

Critical Time Intervention – An Overview

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Critical Time Intervention (CTI) is....

a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.

We focus on the transition because:

- Change is hard... for everyone
- “Solving” one problem often brings to light other problems that were previously unidentified or not yet able to be addressed
- Accessing community supports can be challenging
- Without natural supports and ongoing preventative care and maintenance care, individuals rely on expensive emergency department visits, inpatient treatment, crisis services
- Transitions may disrupt existing services and supports

What kinds of transitions could be better supported with CTI?

CTI may benefit Maryland Public Behavioral Health System (PBHS) programs serving individuals transitioning from:

- Homelessness (including shelters or transitional housing) to Permanent Supportive Housing (PSH)
- Inpatient psychiatric treatment to the community
- Incarceration (jail or prison) to the community
- Residential Rehabilitation Program (RRP) to independent living or PSH
- Nursing home to home and community services
- Inpatient Treatment or Recovery Housing for Substance-Related Disorders to the community or PSH

Why CTI? CTI:

- Is a well-researched & cost-effective Evidence Based Practice proven to assist with transitions
- Is comprised of specialized interventions provided at a “critical time”
- Connects people with formal and informal community supports
- Is a time-limited (typically 9 months from date of transition) divided into 3-4 phases
- Focuses on a targeted number and scope of services areas to promote successful transition and ongoing success

CTI's Phases:

Pre-CTI – Setting Up the Transition,
Getting Ready

Phase I – The Transition, Addressing
Immediate Needs

Phase II – Figuring Out What is Working
and What Else is Needed

Phase III – Setting Up for Ongoing Success
After Graduation

- Housing
- Life Skills Training
- Health and Wellness
- Behavioral Health
- Money Management
- Family and Natural Supports

Focal Areas
to Assess
and Address

CTI Workers – What we do:

- CTI Informed Care Coordination
- Community Based Activities - engagement, assessment, intervention
- Skills teaching
- Attend field coordinator meeting to discuss caseloads
- Attend team supervision meeting (case conferences) and offer peer-supervision
- Support other CTI service advocates
- Develop familiarity with community services and resources
- Advocacy

The Big Picture

CTI Teams Develop a “Shared Culture” to ensure smooth flow of information and coordinate tasks for community-based work...

Which Means:

- The interdisciplinary team develops a shared CTI Culture of work and skill sets
- Work by all parties is consistent with CTI Principles and Practices
- Team Supervision is collaborative and promotes CTI practices and language

What Works

- Go at client's pace
- Activities are phase-based and relevant to phase-plans
- Coordination of care is effective and efficient
- Skills teaching is active – do with, not for
- Work with Individuals and supports on recovery planning and implementation of interventions
- Mediate between clients and supports
- Step back to monitor network and independent use
- Be empowering and use Motivational Interviewing
- Be Person-Centered
- Facilitate Shared Decision-Making
- Engagement is ongoing!

Strategies for Success

Weekly Team Supervision Meetings:

- All team members have peer supervisory responsibility
- They give feedback reinforcing and naming CTI principles that were well implemented
- They draw attention to “drifting” from the model

Smooth Flow of Information:

- Communicating issues that arise in the community
- Identifying priorities for discussion and review
- Using supervision agendas and notes to track follow-through

Pre-CTI: Preparing for Change

- Developing rapport before transitions increases chances of consumers accepting help once the transition starts
- Gives you a head start on addressing specific needs, especially when resources take time or have wait lists
- May give you the opportunity to talk with the consumers' supports for a more comprehensive assessment
- CTI programs often work with people who have fallen through the cracks in the service system and mistrust the system
- CTI programs often work with people who have not had access to supports before or have not engaged with supports before
- The initial transition period is a time of high risk. Rapport is needed to maintain engagement. Rapport takes time.

Phase I – The Transition

Time Frame: Months 1- 3 , Begins the first day the transition

The most intense period CTI where the bulk of the work is:

- Community-based visits
- Engaging in collaborative assessments of current needs and potential long-term supports
- Identifying priorities and planning work on up to three focal areas
- Providing support and connecting consumer to people and agencies that will continue supports post-CTI
- Meeting with existing supports to facilitate orientation to and comfort with transition-related changes
- Addressing crises and urgent needs and needs that can be addressed in short term
- Developing and maintaining working rapport

Phase II – Try Out

Time Frame – Months 4, 5 & 6

Figuring Out What is Working and What Else is Needed:

- Less frequent meetings, encouraging consumer's independent use of longer term supports
- Monitor and strengthen support network and consumer's skills
- Increase direct collaboration between consumer and long term supports
- Monitor effectiveness of supports & intervening and adjusting as needed
- Identifying gaps in services that need further adjustment

Phase III – Moving Towards Graduation

Time Frame: Months 7, 8 & 9

- Planning termination of CTI services with support network safely in place - completing transfer of care to community resources
- Work leading to graduation/transfer has been done throughout previous phases
- Continue stepping back to ensure supports can function independently - monitoring, fine tuning and finalizing long term supports
- Meetings planned and held with consumer and with consumer and their supports to mark transfer of care
- Final Meetings with Individual - to review and **celebrate** progress made

Interested in Learning More?

If you are interested in learning more about implementing CTI in Maryland, please contact: kris.wright@som.umaryland.edu

Maryland's training on and implementation of CTI is based on work with national experts from:

- Center for the Advancement of Critical Time Intervention www.criticaltime.org
- CUCS Institute

