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Implementing a community-based task-shifting psychosocial intervention for individuals with psychosis in Chile: Perspectives from users

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Abstract

Background: Latin America, and Chile in particular, has a rich tradition of community mental health services and programs. However, in vivo community-based psychosocial interventions, especially those with a recovery-oriented approach, remain scarce in the region. Between 2014 and 20l5, a Critical Time Intervention-Task Shifting project (CTI-TS) was implemented in Santiago, Chile, as part of a larger pilot randomized control trial. CTI is a time-limited intervention delivered at a critical-time to users, is organized by phases, focuses on specific objectives and decreases in intensity over time. CTI-TS, which combines both the task-shifting strategy and the use of peers, introduces a novel approach to community mental health care that has not yet been tried in Chile.

Aims: We aim to evaluate the feasibility, acceptability and applicability of such a community-based psychosocial intervention in urban settings in Latin America – specifically, in Santiago (Chile) from a user perspective.

Method: We analyzed 15 in-depth interviews ($n = 15$) with service users who participated in the intervention about their perceptions and experiences with CTI-TS through thematic analysis.

Results: Three themes were revealed. The first was related to the structural characteristics of CTI-TS, especially regarding the timing, duration and phasic nature of the intervention. The second pertained to the acceptability of the in vivo community-based approach. The third theme dealt with the task-shifting aspect, that is, users' perceptions of the peer support workers and the community mental health workers.

Conclusions: CTI-TS was generally acceptable in this Latin American context. Users' perspectives pointed to the need to make adjustments to some of the structural characteristics of the CTI model and to combine this type of intervention with others that can address stigma. Thus, future adaptations of CTI-TS or similar psychosocial interventions in Latin American contexts are feasible and can enhance community mental health in the region.

Keywords

Community mental health; Critical Time Intervention; Latin America; task shifting; user perspective

Introduction

Critical time intervention (CTI) is a well-known evidence-based psychosocial intervention model that was developed during the late 1980s and early 1990s in New York City to assist homeless people escape the 'revolving doors' of shelters and help them become an integrated member of their native community (Susser et al., 1997). CTI has since been adapted to address mental health needs in different populations, including persons with mental illness who were released from prison (Draine & Herman, 2007) and previously homeless persons who were discharged from psychiatric hospitals (D. B. Herman et al., 2011). CTI aims to strengthen individuals' long-term ties to services, family and friends to promote stable recovery and community reintegration (Conover & Restrepo-Toro, 2013; D. Herman & Conover, 2002). Specific elements of any version of CTI can vary, but the basic CTI model is a structured, time-limited community-based intervention that consists of three phases (1 - initiation; 2 - try-out; 3 - transfer of care) and is delivered to individuals during a

critical period of transition (see Table 1; Center for the Advancement of Critical Time Intervention, 2017).

Between 2014 and 2015, a pilot randomized control trial (RCT) of a CTI intervention that incorporates tasks-shifting, CTI-TS, was implemented for the first time in Latin America – specifically, in Santiago, Chile, and in Rio de Janeiro, Brazil. CTI is usually delivered by health-related professionals such as social workers, case managers and mental health counselors. In CTI-TS, the task of delivering the intervention was shifted to a worker pair consisting of a community mental health worker (CMHW) and a peer support worker (PSW). The study was implemented by 'RedeAmericas', a Regional Network for Mental Health Research in the Americas, which was one of the five 'collaborative hubs' funded by the US National Institute of Mental Health to conduct research on task-shifting/task-sharing for the delivery of mental health services to address the mental health treatment gap in low- and middle-income countries (LMICs; National Institutes of Mental Health (NIMH) U19MH095718). The pilot RCT specifically aimed to test whether as compared to the control group (usual care alone), participants who received the intervention (usual care plus CTI-TS) would show a trend toward improved health-related quality of life and report fewer unmet needs at 18 months after the initiation of the 9-month CTI-TS intervention (Mascayano et al., 2018; Susser, 2012). CTI-TS also had an overarching goal of assessing the feasibility and acceptability of implementing recovery-oriented in vivo community-based care – that is, services provided outside the clinic in the user's home or other community settings – for individuals with severe mental disorders in marginalized poor urban communities in Latin America.

Since the Declaration of Caracas in 1990, many countries in Latin America have made significant progress in shifting the focus of care for people with severe mental disorders from psychiatric hospitals to community settings (Pan American Health Organization [PAHO], 1990). Chile and Brazil in particular are among the most advanced, having instituted many progressive reforms in their respective national mental health care systems (Minoletti, Galea, & Susser, 2012). In the case of Chile, although the country has developed a rich tradition of community care, it still has very limited experience in implementing structured psychosocial interventions and has not adopted the use of peers in the delivery of mental health services.

Since 2000, Chile has implemented a series of national mental health policies aimed at expanding access to mental health care by developing mental health expertise within the primary health care system and shifting delivery of mental health services from a traditional, institution-based approach to a more community-based orientation, which was principally achieved by introducing a new group of community and mental health centers: *Centro Comunitario de Salud Mental* (COSAM) and *Centro de Salud Mental* (CESAM) (Araya, Alvarado, & Minoletti, 2009; Caldas de Almeida & Horvitz-Lennon, 2010; Organización Mundial de la Salud [OMS] & Ministerio de Salud de Chile, 2007). COSAMs and CESAMs are both part of the secondary level of care and were designed to serve outpatients with more complex mental health problems in centers located close to their homes. Despite significant progress achieved under these psychiatric reforms, Chile still faces many challenges in providing community care for people with severe mental disorders, such as those with

psychosis. Health professionals have limited training in community mental health, and most services are still provided inside the health facilities rather than in community settings (OMS & Ministerio de Salud de Chile, 2007). In general, Chilean mental health services still primarily focus on the alleviation of service users' symptoms, and have not fully adopted the recovery orientation (Mascayano & Montenegro, 2017) to expand the ability of people to rebuild a positive sense of self and social identity as they continue to cope with mental health problems or related disabilities (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005).

To overcome some of these challenges, in Chile and other LMICs, the World Health Organization (WHO; 2010) promotes the adoption of the task shifting or task sharing strategy (i.e. to train and develop a network of non-professionals such as lay health workers to deliver mental health care, such as psychosocial support). In many Western countries, another strategy – employing peers (i.e. individuals recovering from mental illness themselves) – has in some instances proven to be effective in enhancing care (Coniglio, Hancock, & Ellis, 2012; Gillard, Edwards, Gibson, Owen, & Wright, 2013) and has demonstrated to be an important and beneficial means of engaging and empowering users in their recovery (Castelein, Bruggeman, Davidson, & Gaag, 2015; Gumber & Stein, 2013). CTI-TS incorporates both the task-shifting strategy and the recovery-oriented approach of employing peers. Thus, by combining the strategy of task-shifting to peers with the in vivo community-based component of CTI, CTI-TS introduces a novel approach to community mental health care that has not yet been tried in Chile. This presents an opportunity to further understand and contribute to efforts to improve community care for people with psychosis, in Chile and in other Latin American contexts.

This study examines the acceptability and feasibility of implementing CTI-TS in Chile from the perspectives of users. In particular, we explore users' perspectives regarding the in vivo approach and the strategy of task-shifting community-based mental health support to PSWs and CMHWs, in addition to their perceptions of the core components of CTI. By focusing the analysis on the users' experiences, this study also aims to illustrate the value of incorporating participants' inputs in the evaluation of programs, as their insights can be utilized to improve the acceptability and feasibility of future implementations of CTI-TS or similar psychosocial interventions.

Methods

Data and participants

This present study utilizes data from a larger qualitative study, the Shared Research Project, which examined the barriers and facilitators to scaling up CTI-TS in Latin America. The Shared Research Project was conducted between December 2015 and September 2016, after the conclusion of the pilot RCT, and included a total of 40 interviews with users, PSWs, CMHWs and clinical administrative staff who participated in either of the intervention sites in Santiago, Chile or Rio de Janeiro, Brazil. The study received approval from the Institutional Review Board of Columbia University (New York, USA) and the local review board of the University of Chile.

This article focuses on the 15 in-depth interviews conducted with Chilean users. Interviewees were randomly selected from the 30 total users in the intervention arm. Staff independent from the trial conducted the interviews using a semi-structured interview guide. Interviews lasted between 45 and 60 minutes, were audio recorded, and took place at users' homes. Interviews were transcribed verbatim in Spanish and then translated to English by bilingual speakers.

The sample of 15 participants ($n = 15$) included 10 males and 5 females, whose ages ranged from 21 to 65 years old. Seven participants (45%) were diagnosed with non-affective psychosis and eight (55%) with affective psychosis (Table 2).

Analysis

Analysis for this study stems from the Shared Research Project but focuses specifically on the experiences and perspectives of users regarding the implementation of CTI-TS in Chile. Following the thematic analysis approach (Braun & Clarke, 2006; Ritchie & Spencer, 1994), a core group of research team members for this more focused analysis first read the assigned interviews independently in order to gain familiarity with the data and to generate ideas and codes, which were documented in analytic memos (Birks, Chapman, & Francis, 2008). The team members then came together during weekly conference calls to discuss the notes and ideas, and to identify emergent themes. To enhance analytical rigor during these discussions, researchers were encouraged to apply triangulation techniques such as looking for counter-examples, or assessing whether the findings would be corroborated by the other sources of data from the larger Shared Research Project (Patton, 1999). Additionally, the preliminary findings identified by the core analysis team were checked with the local researchers in order to draw on their insights about the implications of the results.

Results

From the interviews with 15 users in Chile, three themes emerged: (1) structural characteristics of CTI: timing, duration and phases; (2) in vivo services: a road to recovery; and (3) perceptions regarding PSWs and CMHWs.

Structural characteristics of CTI: Timing, duration and phases

Many participants explicitly mentioned the beneficial aspect of the timing of CTI-TS–that it was delivered at an important moment in their life. As a participant (#12) described, the PSWs and CMHWs (CTI workers) offered her much needed support during an important transition: 'After I was discharged from the hospital … I realized that I needed some guidelines to orient me in the process I was going through'. Some participants, however, placed less importance on the intervention's timing. A few users mentioned that they simply liked having somebody 'watch[ing] after' them, or 'just to have something to do'. And for some, participating in the intervention was not directly related to their transition needs; instead, they were motivated by the potential to improve mental health services for others in the future. A participant (#10) explained, '[the program] would help the next generation … for other people, but not for me, because I'm already too old'.

With respect to the duration and phases of CTI (9 months, divided into three phases of 3 months each), many participants expressed some dissatisfaction or a lack of understanding of the intentions of these structural features. Several users stated that the duration of the intervention was too short and wished that the support provided by the CTI workers had been sustained longer. Most participants did not readily recognize that the intervention was divided into three distinct phases with specific objectives. It is discernible from the interviews that some users, especially those who had busier schedules, were unable to establish a good connection with CTI workers in the (first) initiation phase because of their inconsistent or infrequent participation in the program. One participant (#14) stated that sometimes he chose to work instead of meeting with the CTI worker pair and engaging in the proposed activities. Another participant (#9) said that his family, home and work responsibilities made it difficult for him to meet CTI workers regularly. Several participants also had difficulties with the final 'phase out' stage, stating that this phase ended too abruptly. A participant (#1) shared that she had developed a strong connection to the CTI workers, but she 'felt left behind and lonely' when the intervention ended. Another participant (#6) expressed similar sentiments, 'We miss [the CTI workers]. You see, we don't have friends, we've got our family and our family does not come to visit us'.

In vivo services: A road to recovery

Most participants appreciated and supported the in vivo community-based approach of the intervention because, unlike typical services that are centered on medication management, it allowed the CTI workers to observe and understand the context in which users live. As one participant (#14) explained, when CTI workers go to the user's home '[they] can see the person's circumstances that he's living in, the way he lives … if he wants to move on … or if he is doing silly things, not really trying or … if he really needs help'. Another participant (#12) elaborated,

> [At the COSAM] they don't see the details … They don't go beyond [my symptomatic condition] … The doctor goes to see the levels of medications I have to have in my body and the changes. While [the CMHW] was there more to orient me with the problems I have and to overcoming them.

However, some participants expressed discomfort in having CTI workers in their homes. One participant (#1) explained that some users may feel reluctant because they are ashamed of their living conditions: 'Things may be all lying around, anything could be on the table, the dog or anything else could be on the carpet'. Some participants were also uncomfortable having family members who feel uncomfortable with CTI workers in the house or having family members present while they discussed sensitive topics.

Several participants expressed concerns about neighbors knowing that they were receiving specialized mental health services at home. For these participants, the benefits of receiving flexible care at home were weighed against the desire to protect themselves and their families against anticipated stigma. Many participants isolated themselves from their neighbors and hoped that no one would discover that they were being visited by mental health workers. For example, when asked if he was comfortable with telling the neighbors about his mental health condition and his participation in the program, a participant (#4)

responded, ‘Now I feel more comfortable to tell [the neighbors], but when I was receiving the program, I don’t think so … I had some … like shame … because I felt like in a position of weakness in front of them’.

Through ongoing engagement with CTI workers during the intervention, many participants gained an understanding that engaging in new activities, maintaining contact with community members, participating in regular community activities (such as sports), and learning occupational skills were essential to their recovery. As a participant (#3) said, ‘[a] person who receives the [CTI-TS] program has to assume the commitment to feel good and to work with his problems’. Participants would ‘need [to have] self-determination and support’, another user (#8) added. Some users also acknowledged that participants of the study needed to be proactive to benefit from the intervention, and a participant (#14) commented that this type of intervention is not suitable for every person with psychosis and should be used only with ‘motivated, “curable” users who are already in treatment’.

Perceptions regarding PSWs and CMHWs

Users expressed high regard for many of the worker pairs’ characteristics, stating that PSWs and CMHWs were ‘enthusiastic’, ‘committed’ and ‘motivated’. One participant (#6) said that ‘we realized in the first encounter that it was as if we had known each other for a long time and [the CTI workers] spoke to us with so much energy that they gave us that energy’. Many users also acknowledged CTI workers’ availability, reliability and especially their flexibility. For instance, in one participant’s (#8) experience, the worker pair accommodated to the user’s work schedule and arranged the meetings during lunch time; this would not have been possible had it been part of the services offered at the mental health center, adding that ‘care [at the mental health center] is for people who do not work’.

The theme of ‘mutuality’ was also an important aspect of the positive relationship with CTI workers. Participants often stated that it was good to have interactions with PSWs with whom they have shared experiences and similar backgrounds. Many users considered the PSW as a friend. One participant (#12) said, ‘it’s like talking with someone who you understand and who understands you without the need to talk or explain much’. A different participant (#2) stated, ‘I saw myself reflected in [the PSW] and I tried to be like her; alive, so well. Because, she also came from a situation like this. She was always smiling, she didn’t seem like a person with troubles … So, to see her so well gave me more strength’.

Despite a generally positive relationship, some participants described a different dynamic with the PSWs. One participant (#5) spoke to the perceived vulnerability of the PSW, explaining that she had to be careful because she was afraid of harming the PSW if she talked about her personal circumstances. A user (#8) stated that she ‘had a commitment with [the CTI workers] and … couldn’t just leave them’. Another participant (#1) described that she had to help care for the PSW during the intervention: ‘[The PSW] had stopped the medication because he felt better. Then I left him there [at the COSAM] and he stayed over there with a psychiatrist. So, we switched roles [and I had to help him]’.

Many users compared the role of PSWs and CMHWs to that of mental health professionals such as psychologists and psychiatrists at the COSAMs/CESAMs. They often perceived the

doctors' and CTI workers' roles as complementary to each other. As a participant (#6) observed, '[the doctor] gives the medical advice … of medicines, not the social advice. The [CTI workers] talk to us about the social part … they see how you live'. Another participant (#4) added, '[with] the psychologist [it] is more like a conversation. With [CTI workers] it's more about activities with the guys, going out for trips in the neighborhood, to places'. However, even though users appreciated having a more equal status with CTI workers, some expressed preference for the mental health professionals because they perceived CTI workers as lacking professional training. As a participant (#1) explained, 'doctors are competent … I knew [the PSW] was a patient who was in rehabilitation … [The doctor] knows more and so I go more with the doctor'. Similarly, a participant (#8) thought the CMHW should have received training in psychotherapy and occupational therapy: '[The CMHW should be] an occupational therapist … who can orientate you more … If you need a job, she could find a job for you. But she lacks … the ability to help you'. Another participant (#9) also expressed doubt in CTI workers' ability to help users, because '[the CTI workers] don't have so many resources to help me'.

Discussion

Overall, participants of CTI-TS in Chile perceived the intervention to be helpful, as it offered social and community-based supportive services not provided by the usual treatment alone. The users appreciated the more holistic nature of the in vivo community-based approach, perceiving it as complementary to the traditional psychiatric treatment and an important aspect of their recovery. Many participants were receptive to having the psychosocial support provided by the PSWs, who were perceived to be on a more 'equal footing' with them compared to the mental health professionals at the community mental health clinics. In addition to these positive aspects, the findings also highlight important issues that should be considered in future implementations of CTI-TS or similar interventions in Latin America. Below, we discuss three sets of issues corresponding to the three themes identified.

First, users' acceptability of CTI in Chile and similar settings would be strengthened by adapting certain CTI structural characteristics to account for some sociocultural issues that are prominent in Latin America. A signature element of CTI is that it addresses a critical transitional period for users, which most users recognized as important and helpful. However, some of the study participants expressed the sentiment that the intervention was too short. Like others worldwide, mental health clients with psychosis in Chile are used to – and expect – continuous treatment and care, and are thus not familiar with the concepts of brief interventions, such as CTI, which are designed to promote user empowerment by connecting them to existing community-based resources. Accordingly, future implementations of CTI can establish ways to help users understand how a time-limited intervention can benefit their recovery and rehabilitation in the long run.

A related aspect is the perceived abrupt ending of the intervention. Some users had developed friendships with the PSWs and CMHWs, but some felt lonely again when they no longer had relationships with the CTI workers after the intervention. This reflects the reality that either some users did not prioritize the goal of connecting to other community networks

besides the CTI workers, or that the CTI workers did not successfully help users achieve this objective in phase 2. This finding, together with users' sentiments about the short duration of the intervention, suggests that future implementations of CTI models should emphasize that the primary role of CTI workers is to help participants establish community connections that will last beyond the duration of the brief intervention.

Second, although a majority of users expressed appreciation that the in vivo approach of the intervention provided CTI workers with a more holistic understanding of their daily lives and lived experiences, their comments also revealed that mental health services delivered via the in vivo approach can be hindered by stigma, especially from the community. Several participants did not communicate or socially engage with their neighbors, citing this as a strategy to protect themselves and their families from being judged and rejected. Of those who had some social participation, most avoided revealing their mental health conditions. Thus, future applications of CTI should incorporate knowledge about these aspects of the users so that CTI workers can be more prepared to adapt to users' comfort levels in disclosing their mental health status to community members. In addition, community-based interventions can benefit from parallel public awareness campaigns to reduce stigma, especially in Latin America where stigma still has significant impact on people's perceptions of mental illness (Mascayano et al., 2016).

The third set of issues are regarding the task-shifting strategy. Users were receptive of the care and support extended by PSWs and CMHWs, and valued their greater availability and flexibility in comparison to mental health center professionals. Thus, PSWs and CMHWs stand out to be promising additions to the current care approach for mental disorders in Chile. Nevertheless, this study's findings suggest that task-shifting to PSWs and CMHWs in Chile or settings that are not familiar with such approaches would require additional considerations. Particularly, some users in the CTI-TS intervention perceived PSWs and CMHWs to be inferior to mental health professionals. Moreover, although most participants were deeply inspired by the PSWs' recovery trajectory, life experience and attitudes, some participants still held stigmatizing attitudes toward the PSWs. This could serve as a barrier to users' engagement and reduce the effectiveness of PSW and CMHW performance. Thus, future interventions that incorporate PSWs and CMHWs can benefit from being accompanied by efforts to improve the legitimacy of these non-professionals as well. Potential strategies include involving community or trusted leaders in the project or having mental health professionals explicitly discuss with the users the well-recognized values of PSWs and CMHWs (Glenton et al., 2013; Mendenhall et al., 2014). Incorporation of programs aimed at reducing users' self-stigma, such as Narrative Enhancement and Cognitive Therapy (Roe et al., 2014) or local initiatives (Schilling et al., 2015), could also aid in this effort.

Moreover, promoting the recovery orientation is a strategy which can potentially address both community and self-stigma. Research has shown that endorsement of recovery orientation is negatively associated with stigmatizing attitudes among users and mental health providers (Stacy & Rosenheck, 2017). Since most users in CTI-TS seemed to partially understand the main principles of the recovery-oriented approach, a greater emphasis on recovery, which has been promoted by the Chilean Mental Health Plan

(Ministerio de Salud de Chile, 2017), can greatly complement community-based interventions such as CTI-TS (Mascayano & Montenegro, 2017).

Conclusion

This study's analysis of users' perspectives of the implementation of CTI-TS in Chile illustrates that such a structured, community-based, task-shifting psychosocial intervention is generally acceptable and feasible in this Latin American context. Nevertheless, the study also identified important barriers that need to be addressed in future efforts to improve community care for people with psychosis in similar settings. These include, for example, making adjustments to some of the structural characteristics of the CTI model so that it is better suited to local cultural norms and practices, and combining this type of intervention with others dedicated to address issues of public and internalized stigma so that an in vivo community-based intervention with a task-shifting strategy can be fully embraced by users.

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Table 1.

CTI-TS phases, duration and objectives.

CTI-TS phases	Duration (in months)	Objectives
1. Initiation	1–3	User is provided support connecting them to people and agencies that will provide primary support
2. Try-out	4–6	User is monitored to ensure that their social support networks are strengthened
3. Transfer of care	7–9	CTI-TS services are gradually terminated as the support network is put safely in place for the user

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Table 2.

Users: gender, age range and diagnoses.

Gender (*n*)	Diagnosis	Age-range	Participant #
Female (5)	Affective	30–39	8
		40–49	1, 12
		50–65	2
	Non-affective	40–49	5
Male (10)	Affective	21–29	4, 11
		30–39	14
		50–65	6
	Non-affective	30–39	3, 7, 9, 10
		40–49	13, 15