Global Advanced Research Journal of Medicine and Medical Science (ISSN: 2315-5159) Vol. 3(5) pp. 087-089, May 2014
Available online http://garj.org/garjmms/index.htm

Short Communication

Critical Time Intervention – Task Shifting (CTI-TS): a psychosocial intervention for people with severe mental illness in Latin America

Tatiana Fernandes Carpinteiro Da Silva[1]*, Giovanni Lovisi[1], Sara Conover[2] and Ezra Susser[2]

[1]Federal University of Rio de Janeiro (UFRJ) - Public Health Institute (IESC), Rio de Janeiro – Brazil.
[2]Columbia University – Newman School of Public Health - New York-USA.

Accepted 12 March, 2014

The Critical Time Intervention-Task Shifting (CTI-TS) is a psychosocial intervention designed to address a fundamental gap in the services offered by mental health services in Latin America to the treatment of individuals with severe mental illness (SMI). This article aims to describe the principles of this innovative psychosocial intervention, as well report the stages of its implementation process carried out up to the moment. CTI-TS was developed based on a north- American intervention, and had the support of mental health specialist from three Latin countries (Brazil, Chile and Argentina) beyond the creators of the original intervention (NY-USA), to assure that cultural, politics and economic issues from Latin-American reality were considered is its development. This will be the first psychosocial intervention designed and performed simultaneously in three countries of Latin America. Results regarding feasibility and clinical outcomes will be available soon.

Keywords: Psychosocial intervention, Interventional study, Severe Mental Illness, Mental Health, Latin America.

INTRODUCTION

Critical Time Intervention-Task Shifting (CTI-TS) is a psychosocial intervention designed to address a fundamental gap in the services offered by mental health clinics in Latin America. These clinics are the primary locale for outpatient treatment of individuals with severe mental illness (SMI) in the urban areas of Latin America. They offer some basic and important clinical care, such as pharmacologic treatment, onsite. A major limitation of many of these services is that they offer minimal or no resources or training for the provision of *in vivo* community-based services, i.e. services delivered outside the clinic facility in homes or elsewhere in the community. In most urban areas, they are only weakly linked to primary health care and are not easily accessible to much of the population (Almeida J and González J, 2005).

The CTI-TS is defined as a time-limited, 9-month long intervention, provided at the critical time when a person is first offered services at a mental health clinic. During this period, CTI-TS workers forge relationships that will shape the continued use of services and enhance the potential for recovery beyond the termination of the intervention

Furthermore, this model is sensitive to the important need to recognize ethnic and cultural variability and to adapt the ways in which services are offered to meet the needs and priorities of specific ethnic and cultural groups. A growing body of research suggests that consumers and their families will be considerably more likely to

*Corresponding Author E-mail: tatiana_fcs@hotmail.com; Telephone: 55 (21) 9618-7097

participate in and benefit from services that are organized and delivered in a culturally competent fashion (Whitley R, 2007; United States Public Health Service, 2001). CTI workers receive training designed to ensure that their practices take these issues into account wherever possible.

The adaptation of CTI-TS for use in Latin America took this context into account and was a joint effort of the three Latin America sites (Rio de Janeiro- Brazil, Santiago -Chile, Buenos Aires – Argentina) and Columbia University in New York, where the intervention was developed based on another intervention, the Critical Time Intervention (CTI), an evidence-based practice that was originally developed in USA which is used in high-income countries. The development of this intervention considered opinion of mental health specialists of all these countries, to ensure that though some aspects can be adapted to local contexts, other aspects need to remain constant. This is to ensure that structural aspects related to the intervention design and implementation protocol remain comparable across the sites. This article aims to describe the principles of this new psychosocial intervention designed for people suffering of severe mental illness in Latin America.

METHODS

Based on the outlined background, the implementation of CTI-TS will be carried out across three different countries (Brazil, Chile and Argentina), where this intervention will be tested for its feasibility through a pilot –study comprising 120 patients. This implementation process is being carried out according the three stages of implementation described in the literatures, where the stage 1 includes the pre-pilot and the pilot-study, the stage 2 includes a bigger randomized clinical trial, and the stage 3 encompass cost-benefits and generalization studies of the intervention (Rousanville B, Carroll M and Onken L, 2001).

CTI-TS aims to enhance the continuity of care for people with SMI by bridging the gap between treatments and/or services. CTI is straightforward and highly focused (Valencia E et al, 1997). It is implemented by a team with low case-to-worker ratios. CTI –TS is limited both in time and specific objectives, and involves two components. The first is to strengthen the individual's long-term ties to support systems. This includes both informal and formal supports, such as mental health services, family, and friends. The strength and availability of these connections varies, but individuals with SMI and their relatives often need assistance working with each other. The second component of the intervention involves the provision of practical and emotional support during the critical time of engagement and/or transition to long-term services.

CTI-TS will be provided by a team that will be comprised of two types of CTI-TS workers: Peer Support Workers (PSWs) and Community Mental Health Workers (CMHWs), who work under the supervision of a clinical coordinator and with access to a psychiatrist as needed. The CMHWs and PSWs provide community outreach and support to engage service users, their families, primary care practitioners, peers and other community members in the recovery process.

PSWs will be individuals who have experienced a substantial disruptive period caused by a mental disorder in their own life, and who possess some knowledge of the system of provision of mental health services and an interest in peer support work that is oriented toward recovery. CMHWs will be individuals, preferably with a maximum of two years of postsecondary education and with knowledge of the local mental health and other health services, and a commitment to providing *in vivo* mental health service support for the community.

The goals and activities of CTI-TS are directed at creating a sustainable support network and recovery plan for each individual user. The areas of intervention on which CTI-TS might intervene are diverse; however, CTI-TS focuses in on 1 - 3 areas that are deemed crucial to address in order to develop lasting supports. These areas of intervention might include: psychiatric treatment and medication management, money management, substance abuse treatment, housing and crisis management, daily life activities and/or family interventions. These areas are individually defined and shaped from the perspective of the consumer (Silva T et al, 2011; Herman D et al, 2007).

This intervention is carried out in three consecutive and interrelated phases, in which the level of intensity of contact between the CTI- TS workers and the individual declines over time. The role of the CTI-TS is specifically designed to avoid becoming the primary source of care for the individual with SMI. The phases are *Initiation*, *Try-Out*, and *Transfer of Care*. Each phase is implemented roughly over a three-month period.

In the first phase*, Initiation*, the patient and CTI-TS team formulate a treatment plan that focuses on selected areas identified as crucial for strengthening stability and facilitating the assimilation of the individual into community living. The main task of this phase is for clients to become linked to appropriate formal and informal community resources.

The second phase, *Try-Out*, is devoted to testing and adjusting the support systems that have been established in the community. In this phase the basic support systems should already be in place and functioning. This phase allows the CTI-TS workers to carry out a thorough *in vivo* needs assessment of the individual's long-term support system. The CTI-TS workers can observe where holes exist in the system and where the individual needs more or less support and services.

The final phase, *Transfer of Care*, is devoted to making any necessary fine-tunings in the network of supports of the individual. Long-term, community-based linkages that

were previously established should at this point be functioning smoothly. In this phase, the client, CTI-TS workers, and other key service providers should meet to specifically review transfer-of-care issues and long-term goals. The same should occur among the main individuals providing informal support.

Regular supervision is an essential element of the CTI-TS model. The responsibility of ensuring the provision of CTI-TS supervision rests with the team leader, who will be a professional qualified to provide clinical supervision and who is well acquainted with the CTI-TS model. The CTI-TS supervision will be provided on a weekly basis and will be devoted to discussing patients; all members of the team will participate. As the patient progresses, the intervention should focus from 1-3 areas of greatest need. In the weekly supervision meetings, fidelity to the treatment model will be ensured and any difficulties the team encounters in its implementation should be identified and addressed.

CONCLUSIONS

Since the mental health care in Latin America is undergoing a huge transformation with the change of hospital-based care for community assistance, has become clear that the treatment provided to this population did not result in significant improvement of their functional aspects (Thornicroft G and Susser E, 2001; Penn D and Mueser K, 1996). Pharmacotherapy can reduce psychotic symptoms, but has little effect on social adjustment and quality of life, even if there is good adherence to treatment. So it is essential the adequacy of these patients in society beyond simply reducing symptoms, being fundamental to the implementation of psychosocial interventions that benefit this population and their families, meeting their needs in a way adapted to the current economic and social reality in Latin America (Chowdur R et al, 2011).

The CTI-TS stage 1 of implementation was finished, including the development of a manual of the CTI-TS, which describes in detail all the procedures relevant to the intervention; the semantic adaptation of the instruments used to assess the clinical outcomes and the development of a method to assess the fidelity of the implementation process. The pilot-study will compare the usual care offered by the psychosocial centers in community with the CTI-TS intervention. Results regarding feasibility and clinical outcomes will be available soon. This will be the first such undertaking of trying to develop and measure the effectiveness of a community mental health intervention across three countries in Latin America.

REFERENCES

Almeida JM, González J (2005). Atención comunitaria a personas con trastornos mentales severos. *Washington, DC: Panamericana de la Salud.*

Chowdur R, Dharitri R, Kalyanasundaram S, Suryanarayana RN (2011). Efficacy of psychosocial rehabilitation program: The RFS experience. *Ind. J. Psychiatry*, 53: 45-48.

Herman D, Conover S, Felix A, Nakagawa A, Mills D (2007). Critical time intervention: An empirically supported model for preventing homelessness in high risk groups. *J. Primary Prevention*, 28: 295-312.

Office of the Surgeon General. Mental health culture, race, and ethnicity: a supplement to Mental Health, a report of the Surgeon General (2001). *United States Public Health Service.*

Penn D, Mueser K (1996). Research update on the psychosocial treatment of schizophrenia. *Am. J. Psychiatry*, 153: 607-617.

Rousanville B, Carroll M, Onken L (2001). A stage behavioral therapies research: getting started and moving on from stage I. *Am. Psychol. Assoc.* 8: 133 – 142.

Silva TFC, Abelha L, Lovisi G, Calavacanti MT, Valencia ES (2011). Quality of life assessment of patients with schizophrenic spectrum disorders from Psychosocial Care Centers. *J. Brasileiro de Psiquiatria,* 60: 91-98.

Thornicroft G, Susser E (2001). Evidence-based psychotherapeutic interventions in the community care of schizophrenia. *The Br. J. Psychiatry*. 178: 2-4.

Valencia E, Susser E, Torres J, Felix A, Conover S (1997). Critical Time Intervention for Homeless Mentally ill Individuals in Transition from Shelter to Community Living. In Mentally Ill and Homeless: Special Programs for Special Needs. Breakey W and Thompson J (eds). *Harwood Academic Publishers, Amsterdam, The Netherlands,* 75-94.

Whitley R (2007). Cultural Competence, Evidence-Based Medicine, and Evidence-Based Practices. *Psychiatry Services*, 58: 1588-1590.