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

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Promoting Innovation. Restoring Lives.

This material provided by the Best Practices in Schizophrenia Treatment (BeST) Center, Department of Psychiatry, Northeast Ohio Medical University.

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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	

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ORIGINS: WHY AND HOW WE STARTED A CBT-p PROGRAM

CBT-p

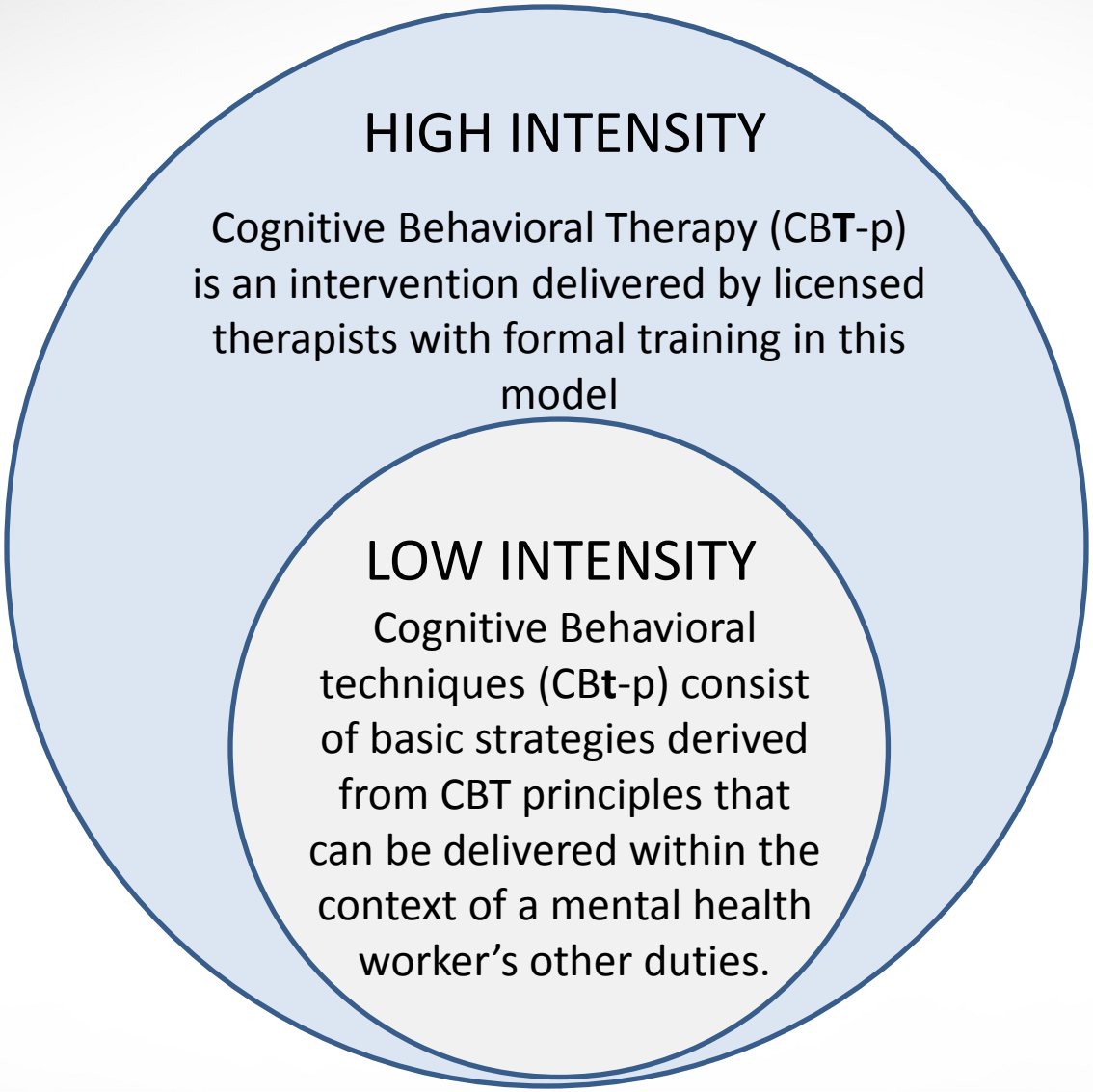
- Evidence-based and popular
- Little training available in the U.S.

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


HIGH INTENSITY
Cognitive Behavioral Therapy (CBT-p) is an intervention delivered by licensed therapists with formal training in this model
LOW INTENSITY
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	
	Intensive Training
	Ongoing consultation groups: -90 min. meetings weekly, moving to bi-weekly, then monthly
	Fidelity reviews and supervisor training -Baseline, mid-term and final
	Integrating clinical notes into the electronic record
	Data collection

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)

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