FULFILLING LIVES
Newcastle Gateshead

Executive Summary: Critical Time Intervention Interim Evaluation

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Introduction

The report presents interim findings evaluating our Critical Time Intervention (CTI) pilot launched in June 2019. We present qualitative findings from interviews with people we have supported on the pilot, Experts by Experience, and frontline staff, both our own and from other agencies supporting our people. The report points to promising practice and early learning and recommendations from the delivery of this pilot and will be followed up with a final evaluation in 2020.

Evaluation rationale and methodology

To our knowledge, this is one of the first full scale CTI pilots in the UK, and working with a relatively static group of people. As such this evaluation brings together existing Fulfilling Lives programme evaluation tools including New Directions Team Assessment and Housing Outcomes Star, as well as a range of CTI fidelity and assessment tools.

This interim report explores our fidelity to the CTI model, how we introduced our CTI pilot, and our early learning. It will be followed up with an impact evaluation and review of outcomes in early 2020. In addition to the fidelity and assessment tools within the CTI model which we used to review our fidelity, we developed our own tools for assessing the quality of our training and support to staff.

We also undertook qualitative interviews with the people we work with, Experts by Experience, System Change Practitioners, our wider team and a small number of external frontline staff to understand their experience of this new way of working. Fidelity to the model has been important to us, however this is a US model and as such some of the language around CTI feels new and different.

What is Critical Time Intervention?

Critical Time Intervention originated in the US[1], and the model has been used on four continents to date. A time-limited practice, it aims to provide support for people during periods of transition, for example from prison to the community, hospital to community or a change of accommodation.

During a transition, the CTI approach works to develop a person's independence, works towards person centred goals and increasing support networks so that they have effective support in place at the end of support. CTI is a three phase practice occurring in three three-month blocks with a pre-CTI phase taking place before the transition occurs.

As the person moves through each phase there is an end of phase celebration, and each phase has a distinct focus, outlined below:

- **Pre-CTI: Relationship:** develop a trusting relationship with the person. The people we take through CTI are well known to us, this is different to the US model.

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[1] See https://www.criticaltime.org/ for further information

- **Phase 1: Transition:** provide support during transition, explore connections to support services - very regular contact, meetings with support network and introducing them to new sources of support.
- **Phase 2: Try-Out:** monitor and build up support network and person's skills - less time spent on face to face support, time spent strengthening support network.
- **Phase 3:** Transfer of Care: this phase leads up to closure of cases and celebrates person reaching the end of their support; worker steps back to ensure that support network is working for the person. FLNG works with person on a Wellness Recovery Action Plan and holds a final session with them and the support network to mark the transferring of their care; reviewing progress made and celebrating.
- **Pause: Phase Paused:** although the CTI nine-month clock does not stop, in exceptional cases a phase can be paused temporarily, freezing the phase at its current point. Once un-paused a case starts up from the same point. Some people continued to experience transitions i.e. being evicted from accommodation, so we used pause. Pause function was also used due to staffing challenges i.e. long-term sick, transition to a new worker.

CTI fidelity: The US context

As CTI originated in the US, the tools/language used around the model have some cultural specificity, particularly in relation to the difference in systems around health, social care, welfare and criminal justice and how people interact with support services. The US model often has employment as a primary focus because it is the only option to secure an income; however access to welfare support and in particular Housing Benefit in the UK changes our focus.

CTI programmes in the US tend to focus on specific transitions, for example prison release, for women leaving hostels and where transitions are generally planned. For the people we work with transitions can be unplanned, with less certainty around the timescale for transition. In addition, the US has a significant emphasis on the notion of fidelity, something not so predominant within homelessness services in the UK, though Housing First is an intervention similarly delivered to a fidelity model. CTI is an evidence based practice, fidelity demonstrates that an intervention is delivered as intended; CTI is a 'top tier' intervention[2].

Rationale for using CTI in Fulfilling Lives Newcastle Gateshead (FLNG)

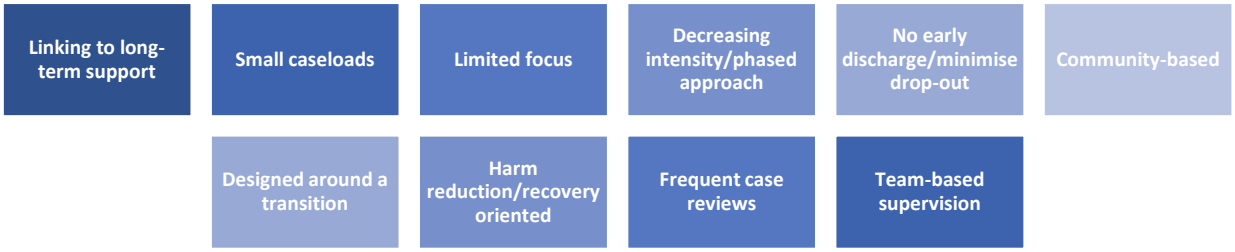
In 2016 we began a full service review into the efficacy of the FLNG delivery model leading to a new model launching in April 2018. Our review told us that people plateaued in their progress on the programme and the frontline team reported feeling stuck. We wanted to explore other ways of working to prevent a cliff edge at the end of the programme, ensuring people moved on appropriately.

In 2016 Homeless Link opened applications to the Transatlantic Exchange Programme and a FLNG System Broker successfully applied and travelled to Los Angeles to experience and report on the use of CTI. Contact was later made with the Centre for the Advancement of Critical Time Intervention (CACTI) and, in consultation with the Core Partnership team, the pilot was agreed.

[2] The model meets the Coalition for Evidence-based Policy's rigorous "Top Tier" standard for interventions "shown in well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizable, sustained benefits to participants and/or society https://www.criticaltime.org/cti-model/evidence

How different a way of working is the CTI approach?

There are ten key principles of CTI:



Prior to this pilot the Service Navigators were working in a way which is very similar to six of these key principles. Community based, taking a harm reduction approach, linking to longer term support, with frequent case reviews we also work with small caseloads and maintain an ethos of 'stickability' even when experiencing a lengthy period of disengagement. CTI is different in bringing a decreasing intensity/phased approach, having a limited focus to a few key goals, being designed around a transition and offers a framework for team based supervision supported by a fieldwork co-ordinator role.

Demographic overview and types of transition

As at June 2019 we have 44 people on our CTI pilot, 29 males and 15 females; this 66%:34% split broadly mirrors our programme average. The average age of people on the pilot is 38 years, slightly higher than the programme average of 35. We have worked with many of these people for years; the average time spent on the programme being three years and five months.

We have coded the different types of transition people have made: 62% experienced an accommodation move, 26% a prison release, 9% hospital discharge and 3% were granted leave to remain in the UK. Four of these accommodation moves were from rough sleeping/sofa surfing to temporary/supported accommodation. It will be interesting as cases progress to explore whether these accommodation changes are maintained.

Interim findings

Our interim findings are themed across six areas:

1. How CTI has been received

- Although too early to reflect on solid outcomes on closure of cases we have identified that this approach is working well for people whose transition experience has given them the stability to begin to explore some person centred goals; this is the case for about 40% of the caseload.
- We identified that 20% of people not engaging with CTI have generally been experiencing crisis; their focus has been on survival rather than goal setting. We had one person refuse to be part of the CTI pilot *"there's no way I'm doing that. Nah. It's not happening"* and another for whom the change from navigation to CTI has been difficult, particularly around the change in timescale *"but you said you'd be with me for 8 years."*
- A further 40% of people appear to have struggled to understand what the CTI approach is. There are varying reasons for this, worthy of further exploration with people and those in their support network in our final evaluation. There is a broad continuum which presents most starkly when considering the person for whom CTI *"is the foundation of my new life"*

contrasted with another case on pause because of the high levels of risk surrounding the person.
- We made inroads in communication, for example with email templates for the support network around the person explaining the model. It is clear from interviews that some people do not understand how we are working with them on the pilot. There is work to do to explore this further as it seems that some people understand something of how we are working with them, but are not engaging with all of the aspects of the model.

2. Operational management

- The Operations Lead role was crucial in driving this pilot. It is a role requiring skills in operational and process management, in depth knowledge of cases and working meticulously and at speed to ensure that phase plans are completed within necessary structured time scales.
- There is a strong sense that we would benefit from having a fieldwork co-ordinator[3] to aid in managing support plans/phase changes. There is a high volume of work to do in the administration of CTI. We did not have this role in place for the start of the pilot nor later owing to staff sickness and data quality has been impacted
- We invested heavily in a structured induction, including comprehensive CTI training delivered by the Operational Lead; this was both needed and appreciated.
- Our Direct Work team experienced three changes during the pilot's roll out: taking on a new role of System Change Practitioner (SCP), being managed by a different organisation via the TUPE process and seconded to a reduced number of organisations within the Fulfilling Lives Core Partnership and implementing a new way of working. SCPs continued to deliver navigation support to some people alongside working through the CTI model with others. Given the high levels of change the team experienced we wouldn't recommend sharing navigation and CTI work in one role. The team's buy-in to this way of working had to be established during the pilot; the FLNG workforce moved towards CTI delivery after four years of Navigation delivery. We assessed their suitability/interest in delivering CTI on the job; it proved to be a different role to the one they originally applied to do.

3. Fidelity to the model

- We note some interesting challenges both in working with an existing caseload and in relation to the uncertainty of lead-in times up to transitions. We have a lower pilot caseload than anticipated, 47 people, where we planned to take 60 people through. This is owing to some people closing before completing phase three, for example owing to a lengthy prison sentence.
- We sometimes have no control over the time spent in the pre-CTI phase leading up to a transition and trying to manage this operationally is difficult. If CTI was implemented as a move-on process in accommodation services they would have much more control/autonomy about when the transition would happen, managing caseloads accordingly. We reference the challenges of ensuring CTI is tailored to a different cultural context and continue to explore this as we review closed cases.

[3] Provides support to CTI workers in relation to managing phases and administrative tasks and supports the case management meetings by coordinating case presentations and writing summary notes/following up on agreed actions.

4. Setting goals

We note early promising practice in goals setting – this feels much more asset based than our traditional support planning, supported by having a creative approach to using our personalisation budget; truly person centred goals can support more creative spending. In coding the goals that people have set for their CTI phases, within this categorisation we see a much more interesting typology of goals compared with our traditional support plan goal setting, for example:

- *"To get a provisional driving license, when he had his motorbike on the road he felt independent so he wants to regain this independence"*
- *"Goal to have access to 5 day Methadone pick up instead of 7 day. This is because she has to travel to a Chemist in Newcastle which means she has regular contact with other drug users who she feels are delaying her recovery"*

As we have more data and begin to close cases we will review progress made working towards goals.

5. Building support networks

- Measuring achievement of goals in this area of the pilot is less challenging than recording data on how support networks have changed. We need to look at how we measure the quality of support networks in our substantive evaluation.
- We note challenges around building support networks, these are not unique to the pilot but exploration of them highlighted two key issues. We have found that it can be difficult to adopt a 'linking role', building the support network rather than being reactive to crisis when immediate support needs arise. As we try to focus on building positive support networks, the team noted challenges around other relationships the people we support have.

6. Building the support network – the Experts by Experience view

- In exploring support networks we wanted to better understand what relationships look like in recovery. Are these different, how did people build these up, did they have support and how do they maintain more positive relationships? Peer research has found that people in recovery talk about loss and isolation, moving away or breaking ties from old associations. We conducted a focus group with four Experts by Experience to understand support networks better.
- We asked one open ended question: "how have your relationships changed over your life journey?" Responses clustered around three key themes: truth, self-awareness and loss.
    - On truth, the group talked about "*truth as an anchor*", being true to themselves which sometimes meant losing relationships; described as "*sticking with the winners*" with one Expert sharing "*having no company is better than shitty company…I'm selfish now in choosing the people I have around me.*"
    - Self-awareness was a key theme, in relation to "*choosing the people I have around me*." One Expert spoke about the fluidity of their relationships and that they choose who they have around them depending on how secure they feel in their recovery "*depending on how much I trust myself to go into those circles or communities*".

  - Experts touched on an additional theme of loss. One Expert talked about the guilt inherent in moving on and away from friendships with another offering peer support *"is it not that their journey goes a different way? – when you change but a friend doesn't – they were part of your journey, they're not coming on this next part of the journey."* Another Expert talked about the power of social media in literally 'blocking people' *"if they're not improving my life they're not in my life."* The group discussed how it can be hard to understand what good friendships are if positive relationships tend to be with workers *"paid to be there".*
- These discussions help us understand challenges people might face in developing support networks and help us explore what positive relationships might look like.

Workforce development

It is clear that our team are working towards a new skill set in their new role; over the next stage of the pilot we will link up with our workforce development evaluation to explore the skills needed, these include skills to act as a care co-ordinator in this role whilst resisting the pull of doing support work type activities.

Early indications from our workforce development evaluation suggest that workers find it hard to build people's motivation to change, and find working collaboratively a challenge. This correlates with our findings in this evaluation; these synergies will be explored in the final evaluation phase.

Further information

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