Center for the Advancement of
Critical Time Intervention

SILBERMAN SCHOOL of SOCIAL WORK
HUNTER COLLEGE | CUNY

Critical Time Intervention For Rapid Rehousing

Manual for Case Managers and Supervisors

SUPPORTED BY
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Acknowledgments

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Daniel Herman
Carolyn Hanesworth
Ben Cattell Noll

Center for the Advancement of Critical Time Intervention
Silberman School of Social Work
Hunter College of the City University of New York

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This manual was developed by the Center for the Advancement of Critical Time Intervention of the Silberman School of Social Work at Hunter College in New York City. It is a product of a two-year pilot study launched in 2016 that tested the use of CTI in rapid rehousing programs in the state of Connecticut.

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Melville Charitable Trust
National Alliance to End Homelessness
Connecticut Coalition to End Homelessness
Connecticut Department of Housing
Housing Innovations

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Background

Adapting Critical Time Intervention for Rapid Rehousing

The original CTI model, created over twenty years ago, was an intensive, nine-month case management approach designed to reduce the risk of recurrent homelessness among single adults making a transition from shelters to housing. In a set of three timed phases, CTI aimed to connect these vulnerable individuals to crucial services and supports and assisted them in navigating complex systems of care during the transition period. The goal was to create deep, lasting connections to supports that would remain in place after the intervention ended, so that its impact would endure well beyond the end of the active intervention period.

The main differences between this original model and CTI for Rapid Rehousing (CTI- RRH) are the target population, briefer duration and the interface with the rapid-rehousing financial assistance. CTI-RRH delivers short-term, targeted services designed to increase economic resources and connect clients to community supports that will help them retain housing after the financial assistance and case management period end.

Like all case management or care coordination models, CTI-RRH relies primarily on mobilizing and effectively coordinating existing services and informal supports; it does not create additional housing, income, treatment or other resources on its own but seeks to maximize access to and the impact of existing resources. Since communities differ significantly on the availability of such resources, its form and impact may vary in different communities.

Organization Support for CTI RRH

A successful CTI RRH implementation depends on the resources available to deliver the model. In order to achieve fidelity, organization must have infrastructure that includes:

- Staffing consistent with the guidelines for caseload size
- Basic resources for fieldwork, including reimbursement for travel and cell phones
- Supervisors with professional credentials and additional training in CTI
- Senior staff who are prepared to serve as advocates for the models with funders and other community providers.

Goals

The primary goal of CTI-RRH is to improve the client's capacity to remain housed during program participation and beyond by effectively connecting them with crucial community supports and helping them to attain greater economic stability.

CTI-RRH aims to support a successful transition to permanent housing by maximizing available resources and supports. In order to achieve this, the intervention focuses on factors that directly influence housing stability, including:

- Obtaining and coordinating financials benefits
- Accessing health care, child care, employment and education services
- Budgeting and management of financial resources
- Connecting clients to effective social and community supports that address barriers to stable housing.

CTI-RRH is not designed to resolve poverty, and in many cases clients' housing will remain precarious, although most are expected not to return to homelessness.

Model Description

CTI-RRH is a six-month case management model composed of three distinct phases; each approximately two months long. The amount of contact between the worker and clients should decrease as clients move through the phases of CTI-RRH, promoting a gradual transition to community supports.

While CTI-RRH shares a number of characteristics with traditional case management approaches, the following are core components that distinguish it from other interventions:

- **Time Limited:** Case management assistance is limited to six months. This may be extended in rare cases but only with explicit justification and prior supervisory approval.

- **Three Phases:** The intervention takes place in three phases, each phase having the same duration.
- **Decreasing Contact:** Workers have fewer face-to-face and telephone contacts with clients as the intervention progresses.
- **Highly Focused:** One to three areas of focus for each phase are selected from the program's list of CTI areas.
- **Small Caseload:** Each worker's caseload size is no more than 20; and is weighted depending on the number of clients in each phase.
- **Community-based:** During Phase One especially, there is significant face to face between workers and clients outside of the office environment.
- **Weekly team supervision:** Workers have weekly team supervision meetings.

Core Values

These core values should guide the delivery of the CTI-RRH model.

Strengths-Based

The CTI-RRH worker should ground his or her approach in a strengths-based assessment of the person or family in their environment. The work should center on leveraging the client's inner resources, and connecting to external resources that serve to support housing stability. Within this frame, the worker should honor the client's right to self- determination by empowering them to make important decisions about themselves and/or their family through a shared decision-making approach. In all cases the worker should work alongside the client as a partner and collaborator in the work.

Individualized

Clients receiving RRH are extremely diverse and will vary in strengths across a broad continuum. Some clients may be capable of resolving their current experience of homelessness with little intervention beyond basic financial assistance. Others may have serious challenges associated with mental illness, addiction, domestic violence, or have persistent barriers to employment. CTI-RRH workers should adjust the level of direct assistance based on an ongoing assessment of need. Caseload size may vary depending on program resources, but should be small enough to ensure that individually tailored services can be effectively delivered.

Culturally Sensitive

The CTI-RRH worker should adhere to a value base that respects the differing world views, perspectives, and experiences of clients. Clients may have deeply held views about money, government assistance, and financial institutions that inform their decision making and may be in opposition to what the worker believes is constructive. To the extent possible, workers should strive to balance the goal of economic and housing stability with a sense of respect for and understanding of client values, needs and choices.

Transparent

Clients have a right to know the nature and extent of the services they are eligible to receive, including the potential duration of financial assistance and case management support. In some cases, workers may believe that clients will lack motivation to complete goals if they know they have several months before assistance ends. However, if clients lack accurate information about the nature and duration of assistance being offered, they may become anxious and confused about how their efforts over the short-term will lead to positive long-term housing outcomes. Transparency maximizes the likelihood of developing an open and productive relationship between worker and client and encourages clients to share important information with their worker. Concerns about motivation should be addressed by communicating with the client about the realities of what they *can* achieve within the given time frame, coupled with a careful plan to achieve those goals. This value should not be in opposition to the value of individualization, as the duration and nature of services will vary based on the particulars of the client's situation and needs and are not designed to be "one size fits all."

Trauma Informed

Substantial research demonstrates that the majority of persons who become homeless have been exposed to one or more severe traumatic stressors in childhood, adulthood or both. Many people experiencing homelessness have histories of domestic violence that also may be the cause of homelessness. These exposures may lead to a variety of adverse health and mental health impacts that effect clients in a variety of life domains and how they approach services. Trauma informed care incorporates an understanding of these impacts into case management practice by emphasizing emotional and physical safety, establishing trust, and promoting opportunities for clients to rebuild a sense of control and empowerment. Trauma informed programming seeks to design services in ways that minimize the chances of re-traumatizing clients and limit their exposure to further trauma.

CTI-RRH Roles

CTI-RRH employs a team approach with two key roles.

CTI-RRH workers— provide all case management services during each phase of CTI-RRH. Effective CTI-RRH workers function as a trusted ally and advocate. They possess a keen eye for detail and timely follow-up. The ideal CTI-RRH worker:

- is committed to applying *Housing First* principles to end homelessness
- has a firm understanding of the personal challenges and systemic barriers associated with poverty and the experience of residential instability
- applies an open, flexible and optimistic approach to the work that does not make unwarranted assumptions or judgments about the client's situation
- is adept at interdisciplinary team work
- is comfortable working in the community rather than the office
- is effective at reaching out and building alliances with other providers
- displays a strong ethical sense and respect for the dignity and worth of all clients

CTI-RRH supervisor— oversees services delivered by the team's CTI-RRH workers and demonstrates proficiency in guiding the workers' activities during all phases of the intervention. He or she:

- ensures that workers' practice is consistent with the phase-specific activities and foci of the CTI model
- carefully monitors the worker to ensure that phase transition dates are observed
- ensures that model-specific case planning and recording documents are being completed correctly and are up to date for all workers
- encourages open communication and demonstrates a willingness to support, as well as instruct, supervisees
- Monitors and manages the caseload to ensure there is reasonable time to provide services as intended
- Works to create relationships with key providers in the community

The supervisor should be a master's level social worker or other human service professional with experience working with people experiencing homelessness.

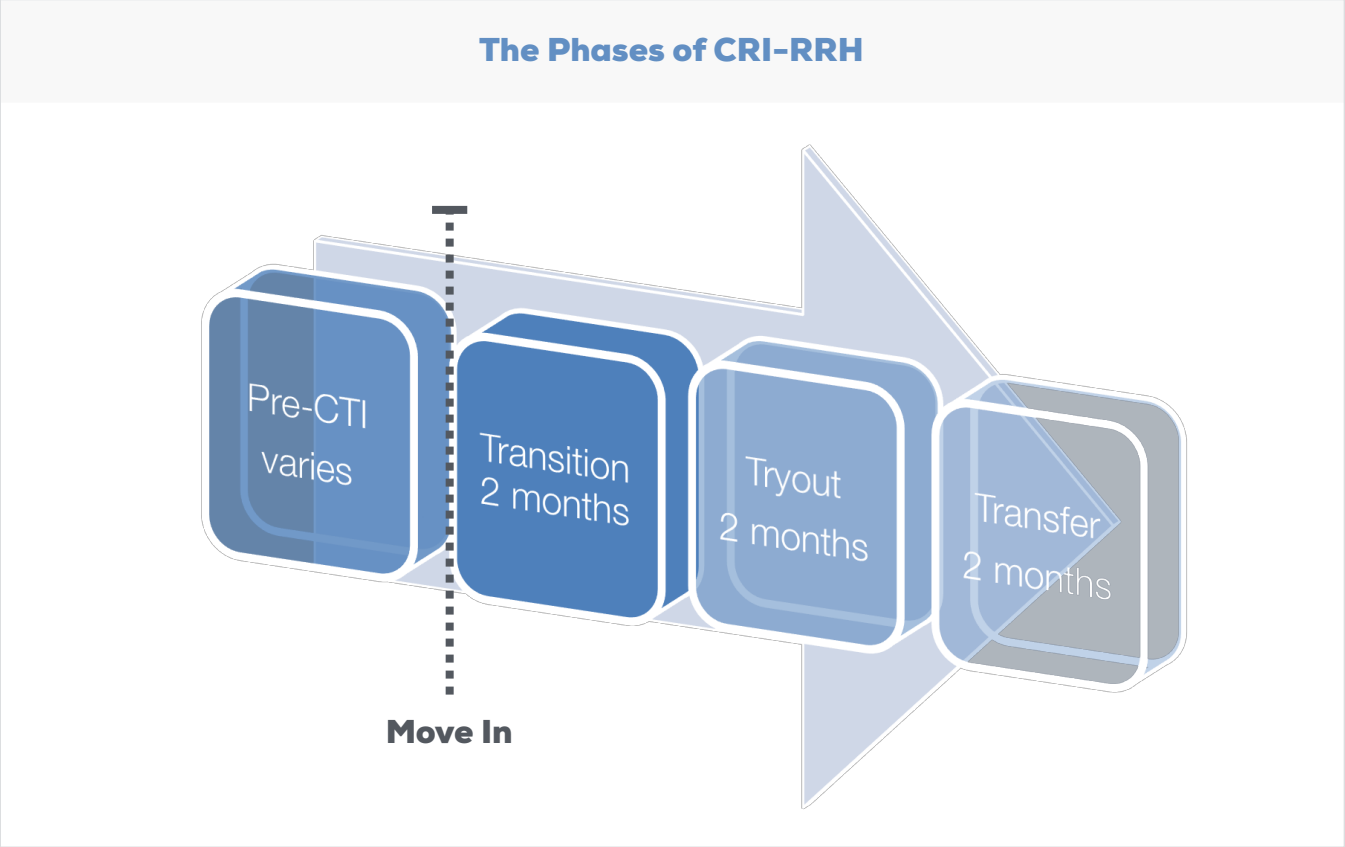
How Does CTI-RRH fit with Financial Assistance and Housing Location Activities?
It is recommended that decisions regarding amounts and duration of financial assistance provided to rapid rehousing clients are standardized and enforced by the larger organization rather than by individual workers. This is intended to promote the development of a strong working relationship between clients and workers in which clients view the worker as an ally. Ideally, clients should be sharing goals, needs and challenges openly and honestly. The worker can and should *inform* decisions about financial assistance.

The duration of CTI-RRH is not dependent on the length of financial assistance. Financial assistance may conclude before, or extend beyond the termination of case management. If financial assistance does extend beyond case management services, it is recommended that clients receive at least monthly phone calls from the worker to check in on their status and potential needs.

Although not feasible in all settings, there should ideally be a separate housing specialist who provides housing services in a "Pre-CTI" phase. The work of a housing specialist is complex and involves both direct client interaction and establishing effective connections with private landlords and local housing organizations, both of which are time-consuming and require specialized knowledge and skills. Some agencies may lack sufficient resources or demand to employ separate workers for these tasks. In these cases, the worker may be responsible for both housing search/placement activities as well as delivering the subsequent CTI-RRH intervention. The description of work to follow presumes a model in which housing location and case management are provided by two separate workers.

What about clients who need more than six months of case management assistance?
The CTI-RRH model is guided by the assumption that the majority of clients can succeed within the six-month timeframe. However, we recognize that some clients may not be stably housed or successfully linked to needed supports by the end of this period. For such persons, programs should have explicit procedures in place that authorize extended or enhanced assistance. However, these exceptions should be rare, carefully justified and require approval by supervisory staff. Examples of circumstances that may require extensions include: time-sensitive issues around benefits, employment, relocation in which some important status change is imminent; a hospitalization or other health-related crisis experienced by the client or a family member; or other situations in which a short extension of services is clearly indicated.

The Phases of CTI-RRH



Pre-CTI-RRH

Housing Search & Placement

Time Frame: Flexible. Unlike CTI-RRH phases I, II and III, which each have a fixed duration, pre-CTI-RRH may vary in duration as the housing identification process is unpredictable. In keeping with the goal of exiting clients quickly to housing, Pre-CTI-RRH should conclude as quickly as possible.

Intensity: Moderate. Worker should be coordinating activities with housing specialist but is not the primary service provider during this phase.

Objective: For the housing specialist, the objective is to locate housing that meets client needs and is accessible to familiar services and supports. The worker's objective is to engage with the client and begin to develop a trusting relationship. Ideally, the worker can

also begin the process of assessment and connection to resources, although this may not be feasible in all cases. In most cases, this process will not complete until the end of Phase I, because typically the client's new housing location will influence both client needs and access to services and supports.

Action Steps

The housing specialist should engage the client in a collaborative process by involving the client in the search, in communications with the landlord, and in lease negotiation. This will promote the client's sense of ownership for their new home and transfer valuable skills. The housing specialist should assess the client's understanding of tenant rights and responsibilities, and aim to educate clients in these areas as appropriate.

The worker should meet with the client regularly in order to start building a trusting relationship and identifying key goals. The worker and client may also initiate some aspects of the housing plan, particularly in areas that might require longer amounts of time such as applying for Social Security benefits or searching for employment.

Potential Barriers

Barriers to successful housing placement may include landlord discrimination, lack of affordability, a limited housing stock, or difficulty locating housing nearby clients' workplace, their children's schools, or family and friends. Families or individuals who settle for poorly located housing may lack access to important supports and services. These circumstances reduce overall housing stability and increase the risk that clients will become homelessness again.

A key barrier for the worker to be aware of is the challenge of negotiating the time and schedule of client meetings with the housing specialist. Some clients may feel confused and overwhelmed when offered services through a two-worker team.

Strategies

Success will depend on the housing specialist's ability to secure relationships with landlords prior to housing search and to advocate effectively. Workers should also be sensitive to vulnerable populations, such as those who may need accommodations for a disability. Domestic violence survivors may need extra consideration in the housing location process to ensure they are safely relocated.

In order to minimize client confusion, the housing specialist and worker should clarify their roles for the client. The housing specialist should be the primary service provider until the client has successfully moved in to their new home. However, the worker should aim to meet the client immediately after their enrollment in rapid rehousing and begin the process of assessment and resource connection. This will promote effective engagement and help the worker develop a preliminary picture of the client's strengths, challenges and priorities. Early engagement will also ensure that no time is lost in acquiring important resources during the housing process.

The transition of primary responsibility from the housing specialist to the CTI-RRH worker should follow in a carefully planned manner. This may include a conversation between the client, the housing specialist and the worker to discuss what was learned during the housing placement phase, along with the passing of information related to the client's needs and strengths that can be valuable to the worker in moving forward to Phase One of CTI-RRH.

Continuing Role of the Housing Specialist

Once the client is housed, there is no need for the housing specialist to continue meeting regularly with the client. However, housing specialists should be accessible to aid in negotiations with landlords should challenges emerge related to rent payment, housing conditions, or other concerns that may lead to the need or desire for a client to transfer to another housing unit.

I. Phase One: Transition

Time Frame: Two months.

Intensity: High. In person visits should occur at least weekly, preferably in the client's residence or in the community.

Objective: While continuing to establish a strong working relationship, the worker and client will complete an initial assessment, develop the Phase Specific Plan and make the connection to resources.

Action Steps:
At the beginning of each phase, the worker and client develop a **Phase-Specific Plan** that identifies a short list of **Focus Areas** to be addressed during the upcoming phase and that will guide efforts to establish effective links to services and supports. The selected focus areas should address needs that are directly tied to the maintenance of stable housing by the family or individual being served and should be selected from a "menu" of areas identified by the program.

Areas of focus may include (but are not limited to):

- Income generation (non- employment sources)
- Income generation (employment sources)
- Budgeting and financial management
- Survival needs (food, clothing, furniture, etc.)
- Physical & mental health
- Child care
- Transportation
- Education (child/adult)

The worker will conduct a brief bio-psycho-social assessment related to housing loss and barriers to stability. The assessment should determine causes for previous housing loss, and identify current stressors, challenges and strengths that inform future housing stability. Areas to explore should include financial history and current status, health (physical and mental), education, and employment. Health and access to education/child care should be assessed for each child in a family.

The worker and client will work collaboratively on a housing plan that is specific, goal-oriented and measurable. One to two goals for each phase should be identified. In Phase I, the worker will attempt to ensure the client is connected to the resources necessary to complete goals.

Potential Barriers

Clients may be weary of services at this point and hesitant to engage. Communities may lack adequate resources necessary for clients to achieve their goals.

Strategies

Workers should strive to present themselves as advocates and allies to their clients, and not as people in positions of authority who are checking in on or disciplining the client. CTI-RRH should never be imposed on a client and will be most successful if the client feels they have some control over the nature and extent of services.

Programs should work to establish resource networks in their communities. Ideally, workers should visit organizations regularly and get to know key personnel who can aid in the referral process. This is an ongoing endeavor, since resources and personnel change frequently. Supervisors should inform leadership about gaps in community services as a means to advocate at the macro level for additional community services.

II. Phase Two: Try-Out

Time Frame: Two months.

Intensity: Moderate. In person visits should occur at least bi-weekly, preferably in the client's residence or in the community.

Objective: To monitor the impact of resources on goal attainment and make adjustments as necessary. To begin empowering clients to maintain resources independently of the worker.

Action Steps:
The client and worker should assess progress made in Phase I, and identify Phase II specific goals related to the Housing Plan. The worker and client should assess the strength and value of current resources and make adjustments as necessary. The worker should decrease engagement in cases where resource linkage is successful and increase engagement in situations where resources are weak or ineffective.

Potential Barriers:
In some cases, the leveraging of community resources, welfare benefits and work will not be sufficient to support the payment of monthly rent without additional financial assistance.

Additionally, having sufficient financial resources to cover rental costs does not necessarily mean clients will always pay their rent in full or on time. Clients may have multiple economic pressures on them that aren't readily visible or that aren't shared. This may include family members in need or unexpected expenses for children.

Strategies:
The worker should provide the minimum amount of assistance needed for client to progress. In this phase, the worker may need to advocate on the client's behalf, but should aim to model and/or teach the client how to self-advocate.

In cases where resources and benefits do not adequately address financial needs to support the housing plan, workers and clients should work together to re-assess the long-term viability of the housing plan and think creatively about other means of increasing resources, such as apartment-sharing or reuniting with family members who can assist.

When sufficient resources seem to be in place to meet the requirements of the housing plan but obligations are not being met, workers should not assume clients are behaving irresponsibly. Clients may be prioritizing other needs and obligations separate from housing that may seem like a low priority to workers, but they may be an opportunity for an individual to give back to someone who has helped them or to feel competent as a provider for their family. Phase Two is a good time to assist clients with negotiating these challenges by discussing how to prioritize competing interests and what other resources might be necessary to ensure all obligations are addressed and to promote housing stability. A strong working relationship, if established during Phase One, will help the worker to initiate conversation around potentially challenging and sensitive topics such as this.

III. Phase Three: Transfer

Time Frame: Two months.

Intensity: Low. In person visits should occur at least monthly. The number of direct contacts with the client should be few during this phase as the worker ideally functions more as a consultant than in a direct helping role.

Objective: The final phase of CTI-RRH focuses on completing the transfer of primary case management responsibility to the community resources that will provide long- term support to the client.

Action Steps:
The main task in the final phase is to ensure that significant members of the support system meet together and, along with the client, reach a consensus about the components of the ongoing system of support. Ideally, this occurs at least one month before the end of the intervention.

Worker and client should review and reflect on the work that has been done over the course of the intervention. Workers should have a strengths-based conversation with their client about the progress they have made and why they feel they are ready to move on independently. The worker should ensure the client is aware of steps they can take in maintaining secure housing should unexpected challenges arise. These steps may include

legal assistance or housing loss prevention services. The worker should also discuss with the client who they will call in case they have questions or need further assistance, especially if the worker will no longer be available as an ongoing support.

Potential Barriers:

As clients begin to operate effectively with greater independence, the worker may be tempted to terminate services too early or forego final visits, especially when new cases in the early phases are demanding attention. This is a common mistake and one that can cause workers to overlook important issues in Phase III. At this point, the client has had an opportunity to utilize existing resources, and yet only begun to practice accessing them independently. Phase III is the time to assess whether the client is successfully maintaining housing on his or her own, and if not, what supports need to be in place to avoid repeated housing loss.

Clients may have anxiety about making ends meet and express doubt in their ability to manage. Workers may have similar worries about how a client will do without their support. These anxieties may be legitimate in the face of ongoing financial strain, and termination may be equally difficult for both worker and client.

Strategies:

Throughout the intervention, the worker should gradually reduce his or her role. This gradual process ensures that termination of CTI-RRH is not perceived by the client as a sudden, potentially traumatic, loss. It also helps the worker to be more confident that terminating the relationship will not lead to abrupt housing loss when the client confronts future challenges.

Supervision

To ensure program quality and encourage fidelity to the CTI-RRH model, it is critical that organizations provide regular ongoing supervision of workers delivering CTI in rapid re-housing programs. Supervisors should be social workers, psychologists, mental health counselors or other masters-level human service professionals.

Supervisors should require the use of CTI RRH forms, which are available through the CACTI website. These include Phase Plans, Progress Notes, Phase Date Forms, and Closing Notes. Agencies that use these forms report more success implementing CTI RRH than those who attempt to use their own forms.

Weekly team supervision sessions are the recommended format, but individual supervision should also be provided, if possible. Team supervision is seen as a critical complement to individual supervision because it encourages sharing of important community resource information between team members as well as providing a forum for joint problem-solving and support. Furthermore, it facilitates the ability of workers to substitute for one other in unusual situations in which a worker may not be available to respond to a pressing client emergency in a time-sensitive manner. Supervisors should also put in place procedures to ensure that case planning and recording forms are completed and updated regularly. Team meetings include the following elements:

- Case presentation of each new client
- Review of cases that will end intervention within the coming month
- Review of cases that are facing major crisis or cannot be located
- Review of cases that have experienced major success or positive change
- Brief review of entire caseload every two weeks to ensure that phase changes are on schedule and that cases are not overlooked

Case Examples

Example One: Diane

Pre-CTI-RRH

Empowering the Client in the Process, Importance of Diverse Options

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Diane is a 45-year-old woman who has been staying in a shelter for the past 8 months. This is her first time experiencing homelessness. Diane injured her back while working several years ago and has been experiencing chronic pain, causing her to be unable to work. She receives about $1300 each month in SSI/SSDI payments.

You meet her and the housing specialist in the shelter to begin the pre-CTI-RRH phase of looking for housing. Diane most recently lived in a very nice neighborhood and reports that she is only really considering three or four neighborhoods to live in due to safety concerns. She does not want to spend more than $600 on an apartment. You explain to Diane that this is unreasonable, since the average rent in the neighborhoods she is interested in exceeds her entire monthly income and she is unlikely to qualify for subsidized housing that could make up the difference. The housing specialist finds two rooms for rent in houses in one of Diane's desired neighborhoods through a Craigslist search for $750 plus utilities. Diane declines to look at the rooms because she says she is an adult and does not want to live with a roommate. At the next meeting, the housing specialist takes Diane to see an apartment in a neighborhood other than where she requested. In talking with Diane after the appointment, you encourage her to move forward with this apartment since the rent is only $700/month and she will have her own space, but Diane immediately rejects the apartment because she does not like the area and feels like the building is too old and run down. You explain that this is the best you can find given Diane's budget and that she is going to have to decide between living with people in the neighborhood that she wants or having her own space in a less desirable area.

Two weeks go by without you hearing from Diane. You reach back out to check in and see how her housing search is going. Diane reports that she applied for a one-bedroom apartment at a building she found in one of her desired neighborhoods for $1,000/month. She reports that she knows money would be tight but that she would find a way to make it work. You agree to check back in a couple of days to see if Diane is approved and agree to have the housing specialist continue looking for landlord partners that might meet Diane's needs. You remember a landlord you've previously worked with who rents their

basement in a neighborhood just beside one of the areas Diane was hoping to live for $725/ month. You reach out to see if the unit is available and they inform you that it is.

Diane calls you the following day and informs you that she was denied for the apartment due to insufficient income. You tell her you are sorry to hear that, but say that you think you may have found something that could meet her needs. You explain that there is a landlord you have previously worked with who lives just beside one of the areas Diane wishes to live and has a house on a quiet street with a basement room with a separate entrance that would not require her to share space with anybody else. Diane agrees to go along with you and the housing specialist to view the apartment and says that she would like to apply for it. The landlord agrees to overlook the usual income to rent ratio because the tenant will be receiving supports from you and Diane moves in the following week.

Comments

Helping clients navigate the housing search is one of the most difficult and important steps in ending homelessness. This example showcases a common challenge with housing location; “unreasonable” demands. Clients who have been out of the rental market for some time may not fully understand the dramatic increases in rent over the past years. Others may be very specific about where they want to live or the kind of apartment that they want. This can be frustrating for CTI-RRH housing specialists and workers, and there is a tendency to want to “reality check” with clients immediately. However, this can be damaging to a relationship and lead to a feeling that we are “putting people in apartments” that they do not want rather than working together with them to find something that meets their needs.

The worker and housing specialist in this case initially come on too strongly by telling the client her needs cannot be met and trying to show her things that are not what she is asking for. This does not help the client access housing faster and leads her to disengage for some time. When the worker and housing specialist take a step back and allow the client to pursue housing that meets her needs- even if they are reasonably confident she will not be approved- it is empowering to the client to try and meet their ideal. When clients with very specific requests for housing have an opportunity to see and experience the realities of the housing market firsthand and be an active participant in the process, they may be more likely to listen to your advice later.

It also highlights the importance of having diverse landlord partners, including housing of different kinds (rooms, apartments, studios, etc.), in different neighborhoods, and at different price points, as well as landlords who are willing to overlook poor credit histories, applicants with low or no income, etc. This can expand the options for clients who may not know how to access certain types of landlords or housing on their own and lead to win-win opportunities like the above example.

Example Two: Ophelia

Phase One: Transition

Identifying Informal and Formal Supports and Prioritizing Goals

Ophelia is a single mother with a 6-year-old son and a 4-year-old daughter. She became homeless after fleeing a domestic violence situation with the father of her youngest child. While staying in a transitional housing program, she was able to complete a home health aide certification and has been working Monday through Friday from 8am-4pm providing care to an elderly woman in the community. Ophelia's son is in school every day and the transitional program provides childcare for her daughter, which will end when she moves into her own apartment.

When you develop a housing plan with Ophelia, she explains that she enjoys providing care as a home health aide and that her goal is to return to school to obtain her LPN license. Her greatest concern is how she will pay for childcare for her 4-year-old while she is working. Additionally, she tells you she recently received information that the father of her daughter wants to seek custody.The top priority for working with Ophelia is to secure childcare for her daughter. Ophelia was able to identify a temporary replacement to care for her patient while she moved in and adjusted, but she cannot afford to miss any more work and still cover her living costs, and she does not know how she will pay for childcare. While researching available options in the area, you come across a Head Start program that serves low-income families with children 5 and under. This seems like a perfect fit for Ophelia's daughter, and you provide her with the information and she is able to enroll her in a full-day program. Ophelia drops her son off at the school's breakfast program at 7:30 each morning and re-arranges her work schedule to arrive at 8:15 so she can drop her daughter off at her program at 8:00.

When Ophelia receives court papers for a custody hearing two months into working with you, you provide her with contact information for a legal aid program in the area. The program office is a long distance from Ophelia's home in an unfamiliar area and so you agree to travel with her for the first meeting. They agree to take on her case and plan to conduct business over the phone and at the courthouse, which is much closer to Ophelia's apartment, moving forward.

As you prepare to conclude case management services with Ophelia, you discuss her desire to increase her education to better provide for her family. Ophelia is not certain how she will be able to balance school with working to pay the bills and providing care and supervision for her kids. Through the process of exiting homelessness and getting back into housing, however, Ophelia was able to reconnect and start to repair a troubled relationship with her mother. Ophelia's mother has been looking after her kids one evening a week for the past month to give Ophelia a chance to relax, and they have started to discuss more frequent childcare arrangement in the future that could allow Ophelia to take some classes. You leave Ophelia with brochures about two educational programs you located and information about how to apply for financial aid and loans.

Comments

This case demonstrates the importance of setting and prioritizing goals. Managing multiple major life changes at once--such as a move into housing, a new job, and education--can be difficult to impossible. Goals must be prioritized based on what is the most essential to meet current needs and what can reasonably be attained within the scope of the program. In this instance, identifying childcare for the daughter was the most critical goal as it allowed the client to work and provide income necessary for housing stability. The custody and educational goals, while important to the client and necessary for long-term stability, were outside the initial scope of the program. Still, the worker assists the client with identifying and taking small steps towards achieving these larger goals by connecting with community providers who can support the client in achieving the goals after the conclusion of the CTI-RRH period.

It also shows the importance of exploring both formal and informal supports. While knowing about Head Start and legal aide resources in the area was crucial for helping the client achieve two of her goals, identifying the client's mother as a key informal support and resource will allow her to take steps towards achieving future goals in ways the formal supports could not.

Example Three: Stuart

Phase One and into Phase Two

Rapport Building, Goal Identification & Resource Connection

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Stuart is a 67-year-old Vietnam Veteran who has been living in a shelter on-and-off for the past 4 years. Stuart occasionally pays for a few nights in a motel to get out of the shelter and relax at the beginning of the month when he receives his $733 SSI check (for a back injury).

Stuart had a bad experience with the VA after returning from Vietnam and has since refused to work with them. He was eager to work with your program to locate housing when he found out you were a community organization separate from the VA. He found a studio apartment in a complex he really liked and was accepted for move-in, but you were concerned that the rental amount- $850- was too much given his income. Stuart outlined in his housing plan that he desired to increase his income through employment, so you approved him for rental assistance to move in and helped him pick out some furniture.

Stuart was thrilled to move in, proud to show off his new apartment, and quick to make friends with neighbors in the complex. Stuart did not start looking for work right away. After several visits, and your providing him job leads and encouragement, he still had not begun the process. When he did, he experienced a few rejections and gave up. He reported that he was not feeling well and did not feel ready to work yet. After a couple weeks, Stuart brought up the idea of working again and even attended a job fair, but became discouraged when an employer reported that in order to drive truck for his company Stuart would need to pass a background check. He said that he would not be eligible due to a previous felony conviction.

A month after you began working with Stuart you attended a training from another community partner about veterans' benefits. You learned that some veterans are eligible for "Service-Connected Disability" payments and that the organization could help veterans file expedited claims with the VA. Knowing Stuart's previous apprehension to work with the VA, you asked his permission to bring up the conversation about applying for benefits. During the conversation, you learn that Stuart's back problems that led to his disability were a result

of work he did with heavy machinery while serving in the Army and that he would be an excellent candidate to apply for these benefits. You encourage Stuart to meet with the community provider to complete an application and offer to accompany him to the first meeting.

Stuart has a positive first meeting with the organization and decides to come back the following week by himself to complete the application. Stuart is approved for a 40% service connection, which increases his income by an additional $590 each month. Through meeting with the veterans' benefits organization, Stuart also learns about a job development program that works specifically with employers who have a preference for hiring veterans, even if they have a criminal background. Stuart enrolls in the job program and continues to look for suitable employment to supplement his disability incomes. Knowing money is still tight, you help connect Stuart with a subsidized phone service, utility assistance, and a local food bank so that he can continue to meet his basic needs after paying his portion of the rent.

Comments

This case study highlights the importance of fully and creatively exploring goals with participants. While Stuart reported that he wanted to work, what was most important to achieve and maintain housing stability was to increase his income, which can be done in a variety of ways. There were benefits available to Stuart that he was not aware of and/or needed help to pursue that could make the difference between him making ends meet or falling short. Rapid Rehousing will likely not solve all of Stuart's financial instability, however, and his rent burden will remain high, so his worker works to connect him to other community resources, as well, that can help alleviate some of the burdens of paying for living costs like food and utilities.

This also highlights the importance of getting to know community providers. One of the foundational principles of the CTI model is connecting to supports in the community, and if providers are unaware of the services that exist they cannot adequately connect participants. Participants may also be hesitant to engage with providers for a variety of reasons and may need some coaching and assistance from a CTI-RRH worker to build the relationship with these critical supports.

Example Four: Roger

Phase Two: Try-Out

Mediating, Testing Resources, Empowering the Client

Roger is a 54-year-old man who completed your program two years ago but has become homeless again and is in need of housing assistance. He has been working as a security guard at a nearby mall for the past three years where he makes about $2000 a month. Roger reports he wants to live in a new neighborhood and that his previous apartment was poorly maintained and unsafe. After several months, you find a room-for-rent in a house that is in his desired location and within his budgeted rental amount of $700.

Days after moving in, however, Roger begins voicing complaints about the new apartment, including a broken lock on the bathroom door, a leaky faucet, and roaches in the kitchen. Roger says he has reported the problems numerous times to the landlord and she does not respond. You inform the landlord about Roger's concerns and she promises to address them.

After helping Roger with financial assistance to move in, you pay only a portion of his next month's rent and he is responsible for the rest. On the fifth day of the month, the landlord calls and informs you that Roger has not paid his rent and threatens to take him to court. Roger states that he is withholding his rent because the repairs have not been completed. After informing him of his rights and responsibilities as a tenant and the procedures for legally addressing his concerns, he agrees to pay his portion of that month's rent. However, the following month Roger has a new list of concerns that are not being met and you again receive an angry call from the landlord stating that the rent has not been paid, that she is taking Roger to court. She states that he must leave the house as soon as possible.

Your initial assessment revealed that conflicts with a landlord have previously led to episodes of homelessness.

You suggest facilitating a meeting between the landlord and Roger to try and resolve the concerns. Roger explains that he is "fed up" with the bathroom door not locking, because privacy is very important to him. He expresses that he is frustrated that he is being charged for utilities by the landlord but is not able to see the actual bills.

The landlord explains that she feels that Roger is being disrespectful towards her by calling and texting her repeatedly when she would prefer he use the system in place for reporting repair requests- completing a paper form and leaving it in a folder by the mailbox. She explains that it is difficult for her to pay for repairs and utilities because she does not receive Roger's payments in a timely fashion. Roger did not know about the process for requesting repairs and began utilizing the forms, resulting in better communication between Roger and the landlord and more timely completion of repairs. This experience enabled Roger to feel more secure in his home, and he started paying his rent in full and on time.

Comments

This case study demonstrates the importance of the landlord as a key partner in promoting housing stability. Roger does not immediately present with common challenges to housing stability in rapid rehousing programs such as: chronic unemployment, extremely low income, and high rent burden. However, the stability of his housing is threatened due to a volatile relationship with the landlord. As a worker, you try several different tactics, such as being an intermediary between the two parties and educating Roger on tenant rights and responsibilities. A successful compromise results when you bring the two parties together, face to face, so that Roger and his landlord are fully able to discuss and resolve their concerns.

This serves as an additional reminder of the importance of understanding what has led to past instances of homelessness and using that to guide current practices to promote housing stability. Roger left a previous apartment because he felt unsafe and had conflicts with the landlord; the worker recognized this pattern repeating itself again and intervened by teaching and modeling a more effective way to resolve conflict.

Example Five: Terrance

Phase Three: Transfer

Dealing with Last-Minute Set-Back, Justifying an Extension

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Terrance is a 48-year old man experiencing homelessness for the third time. He has been sleeping in his car for the past 5 months and recently before reconnected with housing through your program. Terrance reports that finding full-time employment is his top priority and that he is primarily interested in jobs in the security field.

Much of your work with Terrance is over the phone because it is difficult to find times to meet with him. Terrance is doing construction contracting work for a friend, which requires him to be away from home from 6 am to 8 or 9pm. He reports that he still wants to find full-time work and you offer to accompany him to the local job center. Terrance insists he does not have the time to do this, because he will lose critical income and may not be able to pay rent if he misses work.

Throughout Phases I and II you find times to meet with Terrance outside of normal business hours and help him develop his resume and apply for some jobs online.

Thus far, he has not yet received any responses. You continue to encourage Terrance to take a day to connect with the job center, but he declines.

A few weeks before he is scheduled to complete the CTI-RRH program you receive a call from Terrance that he is worried about paying next month's rent because his friend has not had work for him for the past two weeks. You and Terrance agree to go to the job center together on the following day so that he can connect with an employment specialist and start applying for jobs. He keeps this appointment, and the specialist helps him navigate the system. He meets with a specialist who explains how they develop partnerships with employers to get people hired quickly. He and Terrance exchange numbers and set up a meeting for the following week to complete applications. You request approval from your supervisor to pay for Terrance's full rental amount for the final month while he looks for work, and exit Terrance from CTI-RRH services as planned.

Comments

This example highlights the challenge of experiencing a major setback in Phase III of CTI-RRH. While you may try and anticipate problems and address challenges throughout all phases, things do not always work out that way and you may have to navigate how to help a client manage a crisis before their services end.

One of the primary ways this can be navigated is through effective community partnerships. The more a client is able to tap into resources in their own community the better they will address a similar crisis in the future when they are not connected to your services. In this instance, the CTI-RRH worker was able to successfully connect the client to a local employment program, which will be responsible for helping him address his ongoing employment goals.

It is also worth reflecting on strategies in this case (i.e.- Motivational Interviewing skills). The CTI-RRH worker may have been able to engage Terrance earlier in the process, if he had addressed his ambivalence about utilizing employment support services. This may have prevented this last-minute setback

	Pre-CTI: Worker Activities	Phase One: Transition	Phase Two: Try-Out	Phase Three: Transfer
Time Intensity	Flexible	**2 Months** Intense Weekly contact	**2 Months** Moderate Bi-weekly contact	**2 Months** Low Monthly contact
Objective	Relationship Building Assessment	Complete Identification of resources and connect client	Monitor resource impact and client connection/access	Complete transfer of services to the community
Action Steps	Educate/Advocate Begin Phase Specific Plan Begin connection to resources	Accompany client to appointments, follow up to ensure connection Phase I Specific Plan	Make adjustments to plan in collaboration with client Phase II Specific Plan	Meet with new service providers or others in the support system; reflect on work with client Phase III Specific Plan
Potential Barriers	Housing placement may be delayed due to multiple challenges	Lack of resources; Client hesitant to engage Several competing "priorities"	Client may not be ready to assume rent; resources may be inadequate	Both client and worker may have difficulty ending, especially if goals aren't met
Strategies	Collaborate with Housing Specialist to teach/model housing location process; present services as a helpful resource, not an obligation	Do advance work of creating resource networks Prioritize needs based on relevance to housing stability	Empower client to do what they can on their own; *create alternative plans if necessary*	Reduce involvement gradually and inform client early on about the length and nature of CM support

CONTACT

INFO@CRITICALTIME.ORG