

Critical Time Intervention for Prison and Jail Reentry¹

Approximately 170,000 people return to the community from prison each year. Of those, 25 percent or more have mental health problems that were being treated inside prison and require follow-up treatment in the community.

In 2003 and again in 2007, federal legislation was enacted to address the need of these individuals. In 2007, Congress passed the Second Chances Act, which focused on building the nation's capacity to help people transition from prison to the community. Focusing on those individuals with mental health problems, the Mentally Ill Offender Treatment and Crime Reduction Act was passed to build programs that respond to people with mental illness who have contact with the criminal justice system. The act earmarked funds to encourage the development of diversion, treatment, and reentry programs, with the goal of ensuring that lack of treatment does not cause incarceration or that incarceration does not disrupt treatment.

And while such legislation reflects an intense interest in the growing number of people with and without mental illness being released from prison, there are only a handful of intervention models for reentry of people with mental illness into the community. One such intervention, Critical Time Intervention (CTI), strategically uses three phases to support transitions from institutional settings into community settings. These phases, Transition, Try-out, and Transfer to Care, guide a clinical process of supporting vulnerable individuals through difficult transitions while also assuring that most basic human needs of shelter, companionship, sustenance, and a sense of purpose in life are also addressed.

“What is done by, for, and with these individuals under such stress can make the difference between a new life and a return to the old life at a greater risk for a new arrest” (Draine & Herman, 2007, p. 1577).

CTI is a model that combines several evidence-based tools, including cognitive behavioral therapy, illness management, supported housing, integrated dual disorder treatment, and motivational enhancement. The intervention suits the transitional nature of the reentry process, the complexity of service and treatment needs, and the demand for individualized services. Finally, in an environment that is fraught with a focus on social control and managing deficits, CTI

resolutely emphasizes flexibility in service delivery and capacity building in individuals.

CTI was developed in response to a need for transitional services at one of the largest New York City public shelters for homeless men (Bachrach, 1992; Susser et al., 1997). In a randomized trial, 96 men with severe mental illness who were being discharged from the shelter to housing were randomly assigned to receive either CTI or the case-management discharge services typically provided by the onsite psychiatric team. The majority of these men also had a history of drug or alcohol problems. The men in the CTI group received nine months of CTI plus usual services and then only usual services for the following nine months. The men in the control condition group received usual services for the entire 18 months of the study. Complete follow-up data on homelessness—the study's primary outcome—were obtained for 98 percent of the sample (Susser et al., 1997). CTI significantly reduced the risk of recurrent homelessness in the experimental group, compared

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About the Policy Brief

The policy brief series is produced monthly and highlights a policy issue under study at the Center. Policy topics include reentry, diversion, sentencing, recidivism, employment, treatment, and recovery. For more information, see the News page on the Center's website.

The Center is a research unit in the Institute for Health, Health Care Policy, and Aging Research.

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¹ Work on this brief was partially supported by NIMH grant R01-MH076068. Portions of this brief have been drawn from a chapter by Jeffrey Draine and Daniel Herman to be published in the forthcoming book tentatively entitled *Re-Entry Planning for Offenders With Mental Disorders: Policy and Practice* (Henry A. Dlugacz, editor), to be published by Civic Research Institute, Inc. (CRI) For more information about CRI publications, visit their website: www.civicrosearchinstitute.com.

with the control group over the course of the follow-up period. Notably, the impact of the intervention appeared to persist beyond the termination of the intervention. This lends support to the model's approach to linking service recipients to effective community supports.

Since this initial research was completed, a number of studies have demonstrated the effectiveness of the model with similar populations during transitions from other

For more information on the CTI evidence base, visit SAMHSA's National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov>

types of institutions (e.g., Herman et al., 2007; Kasproff & Rosenheck, 2007). CTI aims to build connections for both formal treatment engagement as well as social supports. The process for meeting these needs is illustrated

by TABLE 1. The most intensive part of the intervention occurs in the first stage, the most critical time period in the reentry transition, whereas the second and third stages serve to test and strengthen the connections developed during the first stage, with involvement by the CTI team members becoming progressively less intensive over time.

The intervention is typically carried out in the community by a bachelor's level service provider and closely supervised by a team leader who typically has master's level professional training. Below we describe how the CTI model is applied to prison reentry.

Stage 1: Transition to the Community.

The first stage of CTI focuses on assessing the social relations and resources that exist prior to reentry, providing intensive support to establish community supports and services, and motivating engagement with treatment. The CTI service provider maintains a high level of contact with the client, both through regular telephone calls and home visits. Clients are accompanied to appointments with selected community providers and are introduced to new providers to facilitate the development of durable ties and to establish a process by which clients and providers create goals for satisfactory and effective treatment.

The application of CTI to prison settings requires an adjustment to the usual pattern of planning because prisoners are typically not available for community visits to providers, their families, or other community supports in the key weeks of planning prior to release. For prisoners still incarcerated, the CTI service provider begins the process through contact with the prisoner, complemented by parallel visits to residences and potential community providers and resources.

Stage 2: Try-Out.

The second stage of CTI is devoted to testing and adjusting the system of community supports that was established in the first stage and reinforcing treatment engagement. During this stage, the service provider broadens, observes, and strengthens community supports as needed. CTI service providers may work on expanding the number and diversity of community connections beyond treatment and housing to employment, community involvement, and leisure. The CTI provider meets with the client less frequently, although the frequency and duration of the meetings change if problems arise.

At this point, providers in the community should have assumed primary responsibility for the provision of long-term treatment services. CTI providers emphasize social-skills training and employ effective behavioral change strategies to help clients remain in treatment and achieve their identified goals. CTI staff focuses on assessing the degree to which the treatment engagement and community support systems are functioning as planned. During this phase, the staff supports the client in addressing issues independently.

Stage 3: Transfer of Care.

In the final phase, the CTI worker focuses on completing the transfer of support to the client's support system. Preliminary work leading up to transfer of care has been done throughout the previous stages. The CTI provider remains available for consultation during this period, but does not engage in direct service. The main goal now is to ensure that the most significant support system providers come together and, along with the client, reach consensus about the components of the ongoing system of support. Ideally, this occurs at least one month before the end of the nine-month transition period of active intervention. As CTI is individualized, a small number of clients may not be ready at this point. In this case, the CTI worker will continue work with any client still in the midst of adjustment.

Current Study

Jeffrey Draine (University of Pennsylvania) and Dan Herman (Columbia University) are working on a randomized trial of CTI for men with mental illness leaving New Jersey prisons and returning to Camden County. The research team is working closely with the professionals at Steininger Behavioral Care. With funding from the National Institute of Mental Health (NIMH), the team hopes to provide the first evidence that CTI may be effective in this setting and with this population.

Policy Implications

Prisoners reentering the community after incarceration are experiencing one of the most stressful life transitions in society (Draine & Herman, 2007). This fact is often unrecognized by policymakers because of a societal belief that offenders are getting their just deserts. However, we can change this belief to one that is focused on public health, and on reducing the risk of suicide, substance abuse and criminal recidivism, while increasing the chances of maintaining positive social connections, thriving economically and integrating into community life.

Such a shift in policy discourse may release more resources for housing and economic opportunity. It is one that is also supported by both the recovery movement in mental health and the emergent good lives model in criminal justice (Maruna, 2002). Much of this change depends on both the mental health and justice systems coming up with new resources. With support of research, such as that on CTI, we can provide empirical evidence for what resources, for whom and under what circumstances have the most potential to support successful reentry for people with mental illness.

TABLE 1: Transition Activities by Phase

Stage	Transition	Try-Out	Transfer of Care
Timing	Months 1-3	Months 4-7	Months 8-9
Community Engagement			
Purpose	<ul style="list-style-type: none"> To provide specialized support around establishing community supports 	<ul style="list-style-type: none"> To facilitate and test problem-solving skills 	<ul style="list-style-type: none"> To phase out CTI with community support network
Activities	<ul style="list-style-type: none"> Make home visits Accompany visits to providers Meet with supporters Give support and advice Mediate conflicts Build negotiation skills 	<ul style="list-style-type: none"> Same as Months 1-3, but less frequently Observe adherence behavior Develop long-term goals Build community connections 	<ul style="list-style-type: none"> Assure consensus about continued care and independence in follow-through Celebrate community connections Anticipate further goal attainment with the client
Treatment Engagement			
Purpose	<ul style="list-style-type: none"> To motivate and support treatment engagement behavior, particularly for those with co-occurring substance use disorders 		
Activities	<ul style="list-style-type: none"> Motivational enhancement Developing mutual credibility and trust Initial treatment planning and access Twelve-step facilitation if desired 	<ul style="list-style-type: none"> Social Skills Training for maintaining progress toward treatment goals Assuring behavior change associated with long-term engagement with treatment Twelve-step facilitation if desired 	<ul style="list-style-type: none"> Continued motivational support integrated with observing goal attainment Twelve-step facilitation if desired

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Treatment Relationships: A Key to Success in the CTI Reentry Model?

In addition to testing the effectiveness of reentry programs such as CTI, Center investigators are also examining the processes by which such interventions achieve their effectiveness. The helping relationship is widely recognized as a critical ingredient across a range of mental health interventions (Martin, Garske & Davis, 2000). In fact, some scholars have suggested that in psychotherapy, the development of a therapeutic alliance between client and therapist is more important than what kind of treatment is actually employed. Although some studies have begun to extend this idea to other areas, such as child welfare and probation and parole, no research has assessed whether the quality of the relationship or alliance formed between newly released prisoners with mental illness and their service providers contributes to more successful reentry outcomes.

The randomized trial of CTI for reentry being conducted by Draine and Herman represents a prime opportunity to assess the role of helping relationships in reentry services. Like many outreach-based mental health interventions, CTI entails an intensive package of supports that ranges from home visits to accompanying clients in procuring benefits and services. A trusting, collaborative relationship is essential to ensuring that these contacts are productive and durable. Previous research suggests, however, that treatment alliances may be weakened in certain circumstances, depending on factors like the client's severity of illness, the service provider's skill in engaging clients, and the level of coerciveness the client perceives is occurring over issues such as money disbursement. In such cases, it is likely that the client will disengage from the program or fail to make full use of the services offered.

Using data from the CTI randomized trial, Center investigators Beth Angell and Jeffrey Draine will undertake the first analysis of the helping relationship in reentry services. Using measures that assess both positive and negative features of the therapeutic relationship from the perspectives of both client and provider, they plan to plot relationship trajectories over time, assess whether factors related to the client's criminal history are related to the development of strong therapeutic relationships, and assess whether more favorable reentry outcomes are achieved for clients who develop stronger treatment relationships. If the findings indicate that the helping relationship makes a difference in CTI treatment, the next step will be to query stakeholders on precisely why and how relationships make a difference. That is, therapeutic relationships formed at the intersection of mental health and criminal justice – systems that collectively embody treatment and control – are likely to diverge from the classical psychotherapy relationship in important ways. To tease apart these differences, this study will use qualitative interviews with clients and staff to help identify components that constitute and support solid therapeutic relationships, which the research team will feed into training efforts for reentry personnel.

Reference

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More Information on Critical Time Intervention

See our website www.cbhs-cjr.rutgers.edu for more information on our research on Critical Time Intervention and other reentry initiatives.

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