

Critical time intervention – Task shifting: a new psychosocial intervention for people with severe mental illness in Latin America

Intervenção para períodos críticos – Transferência de cuidados: uma nova intervenção psicossocial para indivíduos com transtornos mentais graves na América Latina

TATIANA FERNANDES CARPINTEIRO DA SILVA¹, GIOVANNI LOVISI¹, MARIA TAVARES CAVALCANTI², CATARINA DAHL², SARA CONOVER³, ELIECER VALENCIA³, EZRA SUSSER³

¹ Universidade Federal do Rio de Janeiro (UFRJ), Instituto de Estudos em Saúde Coletiva (IESC).

² UFRJ, Instituto de Psiquiatria (IPUB).

³ Columbia University, Newnan School of Public Health, New York, USA.

Received: 10/19/2013 – Accepted: 11/6/2013

Silva TFC, et al. / Rev Psiq Clín. 2013;40(6):243

Dear Editor

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 is essential the adequacy of these patients in society, 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^{1,2}.

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 America³. It is a time-limited, 9-month long intervention, provided at the critical time when a person is first offered services at a mental health clinic.

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 psychiatrist coordinator. PSWs will be individuals who have experienced a substantial disruptive period caused by a mental disorder in their own life, and who possess interest in peer support work that is oriented toward recovery. CMHWs will be individuals 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 CTI-TS aims to enhance the continuity of care for people with SMI by bridging the gap between treatments and/or services. It is implemented by a team with low case-to-worker ratios. The goals and activities of CTI-TS are directed at creating a sustainable support network and recovery plan for each individual user. The 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 consumer³.

This intervention is carried out in three consecutive and inter-related 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.

Regular supervision is an essential element of the CTI-TS model. This role will be performed by a psychiatrist well acquainted with the model. The supervision will be provided on a weekly basis and will be devoted to discussing cases with all members of the team.

The first stage of CTI-TS implementation was finished, including the development of an intervention manual, the semantic adaptation of the instruments used to assess the outcomes and the development of a method to assess the fidelity of the implementation process⁴. 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

1. Thornicroft G, Susser E. Evidence-based psychotherapeutic interventions in the community care of schizophrenia. *Brit J Psychiat*. 2001;178:2-4.
2. Almeida JM, González J. Atención comunitaria a personas con trastornos mentales severos. Washington, DC: Panamericana de la Salud; 2005.
3. Herman D, Conover S, Felix A, Nakagawa A, Mills D. Critical time intervention: an empirically supported model for preventing homelessness in high risk groups. *J Prim Prev*. 2007;28:295-312.
4. Whitley R. Cultural competence, evidence-based medicine, and evidence-based practices. *Psychiatr Serv*. 2007;58:1588-90.

Remissive index

Searching for the research keywords can be done at the Journal homepage: www.hcnet.usp.br/ipq/revista/index.html

15N metabolic labeling 51
3D avatar facial emotion recognition 129
acute stress disorder 211
adipocyte 35
adolescents 59, 167
aging 71
agoraphobia 135
alcohol abuse 65
alpha frontal activity 129
Alzheimer's disease 139
animal model 41
anxiety 71
apparitions 157
assessment 215
association 177
astrocyte 35
attempt suicide 220
biomarkers 2, 20, 28, 51
bipolar disorder 93, 220
blood-brain barrier 35
body dissatisfaction 167
body image 59, 167
brain 197
brain regions 10
Brazil 172
burden 162
cardiac arrest 197
caregiver 162
cognitive assessment 139
consciousness 105, 203, 225, 233
cooperativeness 110
coparenting 215
crime victims 191
dementia 77, 139, 162
depression 71
developmental disability 97
diagnosis 2, 20
disorders as posttraumatic stress disorder 211
dissociation 225
dopamine 35
drugs 65
early trauma 93
eating behavior 59
elderly 71
energy metabolism 16
epidemiology 172
epistemology 105
exercise 88
exercise test 88
extrasensory perception 157
Frost Multidimensional Perfectionism Scale 144
G72 51
gender 172, 211
gene 177
gene expression 10
genetic 41
glia 35
glucose 35
glutamate 35
HPA axis dysfunction 20
immune system 28
impact factor 53
in situ hybridization 10
inflammation 28
insulin 35
lymphocyte 35
major depression 93
mass spectrometry 16
materialism 114
materialistic explanations 150
mediumship 157, 225, 233
memory 139
mental disorders 97, 191
mental illness 172
mental phenomena 114
mental retardation 97
mentally ill persons 191
methodology 105
microarray 10
mild cognitive impairment 139
mind sight 203
mind-body dualism 150
mind-body relations 105, 150, 157
mind-brain problem 114
mind-brain relationships 233
mood disorders 88, 93
motor vehicle accidents 211
multicenter study 172
near-death experiences 197
neurodegeneration 35
neurodevelopment 41
neuroimaging 220, 225
neuropil 35
neuropsychiatry 41
neuroscience 53, 114
NK-cell 35
non-local mind 197, 203
obsessive-compulsive disorder 177
oligodendrocytes 16, 35
out-of-body experiences 197
panic disorder 135
parapsychology 157
parenting alliance 215
parkinson's disease 88
peritraumatic dissociation 211
personality 144
philosophy of mind 114
physical activity 59
physical exercise 71
physical violence 172
portuguese 144
prevalence 172
proteomics 16
psychiatric disorders 2, 20
psychiatry 110
psychic gifts 203
psychoeducational group 162
psychology 150
psychophysiology 105, 233
quantitative proteomics 51
reductive materialism 150
regulatory authorities 2
reliability 144
religion and psychology 233
researcher performance evaluation systems 53
respiratory subtype 135
review 177
RT-PCR 10
schizophrenia 2, 10, 16, 20, 28, 35, 41, 51, 129
schools 65
self-directedness 110
self-transcendence 110
sex 172
sexual crime 97
sexual offence 97
sexual satisfaction 77
sexuality 77
smoking 135
SPECT 225
spiritual experiences 233
substance-related disorders 135
suicidal behavior 220
suicide risk factor 220
ternary awareness 110
translational research 41
traumatic experience 93
validation 215
validity 144
victimization 191
virtual reality 129
vulnerability 172