



# **Critical Time Intervention (CTI) Manual**

5/17/2002

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This manual was developed for the NIMH-funded randomized clinical trial entitled "Critical Time Intervention (CTI) for Men and Women with Severe Mental Illness."

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## THE CRITICAL TIME INTERVENTION (CTI) MODEL

The CTI model is a time-limited form of case management that focuses on helping people with severe mental illness (SMI) and a history of homelessness during a "critical time" transitional period in their lives. The impetus for the Critical Time Intervention model came in the early 1980s with the rise in homelessness among people with SMI in New York City. Over the next two decades, homelessness has increasingly become a primary concern of people suffering from severe mental illness. Despite the development of specialized housing and outreach programs in NYC since the problem first emerged, the prevalence of homelessness in this population remains distressingly high.

Mental health professionals, advocates for the homeless, and families of people with mental illness began to see a pattern of a 'revolving door' placements followed by reshelterization. Routine discharge planning was often unable to establish long-lasting residential stability in the emerging context of widespread homelessness and a high prevalence of mental illness among those who were homeless. Even carefully planned residential placements from shelters, prisons and hospitals frequently turned out to be unstable in the long run. Risk for homelessness was especially high during the transition period from an institution into the community. It was time to look beyond further improvements in the institutional experience and community residential models to a system-wide approach for lowering the risk of recurrent shelter, hospital, and prison admissions among people with a history of homelessness.

CTI is a feasible, cost-effective model of care for addressing problems in access to, and delivery of, services through the creation of relationships between clients and individuals in the community and through reinforcement of relationships that already exist. The CTI specialist's role is not only to make 'formal' (professional) contacts in such sites as community mental health clinics, correctional facilities and overnight substance abuse treatment programs, but also to connect with 'informal' sources of potential support for clients, such as with owners of neighborhood businesses, church groups, local not-for-profit organizations that provide free or inexpensive meals and clothing, and the clients' friends, family members and others.

The first clinical trial to assess the effectiveness of the CTI model was conducted from 1990-1994 with men enrolled in the onsite mental health program of a large New York City municipal men's shelter. [The initial housing placement and usual follow-up care was not affected by the presence or absence of a CTI specialist; both groups received the same kind of attention prior to discharge from the shelter and were required to be given the same amount of access to shelter staff during the first 90 days in the community.] Eighteen months after placement from the shelter, the group of men who were randomly assigned CTI specialists, had significantly fewer nights homeless than did the group without CTI specialists.

## THE CURRENT CLINICAL TRIAL FOR DISCHARGED INPATIENTS

For the current trial, the transition and intervention begin immediately after psychiatric hospitalization. Liaison case managers – CTI specialists – are provided to help during the period of transition from hospital to community living, a "critical time" during which there is increased risk for this population of loss of housing and re-hospitalization. Sixty-eight percent of the 1998 admissions to the Rockland Psychiatric Center (RPC) were undomiciled just prior to hospitalization. The long-term objective of your work as a CTI specialist is to ensure continuity of community care and residential stability for your clients. While the nature and purpose of your role differs in some ways from other types of case management, your work depends on your efforts to strengthen the support networks of your clients and their connections with other mental health professionals in the community.

## COMPONENTS OF CTI

One of the hallmarks of CTI is that it is a time-limited intervention, lasting 9 months. CTI does not replace long-term community treatment models such as Assertive Community Treatment (ACT), but is meant to complement these approaches. It consists of *in vivo* training in community living skills and team-managed transfer of caregiving to services and supports in the community. A key aspect of CTI is that the post-discharge phase of the intervention is delivered by CTI specialists who have established relationships with clients during their institutional stay. Effective outreach and support are greatly enhanced by staff knowledge of the population and the strength of the individual relationships that have been previously developed.

It is especially difficult to ensure continuity of care for the homeless mentally ill with their multiple impairments and service needs. A problem also exists on a structural level: the mental health establishment has failed to assess adequately the complexities of deinstitutionalization, which caused care to be dispersed when it had been previously housed under one roof. Although community mental health centers were intended to fill this void, they failed in their mission, as they were effective only for clients who were comfortable seeking out care in mainstream, office-based settings.

CTI is designed specifically to enhance the continuity of care during transition from hospital to community care. It is a relatively simple low-cost, time-limited intervention designed to address an important problem in the mental health treatment system: homelessness among severely mentally ill persons. If the intervention shows promising results in the state hospital setting, we believe that the implications would be important. Not only might the CTI model then be implemented in other similar treatment settings serving adults with severe mental disorders, it could serve as a valuable complement for the most high-risk patients served by ACT programs and other models as these approaches become more widely available.

## CLINICAL PRINCIPLES OF CTI

### **A. Continuity of Care and CTI**

#### What is continuity of care for our clients?

Continuity of care is one of the main goals of CTI work - the assurance that our clients are provided with uninterrupted and coordinated mental health services over time - and that services will endure past the term of our work with clients. This is seen as a critically important element in determining positive long-term outcomes in this population. Part of this process is the successful transfer from hospital-based to community-based treatment. CTI addresses problems encountered during this difficult and stressful transition period by bridging the gaps between hospital-based and community-based treatment services.

Leona Bachrach (Bachrach, 1993) explained that "continuity of care means that the patient will be able to receive all of the different services that he or she needs, even though the service system is fragmented and even though many different service delivery agencies must be involved in his or her treatment" (Bachrach 1984). The CTI specialist makes an assessment of how a client is functioning in his or her new community setting, identifying needed services in problem areas, then helps a client create and strengthen strategies and linkages to solve (and maintain solutions) to identified problems.

CTI accords almost perfectly with the continuity of care principles outlined by Norma Ware and her colleagues in their ethnographic study (Ware et al, 1999). They provided qualitative narratives illustrating the principles of pinch hitting, trouble shooting, smoothing transitions, creating flexibility, speeding the system up, and contextualizing.

### How does continuity of care relate to the move from hospital to community?

Concern for continuity of care harkens back to the 1960s and to the emerging will to return people whose SMI has stabilized back to their families and communities of origin, while maintaining contact to insure that needed future intervention is received, and to prevent loss of contact with someone who might "fall through the cracks" of a yet to be perfected community mental health infrastructure. When newly stabilized people with SMI are placed in less structured community residences, or in unsupervised apartments, or with their family, it remains important to establish who holds the responsibility for their successful adjustment. Caregivers, who know their situation as they leaves the hospital and follow them into the community, can offer timely and focussed advice and assistance that may help prevent or avoid problems.

### Which formal and informal community-based services are addressed?

Continuity of care oversight is key to resolving small and large crises that might interrupt community placement, community employment, family relationships and other important life needs. An individual returning to a community after inpatient hospitalization needs many services, both formal and informal. Those needs that an individual finds difficult to address, and those services that an individual finds difficult to obtain, result in the lack of continuity of care. The CTI specialist gradually shifts all services to the community, identifying people in agencies who would assume coordination of psychiatric aftercare services, including the provision and monitoring of medication. You will help with other relevant aspects of functioning, such as money management. The help you offer fosters self-help and creates linkages that will persist over time. Successful linkages are coordinated and endure over time and include not just the formal, such as mental health services, but also the informal, such as local stores, eateries, and pharmacies. Your interaction with these community contacts will change during the three phases of CTI, as your client attains more and more self-reliance. You can regard the process of establishing linkages and resolving crises as opportunities to teach self reliance to your client, while remaining accessible for needed support and reminders (Step In and Step Back).

### What discontinuity exists without the intervention of CTI?

Continuity of care can either represent the extent to which clients experience gaps in mental health and other needed services or it is a description of the overall organization of these services. If a need is not addressed, such as when a client does not renew a prescription for medication, or when a client does not return to his or her housing, that is a gap in continuity of care. After release from an inpatient facility, to a community residence or to another placement, it may be as if a baton of responsibility is passed, but which might be dropped.

### What differences can a CTI specialist make?

One response to resolving anticipated crises an individual may encounter at a specific, critical time is an intervention by a dedicated CTI specialist who is equipped to provide focussed support and to coordinate needed services. The CTI specialist is aware of the ongoing needs of the client, the current relationship the client has with an assigned case manager, and the gaps that might arise if needs go unmet. Your role is complementary to that of a case manager, but does not replace it. You will have some key selected areas to work on with a client, but will also respond to new areas of need, in order to create linkages that can persist after the you have withdrawn from your time-limited role, and help maintain continuity of care.

### How to prepare for the future support of an individual in the community?

The CTI specialist sets up a mechanism through community linkages for preventing, identifying and responding to crises. The linkages that you identify are crucial to the success of the intervention. These people or agencies are to assume, gradually and with your advice where needed, the primary role(s) of supporting the individual in the community, and in this way helping to maintain continuity of care.

### **B. The CTI Specialist Role**

#### How does a CTI specialist differ from a case manager?

Coordinated case management is seen as the mechanism that makes continuity of care in the community possible. In supporting needed services, good continuity of care would include a primary case manager who makes sure that an individual gets needed therapy, medication, day programs, or inpatient treatment. A variety of case managers and even overlapping case management supervision and plans may be in place for an individual who has been discharged from an episode of inpatient hospitalization. Different inpatient psychiatric hospitals provide different amounts of case management after discharge. Some provide transitional case management, at least insuring that a discharged individual reaches his community placement and has a follow-up clinic appointment scheduled. Sometimes the case manager only follows-up with and meets a few individuals on his caseload, i.e. those who have encountered problems which were communicated back to the inpatient staff. Sometimes that case manager is unknown to the individual he attempts to help. Some of the titles of case managers who are assigned to and responsible for an individual may include Case Manager, Social Worker, Counselor, Runaway Finder (at Bronx Psychiatric Center), Personal Service Advisor (at Rockland Psychiatric Center), or Assertive Community Treatment (ACT) team member. Sometimes the same individual can be referred to by multiple titles at separate times or by different people.

#### Why is the period of action by the CTI specialist time-limited?

The period of action by the CTI specialist is time-limited. It lasts for 9 months after hospital discharge. It is time-limited by design, in order to encourage a personal assumption of responsibility and the development of community supports. Therefore, it becomes important to identify in the phase treatment plans the specific short-term and long-term goals that will be acted on. Issues that can be addressed immediately, enabling an individual to act as his or her own advocate, must be distinguished from those more problematic or complex issues which would be passed on to the community supports. The transfer of responsibility to the community supports (people important to that individual, or agencies) are intended to establish a support network that would address the needs of the individual and prove durable, ultimately outliving the CTI intervention period. The relationship that you have developed enables you to act as a broker, mediating between the individual and his or her respective networks of support. You assist the individual in developing skills toward advocating for himself/herself. In the first few weeks following placement in community housing, you maintain a high level of contact, in person and by phone with the individual, and make an assessment of the individual at the new residence to evaluate his or her adaptation to community living. Accompanying your client to appointments with new agencies or providers facilitates the development of a linkage, and building skills to do this alone. As CTI specialist, you can role-play (or practice test "*in vivo*") to help in your client's deficient areas.

#### Which specific problems will the CTI specialists try to prevent?

The usual care of a client includes community-based treatment and service networks and family and friend support networks that can be rebuilt and strengthened. The CTI specialist has a role of insuring that a stabilized SMI person can rely on these networks to get support

when responding to new situations and potential crises. You might encourage the person to seek help from appropriate and responsive providers. You might further ascertain that a concerned social network of family and friends notes any ongoing problems, and that these problems are addressed, resulting in continuity of care. You are interested in ensuring a smooth transition from hospital to community. In the transition from inpatient to community-based care, the client may be passed from one system to another and from one case manager to another. In the event that your client has a poor relationship with an assigned case manager, or has a treatment plan that does not cover all current problem areas, you can work with your client to improve his or her relationship with the case manager, and to set workable interim goals.

#### What are key aspects of the CTI specialist role?

- You should make sure that service planning specifically around maintenance of housing begins at the institution with case workers and discharge planners and continues in the community.
- You should be able to Step back and Step In. You should Step Back and let the client try to manage routine activity and crisis events, but should be ready to Step In whenever needed. This is a stance that fosters personal autonomy, while you remain available when needed.
- You should be an ally (an advocate for your client) who is also a service provider (and not primarily a rule enforcer, like case managers or family at the housing site). This may be especially important if your client refuses treatment from other new providers.
- You should be an information source and negotiator for (and to) community service providers during the transition from institution to community. You may be able to provide (or obtain) information about your client's history, and you should also try also to keep track of your client's status during the transition.
- You should be an intervener in housing-related crises. You should know application information about other housing sites and substance abuse services. You should be ready to act when your client is in danger of losing housing and when your client has actually lost housing. The goal is to help your client return to housing with the least delay.
- You should keep to the plan but know the pitfalls. You will help a client design his or her own treatment plan, which focuses on a few key goals. At the same time, you should be alert for potential problems in other areas. You can accompany your client to a court hearing. You can prepare your client for a job interview. You can maintain contact with psychiatric emergency rooms to catch your client before a crisis encounter leads to reinstitutionalization. You can accompany your client during the move to a new home. As friendly and welcoming as the staff and housemates may be, your client may feel lonely and scared. You can introduce your client to a bodega owner or bank manager in a new neighborhood.

#### Which community-based services can be used?

Clarify how you can help the following to get to know the client:

- Medical and psychiatric services
- Social workers at a client's residence:
- Supervisor of workers who are familiar with CTI
- Directors of psychiatric programs in the area who are familiar with CTI

Other community-based services:

- Bank officers or a person in charge of accounts at bank – help ease opening of a new account for your client without the difficult interview and common demand for types of ID that your client often can't produce.
- Pharmacists – make plans in advance for them to automatically give one week of medications at a time if your client loses his or her meds.
- Store workers at bodegas near the client's residence – for instance, you may ask them to open a small "account" for your client to be able to charge food and sundries.
- Travel agency - help your client get a good price based on the premise that you will have lots of clients who could arrange travel there.
- Director, staff and other clients at residence - arrive with client on first day.

### **C. Examples of Continuity of Care in CTI**

How can CTI help a client connect to informal supports?

Raul was abusing substances, HIV positive, was not adhering to medications, and had difficulty with money management. He was initially placed with his mother, and his CTI specialist set up several referrals for him -- for medication, psychiatric follow-up, and AIDS services. Since Raul did not attend these appointments, however, the CTI specialist engaged the family to help with medications and introduced the family to other parents of mentally ill chemically addicted (MICA) individuals. Raul, however, continued to refuse any referrals to substance abuse programs, which caused ongoing tension at home. In fact, his mother soon kicked him out after an argument about his continued substance abuse. His CTI specialist had been trying to arrange for an appropriate community placement, but there were problems securing SSI for him. Since Raul had no other housing options at this time, his CTI specialist tried to negotiate a contract between Raul's family and him -- no theft, no getting high. In order to bring this about, he tried a culturally relevant strategy, which was to effect this reconciliation on Mother's Day, which in Latin cultures is a symbolic time when reconciliation can occur. This was successful, and Raul moved back in with his family. Soon after this, however, he started avoiding contact with his CTI specialist. The CTI specialist, then, did more psychoeducation with the family, in an attempt to help them work with Raul's substance abuse and declining health due to HIV disease. This intervention was successful in keeping Raul housed for many months afterwards.

How can CTI help a client stay in housing settings?

Hal was very difficult to place in community housing because of a prior arson conviction. In addition to this, he did not want to live in any supported setting. Against the advice of his CTI specialist he decided to live with his mother. The CTI specialist's misgivings stemmed from the fact that his mother had a history of behaving violently. Because Hal had made his decision, however, his CTI specialist tried to work with him on money management, in order to make the best of the situation. Despite this, the money seemed to disappear, and it appeared that Hal's mother was using it to buy alcohol. The CTI specialist also tried to get him connected to a psychiatrist, but Hal did not make his appointment. Shortly after his initial placement, he became homeless again when his mother threw him out. His CTI specialist was persistent in trying to get him into a supported setting. She got him an interview at a transitional living community (TLC), which did not go well, and then at another MICA residence which was not a TLC. He was accepted at this second place and moved in. He found the structure hard to take, however, and left, becoming homeless again until he moved in with an aunt. At the aunt and the CTI specialist's suggestion, he agreed to return to his residence, and was slowly gaining insight into his substance abuse problem. The CTI



specialist helped the staff at the residence understand the client -- she put into context how far he had come, and also let them know that he might move more slowly than other residents. In the end, Hal was able to maintain his room. Without the CTI specialist's careful and persistent intervention, however, he would likely have stayed home.

#### How can CTI help a client cope with emotional episodes and crises?

Andre felt very paranoid about his residence when he first moved in -- was suspicious of the food, and didn't like the other people. His CTI specialist convinced him to give it a little more time, and Andre agreed. When the CTI specialist next visited him, he had made friends and reported feeling much more comfortable.

Still another client, Pedro, was placed in a supportive residence, but did not like the structure, saying he preferred to do things on his own. Soon after placement, he decompensated and became violent. His CTI specialist convinced him to go to the hospital, where he soon got better. He was then readmitted to the same agency, but to another supported housing site, not the one he was violent in. He eventually adhered to his medication there, and ended up staying at this site.

#### How can CTI help "contextualize" a client's situation to caregivers?

Roderigo was unhappy with his residences structure, and the residence staff was unhappy with Roderigo's lack of participation in groups. His CTI specialist convinced both parties to be patient with each other. He explained to the staff case manager that Roderigo was shy, but that his experience with him from the shelter showed that he would eventually participate in activities if allowed to proceed at his own pace. In doing this, the CTI specialist was "contextualizing" according to Norma Ware's principles of continuity of care. This strategy worked -- Roderigo and the staff adjusted to each other, and Roderigo ended up staying at this placement.

#### How can CTI help a client to bridge crises and find good housing placements?

Raymond chose to live with his mother and brother in the Bronx. Soon after moving in with them, he took himself off his medication, decompensated, and started threatening his mother. She kicked him out, and moved into a shelter, looking psychotic and frightening. Before the shelter's psychiatry day program was able to stabilize him, he left again, and moved to the rooftop of a building he believed was owned by his grandmother. Upon learning of all this, Raymond's CTI specialist contacted the building he was camping out in, and explained to the staff the situation. The building staff then convinced Raymond that the building did not belong to his grandmother, and his CTI specialist encouraged him to go to the hospital. After he was admitted, his CTI specialist convinced Raymond's hospital social worker to find him supported housing, rather than allowing him to be discharged to an unstable living situation. The social worker agreed to this, and Raymond was kept in the hospital an additional two months, until appropriate housing was found for him. When he was discharged, he went to a highly structured residence, where there was around-the clock case management. When he saw his CTI specialist next, he looked great, and had enrolled in a hospital work program. Raymond stayed at the residence. Here the CTI specialist "trouble shoots" in Ware's continuity of care terms: the CTI specialist realizes that the hospital will probably discharge Raymond to an unstable living situation, where he will go off his medication again, and have to be rehospitalized. To try to avoid this she helps him get structured housing.

## What problems can CTI clients have with housing placements?

- dissatisfaction with current placement, e.g., the rules are too strict, it's too crowded
- interpersonal tensions -- client is upset about a relationship
- eviction
- client finds another place he prefers
- money problems -- rent is too high, or client uses rent money on drugs
- arrest, incarceration
- enters drug treatment program
- hospitalization

## THE THREE PHASES OF CTI

Phase 1: *Transition to the Community*

Phase 2: *Try-Out*

Phase 3: *Transfer of Care*

### **A. Introduction**

CTI is sensitive to the changing needs that clients have during the nine-month transitional period from institutional to community living. Very different challenges characterize the first months, the middle period, and the termination phase. Therefore, CTI is conceptualized as moving in three distinct phases, each approximately three months long. This is not to say that these phases are completely self-contained; challenges for the client and tasks for the CTI specialist, though often peaking in a particular stage, are likely to recur throughout the intervention period. The three phases are: Transition to the Community, Try-Out, and Transfer of Care.

In the following section on the three phases of CTI, consideration is given to three principal themes we can follow in understanding the work of the CTI specialist. These are:

1. *Assessment of concrete needs and linking*
2. *Assessment of psychological needs*
3. *Assessment of client's strengths*

Each of these themes is discussed, in this order, in the following description of each of the three phases of CTI. In conducting the CTI work in accordance with these three themes, you will be recreating for each client a mode of carefully considered helpfulness and guidance that can be called the CTI specialists' therapeutic stance.

### **B. Phase 1: Transition to the Community**

#### Assessment of concrete needs and linking

Before the client first moves to community housing, the CTI team formulates a treatment plan with specific attention to the five areas described above as facilitating community stability: psychiatric treatment and medication adherence, money management, substance abuse management, housing crisis management, and family interventions. Special attention is given to factors precipitating housing loss in the past, as well as current needs and difficulties. Since the intervention is time-limited, services must be prioritized; some will need immediate attention, and others can be addressed later.

The main task of this phase is linking clients to appropriate resources, and moving away from providing assertive, direct care. The client will need a psychiatric provider, and may also want to attend a day treatment program or clubhouse. Some clients may want vocational training, and some may want to find work. You should work with the client in determining which options would be most realistic and beneficial.

Good linkages are crucial to the success of the intervention; these are the people and agencies that will gradually assume the primary role of supporting the individual in the community. It is essential that the formation of a linkage be a gradual process that is tested and modified as indicated. Previous linkage models have been criticized for passing along the responsibility of providing care without guaranteeing continuity. The Assertive Community Treatment (ACT) model was developed, in part, to counter the tendency to pass clients along without anyone taking responsibility for assuring continuous care.

The process of forming linkages to community providers can be illustrated by a relay race. Although there is a delineated area in which the baton must be passed in any relay (the nine-month limit in CTI), the process is best accomplished when the runner receiving the baton gets a running start. The runner passing the baton then must run together with the receiver until the grip on the baton is secure. For a while, both runners share a hold of the baton. This is a metaphor for the shared responsibility for the client's wellbeing that especially marks the latter part of the Transition to Community phase of CTI, heading into the Try-Out phase. We will explore the process of evaluating the strength of these linkages in our discussion of the Try-Out phase.

During the Transition to Community phase, you will have a high level of contact with the client, maintaining regular phone contact, and visiting the new residence to evaluate the client's adjustment to community living. The client may not immediately feel comfortable with his new treatment provider, or the new program or agency he is attending. Accompanying clients to appointments with new agencies may help smooth this stressful experience. There is the potential for conflicts to arise as the new providers and the client adjust to one another. The relationship established between you and the client prior to community placement will guide you as you mediate between the client and the prospective network of support. You will also work with clients to strengthen their ability to advocate for themselves. These linking services will taper off as the intervention progresses, with the expectation that the client will eventually be comfortable interacting with his treatment providers on his own.

### Assessment of psychological needs

When a client first leaves a shelter or hospital, or even a jail or a prison, separation issues will arise. Although the client might not have been particularly happy to be living there, he will likely have achieved some level of comfort and familiarity in that environment. In addition, it is likely that he will be leaving behind some important relationships. This is usually difficult for anyone to do, and the situation carries special freight for a person who has been homeless and has a mental illness. Studies have shown that many in this group have a childhood history of out-of-home placement, such as foster care, group home placement, or running away (Susser et al, 1991). Therefore, times of transition and separation may revive these traumatic experiences. CTI, therefore, tries to provide the opportunity for a gradual, empathic separation, so as not to compound the challenges of this already difficult time. This might include encouraging the client to call the discharging hospital to let the staff know how he is doing. Clients might also want to work as consumer advocates with people still in the hospital, talking with them about the experience of moving into community housing, and inviting them to see their new residences.

You will probably need to have a good deal of contact with clients during this period, as their need for support is perhaps at its highest. You may also need to increase contact if the client seems to need it. Increased peer or family contact may also be recommended. When treatment is refused around the period of the Transition to Community, one must always think of the stress associated with moving into the community. Loss of contact with peers and staff might play a role, as might living up to new expectations in the community. You should be aware that in some cases, clients in this phase may sabotage progress they have made in order not to re-experience distressing separations, and to avoid the vulnerable feelings new relationships can bring. Clients may also have poor self-esteem and feel they are not worthy of good things, and consequently may feel guilty when they are thriving. This sense of unworthiness or guilt may not even be in the client's conscious awareness. The case of "Charles" discussed below (p.21-23) illustrates some of these conflicts. If the client seems to be floundering in the community, these difficulties should be considered as possible causes, and the situation should be addressed with the client and discussed in CTI team supervision meetings. More than anything, managing this "critical time" is what CTI is all about.

### Assessment of client's strengths

A vital strength that can help the client in this period is the ability to form new relationships. These new relationships, in the residence, community, and with new mental health providers, will become the bedrock of the client's adjustment to his new living situation. It is important, therefore, for you to gauge how easy it is for the client to do this. If this strength is not present, you may need to be a bridge between the client and those with whom he will be forming new relationships.

Other strengths that must be assessed in the initial phase are adult daily living (ADL) skills. Can the client cook, clean, do laundry, use public transportation, or find his way around the neighborhood? You may need to step in and teach or model these skills when necessary. If possible, however, you should try to mobilize the client's own natural support network. For example, if the client has a brother who cooks well, this brother might be enlisted to give cooking lessons. Or, if the client has a friend living in the community he is entering, that friend might give him a tour, pointing out such things as the grocery store, a pharmacy, bus and subway stations, etc.

Perhaps most importantly, the client will need to be able to ask for advice and support during this difficult initial transitional time. Many issues will come up in this period, and the client may not know how to deal with some new situations. You may have to encourage the client to call her in these situations, if the client seems unlikely to do so naturally.

### Clinical example

The following case illustrates common psychological and practical dilemmas that come up for a client during the Transition to Community phase, and how several CTI clinical principles are used to successfully deal with these issues.

Charles is a 37-year-old African-American man who was unfocused, disorganized, dressed bizarrely, and had a delusion that he was an important attorney when he was first admitted to the hospital. Charles had an extensive history of psychiatric hospitalization, and had been homeless for many years. After discharge, he was unable to acknowledge his need for treatment in the community. The director of his community residence warned him that he could be evicted if his symptoms were not under control with medication. The CTI specialist was able to engage Charles around his delusion of being an attorney. This was accomplished by letting Charles use yellow legal pads to take notes relating to his delusions. As the relationship between Charles and the CTI specialist developed, the specialist explained to Charles that the yellow pads, property of the community mental health program, had to stay in the program, but Charles was invited to come in and use them there. Over a period of

several months, this finally led to Charles getting to know the program staff better and trusting them enough to accept their recommendation that he take anti-psychotic medication. With this, Charles improved dramatically and remained stable.

During the Transition to the Community phase of CTI, Charles unexpectedly acted out in ways that jeopardized his housing. He began to associate with a woman who was using crack cocaine. Charles began to show signs that he too was using. Despite encouragement to stay in the residence and receive help, Charles decided to move into the woman's apartment, paying a share of the rent. Recognizing that this was an impending housing crisis, his CTI specialist arranged a meeting between Charles and the staff of the residence.

At this meeting, it became clear that Charles was reacting to the stress of the transition to the community by breaking ties to the mental health system and trying to establish his "independence." On the strength of their ongoing relationship, the CTI specialist was able to effectively confront Charles with the fact that he was setting up a fragile and false sense of independence that would surely lead him back to the hospital. It was suggested that Charles might not be aware of it, but he may prefer this to the stresses of forming new attachments in the community.

The CTI specialist also anticipated that drug users might come into the apartment and steal his things; that the woman with whom he was living might demand more rent money (he did not have a lease with her); and that he might suffer a relapse under the influence of cocaine. Charles considered all this carefully and was sincerely grateful for the concern, but still decided to stay with the woman.

After the meeting with Charles, the CTI specialist proposed that the residence hold Charles' bed for as long as possible. It was agreed that they would do this for two weeks, but after that time, Charles would his room. This was conveyed to Charles. As predicted, before the two weeks passed, Charles's things were stolen from the apartment and the woman with whom he lived was asking for more money. Charles moved back to the residence and, for the past six years, he lived there and later in another more independent residence run by same agency.

### Discussion

A point worth emphasizing about this case is that while the CTI specialist recognized the danger of Charles's behavior, he also respected his need to make choices and to discover things for himself. His understanding of Charles' desire for autonomy and independence were conveyed to him in an empathic way, while at the same time he maintained that supportive housing, medication adherence, and abstinence from drugs were in Charles's best interest. Since Charles needed to find his own way, he was flexible enough to allow him the time to do this. It is easy to imagine mental health providers reacting to Charles's subsequent failure with a, "We told you so. You'll have to live with the consequences of your mistake now." Instead, the CTI specialist resisted being punitive towards him, and created a safety net for Charles. The housing providers were also flexible in holding Charles's bed for him. This combination of flexibility and consistency, so essential to CTI, helped preserve the alliance between Charles and his providers, ultimately preventing another hospitalization or episode of homelessness.

### Summary

The essential task of the Transition to Community phase is to facilitate clients' transition from the hospital, and begin linking them to services in their new communities. A multitude of practical and emotional issues arise during this period, including finding good service linkages, and helping the client to deal with the anxieties and challenges of moving into the community. The CTI specialist's skills in dealing with the difficulties inherent in this phase will be vital, as

will be finding ways to access and nurture the strengths the client will be bringing to his new situation.

### **C. Phase 2: Try-Out**

#### Assessment of concrete needs and linking

This stage is devoted to testing and adjusting the systems of support that have been established in the community. The CTI specialist should pay particular attention to the five areas of intervention previously outlined, and determine how the client is faring in area applicable to him. Some areas will need to be targeted for more intensive work, especially those that have triggered a housing crisis in the past. The specialist must use her judgment about how active to be at this stage; if possible, she should step back a bit and observe how sturdy the new community links are. If the system seems to be operating smoothly, she can become less active with the client.

However, systems usually need more time to run smoothly. Most likely, problems will arise which will require mediation and resolution. In this stage, the CTI specialist can make a fuller *in vivo* needs assessment; since the basics should already be in place, he or she can observe where there are holes in the system, and where the client needs more or less support or services.

When problems arise between the client and new community providers, the CTI specialist might schedule a meeting with all parties to try to resolve the difficulty. It is very important during this stage for the specialist to act as a liaison between the client and his or her group of care-providers. These new community links are still tenuous, and need to be reinforced as much as possible. For those clients with ongoing substance abuse issues, motivational interviewing is typically reintroduced in this stage.

#### Assessment of psychological issues

In this phase, the CTI specialist needs to step back to see how well the client can manage new independence, and be ready to step in if need be. The goal is to allow the client to maximize his strengths and capabilities, and to be available to help in areas where the client cannot cope well on his own. While some direct, assertive intervention by the CTI specialist may still be necessary, the priority should be placed on strengthening the client's skills and his linkages with community-based supports. In assessing the linkages, emphasis must be placed not only on the client's ability to seek help, but also on the ability of the community resources to respond to and meet the needs of the client.

We believe that many of our clients, by virtue of their experiences of shifting caretakers and housing placements, struggle with separation-individuation and trust vs. mistrust during the transition to the community.

- *Separation-individuation*: Margaret Mahler's (1972) theories of separation and individuation offer a helpful model for the psychological tasks that are particularly relevant to this stage of CTI. This is a time in a child's life that is characterized by exhilarating exploration of the world, alternating with periods of "low-keyed-ness" when the child becomes aware of the absence of the mother.
- *Trust vs. mistrust*: Levy (1998) applies developmental theories when addressing one of the key challenges of outreach and one that we see, especially in the Try-Out phase of CTI. Levy invokes Erikson's stage of trust vs. mistrust when he writes: "How does one promote trust in the sphere of interpersonal relationships, while providing appropriate boundaries regarding dependency issues?"

Although the many changes experienced during this transition may threaten to destabilize a client, they also offer an opportunity for emotional growth and reparation of developmental delays. A key factor is the gradual transition CTI offers, rather than the abrupt, traumatic rejection typifying these clients' past experiences.

The CTI specialist functions as a "refueling station," to paraphrase Mahler's terms, allowing the client to explore his new world in the comforting presence of a familiar, caring figure. The most important challenge for you is to decide when to stand back and when to actively intervene. Clinical judgment is of the utmost importance in these situations, but the rest of the team and the clinical supervisor will offer guidance.

When crises occur in treatment at this stage they can often take the form of the client expressing a simultaneous need for help and a rejection of the very things he most needs. When this dilemma is enacted in the client's behavior, housing is often jeopardized. We view this as an expression of the client's wish to return to a familiar structure at the expense of other freedoms. Thus, we see clients who seem bent on returning to the hospital or to a shelter or to the criminal justice system.

Failing to recognize the emotional conflict underlying the client's acting out can make you feel angry, frustrated, and helpless. By remaining available (both physically and emotionally) and resisting the temptation to completely withdraw or to jump in and take control, you can facilitate the successful navigation of this trying phase of adjustment to life in the community. Here perhaps more than anywhere else, you function as a therapist helping the client recognize, verbalize, and ultimately cope with his deepest anxieties.

During this Try-Out phase, then, clients might refuse treatment out of fear of further progress and independence. Conversely, the client who has made progress might "outgrow" his treatment and refuse services that feel too restrictive or paternalistic. Knowing the difference is a key clinical decision. In the former case, you would provide the opportunity to discuss the client's anxieties about moving forward, offer reassurance and perhaps greater structure in the short-term, and temporarily increase phone or direct contacts. In the latter case, you would meet with the client to formulate a new plan that would allow greater growth and independence, encourage maximizing the client's active participation in his or her treatment and rehabilitation, and taper down the amount of contact.

#### Assessment of client's strengths

During this phase, the client will need to begin to rely on community resources, and be consistent in maintaining these new relationships. For example, he might have monthly meetings with his psychiatrist. This will require organization, so the client knows the time and the date of the appointment, and how to get to the site. If the client is forgetful and has a tendency to miss appointments, he might find ways to compensate for this; for example, by putting reminder signs around his room, or asking someone to remind him. In general, important strengths during this period are the ability to access and utilize community resources, money management, and adult daily living skills. This also might be a time when clients might want to strengthen ties with friends or family, if these people might be good supports.

#### Clinical example

Frank is a 42-year-old man with schizophrenia who has a long history of relapses due to non-adherence to medication. Several times in the past, he experienced episodes of homelessness and hospitalization after a psychiatric decompensation. During a two-year stay in the hospital, he was finally stabilized on a combination of a decanoate form of neuroleptic and an oral dose of an atypical antipsychotic medication.

Frank was able to obtain housing in a community residence with 24-hour staff support, and was doing quite well there during the first few months of his stay. Most notably, he had saved a significant amount from his monthly SSI checks in order to take a trip to Philadelphia, where his adult son lived. Recently, however, Frank had clashed with the staff about the dispersal of his money; the residence had a policy of being the payee, and Frank got his money in weekly increments. He wanted to get the entirety of his check when it came in, in order to have the necessary funds to hasten his upcoming trip.

Now, in the fifth month of CTI, Frank is becoming increasingly angry towards the staff at the residence, and has accused them of wishing to control his every move. His hygiene has started to decline, and other residents are complaining that he smells. He recently told his case manager at the residence that he does not want to continue with his medication, as he feels his taking it is a capitulation to staff's control of him.

At a meeting with his CTI specialist and the residence's case manager, Frank complained once again about the residence's control of his money. Together, the three of them went over Frank's budgeting thus far. The CTI specialist pointed out that he had proven that he can effectively manage his money, since he has been able to save a fixed amount from every check, and asked the residence case manager if they could make a time table for when Frank might be able to take over his monthly check. The residence case manager, persuaded by the evidence, decided the time table would be unnecessary, and agreed to let Frank receive his next check all at once.

The second issue the group dealt with was the recent changes in Frank's behavior, from his angry outbursts to his skipping showers. Frank admitted that he had stopped taking his oral medication a month ago, when residence staff had been refusing to let him manage his own money, and was planning to refuse his next injection of decanoate. When the CTI specialist asked him if he had been experiencing side effects that bothered him, he admitted that he recently had two episodes of impotence with his new girlfriend. Too embarrassed to bring it up with his psychiatrist (who did not ask him about it), and too angry with the residence staff to talk to them about it, Frank decided on his own to stop his medication.

Knowing Frank's history of relapse secondary to medication refusal, his CTI specialist had noticed the incipient signs of decompensation, and was not surprised to see that Frank was in danger of reenacting this pattern. His going off the medication was both an attempt to regain his autonomy, and an attempt to solve the problem of impotence. His specialist explained to Frank that it was likely that medication changes could resolve the problem without the unnecessary risk of relapse he was taking. Since Frank now felt his autonomy was respected, because he would be allowed to manage his next check himself, he was more amenable to talking with his psychiatrist about his impotence, and giving the medication another chance. Together, Frank and his CTI specialist went over ways that he could bring it up, and what kinds of questions he might ask. Soon after this conversation, Frank was able to talk to his psychiatrist, and they came up with an alternative regimen without the side effect of impotence. Frank also was able to take his trip to Philadelphia for a weekend, and returned to the residence feeling happy about the time he had spent with his son.

#### Discussion of clinical example

In this Try-Out phase, the CTI specialist was monitoring areas in which Frank might need more or less support. Frank was showing the strength of being able to set a goal for himself, and budgeting his money to be able to reach that goal. However, he was not able to communicate clearly enough with the residence staff about his goal, and approached them with hostility whenever he talked with them about releasing his money. The residence staff, put off by his anger, did not carefully evaluate his request. The CTI specialist, then, had to encourage both the client and the residence staff to accommodate to each other. This is in



keeping with the philosophy of CTI: it aims to help the client adapt to his new environment, and to help the environment adapt to the client.

The second issue that the CTI specialist dealt with was Frank's stopping his medication. Noticing the nonverbal cue of not showering, and his increasingly angry outbursts, she suspected that Frank had stopped taking his medication. Rather than being critical of him when he admitted this, however, she took an empathic stance, and asked him if there was something about the medications that bothered him. In this way, she conveyed to him her understanding that there might be very good reasons why he might not want to take his medication. With this approach, Frank was able to reveal his recent impotence. The CTI specialist could then step in and help adjust another community linkage-- Frank's relationship with his new psychiatrist. By encouraging Frank to talk with his psychiatrist about his problem, and role-playing with him how he might broach the subject, the CTI specialist helped them establish a stronger therapeutic alliance, and set the stage for improved communication in the future.

### Summary

The essential task of the Try-Out phase is assessing the client's level of functioning, and working with the client to maximize his strengths, and anticipate his vulnerabilities. To this end, the client and CTI specialist will evaluate the linkages made with community support systems, and adjust them as necessary. The CTI specialist will see how well the client can manage his new independence, and be ready to step in, or step back, as necessary. The client might need more or less support in certain areas. For clients with substance abuse problems, motivational interviewing occurs in this stage. The main psychological task of this phase is working through separation/individuation issues-- optimally, the client will become more independent, and less reliant on CTI services.

### **D. Phase 3: Transfer of Care**

#### Assessment of concrete needs and linking

Since the CTI relationship will be ending in this phase, it is vital that all links to community providers are secure. Last minute fine-tunings may be needed, but ideally everything should be in place for the client's network of long-term support. During these last three months, the CTI specialist, client, and various key players should meet together to discuss the transfer of care, and go over long-term goals. These key players might include family members, a therapist or psychiatrist, or someone from the client's residence, especially if he lives in a residence with supportive services. Ideally, this discussion should take place one to two months before the end of the nine-month CTI period, to allow time to correct any snags.

#### Assessment of psychological needs

The most salient issue psychologically during this phase is dealing with the end of the CTI relationship. As in the Transition to Community stage, separation issues may be revived because of the upcoming termination with the CTI specialist. Depression might set in as termination evokes feelings related to past losses. Underlying feelings of anger and abandonment might fuel a treatment refusal. Clients might also be tempted to sabotage progress as a means of obtaining increased contact with the specialist. In these cases, the specialist should let clients know that he or she is available to witness progress, and need not only be called upon in times of trouble. For example, the specialist might let clients know he or she would be happy to visit them at the clubhouse they are attending, where they have recently been making friends and becoming involved in activities.

This stage is also a good time to review and reflect on the work that the client and specialist have done together. They might want to look at where the client was in the beginning of the intervention, where he or she moved to during the intervention period, and what are

possibilities that lie ahead in the future. It is important that the CTI specialist convey confidence that the client can continue to make progress and grow. The termination of the CTI relationship can then be a step in the journey to greater self-improvement. Now that the client is stabilized, he or she may be able to tackle things which have been on the back burner for years. The conversation, however, should also be framed with an understanding of what are reasonable goals to set at the present time. In this context, the two should discuss the client's strengths, new skills, vulnerabilities, and the "safety net" in place should the client need it. Finally, the client and CTI specialist should talk about their relationship-- what it has meant to them, and what they have gotten out of it. A celebration might also be a nice way to mark the end of the CTI relationship.

### Clinical examples

Travis is a 22-year-old man with a diagnosis of bipolar disorder. A year ago he had a suicide attempt when he heard that he was to be evicted from the room he was renting. Already in a deep depression, Travis could not imagine finding another place to live or a way to survive, and overdosed on his Lithium. After a neighbor found him unconscious on the floor, he was hospitalized.

During the nine-month CTI period, Travis made many changes in his life-- he successfully retained housing in a community residence, and made friends there. He saw a psychiatrist once a month, and a therapist once a week. None of these linkages to community providers were made easily-- in the beginning of the CTI period, Travis denied he had any psychiatric problems, and believed seeing any kind of doctor or therapist was a waste of time, or worse, would be damaging to his stability. Because the residence he lived in required that he be engaged in treatment, he reluctantly attended his meetings. Through his strong alliance with his CTI specialist, he was slowly able to engage with his treatment team in the community, and now attended all his appointments. Medication had also been a huge issue for Travis-- he refused to take Lithium because he said it reminded him of his overdose, and triggered suicidal ideation. His psychiatrist, then, prescribed another mood stabilizer that Travis agreed to take.

In the last month of CTI, Travis started to miss his meetings with his CTI specialist. Claiming that he was busy trying to create opportunities for his music career, Travis missed two appointments in a row. Although he appeared to be functioning very well, and the residence staff said he was thriving, the CTI specialist was concerned about his avoidance of her. Suspecting that he was trying to avoid dealing with this painful loss, and that this avoidance might lead to self-destructive behavior down the road, she insisted that Travis attend their next meeting.

In this meeting, Travis described the band he was trying to put together, and all the new people he had been meeting. The CTI specialist expressed admiration that he had been able to make so many strides in so short a time. She said she wondered, though, if Travis might be trying to show her that he could make it on his own, and that she no longer mattered to him. She said that while she had no doubt that Travis could indeed make it on his own, she imagined it might be hard for him to lose her all the same. Travis admitted, then, that he "wasn't doing well" with the thought of their upcoming termination. When asked what he meant by this, he said he had been feeling very sad and wondered if he might "slide back down that hill." The CTI specialist reframed what he considered "not doing well", and said that she saw these feelings as a sign of health-- for the first time in his life, Travis was able to feel sadness over the loss of a relationship, rather than only anger and confusion. Further, she pointed out that his fears of going back to old behaviors were normal, and that as long as he recognized that they stemmed from the difficulty of losing their relationship, he might not act on them. Travis then realized that this was the first time he ever had the chance to say goodbye to somebody in a way that was not abrupt and traumatic. Together, Travis and

the specialist decided to use this as an opportunity, and for Travis especially to work on realizing that he could retain many of the good things that had come out of the relationship. In this sense, the CTI relationship would always be there for him in his heart.

The following dialogue is a compilation of many such interactions between CTI specialists (S) and clients (C) who are in the final stages of CTI:

- S: It's hard to believe it, but we're at the end of our time working together.
- C: You know it. I never thought I'd get here. My own room, a job program, and I've been clean for 13 months (shows the S his AA key chain).
- S: It wasn't an easy road.
- C: No way. When I first met with you, I thought you were trying to keep me down. You know, control me and my money so the program would profit. That money management was the roughest part.
- S: But without it, you'd have blown it all on crack.
- C: Yeah, but I couldn't see it then. I didn't trust you. But now I see you were trying to help me. Part of it was that you're a woman. All the women I ever knew just wanted to take—your money, your drugs, your manhood. When I spoke to Dr. D (the director) and Mr. G (a case manager on the team), they helped me see that you were looking after me. I gave you another chance and you hung tough with me.
- S: And now it's time to move on to even bigger and better things. Are you ready?
- C: Yeah. Well, sometimes I see myself back on the streets smoking crack. It's not pretty, but sometimes I miss the feeling.
- S: What do you do then?
- C: You know, I call my sponsor, or sometimes I just walk it off. I'll walk real fast and start thinking about my kids and how I want them to have a father who's not a bum. The medications help calm me down too. And I make my meetings. One day at a time. That's what it's all about.
- S: I can't tell you how great it makes me feel to hear you say these things and see the progress you've made. I want you to have this gift as a sign of how proud we are of you.
- C: (Opens the gift to reveal an address book).
- S: You'll find our address and phone number under "C" for CTI. Don't be a stranger. We expect cards on all the major holidays. Just kidding, but please drop us a line or call to let us know how you're doing. If you want to come back and talk to the men in the housing group or one of the MICA groups, you're always welcomed.
- C: I might take you up on that. And here, I have something for you. (Pulls out a business card from his pocket and hands it to the S).
- S: (Reading from the card): "Professional lover." I didn't know you started your own business. (They share a laugh together). I'll miss you, C. Good luck.
- C: I'll miss you all too. But I have people around me now who support me and my sobriety. I'm ready for the next step.

## Discussion of clinical example

On one level, Travis' burst of activity in the final phase of CTI looked like the culmination of a success story-- he was completing the transfer-of-care to providers in the community, and needing his CTI specialist less and less. However, given what the CTI specialist knew of his attachment to her, something seemed to be missing from the picture. Concerned that his independence was masking his feelings about separation, she set about trying to talk about this with him. Their ensuing discussion gave Travis a real opportunity-- he could now think about his feelings of sadness as an achievement, rather than as a weakness. He was also then less afraid of acknowledging all the relationship had been to him. Going over the progress of the last nine months was a way for him to acknowledge his accomplishments, as well as a way of keeping the CTI relationship alive for himself in the future, as he continued to work on the long-term goals he had set in this period.

## Summary

The essential task of the Transfer-of-Care phase is to deal with the end of the CTI relationship, and to address the client's long-term needs. Fine-tuning in the client's system of community care may be needed, but optimally everything will be in place at this stage. It is important to bring together all the key players in the client's treatment at this time, to discuss work accomplished and goals for the future. CTI specialists must be especially alert to dealing with client's feelings about separation, as the termination may bring up painful past losses. One of the ways that the CTI intervention can be effective is in allowing a very different type of separation-- one that is planned for and dealt with, both practically and emotionally.

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