Critical Time Intervention

CTBOS

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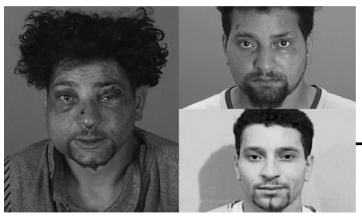
HOUSING INNOVATIONS



Recovery Goals

- Assist each consumer to achieve their recovery goals
- Find a safe place for each person to live
- Use time in a meaning-ful way
- Have healthy relation-ships
- Access public assistanc e when necessary
- Weather crises success-fully
- Have the best possible physical health

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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

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Transitions

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Core Components of CTI

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

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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

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Assessment and Planning Domains

CTI Assessment 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 reviews history, current, strengths, barriers and GOALS by domain

Assessments/service plans conducted monthly during Pre-CTI and updated during each phase

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Focused Service Planning

Housing Stabilization Plan

Limit the areas of intervention

Focus on the most pressing needs that impact stability

Relate all interventions to long term goals

Usually not a linear process

Help people move away from crisis-driven lives

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Focus Areas for Service Plan

Focus on Self Sufficiency
- Goal setting by person in partnership with the worker
- Connection to high quality sustainable services and supports
- Shared-Decision Making (SDM) model and Harm Reduction approach

Focus on Long-Term Stability
- Use person'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
- Considers purpose and activity
- Transition and recovery of valued life roles

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Case Management and CTI

"Case management makes continuity of care possible.
- Although definitions of case management vary widely, most would agree that it consists of some combination of:
  - Linking, which involves connecting clients to available resources, and
  - Direct clinical care

Case management focuses on treating the individual and his or her environment.

This occurs both through the clinical relationship, and through the case manager's intervening in the client's external world, in order to create a more responsive care environment (Swayze, 1990)"

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Case Management and CTI - 2

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

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Housing Perspective

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

Conditions of the lease must be made 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

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The Evidence and Resources for CTI

- Recognized an Evidence-Based Practice (EBP) by the Substance Abuse and Mental Heath Services Administration (SAMHSA): www.samhsa.gov
- Based on the original research at Columbia University on work with homeless single adults with serious mental illness
- Applied and researched in a variety of setting and with different populations
- 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

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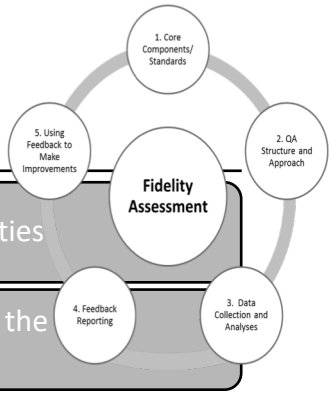
Fidelity to the CTI Model



Fidelity Scale provides guidance for program design and activities

Assess the level of consistency (fidelity) that a program has to the model as designed and researched

Full Fidelity Scale Review will be conducted by Housing Innovations (Goal:90%)

The "CTI Implementation Self-Assessment" is a tool that staff can use to assess the program's adherence to the model before and after Fidelity Reviews

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CTI Implementation Self-Assessment

- Tool to assess progress on implementing core practices
- Scored on scale of 1 to 5
- 30 domains
- Score is an average w/max 5
- Conduct post-implementation as check in
- Embedded Document:

PDF
CTI
ɜmentation Assess

Reviews the following Areas:

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

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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

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Structured Supports

Supervision:

- Weekly individual staff supervision meetings
- Caseload tracking though the phases (see handout)

Microsoft Word Document

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 and identify common barriers, share information and resources among team members, alert team to people in distress or crisis, identify best practices, review everyone at least briefly

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Clinical Consultation

- Specialized clinical consultation is essential
- Using resources from psychiatry, medical and substance use, trauma specialties within the clinic or in the community to provide these services
- Provide input into assessments and plans
- Can see tenants individually when another assessment is needed or may be their regular treatment provider
- Assist with coordination of care
- Provide connections with specialty services (such as inpatient programs, PTSD treatment)

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Workload Management

Case loads: Recommended caseloads for CTI Team is up to 1:18

CTI operates in teams: Time is needed to allow for at least weekly team meetings, for individual supervision and for clinical consultation

Most Intensive Times: Research shows that the most intensive period of service is the first 6 months. Planning for that period is key

Home Visits: CTI services are largely in the community and in the home. This can be time consuming for travel and is a shift for facility-based staff.

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Work Load Management

Think about who your CTI team would be

- Residential Services
- PRS
- DBH
- Outreach and Entry Programs

- How will you put together your Team?

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Oversight and Support

Team Leaders and supervisors need supervision and support in managing their responsibilities.

Data: in order to improve services, outcome data and planning to adjust services based on results – housing retention, increase in income

Identifying patterns of barriers and successes: highlight best practices, common barriers, patterns and challenges in implementation

Providing one on one supervision helps look at the practice critically, assess implementation and work on program planning

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Education and Training

In House Training:

- Done by supervisory familiar with any strengths and gaps in knowledge base
- Begins with an overview and fidelity discussion that reflects how CTI is being applied
- Provides targeted skills training

Training on EBPs

- Motivational Interviewing, Stages of Change, Wellness Self Management Person-Centered Planning, and Permanent Supportive Housing
- Housing training: Fair Housing, Tenants Rights, Eviction Proceedings

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Brokering Resources

The CTI team relies on a brokerage model. Developing supports, treatment, housing and services in the community to meet the needs of the participants

The Relationship with treatment providers (both community and within the clinic) is often negotiated on an agency basis with senior staff available to trouble shoot if there are problems and to support strong partners

MOU or agreements with community providers: Agreements to provide services in writing with clarity around commitments

Housing Connections and Negotiation is often done on a community level with a centralization of housing resources and landlord cultivation

The team is responsible for managing the services, identifying any patterns that are developing and teaching skills to participants to begin to manage connections themselves

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Resources

Resources: to communicate from the field (cell phones) and on call procedures

Resources: Providing minimal annual budget per participant to cover incidental costs of taking someone for lunch or coffee, minutes for phone, transportation

Resources: frequently used community resources often need to be negotiated at the program level

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Housing Stability

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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

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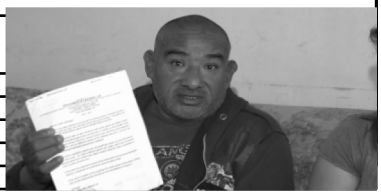
Obligations of a Lease/Tenancy

- Allow all residents to have quiet/peaceful enjoyment
- Not engage in criminal activity in unit, common area or grounds
- Keep unit free of health and safety hazards
- Dispose of garbage and waste appropriately
- Make required rental payment to landlord on time
- Keep utilities current and paid



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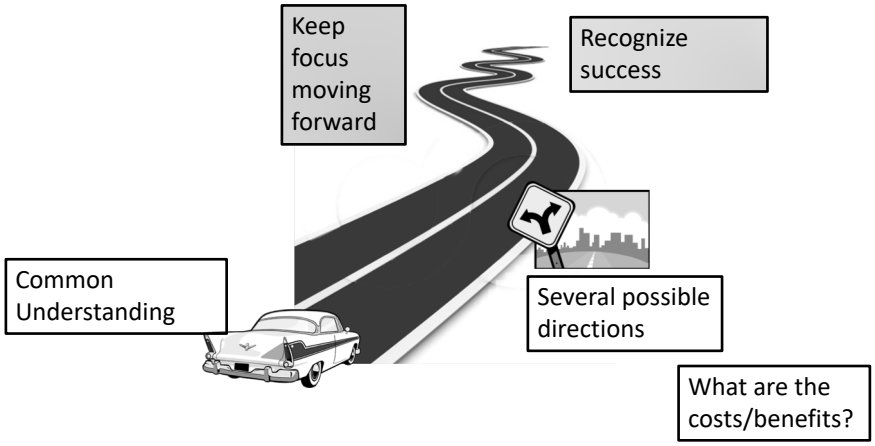
Motivating Change



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Motivation and Change

Behavior-specific (people have different motivations around different issues)

It is also person-specific (each person is motivated to change by unique factors)

Compliance does not equal change

- Change that occurs because of external pressure tends to be short lived
- More that someone "owns" (internalizes) the reasons for change, the more likely change will endure

Change is always hard and motivation gets you through it

Motivation fluctuates from one time and situation to another; not a fixed trait

Motivation can be influenced by outside influence; it does not reside solely in the person

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

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Assessment and Planning

HANDOUTS: ASSESSMENT DOMAINS, HOUSING STABILIZATION PLAN

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Assessment and Planning Domains

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- Health and medical issues

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

Assessments and service plans reflect the participant's goals

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Focused Service Planning

- Limit the areas of intervention
- Focus on the most pressing needs that impact community living
- Relate all interventions to long term goals
- Be aware this may not be a linear process
- Be mindful about moving from crisis

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Use Stages of Change

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

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Components of the CTI Plan - Goals

- Goals set as a team of client and worker
- Focus on the issues that affect stability in the community – base on the current crisis and previous episodes of homelessness/ community 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.

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Components of the CTI Plan - Roles

Participant and Worker Role

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

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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.

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Evaluating the Plan

Measure Success

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

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Phases of CTI and Worker Tasks

HANDOUT: TRANSITION THROUGH THE PHASES

Phases of CTI

Pre-CTI: Discharge, Housing and Community Planning

CTI Phase 1: Transition to the Community

CTI Phase 2: Try-out

CTI Phase 3: Termination /Step Down

Phases 1-3 last approximately 3 months each

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Tasks for Pre-CTI Planning

- Educate on Options and Expectations of Each
- Identify Goals and Preferences
- Assess Community Living History
- Assist to Connect to Benefits
- Gather Documents for the Application Process
- Connect to Resources that Support Housing Stabilization – Tx and Supports
- Develop a Stabilization Plan

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Engagement

Engagement begins the first time you meet a person

It begins wherever a person enters the system

Engagement is a way of being with a person, it sets the tone for all future interactions

We listen to each persons story, why they came to us, what their concerns are, what they want.

We evaluate each person, assessing what they tell us, where they live, how they interact with their surroundings

We seek information from HMIS and other providers that have had interactions with each person

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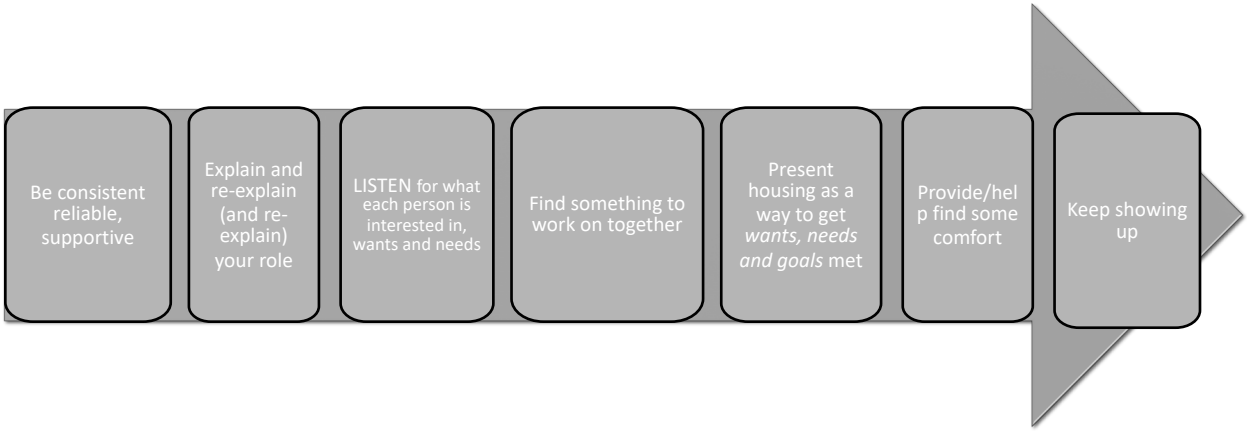
Engagement Tips



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Application to Outreach

- 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
- <u>Building motivation for a home and connecting it to the person's goals is the worker's focus during engagement</u>

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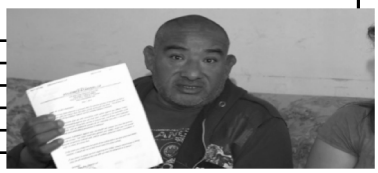
Obligations of a Lease/Tenancy

- Allow other tenants the peaceful enjoyment of homes
- Make required rent payment on time
- Keep unit free of health and safety hazards
- Only allow people on the lease to live there
- No criminal activity in unit, common areas or grounds
- Keep utilities current and paid



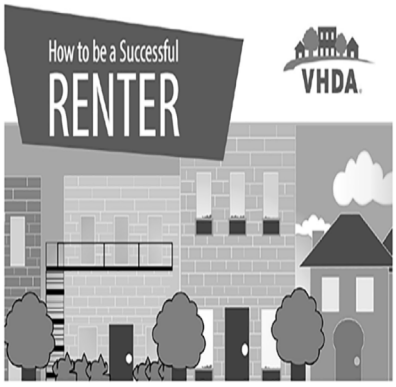
Resources for Tenancy Education

HUD Tenant Rights by State

- https://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/tenantrights

Rentwise: Renters Workbook and Organizer (University of Minnesota):

- https://marketplace.unl.edu/extension/rentwise-workbook-organizer.html



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Preparing Documents and Making Referrals

- Unable to start process without essential documents such as ID
- Assembling documents needed for housing applications can be time consuming
- Some people will require staff to accompany them to Social Security, Banking and Vital Records offices
- People may want to apply for benefits and/or get involved in job training to increase their income
- Some residents will want a connection to needed treatment resources
  - Often symptoms that make the person uncomfortable
- Connecting people to supports from peers, family and friends will also increase the motivation for housing and make people more comfortable once there

Understand Housing Needs and Preferences

Location
Access to Transportation
Proximity to Significant Others
Proximity to Services
Unit Size and Housing Density
Pets
Ideal v. Acceptable, Negotiable/Non-Negotiable

Attached: Housing Planning Discussion Framework

Housing Planning Framework

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Understanding Housing Preferences

Housing Planning Discussion Framework

Housing Features	STATUS *Where I am now*	IDEAL *What I would love – my dream*	NEGOTIABLE/NON *What I would accept*
Location/neighborhood			
Unit type – apartment, house, etc.			
Housing Program Type – PH, PSH, Board and Care, Shared etc.			
Access to transportation			
Proximity to significant others			
Proximity to services			
Services availability on site			
Elevator			
Cooking facilities			
Shared amenities – kitchen, bath, living space			
Pets			
Wheel chair accessibility			
Disposable income			
Meal service			
Other amenities – outdoor space, laundry on site, near shopping, common space etc.			
Reasonable adaptations/accommodations needed			

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Talk Housing

What will it take?

What are the options?

What are the requirements?

What are the rights?

What are the responsibilities?

How does it connect to what persons want?

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Hand Off to Housing

Each person will know their rights and responsibilities for Housing

Each will know the expectations of each service and workers role

- What can persons expect from the first worker – how will follow up be handled?
- Most teams set up at least weekly meetings to discuss new persons and persons transferring between programs.
- Ensuring all information is communicated
- Being available to meet with the person and the new worker
- Agreeing to a series of visits
- Agreeing to consult when needed

Staff Roles in the Pre-CTI Phase

- The Pre-CTI phase is often time consuming
- Each program will examine their resources and skills to see what can be accomplished.
- Tenancy courses are provided before housing so that persons may prepare, however the materials will be repeated after housing.
- Assembling documents happens once a resource has been identified
- Connections to resources and supports is often a shared task. Depending on the connection to the resource, person need, and preference
- Increasing income is a priority. Some programs recommend that persons are connected to benefits and employment resources in the first month of contact.
- All programs should review new persons to the homeless programs to ensure continuity, identification of needs and a path to the most effective program for each person

Discussions

Accomplishing Pre-CTI Tasks:

- Working in inter-program groups, review the list of Pre-CTI tasks, identify who is currently performing these tasks, what is not getting done, and what would be helpful to develop or implement in your program for the housing planning and preparation phase.

Phase One: Transition to the Community

Assistance in making linkages:

- Meeting with the person and the resources
- Refine communication structures with supports

Assessment of new needs and resources:

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

CTI planning revision

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

Skill building for community resources

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

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Phase One: Worker Role

- Accompany to housing, meet with housing provider and assist to set up apartment and acclimate t neighborhood
- Frequency of contact: at least weekly/more frequently based on need.
- Frequent contact with all services, supports and housing provider.
- Develop plan to access needed resources
  - Accompany to resources and teach skills
  - Define role of worker and participant
  - Ensure communication with each source of services and support
- Focus on purpose, role and activity

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Building Skills

- Educating on rights and responsibilities
- **Modeling** for each person/family to negotiate for services
- 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

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 outside the hospital

Developing new or changed life roles
- From patient to tenant, family member, student, worker, advocate, artist

Phase Two: 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
- Monitor progress and connections

Developing longer term plan
- Look at non-immediate needs such as education planning, career goals, long term plans for a "home"

Continue to use Motivation – Building techniques

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Phase Two: Worker Role

Frequency of contact: at least bi-weekly depending on consumer.

At least monthly with services, supports and housing provider.

- This is the beginning of the step down process and a shift towards resources

Revise plan to address changing needs and resources

- Focus on longer term supports and services

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Negotiate a Crisis Plan

A key element of CTI is moving away from crisis

We want each tenant to design their own plan for what works for them

Loosely based on a wrap plan

Crisis Planning Discussion

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Update:

Update the assessment:

- Recognize progress
- Redefine set backs
- Look at missing pieces in past assessment

Update plan

- Review what worked
- Discuss what didn't work
- Integrate the missing pieces
- Goals discussion (importance, priorities and resources)

Phase Three: Termination or Step Down

Fine Tuning Linkages

Higher Level Skills Training

- Focus on Negotiating Skills

Plan to Address Risks to Community Stability 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

Planning for the long term

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Phase Three: Worker Role

- Frequency of contact: monthly with resident and at least monthly with services, supports, and landlord.
- Planning for 6-9 months and beyond - Working with resident to use resources in future (for specific tasks). Develop list of all contacts and supports with the resident
  - WRAP plan and a crisis plan if needed
- Discuss progress, skills and resources developed

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Phase Three: Worker Role

- Review progress made
  - Evaluation of the work in CTI and any recommendations for the future
- Case Closing/Transition meeting with all resources including family, housing, services and supports – discuss roles
- Develop a plan for next six months
  - Identifying more long term goals and identifying resources for assistance
  - Document Plan
  - Sometimes had to be separate meetings

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Community Resources

HANDOUT: RESOURCE GUIDE

Focus

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




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Community Resources

- Develop a person focused resource list
- Identify resources by CTI focus areas and tasks
- Review resources in current use
- Add resources developed through work with other consumers
- Identify needed connections
- Income, benefits AND services
- Could develop resource directories by region

- HANDOUT: RESOURCE GUIDE

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Using Resources

•Home Base: housing, residential programs and families

•Financial: benefits and employment

•Health/Mental Health: treatment and support

•Substance use: treatment and support

•Family and relationships: support structure

•Life skills: services for assistance/support, skills for adulthood

•Education: educational opportunities

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)
- Accompany person to assist with engagement with new service
- Maintain regular contact to see how things are going
- Keep your promises

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Links to Resources – 2

Clarity about our role

- Response times
- On-call hours
- Schedule of contact
- Access to funds, treatment, services
- Joint planning and coordination of services
- Tension caused by CTI worker's frequent check-ins

Expectation that person learns to meet community norms, expectations and standards

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Resources for Programs to Secure

- AA/NA
- NAMI (National Alliance for the Mentally Ill)
- Veterans Administration
- Office for People with Developmental Disabilities
- Specialized housing: Corrections, HIV/AIDS, TBI (traumatic brain injury), Veteran
- Home Maker/Visiting Nurse Services
- Service Area Navigators:

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CTI Case Studies

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Case Study Questions for Discussion

- What is the barrier?
- What are the strengths the person/family brings to the problem?
- What information do you need?
- What are the options to resolve the problem?
- What tasks should the worker be focused on?
- Where is this person in terms of progress to the next phase?

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Case Example: Pre-CTI Planning

Debby has been in on the street for over a year. She believes people can read her thoughts and has become violent when she feels threatened. Debbie has been hospitalized twice in the last year. The medications have helped to decrease her agitation and she has used the structure of the hospital to deal with her intrusive thoughts. She got out and stopped all medication. There is a concern about Debbie maintaining a scatter site apartment. There are supportive housing projects available but she doesn't like the neighborhoods. She really wants her own place.

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Case Example: Pre-CTI Planning

Jack is sleeping on the streets. He lived with his sister for a while. He had been in a board and care but was asked to leave. Nothing worked out. His sister is still his rep-payee. She explains he has outbursts and is up all night, sometimes shouting. It is more than she can tolerate.

On the streets he has friends, they drink together. The problem is he keeps getting taken to the ER by the police. He gets high and screams. He is willing to talk to you as long as you do not talk about programs. He wants to live on his own. He is worried that he will go back to the hospital or jail. He wants some help.

Case Example: Phase One

June has recently moved into housing. You have helped her to set up her unit and met with her and the property manager. You have regular contact with the on-site team. You visit June and she is not interested. She has her housing and would like to be left alone. The team lets you know they rarely see her. She has also not been going to her psychiatric appointments.

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Case Example: Phase One

Trudy is 22 and living in and out of shelters. She has been hospitalized several times for cutting and suicidal thoughts. She made one attempt with Tylenol that almost killed her. She was not able to go home because of the abuse. The shelter is worried that Trudy is vulnerable to others abuse and would hurt herself unless she gets some supervision. She was referred to an SRO. She hates it there. It is full of "old crazy people" She wants to live with her boyfriend she met last week. She has begun cutting again. The SRO is trying to include more youth and design specific activities for them. Trudy doesn't want to hear of it. She has left several times and the last time was arrested with a man she met on the street.

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Case Example: Phase Two

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. Judy had been working with her psychiatrist to decrease her medication. 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. The services in the housing feel she needs detox. She wants you to stop talking to them.

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Case Example: Phase Two

Troy has struggled in housing. He had trouble with the rent and now has a rep payee. He is 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.

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Case Example: Phase Three

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 to see you.

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Case Example: Phase Three

Perry has maintained his housing in spite of quite a few set backs. Crisis has decreased and services and supports are in place. The property manager values him as a tenant. 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. The services are not really responding to this crisis.

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Closing and Discussion

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