FULFILLING LIVES
Newcastle Gateshead

# Implementing a Critical Time Intervention model: Interim Evaluation

**October 2019**

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**Implementing a Critical Time Intervention Model: Interim Evaluation**
**Ang Broadbridge and Alex Smith**
**October 2019**

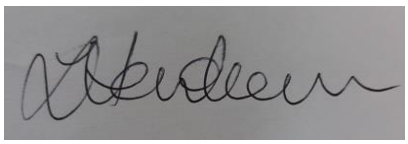
## Foreword

When we first considered CTI as a viable pilot for the Fulfilling Lives Newcastle Gateshead programme it was due to increasingly questioning if our open ended navigation approach continued until the end of the programme; would that be leading the people we support towards a cliff edge?

I feared that we would become another service the people we support believed had abandoned them and it felt the right move to test the structured and time bound approach of Critical Time Intervention to try and help people move closer to a fulfilled life.

Testing a new approach sits perfectly within our role as a learning programme and it has been an interesting pilot so far. We are already showing some promising practice even though it has been quite challenging for our team to embark on a more structured way of working as well as retaining some navigation work.

We therefore hope that other services will be able to build on our learning outlined in this interim evaluation and we look forward to sharing the overall learning in a final report when the pilot ends next year.



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## Introduction

Critical Time Intervention is part of Fulfilling Lives Newcastle Gateshead's Direct work with people experiencing multiple and complex needs (MCN) and is one of the 5 workstreams forming our new programme delivery model for 2018-2022, launched in April 2018:

- Direct work: System Change Practitioners (formerly Service Navigators) and our Operational Lead continue to use a navigation approach and pilot an innovative American model of support called Critical Time Intervention (CTI) between 2018–20.
- Experts by experience (EBE): Co-Production Workers facilitate and build a network of people that values the voice of lived experience, uses peer research to understand how services can better support people experiencing multiple disadvantage and informs all programme activity.
- System Change: our System Change Lead, supported by all members of the FLNG Team including experts by experience, supports the 'system' to think differently about multiple disadvantage focusing on mental health, transitions and commissioning.
- Research and evaluation: led by the Research and Evaluation Lead, supported by the Data Analyst, peer researchers, volunteers and the communications team; we get our evidence out there to influence policy and practice.
- Workforce development: all members of the FLNG team including our experts, help the Workforce Development Lead deliver training to build understanding, capacity and increase the skills of Newcastle Gateshead's workforce to better meet the needs of people with multiple and complex needs

The new offer to people experiencing MCN in this model, as set out in our Year 4 Learning report means Fulfilling Lives Newcastle Gateshead (FLNG) will:

- Cease referrals and work with our existing (107) people to encourage appropriate move on and prevent a feeling of abandonment before the programme ends

- Retain some navigation work but test a new model with some of our people appropriate for Critical Time Intervention (CTI) between 2018-20

- Work with less people than originally agreed but subsequently reach more people through the renewed EBE, Peer Research Network and system change activity

- Recruit more people to the EBE network and encourage their involvement in its activity, particularly in the stages of the CTI model to increase community connectivity and move on from the programme for the people we work with

- Gather more in-depth learning and evidence from existing experiences and share this locally and nationally through case studies

This interim evaluation sets out our learning from nine months of working on the CTI pilot.

## Evaluation rationale

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 have introduced our CTI pilot, and our early learning. It will be followed up with an impact evaluation and review of outcomes in early 2020.

## Methodology

There are a wide range of fidelity and assessment tools within the CTI model which we used to review our fidelity and their results are presented here. We developed our own tools for assessing the quality of our training and support to staff and 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 CTI model has been important to us, however this is a US model and as such some of the language around CTI may feel quite new and different. Keeping fidelity to the model means that some language, for example 'transfer of care' and 'team functioning assessment' is relatively technical. We define these terms throughout this report.

## What is Critical Time Intervention?

Critical Time Intervention (CTI) 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, work towards person centred goals and increase their support networks so that they have effective support in place at the end of support.

CTI is a three phase practice occurring in 3 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. We note that the people we take through CTI are well known to us and this is different to the US model where the person would be new to the service and is discussed later

Phase 1: **Transition:** Provide support during the transition and explore connections to support services. This involves very regular contact, meetings with their support network and introducing them to new sources of support

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

Phase 2: **Try-Out:** Monitor and build up the support network and the person's skills. During this phase less time is spent on face to face support and time is spent observing the support network and supporting it to become stronger

Phase 3: **Transfer of Care** This phase leads up to the closure of the case and celebrates the person reaching the end of their support. Here the worker steps back to ensure that the support network is working for the person. FLNG works with the person on a Wellness Recovery Action Plan and holds a final session with them and their support network to mark the transferring of their care; reviewing progress made and is intended to be a celebration.

Pause: **Phase Paused:** Although the CTI 9-month clock does not stop, in exceptional cases a phase can be paused for a temporary period. This pause would freeze the phase at its current point and once un-paused, would start up from the exact same point. The phase would never be restarted from the beginning.

CTI fidelity plans suggest that Pause should be used infrequently and only in exceptional circumstances. The intention is to create a temporary pause to the CTI clock where the phase will be frozen and once un-paused, will resume at the same position in the phase. This is not desirable as it prolongs the overall intervention intended to be 9 months thus not adhering to the fidelity of the model. The reality of the FLNG caseload, which possibly differs to CTI caseloads in the US, has meant that a number of people have continued to experience transitions, returning to custody or hospital and being evicted from accommodation where a decision has been made to pause due to the unpredictability of the new transition. For some people this has worked well, where there has been a short return to custody and the phase has been resumed within approximately 4-6 weeks; however, there is also one person who has been paused in Phase 1 for over 6 months as they are waiting to be sentenced and remanded in custody for an unknown length of time.

In addition to unpredictability of transitions, the pause function has also been used where we have experienced staffing challenges, for example long-term sick or transition to a new worker.

**CTI fidelity: The US context**

As CTI originated in the US, the tools and 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. In the development of our understanding of CTI it was important to apply a cultural filter to ensure the language and practice was translated and relevant to the UK context. 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. We note that 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 time scale for transition taking place.

We agreed to hold the celebration at the end of phase three as the System Change Practitioner team felt it would dilute this celebration if marking the end of each phase. We marked the end of each phase instead by reflecting on progress with the person, captured in the end of phase progress note.

In addition, the US has a significant emphasis on the notion of fidelity, something which is not so predominant within homelessness services in the UK. CTI is an evidence based practice, fidelity demonstrates that an intervention is delivered as intended, and CTI is a 'top tier' intervention[2]. The initial navigation model within the Fulfilling Lives programme was not measured against a fidelity assessment and so the introduction of CTI, with its fidelity structure, has felt quite different to implement.

**Rationale for using CTI in Fulfilling Lives Newcastle Gateshead**

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. Between 2016 and 2017 we consulted with FLNG staff, our core partnership team and brought these findings together with FLNG programme data, case studies, and a report we commissioned from New Economics Foundation (NEF) to review our system change activity. Our review told us that people plateaued in their progress on the programme, their New Directions Team Assessment scores (also known as the chaos index) plateaued at around 18 months 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.

From 2016 and in response to the NEF report findings we also revised our system change priorities. The area of 'transitions' was agreed as one of these areas including; moving between accommodation, prison release, migration to the new Universal Credit benefit and hospital discharge. For each transition point, the evidence showed that people with multiple complex needs often fall through the gaps with services not being well co-ordinated in their approach and people dropping in and out of service provision with little continuity of care and support.

At the end of 2016, Homeless Link opened applications to the Transatlantic Exchange Programme with CTI being one of the five key areas. A System Broker within the FLNG programme successfully applied to take part, with the hope that learning about the CTI approach to support people through transitions may be of benefit to the caseload and create potential for an innovative way to work effectively with people in the UK.

[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/

The System Broker travelled to Los Angeles, USA to spend two weeks with the organisation 'Brilliant Corners' and their Breaking Barriers programme. During this time, they wrote a series of blogs and following the exchange produced a full report outlining the potential benefits of implementing CTI within the FLNG programme. Direct contact was then made with Dan Herman, Director for Centre for the Advancement of Critical Time Intervention (CACTI) and FLNG's Programme Manager to explore further and in consultation with the Core Partnership team, the pilot was agreed.

## Planning for CTI implementation

### Pilot setup

CTI implementation planning began at the end of 2017. In January 2018 a scoping exercise took place which identified approximately 60 people of the total active caseload (107) who were likely to be suitable for the CTI model, due to a transition expected within the next 12 months. We staggered the implementation of the pilot to ensure fidelity to the caseload formula. As part of the new delivery model a new role of System Change Practitioner (SCP) was introduced, replacing the Navigator role. The Operational Lead role was also introduced, responsible for the implementation and management of the CTI model. In preparation, the Operational Lead completed a 5 week course Understanding Critical Time Intervention provided through CACTI. In addition, a series of Skype conversations took place with the director for CACTI about CTI in the UK.

The FLNG programme uses a bespoke InForm case management system, a decision was made to integrate CTI into this system rather than creating additional processes. As there are a number of implementation/management documents for CTI, the process was made as simple as possible and the InForm system was amended to include: Phase plans, progress notes and closing notes. Training was given on using these processes during the team's induction period beginning April 2018.

From April until the launch of CTI in June 2018, we staggered implementation with each worker moving over to the CTI model in quarterly cohorts; 1 person per SCP in June, 3 people per SCP in September and 4 people per SCP in January 2019.

**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 through our navigation model:

- **Small caseloads** – Navigator caseloads were less than 15 people per SCP. CTI recommends that caseloads are no higher than 20 per practitioner. The caseload formula for CTI takes account of the decreasing intensity of work with people over the course of the three CTI phases. A typical caseload would be weighted:
    - Phase One x 2 weighting
    - Phase Two x 1 weighting
    - Phase Three x 0.5 weighting

- **No early discharge** – Navigators always maintained an ethos of 'stickability' even when experiencing reduced engagement from the person or a lengthy period of disengagement
- **Community-Based** – we take an assertive outreach approach
- **Harm reduction** – a dynamic risk approach/find ways to work with people and keep them as safe as possible
- **Linking to longer-term support** – navigating through the complex system to find the services people need to progress
- **Frequent case reviews** – under the Navigation model we had frequent but less structured/ad hoc case reviews

The difference CTI brings:

- **Decreasing intensity/phased approach** – other than a process of changing status from active to move-on, we had an open-ended approach with the intensity of work fluctuating based on (perceived) need.

- **Limited focus** – we have previously had a very open and flexible approach to the work we have done and although loosely structured around our 4 key areas (homelessness, substance use, mental health and offending) it has been a broad rather than limited approach.
- **Designed around a transition** – our work has previously not focused on specific transition points, though people have many, and we have worked with people regardless of their circumstances (within the Fulfilling Lives NG programme criteria)
- **Team based-supervision** – previously we didn't have a standard team case review process as the then Service Navigators were dispersed in different organisations with different line managers
- **A fieldwork role –** provides support to CTI workers in relation to managing phases and administrative tasks; supporting case management meetings by coordinating case presentations and writing summary notes/following up on agreed actions. This support did not exist as all FLNG staff are responsible for their own administration.

**Workforce development: preparing the team to implement CTI**

CTI training for our team was developed and delivered by our Operational Lead in May 2018 following the 5-week 'Understanding CTI' course). The training covered the 10 key principles of CTI, understanding the phased approach, how to work in a focused way, and implementation for the programme over the next 12 months. The direct work team expressed concerns about changing to a CTI model, including: pre-existing relationships and changing course, managing expectations about the offer from FLNG and most significantly the change to a time-limited intervention; something not previously featuring in the navigation model.

A crucial part of the training included a role play exercise where practitioners were paired with non-practitioners to work through the introduction of CTI and to develop skills in dealing with questions and concerns. There was particular positive feedback around this, with practitioners feeling more confident to discuss CTI with our people and their existing networks. The research and evaluation team were involved in both attending this training to understand the model, and in delivering InForm training on the CTI data module to the wider team. Overall, the training received positive feedback and staff felt well supported and were looking forward to taking CTI forward. In addition, the team had a full induction introducing them to a wide range of tools in the 'CTI toolkit.' This toolkit pulls on good practice from motivational interviewing, trauma informed care, harm reduction and strengths based working. These tools are not unique to a CTI pilot, but complement the structured and intensive approach of CTI.

In addition to direct training with the FLNG team, the CTI model was also discussed through various local and national presentations and workshops, including Homeless Link's Under One Roof annual conference and the FLNG annual event,

to ensure partners understood both the rationale and changes to be expected within the CTI implementation.

We supplemented internal training for the staff team with a one-day masterclass with Sally Conover from CACTI (the Centre for the Advancement of CTI) in September 2018.

Sally was part of the original team that created CTI in the 1980s and has been instrumental in disseminating the CTI model globally. We opened up this event in September to our core partnership and to other interested agencies and as well as our 18 staff and core partnership members we were joined by 14 staff from 7 external agencies. Interestingly feedback for this training was generally rated more positively by external agencies, who said that they came into the session knowing very little about CTI and left with a good basis of knowledge:

*"I have a clear understanding of the principles of CTI and how it works as a model, and can explain this to others. It worked well as a masterclass."*

Our internal staff team and core partnership took little new away from this session, generally comments suggested that the internal training they received during their induction had already covered much of this material, though some reported that the session helped them to think about some of the challenges of working CTI within 'messy' systems. Many of the comments about the day's session suggested that a more structured session would have been appreciated, with more opportunities for smaller table discussions:

*"I felt frustrated this was a very simple powerpoint "lecture" really"*
*"There needed to be more table discussion, there were too many open questions"*

Following this masterclass and reflecting on how different the group of people we work with on the CTI pilot are compared with the case examples CACTI shared, along with the cultural differences inherent in this model, has given us food for thought about the opportunities CTI presents working with people with multiple complex needs. For example, we discussed with Sally how approximately 20% of our active caseload have a current or historical diagnosis of personality difficulties (PD). Sally felt that the CTI model is unlikely to be effective with people experiencing these difficulties and this is something we will need to explore further over the next 12 months of working CTI.

**Operational management of the pilot**

For the first CTI cases, our operational lead provided intensive 1-2-1 support for each SCP regarding phase planning, goal setting and managing data recording requirements with support from the research and evaluation team. During this initial implementation, we noted three key challenges for the programme in relation to integrating CTI into a well-developed programme of navigation support:

1. Working with an existing caseload has been difficult in that we created a set of expectations for the people we support by using an open ended navigation model, which is being changed. We tried to mitigate this by

having ongoing conversations with the people on caseload and ensuring we are explaining CTI well and focusing on the positive aspects of being involved with the pilot

2. Timing the transitions and balancing this work with an existing navigation caseload is an ongoing challenge as our people are in transition at different points. This does not always align with our availability and CTI planning. For example, one person has been unable to start Phase One of CTI as we are still waiting for his move-on accommodation to become available
3. Staff have been asked to change their practice significantly, from open-ended, flexible and responsive support to a structured, timed and a limited focus approach with some of the people they support – this requires intensive support and ongoing skills review.

Every Monday morning we hold a case management meeting chaired by the operational lead and attended by all SCPs. The meetings are very structured, with each SCP preparing a case presentation the Friday before, including a summary of the case and key challenges or questions to present to the team. Feedback, support and ideas are shared and all key points of the discussions, along with actions and timescales, are recorded in a case management summary. Our SCPs noted that a change to a more structured way of working has been challenging but they feel generally positive about this regular point of check in each week.

The FLNG programme has not had a consistent fieldwork coordinator function within the team; we did put this function in place but staff sickness impacted on this and consequently much of the coordination tasks have been managed by the operational lead. We have also had periods of time where we have had 50% of the frontline team off with medium to long term sickness. This has made the operational management of the pilot more challenging particularly around Phase Plan management and ensuring that the caseload progresses through phases in a timely manner, adhering to the fidelity of the model. This process was largely managed by a spreadsheet that in hindsight was not fit for purpose and therefore required constant review and reminders outside of the case management space. Although the team welcomed a point of check-in each week, the structure of planning and providing a case presentation in advance of the Monday meeting required intensive management supervision with a lack of time and thought being dedicated to the task, meaning that we were generally poor at prioritising people for discussion and cases were brought in a more adhoc way.

As CTI was being introduced to an existing caseload it was very difficult to adequately balance the staggered introduction so as not to overwhelm practitioners and manage timing the start of CTI with a transition, which we had no control over. To manage some of the difficulties the team met in May, August and November to plan and agree the next quarter's cases. These plans were largely helpful although a significant degree of flexibility was needed to work around unpredictable transition dates. For example, this meant that some transitions happened much earlier than when the person started CTI.

## Demographic overview

As at June 2019 we have currently 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. When we later discuss the challenges of introducing a new way of working with people, this length of time becomes very relevant.

In our CTI caseload Gateshead people are slightly over represented compared with our overall caseload 50:50 split; for the CTI caseload 43% are Newcastle and 57% Gateshead.

## Types of transition

We have coded the different types of transition people have made:

| Transition type | Number of people | Proportion |
|---|---|---|
| Accommodation move | 21 | 62% |
| Prison release | 9 | 26% |
| Hospital discharge | 3 | 9% |
| Granted leave to remain | 1 | 3% |
| Total | **34** | |

Four of these accommodation moves were from rough sleeping or sofa surfing to temporary or supported accommodation. It will be interesting as cases progress to explore whether these accommodation changes are maintained; it is too early to understand the full range of outcomes for these people as we are currently still working with them. Interestingly a higher proportion of women than men joined the CTI pilot with a transition from prison (33% compared with 23% for men), perhaps this is linked to women receiving shorter prison sentences than men[3]

## How CTI has been received by people we work with

As our pilot grows we will continue to review how people moving into the pilot receive CTI. As outlined earlier we introduced people to CTI who had worked with us for up to four years. There have been challenges in introducing this approach, though as seen when we explore goals later in this report some people responded well to this new way of working. In March 2019 the team were asked to give an appraisal of each of their cases, seeking to understand what proportion of people we are working with understand and are engaging with this new way of working.

In addition to one person refusing to be part of CTI *"there's no way I'm doing that. Nah. It's not happening"* and another for whom the change from navigation to CTI

[3] Office for National Statistics: Statistics on Women and the Criminal Justice System 2017; https://www.gov.uk/government/statistics/women-and-the-criminal-justice-system-2017

has been difficult, particularly around the change in timescale "b*ut you said you'd be with me for 8 years"* we also have a number of people who do not understand CTI. Their SCPs report that they feel it is too complicated to grasp or they are disinterested and not motivated to listen. This has been a source of anxiety for the team as they are keen for people to understand the change in approach and ensure they are able to work in collaboration around goal setting and moving through the phases. The team identified that for those people who do not understand CTI there are two key issues impacting on their understanding;

1) some people we are working with have a learning disability or difficulty and did not generally understand how we were working with them under the navigation model, seeing the worker as a support worker 2) some people are heavily preoccupied by what we might term day to day survival and consequently the team feel introducing a new way of working has not been effective, particularly where people have dipped in and out of support with periods of disengagement.

A SCP developed a standard CTI email (see appendix) which is being sent to other support services and this is helping to give a consistent message to external staff working with them.

We have found that four people who were wary of this new way of working have become slowly more positive about being part of the pilot and they are now engaging with the goal-setting element.

**Setting goals with people**

During the four years we worked with people using the navigation model we produced a new support plan for people every 6 months. Where practicable these are developed in partnership, but in reality they are worker-led, drawing on their knowledge of the person's views and wishes.

A review in May 2018 of support plans, and a follow up study asking the team to identify goals was reviewed by the programme manager, Research & Evaluation and Operations Leads who reported feeling "flat" about the goals recorded. The team's reflection on this data was that goals did not feel asset based, and were often the worker's interpretation of the area they have done much of their navigation to, e.g. 'harm minimisation.' These felt like traditional support plan outcomes; "stay on a script", "sort accommodation," "get mental health medication". Only a few goals were recorded that felt more positive "get a flat with a washing line to get fresh air!" and "learn to drive, driving license, get job".

Our programme model includes a personalisation pot and during the induction process we emphasised the need to use personalisation more creatively and positively rather than filling service gaps. Supported by the implementation of CTI Phase One, we have seen some positive changes in the SCPs' approach to personalisation already:

*"We attended a Turkish restaurant and had food. We had a positive conversation around Newcastle United, World Cup, and transfers. We attended Primark where [they] brought a new shirt, tie, trousers, and new shoes. [they] looked very smart and was happy with what he had brought."*

This person had previously received around £400 personalisation in total, with spends often meeting basic needs such as food, mobile phones and a sleeping bag. This new approach to personalisation as seen by the quote above brought forth new conversations and positivity.

There is a sense that we are beginning to use personalisation in a different way for people we are working with on this CTI pilot. One person reflected that once his accommodation had become settled he and his SCP were shifting their focus to something fun, going go karting together.

We found early on that we needed to frame this for the team as we identified we are working with perhaps a different group of people, with different challenges and system than in the US model. We had been encouraged by Sally to focus on the goals and keep this focus in spite of crisis. One SCP reflects on the positivity inherent in this approach:

*"I told him…we're going to focus on the goals you want. So seeing your grandma and grandad. After that his face lit up with a smile."*

*System Change Practitioner*

Reflecting on this theme of crisis we have noted that SCPs can find it difficult to focus on the agreed phase goals when the person goes through a period of crisis:

**Case study: Setting goals in crisis**

For this person there have been multiple periods of transition since the start of Phase One with the person in and out of custody and with two out of area housing placements. Contact has been sporadic and the times we managed to speak to the person, has been to provide practical support only around securing or arranging transport/belongings. Personalisation use reverted back to crisis management, purchase of food, phone and transport with no focus on the goals of going to a football match or securing a passport.

The question of balance has been present since the beginning of the CTI journey for FLNG. Balance is needed between the two main aspects of CTI; goals and the support network alongside the traditional navigation work of responding to and managing crisis situations. In discussions with Sally, she reflected:

*"The meaning of "person-centered goals" in traditional case management is not the same as the way that CTI's short-term "focus areas" are decided upon in the context of linking to community supports. The purpose of CTI isn't to reach milestones (e.g., getting a job, decreasing drug abuse). The purpose is to ensure that the person is well-connected to providers and informal supports who will take responsibility for working with the person after CTI for as long as necessary towards these milestones. Therefore, rather than measuring success in terms of how much progress the person has made during CTI toward getting a job, you look at competence and commitment of the supports to help in specific ways, and at the strength of the relationship. (Of course, all the CTI linking work must be done with an understanding of the person's own long-term recovery-oriented goals.)"*

In practice this has been challenging and this has been linked to 2 specific points;

1. Engagement with services can be difficult. The people we support have difficulties building relationships of trust and services find it difficult to manage risk and crises presented when trying to deliver specific targeted interventions.
2. Due to the challenges of engaging the people we work with our traditional practice has been sometimes more about doing rather than linking and it is difficult for the SCPs to pull back from this.

Reflecting on point 2 above highlights how programme restructure issues have impacted here. Our frontline workforce were previously service navigators based within different employing organisations. When we created the System Change Practitioner role we had to offer and move navigators (via TUPE process) into new roles they may not have been interested in or suitable for . An additional reflection is to acknowledge that the SCPs were expected to maintain their navigation caseload alongside implementing a new way of working which can be challenging especially when managing the change of moving from their previous place of work.

As a result it has not always been possible to weave goal setting with building the network and they have at times felt like two distinct tasks, to reach a milestone rather than focussing on the connection to the network. The goals that have been set are generally goals owned by the person and their practitioner, it is unusual to see the goal owned by the person and somebody else within the network.

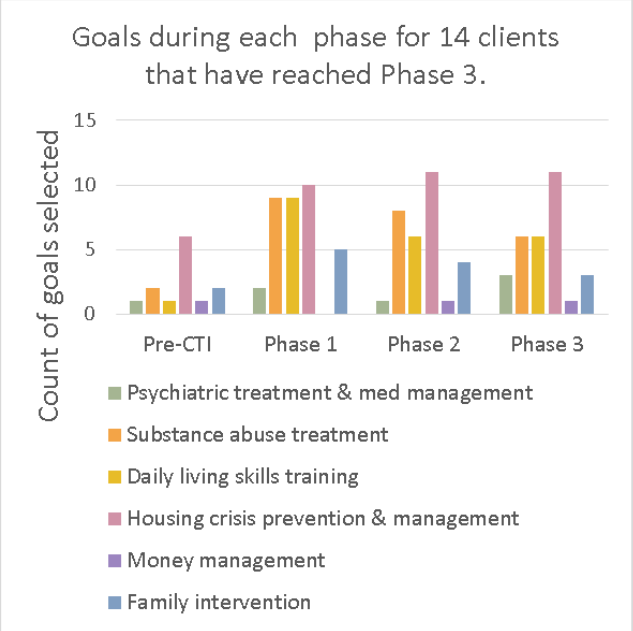
In addition to this we had a number of people who became disengaged throughout the CTI phases, either through a return to custody, moving accommodation or simply choosing not to be in contact. It has therefore been very difficult to ensure continuity around focus areas and building the network, as casework reverted to crisis management.

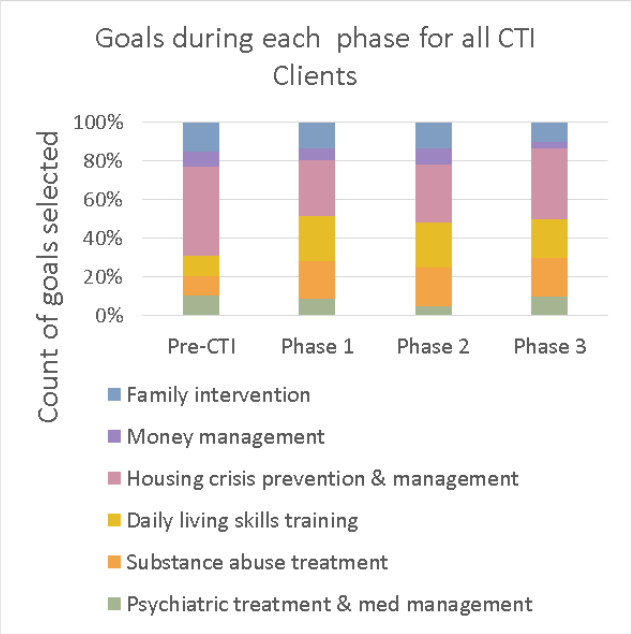
Coding these by the traditional CTI typology (n.b. more than one goal per person) shows that much of our work in the early phases is focussed around housing crisis prevention and management, and that following this people also want support with accessing substance abuse treatment and daily living skills training.

| | **Psychiatric treatment & med management** | **Substance abuse treatment** | **Daily living skills training** | **Housing crisis prevention & management** | **Money management** | **Family intervention** |
|---|---|---|---|---|---|---|
| **Pre-CTI** | 4 | 4 | 4 | 18 | 3 | 6 |
| **Phase 1** | 7 | 16 | 19 | 24 | 5 | 11 |
| **Phase 2** | 3 | 12 | 14 | 18 | 5 | 8 |
| **Phase 3** | 3 | 6 | 6 | 11 | 1 | 3 |

This becomes clearer to understand in graphical format (n.b. people set multiple goals at each phase). The focus in the pre-CTI phase is around housing crisis

prevention/management, and as people move through the phases other goals come to the fore. Generally, the picture is relatively static, this is understandable as we find that people are still experiencing crisis/facing challenges:




**Sample of CTI goals**

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. A sample has been selected here:

*"He said he has an interest in golf but has never done it for years due to his life style…hopes for this goal: to attend a golf driving range and re-live his youth"*

*"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"*

*"Support with daily living, he chose this goal as he believes this will be important part of him addressing life after having his leg amputated. He has also stated he would like a laptop to occupy his time and build skills as physically he is going to face challenges."*

**Building the support network**

Having regular case management sessions with the team highlighted how difficult it can be to adopt a 'linking role'; building the person's support network rather than being reactive to crisis when they have immediate support needs and are not engaging with other services. The SCP team often feel drawn into support work and away from navigation, particularly around welfare benefits support and advice. This meant a shift to a CTI approach has been very difficult for some SCP and the people they work with to do. This theme is revisited regularly in case management sessions to ensure we are able to refocus on *linking* and move away from *doing*.

We spoke with representatives from a small number of local agencies for this interim evaluation and found that they were responding positively to the pilot once they understood this new way of working. This was supported by a letter (see Appendix) developed by SCPs explaining the model; this was developed as the team identified that other services needed to comprehend the model to help support the people we work with to understand the model in turn. We will focus on more in depth interviews with other services in our final evaluation.

As we try to focus on building positive support networks around people the team noted challenges around other relationships the people we support have. We often talk about people being "drawn back into" these relationships which are often focused around crisis, criminal activity, substance use and domestic abuse. For example, one person is constantly drawn back toward their brother and disappears from their own flat for days/weeks at a time, often only reappearing at the point of crisis. Another person has been in and out of abusive relationships for many years and started a new relationship at the time CTI began. This meant she abandoned her accommodation, moved out of area and is now unable to see any support workers without her new partner being present.

**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? Our peer research activity highlighted that people in recovery spoke to us about loss and isolation, moving away or breaking ties from these old associations. We don't currently have a tool for assessing the quality of relationships in the person's support network so in March 2019 we conducted a focus group with four Experts by Experience to understand this 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" and being true to themselves. Linked to this Experts spoke about the quality of relationships in recovery. Being true to themselves 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 some 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 talked about how hard it can be to get an idea of what good friendships look like, particularly as more positive relationships tend to be with paid workers who are *"paid to be there".*

These discussions with Experts by Experience help us understand what challenges the people we work with might face in developing supportive networks and help us start to explore what positive relationships might look like.

**Fidelity to the CTI model**

We have used three CTI tools, the CTI fidelity scale, the data abstraction form and the team functioning assessment.

CTI fidelity scale (appendix 1 – n.b. see Technical Appendices document): The CTI fidelity scale assesses our fidelity to the CTI model, with a score out of five denoting CTI is ideally implemented. In June 2018 our initial self-assessment score was 2.7, CTI was adequately implemented, in January 2019 our self-assessment increased to 3.5, moving in to the 'CTI well implemented' scoring range.

Data abstraction form (appendix 2): This measures fidelity on an individual person's case. We have only completed phase three with one CTI case at this stage, this data abstraction form is presented in Appendix 2. This person's abstraction form indicates a score of 22, where a score of 19 denotes all of the CTI fidelity criteria were met on the individual case; hence there are three areas where the fidelity criteria were not met. In this case two of these criteria are about the number of contacts made with the person during pre-CTI and phase 1 stages, and one of the criteria was about contact reducing in phase two, where contact for this person remained the same.

Team functioning assessment (appendix 3): The team functioning assessment assesses how well the team is meeting criteria related to supervision, fieldwork reviews and documentation. This assessment, completed in May 2019 indicates that there are only two areas where we are not in fidelity with the CTI model in regards to team functioning, as we do not complete a weekly team supervision form, and we do not have a fieldwork co-ordinator to allocate cases for discussion at case management meetings.

At this point, as we start to close our first CTI cases these scores are encouraging, and the self-assessments outlined in Appendix 2 highlight some clear areas for further work which would see us increase our fidelity scores further. These in the

main are areas for further exploration in reflective practice. For example we identified that workers can have a tendency to drift into support work, particularly around housing issues. We also note that it continues to be challenging to reduce contact with people due to ongoing support needs however decreased contact has been possible with some people. Our frontline staff also find endings challenging, we have developed a long term relationship and connections with the people we support and have explored endings in reflective practice sessions with the team. These issues are also identified within delivery of the navigation model, so are not new issues, but warrant further exploration.

**Conclusions**

These concluding comments draw together early promising practice and recommendations in relation to implementing a CTI model with people with multiple and complex needs. We will focus on an in depth review of outcomes and impact in our final evaluation.

**How CTI has been received**

- We identified some trends around some people not understanding the CTI model consequently developing a letter to the person's support network to support their engagement and understanding. The team, in thinking about their caseloads reflected that they feel 40% of the people they support understand CTI and are engaging with it, 20% understand CTI but are not engaging with it, and a further 40% do not understand CTI. This includes people at the pre-CTI stage.

  Cross referencing with our phase progress plans confirms this picture. There is further work to be done to explore people's understanding of CTI and the wider workforce's understanding, as discussions do bear out that there are some people we have not been able to engage in this new way of working. Others have learning difficulties that made understanding the navigation role challenging, however on further probing some people did understand aspects of the model. We therefore want to explore how we are explaining the model and whether these are skills to highlight as gaps in our forthcoming workforce development work.

- 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 case load.

- We identified that 20% of people not engaging with CTI have generally been experiencing crisis and their focus has been on survival rather than goal setting.

- A further 40% of people appear to have struggled to understand what the CTI approach is. There seem to be varying reasons for this, worthy of further exploration with people and those in their support network looking

ahead to 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 person we are pausing because of the high levels of risk surrounding them.

- We have made inroads in communication, for example with email templates for the support network around the person explaining how we are working with people. It is clear from speaking to people that some of them do not understand how we are working with them on this pilot. There is work to do to explore this further as on further discussion it seems that some of these people do understand something of how we are working with them, but they are not engaging with all of the aspects of the model.

**Operational management**

- Reflecting on the process of setting up the pilot, having an Operations Lead in place to lead on training and development of the team and developing bespoke training seems to have been positive. We invested heavily in a structured induction and feedback from the team shows this was needed and appreciated.
- The Operations Lead role has been crucial in driving this pilot, it is a role which requires skills around operational and process management, and in depth knowledge of cases, working at speed and meticulously 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 to aid in managing support plans and phase changes. There is a high volume of work to do in supporting practitioners to administer CTI. We did not have this role in place for the beginning of the pilot nor later owing to staff sickness and this seems likely to have impacted on the quality of our data as a result.
- Our team experienced three changes in the implementation of the CTI model, seconded to a reduced number of organisations with contractual arrangements managed by Changing Lives, in new System Change Practitioner roles and implementing a new way of working through the CTI pilot. SCPs continued to deliver navigation support to some people alongside working through the CTI model with other people. Given the high levels of change the team were experiencing we would not recommend sharing navigation and CTI work within one role.
- Furthermore, 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 working with a Navigation model. This meant that we assessed the team's suitability and interest in delivering the CTI role on the job, this was very different to the roles that they originally applied to.

**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 caseload than anticipated on the pilot, 47 people, where we planned to take 60 people through the pilot. 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 and plan caseloads is very difficult. If CTI was implemented as a move on process in accommodation services for example the service would have much more control and autonomy about when the transition would happen, managing caseloads and support around this.

- We reference the challenges of ensuring CTI is tailored to a different cultural context and will continue to explore this as we review closed cases.

- The self-assessment documentation for CTI is robust but is also very quantitative. We have made a strong start involving people we support and Experts in this evaluation, but we need to do more about talking to the support networks around our people and getting feedback from them.

**Setting goals**

- We note early promising practice in goals setting – this feels much more asset based than our traditional support planning, and is supported by having a creative approach to using our personalisation budget; truly person centred goals can support more creative spending. As we have more data and begin to close cases we will review progress made working towards goals.

**Building support networks**

- Measuring achievement of goals and outcomes in this area of the pilot is less challenging than recording data on how people's support networks have changed. We have work to do over the next few months to set up a more robust process for assessing the efficacy of the support networks we are building, and will work with Experts by Experience to explore how they might contribute to this in the form of peer research.
- We note some challenges around building support networks, these are not unique to the CTI pilot but exploration of these challenges have highlighted two key issues. We have found that it can be difficult to adopt a 'linking role', building the person's support network rather than being reactive to

crisis when they have immediate support needs and are not engaging with other services. As we try to focus on building positive support networks, the team noted challenges around other relationships the people we support have. It feels important to focus our data collection plans around how we measure the quality of relationships and support networks as we move into the next phase of our evaluation.

**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 CTI evaluation and these synergies will be explored in the final evaluation phase.

**Next steps**

- This report will be shared locally at the FLNG Annual event in November 2019, with the FLNG strategic group and EBE Network, nationally via the Fulfilling Lives System Change Action Network and internationally via CACTI
- We will link the findings around workforce skills and training to our workforce development plan
- We will explore methodologies for assessing the quality of a person's support network involving Experts by Experience in our data collection.
- We will complete a review to cost our CTI pilot
- Our final CTI pilot evaluation will focus heavily on outcomes both for people and of this pilot

**Appendix sample letter to support network**

Dear [],

I want to give you a brief update on the new model that Fulfilling Lives is going to be using for some people who are experiencing transition. (Transition is anything that involves a change of environment i.e. prison leaving, hospital discharge, homeless to being accommodated). Fulfilling Lives is a 'time limited programme' funded by Big Lottery, my role will end March 2020. The model is called 'Critical Time Intervention' and is an evidence based approach designed to help people through transition, using time limited interventions implemented by services/agencies in the community. The aim is to provide continuity of care and community integration, securely linking people to networks of support. The model operates using a 9 month clock – (3 months per phase), it starts on day one phase one (this will be agreed with [x]), it does not stop (at the end of the 9 month CTI Fulfilling Lives will step back and support networks will be in place to take over)

PHASE 1 (3 months)

Provide support & begin to connect [name of person] to people and agencies that will assume the primary role of support (if not already in place)

PHASE 2 (3 months)

Monitor and strengthen support network and [name of person's] skills
• Observe operation of support network, mediate conflicts, help modify network as necessary and encourage them to take more responsibility

PHASE 3 (3 months)

Terminate CTI with support network safely in place. Fulfilling Lives step back to ensure that supports can function independently. Develop and begin to set in motion plan for long-term goals
• Hold meeting with [name of person] and supports to mark final transfer of care – this could be in the form of a 'celebration' to review progress made
At the end of each 3 month phase it would be good if we could hold a joint meeting, with [name of person], to review that past phase and set goals for the next phase, whilst celebrating any achievements made so far.

I will keep you updated on the times and dates of each phase and hopefully we can all meet together to review how the model is progressing. If you have any questions do not hesitate to contact me.