STRENGTHENING
At Risk and Homeless
Young Mothers and Children

Young Family Critical Time Intervention (CTI):

Successful Transitions from Homelessness to Stability

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An initiative of the Conrad N. Hilton Foundation, in partnership with The National Center on Family Homelessness, National Alliance to End Homelessness and ZERO TO THREE: National Center for Infants, Toddlers and Families.

Summary

The Young Family Critical Time Intervention (CTI) model was designed to provide continuous assistance to young homeless families as they transition from shelters to stable housing. CTI is a time-limited, structured case-work model that utilizes housing first and provides continuity of care from homelessness to housing. As adapted for young homeless families, it focuses on both the strengths and needs of young parents. The first implementation of the Young Family CTI model was the Second Chances Program in Westchester County, NY, which included a program evaluation component and resulted in positive outcomes such as reduction in risky behaviors and an increase in income and independence.

Why Young Homeless Families Are Different

There is mounting literature documenting the characteristics and needs of homeless families and the housing and service programs that support them (for example Shinn et al., 2005; Bassuk et al., 1997; Bassuk et al., 2006; Burt, et al., 1999; Rog et al., 1995a & 1995b; Rog & Buckner, 2007; Rog et al., 2008). However, little is known about programs specifically geared toward helping young homeless families who share some of the vulnerabilities of other homeless families, but who also present some unique characteristics associated with the mother's age—mothers under the age of twenty-five.

Many young homeless mothers are pregnant, which we know from other research to be a risk factor for homelessness and can in a loss of housing (Weitzman, 1989). Those they live with may not welcome an infant. The addition of an infant may cause overcrowding in the home, thus pushing a young mother and her child out of housing. Some young women need to escape from a harmful or dangerous situation. Often, young mothers and their children rely on relatives and friends for a place to stay, moving from one to another as their welcome wears out. The result for young mothers is often a dismantling of their support systems.

The mothers' young age; their lack of education, training, or work experience; their histories of family separations; subsisting below the poverty line--all of these challenges put young mothers and their children at a very high risk for a lifetime of challenges including housing stability. Young homeless mothers are often inexperienced with child and baby care. They are transitioning into adulthood themselves, and caring for a baby may be overwhelming.

The Young Family CTI model is designed to help young families overcome these challenges by building on the mother's strengths and instincts while increasing access to tangible supports such as housing, income and health care, and helping strengthen emotional supports by connecting to their community, family and friends.

What Is Cti?

CTI is an evidence-based practice originated and tested with homeless single men in New York City. There have been numerous adaptations of the CTI model, most often for homeless and at risk populations. There is more than a decade of research supporting its effectiveness for improving mental health, substance abuse, and housing outcomes for homeless single adults (Valencia et al., 1997; Susser et al., 1997; Herman et al., 2000; Herman et al., 2007). The CTI model, as adapted for homeless families, is cited as a model program in the President's New Freedom Commission on Mental Health's final report, *Achieving the Promise: Transforming Mental Health Care in America* (New Freedom Commission on Mental Health, 2003).

The CTI model was also modified for young homeless families. The application of the CTI model for young families results in an effective, time-limited, intensive intervention that provides mental health and substance abuse treatment, parenting guidance and family preservation services to homeless mothers who are caring for dependent children. This is a housing first model and assumes that every attempt will be made to help families secure permanent housing. Breaking the cycle of residential instability with young families is a positive step toward the prevention of future homelessness. The program has led to success for young mothers in many areas, such as education and income, and is likely to have longer term impacts on these vulnerable families.

Phases Of Work In The Young Family Cti Model

The Young Family CTI model, like the original CTI model, is a time limited, 9-month intervention divided into three 3-month phases. The first phase is the most intensive, requiring multiple contacts each week between the CTI worker and the family. Then, the intensity of the model tapers off and, by the end of phase 3, the CTI worker makes infrequent visits to the family while continuing as a vital resource when requested by the family.

Phase 1. *Transition to Community: Months 1-3*. This phase begins when the case worker is introduced to a family. Phase 1 is the most intensive phase of the model, and requires at least weekly visits from the CTI worker. There is a lot to accomplish during these first three months and frequent contact will help with engagement and the start of case work. An important feature of CTI is continuity of care. Thus, it is important that the CTI worker begin working with the family as soon as possible after the family becomes homeless and continues working with the family through their move to housing. During this time, the engagement process begins. The case worker's main task during this phase is to help the mother assess her strengths and needs, and those of her children, and to develop a plan for the transition to housing.

For young women who are pregnant, an immediate concern is prenatal care. The case worker should be ready with suggestions for the mother, regarding appropriate health care providers. The case worker should be mindful to empower the mother to seek the care she needs, by being supportive and providing information. Key to the success of the intervention is creating appropriate and effective links to agencies and individuals that can play an instrumental role in supporting the family upon completion of the program. Common tangible supports include:

- income sources, such as TANF, work, job training programs
- health insurance, such as Medicaid/CHIP
- food and nutrition including SNAP (food stamps), food pantries
- health and behavioral health providers for the mother
- pediatricians for the children
- education and programs for children, such as Head Start/Early Head Start or public pre-K

During this phase, the family should also receive assistance in locating and moving into appropriate permanent housing. The Housing First approach, as used in this model, is described below. With this in mind, it is important to help young mothers connect to supports in the area of their new residence.

Housing First: The Housing First approach simply means that homeless families are best assisted when their need for permanent housing is addressed first. For young mothers, this does not always mean moving to their own apartment or house; other options should be explored. In some cases, it may be possible to repair relationships with other family members who are willing and able to absorb this young family into their household. The CTI case worker should help the young mother assess her housing options and her relationships with others who may be able to provide her with emotional support and a permanent residence. The case worker can accompany the young mother on visits to her housing options and assess the likelihood of a positive experience and outcome for the young family in each living situation. When possible, the mother, case worker, case work supervisor, and clinical director should meet with the relative who is willing to take in the young family to help determine if the living situation will be one that has a high likelihood of success. This also gives the clinical director the opportunity to discuss access to services in the community that can strengthen the relationships within the new household.

Phase 2. *The Try-out: Months 3-6.* This phase is devoted to testing and adjusting the support systems established while at the shelter and after the family has moved into the community (Valencia et al, 1997). During this phase, the intensity of the model tapers off as contacts between the CTI worker and mother begin to decrease from weekly contacts to 2 or 3 a month.

As the young mother and CTI worker complete the work of putting supports in place, the CTI worker can observe where the mother and family need more or fewer supports and services, and target those areas that need more intensive work. In some cases, simply linking a young mother to routine pediatric care for her child(ren) may result in identification of health and developmental issues. The CTI worker should then assist the mother with additional sources of care and support for her child(ren). In addition, once settled in their new home, the CTI worker may help the mother with identifying a need for assistance with household chores, such as maintaining a clean, healthy environment; budgeting issues; or lack of parenting skills. While the CTI worker can provide immediate assistance with these tasks, the goal is always to link the mother to available resources in the community that can provide appropriate and, if needed, longer term assistance.

The goal during this phase is for the case worker to allow the mother the space to maximize her strengths, while remaining available to help in areas where the mother is having difficulty coping. The task for the worker is to develop trust, while establishing boundaries regarding dependency as the mother copes with the new changes in her family (Levy, 1998).

Phase 3. *Transfer of Care: Months 7-9.* In this phase, fine-tuning is made to the family's support system to ensure that long-term community-based links are established (Valencia et. al., 1997). The case worker reaches out to the family infrequently and encourages the mother to take the lead on all issues related to her family. As many of the skills and tasks of living independently can seem overwhelming to a young mother, the CTI worker should help redirect her to her support network, particularly during this final phase of the model.

One of the most difficult issues to address during the *Transfer to Care* phase is the end of the relationship between the case worker and the young mother. Separation issues for the mother are bound to arise because of the upcoming termination with the worker and transfer to the other sources of care in the community that were established during the intervention. This is the culmination of the intervention, and the expectation is that the mother and her family will be able to continue to make progress within the safety net of community care that was established over the 9-month period.

Young Family Cti Model Practice Strategies

The Young Family CTI model has many components similar to the original CTI model and uses the same practice strategies. However, the model has been tailored to meet the special needs of young homeless families. The model employs practices familiar to the field, such as motivational interviewing, and includes a number of key components geared toward helping young mothers address and prevent problems that she and her children face. Because the model is built on voluntary participation in social services, health services and skill building programs, techniques such as motivational interviewing are key to helping young families move toward stability, independence and a healthy lifestyle.

Motivational Interviewing. Motivational interviewing (Rollnick & Miller, 1995) provides a framework for the development of the helping relationship between the CTI case worker and the young mother. Motivational interviewing is designed to mobilize the mother's own desire to change her family's life. Its techniques are non-confrontational, and geared to minimize the defensiveness often created by traditional confrontational techniques. It assumes that the responsibility and capability for change lie within the mother. For young mothers, the changes to consider are more often NOT related to substance abuse – the issue for which motivational interviewing was originally designed – but related to the mother's life situation of homelessness, extreme poverty, not being employed, few job skills, not attending or completing school, and raising young children alone. Many young homeless mothers also have experienced childhood trauma and exposure to violence, and may face mental health issues. By using motivational interviewing techniques, the CTI case worker can help the mother address these issues and challenges from a positive, strength-based perspective.

Motivational interviewing has been modified for young homeless families, using only the interviewing techniques. *Note: the original motivational interviewing was part of a substance abuse treatment strategy*. However, the case worker should take a history of substance use as part of their initial intake assessment.

While motivational interviewing techniques can be used throughout all phases of the Young Family CTI intervention, it is recommended that case workers emphasize motivational interviewing in the beginning of the second or "Try-Out" phase of the intervention. This allows time for the mother and case manager to establish a therapeutic alliance, and for the mother and her children to have settled into their new housing. Carrying out motivational interviewing in the middle of the nine-month intervention also allows about three months for the case manager and mother to continue the interviewing if it has not yet inspired change, or to get the mother involved in long-term services if she has decided she wants them. Whenever possible, a person important to the mother should be involved in the interview sessions. This could be a family member, spouse, a friend, or a sponsor from a 12-step group. This significant other can help support the mother in her commitment to change well beyond the nine-month intervention period.

Harm Reduction. Harm reduction (Marlatt & Tapert, 1993) is based on the idea that risky behaviors exist on a continuum of abstinence to abuse. If a person reduces the quantity or frequency of risky behaviors, harm will be reduced. Although abstinence may still be the ultimate goal, any reduction in harmful behavior is encouraged. Harm reduction in the Young Family CTI model is used to address and assess behaviors such as substance use, unprotected sexual encounters, prostitution, and any other risky behaviors mothers may be exhibiting. This stance is in contrast to traditional all-or-nothing approaches to risky behaviors, such as in traditional substance abuse treatment, where clinicians refuse to treat anyone who has not made a commitment to abstinence. In the Young Family CTI program, the list of risky behaviors to reduce included additional pregnancies for the young mothers. Through work in group sessions with the clinical director and individual work with case workers on issues related to family planning, and the risks associated with unprotected sex, none of the

young mothers in the Westchester County Second Chances program became pregnant again during the two years of the program's evaluation.

Clinical interventions for the young mother. For the most part, clinical services are NOT provided within the CTI model; rather, young mothers are linked to services in their community of residence. The intake assessment for the CTI program should include information regarding the mother's current and past need for health, mental health and other social services. Aside from working with mothers to secure their entitlement benefits, case workers assist in helping mothers find appropriate services to meet their needs. These services might include: mental health, domestic violence prevention, substance abuse treatment, financial management, financial independence planning, parenting workshops and discussion groups, reproductive health counseling, education programs (such as GED), and skills training/ employment assistance.

Services directed to children through mother. In addition to clinical services for the mother, the Young Family CTI model encourages these young mothers to further develop their parenting skills by providing opportunities through group learning and behavior modeling on topics such as: maternal care giving, appropriate infant and child health care, tracking development, nutrition counseling/workshops and cooking, locating and assessing appropriate and safe childcare/daycare, and school placement and special educational needs.

High priority issues (aside from housing and benefits). Because these mothers are young, they often lack the life skills that come with age and maturity, and are necessary for successfully managing a household. The Young Family CTI model addresses these deficits by working with the young mothers in areas such as planning skills. This is done by employing motivational interviewing, which is often driven by the mother's goals for independence through education and work, and her desire for healthy and safe children who can become happy and productive adults.

Staffing Strategies

In order to achieve each family's goals within the limited timeframe of the program – nine months – it is important to carefully consider staffing recommendations that are part of the model. The Young Family CTI team includes case workers, case work supervisors, and a clinical supervisor.

Case worker ratio. The recommended family–to-case worker ratio for this program is 12 to 1. With a total of 12 families on their caseload, workers are able to provide both the intensive assistance required in phase 1 of the model, while ensuring a positive and successful transition to the community for families in phase 3. The case ratio is best implemented so that each case worker has no more than 4 families in the intensive first phase of the model. Thus the suggested pattern is for each worker to have 4 families in phase 1, 4 families in phase 2, and 4 families in phase 3 at any given time.

Clinical supervision. A unique aspect of Young Family CTI is the requirement for high level clinical supervision within the program. This role is best filled by a psychiatrist who in addition to regular duties can provide clinical services in a crisis such as the need for admitting of a family member to the hospital or immediate medication prescription needs. Regular clinical supervisory duties include attendance at weekly CTI team meetings, assisting case workers with family member assessments when requested and participating in home visits when the team believes an *in vivo* observation would be helpful. In addition, the clinical supervisor is encouraged to run group sessions with the young mothers on topics such as child development, increasing healthy relationships and other topics specifically chosen to address the needs of the young mothers.

Because the relationship between the case worker and client is crucial to the success of the CTI model, a primary role of the clinical supervisor is to help support and improve that relationship. This includes deepening the case workers' understanding of the dynamics of their relationships with the young mothers, and how the mothers' past relationships,

experiences, and history of trauma, abuse, and neglect may play a role within each client relationship. The clinical supervisor helps guide the work of the case worker, providing assistance with the assessment process and service plan negotiations, identifying areas that may require further exploration and support, and helping case workers understand and identify children who may require additional supports due to a developmental delay, conduct disorder, learning disabilities, or other challenges.

Organizations may see this requirement as burdensome. However, it can be achieved with minimal resources and maximum impact. The Second Chances Program employed a Child Psychiatrist for this role, although the psychiatrist was contracted to work with the program only one half day per week. This economical solution is one of many; others might include utilizing local university and medical school resources to secure the assistance of a psychologist or psychiatrist for the program. It is also recommended that this clinician be well-educated in the special needs of at risk children, particularly identification of developmental delays. Below are some of the factors that drive the requirement for high-level clinical supervision within the Young Family CTI model:

- The psychodynamic understanding of the case worker/client relationship, which is crucial to the general CTI model.
- The high rates of trauma, abuse, and neglect that are so often present in the families' past and present circumstances.
- The mother's personality and her relationship with the case worker, which frequently determines the outcome of the intervention.
- The need for deep experience in the assessment process and negotiation of service plans.
- Psychodynamic aspects of the family members' histories that can often be overlooked.
- The head-of-household's past relationships and experiences, as well as the current family dynamics, which need to be thoroughly explored to prepare the case worker for what to expect as a relationship with the family develops.
- The children of young homeless families are at risk for developmental delays, learning disabilities, depression, conduct disorders, and substance abuse or dependence.

Additionally, the use of a psychodynamically-oriented community psychiatrist as an additional supervisor of non-professional case workers elevates the level of all services and interactions with families.

Why Does Young Family Cti Work?

The Young Family CTI model derives its core and key components from the original CTI model, which is an Evidence Based Practice. The model is goal oriented for both the case work team and the families. Thus, it builds on the strengths of the CTI worker's training and the mother's internal strengths, and their relationship to accomplish the established goals. The model provides a high level of clinical guidance, which serves to both prevent roadblocks from developing throughout the model and provide solutions to problems that may occur. The model is also flexible and can emphasize the special needs of young mothers in general and be tailored to meet the needs of individual families.

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Strengthening At Risk and Homeless Young Mothers and Children
Young Family Critical Time Intervention (CTI): Successful Transitions from Homelessness to Stability

Strengthening At Risk and Homeless Young Mothers and Children is generating knowledge on improving the housing, health and development of young homeless and at-risk young mothers and their children.

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For more information on this *Initiative*, please contact The National Center on Family Homelessness, 181 Wells Avenue, Newton Centre, MA; (617) 964-3834 or at www.familyhomelessness.org.

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