ▶ Contact case manager early on when problems first arise
- ▶ Provide written notices to tenants of rule, lease violations or late rent payment
  - ▶ Ideally, cc the case manager
- ▶ Work with Case Manager to resolve barriers to maintaining unit.

# Resources to Support the Process

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- ▶ **Landlord/tenant mediation services**
  - ▶ Funded as homelessness prevention
  - ▶ Education for case managers as to legal requirements/process
- ▶ **Use of the courts**
  - ▶ Stipulation process
- ▶ **Planning for emergency resources**
  - ▶ Rent and Utility payment
- ▶ **Housing plan to maintain tenancy**



# Managing a Collaboration

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- ▶ Agreement on project goals: Assisting Tenants to Maintain Housing
- ▶ Acknowledge that the services are transitional but also will identify on-going supports
- ▶ Each is oriented to each other's roles
- ▶ At least monthly communications focused on tenants compliance with lease
- ▶ Input and feedback from property management staff is sought and valued
- ▶ Support and acknowledge the landlord/property management role



# Sharing Information and Confidentiality

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There is often a great deal of confusion and frustration around what information can be shared and what information is confidential

## EXAMPLES

Public display of intoxicated behavior: Public Information

Tenant disclosing a mental health diagnosis or medical information: Confidential

Other CONFIDENTIAL information: Any information that is obtained in the context of professional services is deemed privileged information

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# Mainstream and Community Resources

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- ▶ Develop a individually focused resource list
- ▶ Identify Resources by Focus Areas and Tasks
- ▶ Review Resources in Current Use
- ▶ Add resources developed through work with tenants
- ▶ Identify Needed Connections
- ▶ Income, benefits AND services
- ▶ Using Client resource directories in each region

# Categories of Assistance

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- ▶ Benefits and Entitlements including Emergency Assistance
- ▶ Financial literacy and credit repair services
- ▶ Employment Programs
- ▶ Education and Job Training Programs
- ▶ Legal Services
- ▶ Food and Nutrition Programs
- ▶ Children's Services
- ▶ Clothing and Furniture Banks



## Categories of Assistance - 2

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- ▶ Health Clinics
- ▶ Dental Services
- ▶ Mental Health Services
- ▶ Substance Use Treatment Programs
- ▶ Counseling Services – Family, DV, Trauma
- ▶ Lists of AA and NA meetings
- ▶ Emergency Services – DV Hotline, Child Abuse and Neglect Reporting, Mobile Mental Health Services
- ▶ Social, Spiritual and Recreational Opportunities

# Other Community Resources

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- ▶ Public transportation
- ▶ Community centers
- ▶ Camps and employment programs for adolescents
- ▶ Libraries
- ▶ Civic associations
- ▶ Settlement houses
- ▶ Parks, recreational and sports facilities
- ▶ Places of worship
- ▶ Adult education, classes and workshops
- ▶ Tutoring and mentoring programs for children
- ▶ Arts organizations
- ▶ Clubs and hobby groups



# Links to Mainstream Resources

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- ▶ Ensure knowledge of them – directory, visits to programs, ask clients, goals and what they provide
- ▶ Introduce yourself and your agency, especially if there will be a lot of referrals
- ▶ Explain your role and what they can expect
- ▶ Attempt joint or coordinated service planning
- ▶ Gather and share history (with client's consent)
- ▶ Accompany person to assist with engagement with new service
- ▶ Maintain regular contact and keep your promises

# Working Effectively with Other Providers

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- Be Persistent, Patient And Reachable
- Provide information about the person that helps them to do their job
- Recognize Each Program Has Their Personal Service & Outcome Goals
- Ask About And Understand Expectations For Participants
- Be On Time For Appointments And Follow Up With Any Information They Require For Admission
- Understand How The Program Interacts With Your Client's Health Insurance, Entitlements, Patients Rights To Services, & Other Collaterals
- Assure The Provider Of Your Involvement

# Keeping Everyone in the Loop

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- ▶ Educating on the process
- ▶ Helping tenants to negotiate for services and enlisting the services help
- ▶ Establishing regular check ins
- ▶ Recognizing strong partners
- ▶ Renegotiating the relationship as necessary



# Stages of Change

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- Focused on their natural stages that people moved through as they made changes on their own
- Begins before a person has even made a decision to change a behavior
- Identifies which interventions will be most effective at each stage to help a person move forward in the process of change.
- Has been particularly effective at working with substance use disorders but can be applied to many different types of problem behaviors.
- Sees relapse to the problem behavior as a part of the process and normalizes setbacks.



# Motivational Interviewing

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- Building motivation for change is a key task of the Case Manager.
  - Motivational interviewing is a counseling technique – a way of being with people.
  - Motivational enhancement and interviewing techniques are used with the Stages of Change model.
  - Focused on seeking to understand the person's frame of reference
    - Expressing acceptance and affirmation
    - Eliciting and selectively reinforcing the client's own self motivational statements, expressions of problem recognition, concerns, desires, intention and ability to change
    - Monitoring the client's degree of readiness to change, and ensuring that resistance is not generated by jumping ahead of the client.
    - Affirming the client's freedom of choice and self-direction”
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- Rollnick and Miller. (1995).

# Housing First

- Rapid access to housing
- Low or no thresholds for acceptance
- Housing stabilization and improved well-being are the primary goals of services
- Services are focused on helping people meet lease obligations and changing the behaviors that are creating these problems
- Substance use is addressed through a harm reduction approach. In some Housing First programs, the ultimate goal is abstinence; in others it is not.
- 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 do so successfully



Pre-Move in

Planning Stage

# Workers role: Eligibility

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## ▶ Eligibility:

- ▶ Establish eligibility for different types of housing.
- ▶ Establish eligibility for the CTI Program.
  - ▶ The CTI EBP begins at move in
  - ▶ Pre-CTI was added to assist with placement and engage people into the program
  - ▶ Eligibility is determined by housing, diagnostic information and need/willingness to participate
  - ▶ Eligibility is also determined by time frame to access housing placement
    - Undocumented immigration will limit available options for housing, income, and services.
    - Recent felony histories may also limit housing choice, available subsidies and services.
    - Though CTI techniques may apply enrollment is determined by housing placement.



# Worker Role:

## Plan for Transition to Housing and CTI Services

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- ▶ Establish long term housing goal
- ▶ Discuss available options and positive and negatives of each
- ▶ Discuss rights and responsibilities of housing
- ▶ Assess each person's housing resources, skills and barriers to access and maintaining housing (address focus areas in context of housing)



# Planning Stage: Worker's Role

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- ▶ Negotiate options and supports (factoring in CTI workers role)
- ▶ Develop a plan to access with timeframes and worker/resident roles
- ▶ Assist individuals and families to gather the skills and needed supports to access housing
- ▶ Assist individuals and families to apply for housing and/or manage process



# Assessment Domains

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## ▶ Housing

- ▶ Housing History, Preferences, and Barriers
- ▶ Safety
- ▶ Legal

## ▶ Health and Mental Health

- ▶ Health and Dental
- ▶ Mental Health
- ▶ Trauma

## ▶ Financial

- ▶ Employment and Income
  - ▶ Education
  - ▶ Legal and Debts
- 



# Assessment Domains

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- ▶ Substance
- ▶ Life Skills
  - ▶ Record Keeping
  - ▶ Advocacy
- ▶ Family and other Relationships
  - ▶ Supports and roles
  - ▶ Spirituality
- ▶ Motivation for Change



## Case Example: Gwen

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- ▶ Gwen wants to know how she can get into this new housing. She is sick of not having a place of her own. She wants some place to keep her stuff, lots of it.
- ▶ You know Gwen has only general relief. You believe she has been on SSI but does not seem to be on it now. She collects cans to make ends meet.
- ▶ Gwen also drinks, how much you are not sure. She smells of alcohol but you have never seen her intoxicated. Gwen explains she needs the alcohol to deal with being homeless; when she gets housing she will stop.



# Janet and her children

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- ▶ Janet is referred to the program. She has three children and no place to go. She has left the children's father and is staying in a shelter. She wants help. She looks a little disorganized and the kids look blank. Her husband had been going after the children. She had to leave. She does not want her kids to be homeless. She wants you to fix it.



# CTI Housing Plan

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- ▶ Negotiating Goals
- ▶ Prioritizing the Areas of Focus
- ▶ Time Frames
- ▶ Defining Role of Worker and Tenant
- ▶ Identifying Resources



# Janet

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- ▶ Their marriage had been rocky for years
- ▶ He has been away in prison
- ▶ She lost her job while he was gone
- ▶ The bills have piled up and they might lose their house
- ▶ Both parents have been drinking more
- ▶ They get in physical arguments
- ▶ He has been going after the kids as well.
- ▶ He broke his son's arm
- ▶ The hospital involved child protective services
- ▶ Janet's sister took her to the shelter



# Pre-CTI Plan: Janet

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- ▶ Short Term: access emergency housing
- ▶ Long Term:
  - ▶ Access permanent housing
  - ▶ A better life for her children



# Pre-CTI Plan: Janet

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## ▶ **Housing:**

- ▶ Identify immediate options
  - ▶ Through: child protective services, HPRP, DV shelter, family shelter, legal services
- ▶ Identify preferences and what Janet's family might be eligible for and the requirements of each option
- ▶ Assess needed services and option to remain housed

## ▶ **Family:**

- ▶ Work with child protective services to assess and maintain the family
  - ▶ Access to legal assistance and family counseling
  - ▶ Support parent role
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# Pre-CTI Plan: Janet

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## ▶ **Income:**

- ▶ Identify what family is eligible for
- ▶ Assist to apply for benefits.
- ▶ Address employment issues ongoing
- ▶ Confer with Legal Services about child support issues

## ▶ **Safety:**

- ▶ Work with child protective Services to determine risk to children
  - ▶ Develop a Safety Plan
  - ▶ Work with legal services and Family counselor to develop options
- 



# Pre-CTI Plan: Gwen

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- ▶ Short Term: Access housing
- ▶ Long Term: a better life



# Pre-CTI Plan: Gwen

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## ▶ Housing:

- ▶ Determine eligibility and preferences
  - ▶ Complete application materials
- ▶ Detail expectations of tenancy and plan to meet them for each option
  - ▶ Agree to begin to sort possessions

## ▶ Financial:

- ▶ Address financial barrier to housing
  - ▶ Work on securing income beyond general relief
  - ▶ Develop budget for needs in housing

## ▶ Substance

- ▶ Discuss the effects of use on housing, symptoms and goals
  - ▶ Support plan Gwen has to stop drinking
  - ▶ Consult psychiatrist for assessment

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## ▶ Housing Stabilization Plan

# CTI Phases

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## Phase I: Transition To The Community

- ▶ Engagement/Assessment with Tenant and Developing Linkages

## Phase 2: Try Out

- ▶ Developing Linkages to fill gaps in Services/Supports, Negotiating, Mediating

## Phase 3: Transfer Of Care

- ▶ Terminating or planning for less intensive services
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# Phase 1: Transition to the Community

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- ▶ Re-Engages Tenant and Re-Negotiates Role
  - ▶ Defines role, acclimates to new surroundings
  - ▶ Assists to set up unit, familiarizes with building and neighborhood
  - ▶ Spends time with the resident in new place.



# Phase 1: Transition to the Community

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- ▶ Refines Housing Plan Based On Some Of Six Focus Areas and barriers to Housing Retention:
  - ▶ Includes short and longer term goals
  - ▶ Establishes role, responsibilities and time frame
  - ▶ Defines use of support and needed services
  - ▶ Crisis prevention planning



# Phase 1: Transition to the Community

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- ▶ Most intensive period for CTI
- ▶ Meet With Community Caregivers and Supports:
  - ▶ Set up a system with property management and team to monitor tenancy.
  - ▶ Accompany and advocate for access to services
  - ▶ Encourage partner and community supports
  - ▶ Define roles across CM services with the tenant:



# Phase 1: Transition to the Community

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- ▶ **Assess Potential Long-term Supportive Systems & Provides Direct Service As Needed**
  - ▶ Assess with each tenant and providers what is working and not working. Explore continued eligibility.



# Gwen : assessment

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- ▶ **Housing:** She was able to complete all the requirements for move in with some assistance. Isolation is an issue. She does not have activity.
  - ▶ **Financial:** Gwen gets food stamps and a little money from relief. She has applied for SSI. She is interested in work but not moving on this. She needs more money
  - ▶ **Health and Mental Health:** Gwen sleeps during the day and you suspect she drinks at night. She seems depressed. She always reports being tired. You know she is diagnosed with bipolar disorder but do not know the cycle or if there is one.
  - ▶ **Substance:** Drinking at night. This is not interfering with housing at this point however it seems to be contributing to the depression and lack of activity.
  - ▶ **Life Skills:** No supports except workers, purpose and activity is not there.
  - ▶ **Family and others:** No social supports at this time
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# Gwen

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- ▶ Gwen has moved in and did well for the first month. She participated in some activities and met with her case manager reluctantly. She had seen the psychiatrist and got help with her SSI which is pending. She had been diagnosed with bi-polar disorder; Gwen says that is inaccurate. She will not consider medication. She believes her problems were connected to homelessness and will resolve now she is in housing. She has stopped going to activities as they are “dull”. She spends more time outside the building at night searching for things she can sell. She wants you to help her get a loan for her business. She feels she does not need SSI. She needs to work.
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# Gwen: Phase 1 plan

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- ▶ **Health and Mental Health:**
  - ▶ Talk to psychiatrist team and detail behavior
  - ▶ Talk to shelter staff for specifics on behavior in shelter
  - ▶ Encourage Gwen to see psychiatrist to address sleeping patterns
- ▶ **Financial**
  - ▶ Develop budget based on what Gwen needs to live on
  - ▶ Assist with SSI
    - Connect SSI with seeing psychiatrist
- ▶ **Life Skills**
  - ▶ Address expectations of tenancy
  - ▶ **Focus on purpose and activity**
    - ▶ **Identify one thing Gwen could do and enjoy in a week**



# Janet

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## Update:

- ▶ Janet stayed in a DV shelter with her children
  - ▶ She has had contact with her husband
  - ▶ Child protective services is investigating
  - ▶ The family is on TANF
  - ▶ Janet attended but hated the support groups
  - ▶ Her husband sold the house; she got nothing
  - ▶ She got an apartment far from her previous neighborhood and children's school
  - ▶ She sits at home
  - ▶ She got an order of protection
  - ▶ She thought it would be better
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# Phase 1CTI Plan: Janet

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- ▶ **Short Term: Maintain Housing**
- ▶ **Long Term: Home Ownership, a better life**
- ▶ **Housing:** Setting up the apartment, Familiarizing with the neighborhood, Planning transportation to church, school, family. Reviewing the lease. Connect with landlord. Talk about long term goal of homeownership and other options
- ▶ **Family:** Support Janet's role as a parent including assisting her to set up a school conferences and after school programs. Work with CPS to make a plan and set expectations. Involve AOD worker to help her to meet expectations. Involve Legal services with both parents to determine options. Offer support to family through counseling and support groups.
- ▶ **Income:** Go through the rights and responsibilities of TANF recipients. Including work requirement and Address employment issues ongoing.

## Phase 2: Try-out Phase

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***Fewer crisis, services and supports in place,  
focused on long term***

- ▶ **Adjusting The Systems Of Support**
    - ▶ Assessing for threats to housing stability and change in functioning
    - ▶ Identify gaps in systems of support and care
    - ▶ Negotiate with the tenant regarding what is working and not working, trying new supports
    - ▶ Establishing a plan to address barriers
    - ▶ Developing the CTI Phase 2 Plan based on focus areas and any barriers to housing retention.
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## Phase 2: Try-out Phase

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- ▶ **Monitoring The Effectiveness Of The Supports Set Up And Intervening When Trouble Comes Up**
  - ▶ Monitoring use of services and supports, consistently in touch with landlords.
  - ▶ Working with the supports and care providers
  - ▶ Assisting each woman to negotiate with supports and services



## Phase 2: Try-out Phase

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- ▶ Decrease intensity of direct services  
focusing on monitoring and negotiation  
with support and care
- ▶ Planning for Phase Out



# Janet: update

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- ▶ Janet is required to take parenting classes by CPS.
- ▶ Her drinking is an issue and may jeopardize her custody
  - ▶ She is talking to the AOD worker
- ▶ The children's father visits regularly and gives some money; he paid the light bill
  - ▶ Despite the CPS Supervision
- ▶ Janet saw the lawyer but has not pursued legal separation
- ▶ She wants everyone out of her life
- ▶ She does go to church and gets comfort there
- ▶ She likes the landlord and has been able to negotiate several repairs in the unit.



# Janet: Phase 2 Plan

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## ▶ Housing:

- ▶ Support Janet's working with the landlord
  - ▶ Regular contact with landlord
- ▶ Review rights and responsibilities of tenancy and bill paying

## ▶ Family:

- ▶ Look at requirements for CPS
  - ▶ Develop detailed plan with time frames to end supervision
  - ▶ Address substance issues in this context
- ▶ Develop options with Janet for relationship with husband
- ▶ Focus on children: develop a check in with Janet
  - ▶ School, behavior, activity, church



# Gwen

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- ▶ Gwen just got her SSI with a condition she be on rep-payee. She was not happy. She struggled in the last few months with keeping her unit in compliance with inspections. She accepted some medication to help her sleep. She has begun to talk with the psychiatrist about the highs and lows. She is angry to end up like this and resents not getting enough help. She complains about the other tenants in the housing and sees them as different from her. She wants out. She wants her business. She wants her life. Her drinking has increased.
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# Questions

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- ▶ How has Gwen's housing been affected?
- ▶ Discuss assessment domains and priority focus areas.
- ▶ What are your/ her concerns?
- ▶ How can the concerns be addressed and be connected to her goals?
- ▶ Consider the goals of getting off rep payee, getting a job and moving on.
  - ▶ How would these goals affect the plan?
  - ▶ How does the barriers assessment affect the plan?
- ▶ What would the plan look like?



## Phase 3: Transfer of Care (7-9 months)

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- ▶ **Fine Tuning Systems That Have Been Established**
  - ▶ Continued negotiation with supports, filling gaps and assisting the resident to negotiate
- ▶ **Finalizing Long-term Supports and CTI Worker Role**
- ▶ **Developing a CTI Plan for Phase 3**
- ▶ **Transferring Care (Includes An Official Meeting )**
  - ▶ This could be the transfer to less intensive services within DWC
  - ▶ The plan defines roles of the tenant, workers and supports going forward



# Janet: update

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- ▶ **Janet is working with CPS to address the issues**
  - ▶ Working with AOD specialist Janet has decreased her drinking
  - ▶ She talked to her PC doctor about sleeping
  - ▶ Janet's mother watches the children one weekend a month and she can enjoy herself
  - ▶ She and her husband have worked out a separation agreement
  - ▶ She receives child support
  - ▶ She has begun to work at the church



# Janet: Phase 3 Plan

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## ▶ **Housing:**

- ▶ Work with Janet to pay the rent and utilities
- ▶ Check in with landlord

## ▶ **Income:**

- ▶ Follow through with TANF
- ▶ Encourage the job at church and plan for next step

## ▶ **Family:**

- ▶ Move toward check in s with Janet, CPS and Lawyer to monitor progress
- ▶ Plan for Janet to access your support and when
- ▶ Check in on plan to monitor children's progress
- ▶ Support Joyce's role in the church and support it gives

## ▶ **Develop with Janet: a plan of support.**

- ▶ Detailing how she uses above support and how she uses worker in the future
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# Gwen

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- ▶ Gwen has the goal of ending rep payee, moving on and working. She has worked with the employment program to review her benefits and options for working. She has enlisted their help to develop a plan to get off rep-payee.
- ▶ The CTI worker has helped Gwen to develop a plan to move on which includes meeting the responsibilities of tenancy and securing a reference from PM.
- ▶ Gwen has accepted some help from the psychiatrist with mood stabilizers and is talking about her drinking.
- ▶ Gwen would prefer to work more closely with the worker at ATFGC. She has begun to volunteer there and assist with donations and the food pantry.



# Questions

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- ▶ What is the assessment
- ▶ What is the plan?
- ▶ What is the CTI workers role?
- ▶ What other services and supports are involved?
- ▶ How will they continue?



# CTI: essential elements

- ▶ Longitudinal: adapt to tenant's functioning over time
  - ▶ Individual: care and support is planned with the person and addresses particular needs
  - ▶ Comprehensive: person can receive a variety of services and supports related to their needs and goals
  - ▶ Flexible: tenants progress at their own pace
  - ▶ Accessible: people are able to access services and supports when they need them and in a way which is financially and psychologically manageable
  - ▶ Communication: between tenant and case manager and service / support providers and among service providers involved in the family's care
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- ▶

# CTI

- ▶ Transitional. This increases cost-effectiveness, maximizes number of individuals served and increases independence.
- ▶ Flexible: Services may be direct and assertive AND/OR maximize linkage to community resources.
- ▶ Recovery oriented: Services aim to increase autonomy, self-care, and recovery.
- ▶ Adaptable: CTI techniques can be used with a variety of different settings and populations

# Discussion

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Thanks!

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