IMPLEMENTING COGNITIVE BEHAVIORAL THERAPY FOR PSYCHOSIS (CBT-P): THE BeST CENTER APPROACH

HARRY SIVEC, PH.D., CONSULTANT AND TRAINER
VICKI MONTESANO, PH.D., ASSOCIATE DIRECTOR
LON HERMAN, M.A., DIRECTOR
THE BeST CENTER
BEST PRACTICES IN SCHIZOPHRENIA TREATMENT (BeST) CENTER AT NEOMED

**BeST Center’s Mission**
- Promote recovery and improve the lives of individuals with schizophrenia
- Accelerate the dissemination of effective practices
- Build capacity of local systems to deliver state-of-the-art care

**BeST Center Offers**
- Training and consultation
- Education and outreach activities
- Services research and evaluation

**The BeST Center was established:**
- Department of Psychiatry, NEOMED
- Funded from private, state and federal sources
ORIGINS: WHY AND HOW WE STARTED A CBT-p PROGRAM

CBT-p
- Evidence-based and popular
- Little training available in the U.S.

Learning the approach
- Consulting with experts:
  - Insight Partnership (UK)-provided initial training of consultants and first two agencies
  - CBT-p modified for case managers (non-licensed staff)
LEARNING AND GROWING

• Training materials developed/modified:
  • Intensive training package
  • Manual with handouts
  • Visual and memory aids to help learners
  • Consultant and Trainer embedded at agencies – in vivo supervision

• Consultation: Torrey Creed, Ph.D. (The Beck Initiative)
  • Provided training in CTRS for supervisors
  • Shared information related to RFPs
  • Helped with initial modification of CTRS for case managers

• Continuum of care from low to high intensity CBT-p interventions
Cognitive Behavioral Therapy (CBT-p) is an intervention delivered by licensed therapists with formal training in this model.

Cognitive Behavioral techniques (CBt-p) consist of basic strategies derived from CBT principles that can be delivered within the context of a mental health worker’s other duties.
IMPLEMENTATION PROCESS

Engaging Partners

- Send RFP to prospective agencies
- Meet with stakeholders
- Address funding for implementation

Tools to Guide Implementation

- Staff selection (in the RFP)
- Planning intensive training (in the RFP)
- Preparation of clinical lead, executive administrative lead and supervisors prior to intensive training
## IMPLEMENTATION STRATEGY

### Components of Implementation

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<th>Intensive Training</th>
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<td>Ongoing consultation groups:</td>
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<td>-90 min. meetings weekly, moving to bi-weekly, then monthly</td>
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<td>Fidelity reviews and supervisor training</td>
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<td>-Baseline, mid-term and final</td>
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<td>Integrating clinical notes into the electronic record</td>
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<td>Data collection</td>
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DATA COLLECTION STRATEGIES

Symptom outcomes

- **Quantitative:** Turkington, et al., 2014
- **Qualitative:** Sivec, et al., 2015

Program Evaluation Categories

- **Symptom Rating:** Clinician rated scale
- **Functioning:** Quality of Life index and recovery goals
- **Service Utilization:** Number of different services
- **Clinical Competence:** Fidelity ratings
COMMON BARRIERS AND FACILITATORS

Organizational factors

Agency Culture
- Rigid vs. Creative, Active Leadership

Administration approach to EBP
- Lack of Understanding vs. Recognized Value

Service Provider factors

Skill Development
- Lack of EBP knowledge vs. Familiarity with EBP

Perceptions/Attitudes about recovery
- Pessimistic views of recovery vs. staff openness
LESSONS LEARNED

• When reaching out to prospective agencies
  • RFP must spell out clear expectations but not so many as to overwhelm the agency

• When developing an implementation plan
  • Tie incentives to outcomes (if possible)
  • Identify leaders and supervisors and set expectation for the agency to take responsibility for action steps and problem solving early and often
  • Modify existing procedures/practices rather than installing new ones

• When providing training
  • Keep it interactive, practical and skill-based
  • Give examples, time to practice and feedback (often)
BeST CENTER CONTACTS

• Harry Sivec, Ph.D., Consultant and Trainer
  hsivec@neomed.edu, 330.325.6699

• Vicki Montesano, Ph.D., Associate Director
  vmontesano@neomed.edu, 330.325.6696

• Lon Herman, M.A., Director
  lherman@neomed.edu, 330.325.6695