CBTp: The Evidence-Based Treatment for Psychotic Disorders

Melissa Moore, Ph.D.  
Founding Director, Felton Institute Research and Training Division

Kate Hardy, Clin. Psych. D.  
Percy Howard, LCSW  
CIBHS

Cognitive Behavioral Therapy for Psychosis (CBTp)

Objectives:

• Identify what each person here wants from the day of pre-training
• Identifying our lens for implementing CBTp
• Review the basics of Implementation for sustainability for all EBPs
Cognitive Behavioral Therapy for Psychosis

Getting to know you

Cognitive Behavioral Therapy for Psychosis

Checking our Perspective on The End Game

The Bureaucrats at 30,000 feet

Middle Management Or Clinical Supervisors Multiple concerns

Line Staff
Felton Research and Training Institute

- 2007 – 2012: NIHH funded IP-RISP to support Community-Academic Treatment and Assessment for Low-Income Aged Consumers (CATALAC). PI UCSF; Patricia Arean
- 2007: PREP (Prevention and Recovery in Early Psychosis) is founded, funded in part through the California Mental Health Services Act (MHSA) ‘millionaires tax’
- 2008: CIRCE, Felton’s web-based HIPAA compliant electronic case management information system, wins the Salesforce “Appy” Award for best non-profit application
- 2007 – present: PREP program operating in San Francisco, Alameda, and San Mateo Counties with MHSA funds, and in San Joaquin and Monterey Counties, with funding from a Centers for Medicaid and Medicare Services (CMS) Innovation Fund Award
- 2012 – present: PCORI (Patient Centered Outcome Research Institute) award for mPOWR (Moving Patient Outcomes toward Wellness & Recovery) toolkit, a shared decision making protocol for working with severe and chronic mental illness. mPOWR is being tested in rural new Mexico and inner city San Francisco
- 2014: The National Council for Behavioral Health recognizes PREP with the Science to Service Award for inspiring hope, leadership, and impact in mental health field
- 2015: The National Council for Behavioral Health recognizes Alameda PREP Peer & Family Support Coordinator Dina Tyler with the Peer Specialist of the Year Award

New Practice Implementation is a lot like turning an elephant in a bathtub
Training Models: The Good News

- International mandating of implementation of EBPs (DoH, VA, State, and Counties)
- Increased public awareness of EBPs and demand for effective treatments
- Statewide support for EBPs and effective implementation
- We have the means for better outcomes -- through shared experience we are learning how to land EBPs better!

Training Models: The Bad News

- Average of 10 years for EBPs to reach community setting (Kuipers, 2000)
- Clinicians are still being trained in approaches with limited evidence base for SMI
- Clinician burn out may prevent adoption of new models (Corrigan et al., 2001)
- Estimated 50% of implementation efforts result in failure (Klein & Knight, 2005)
Why the Partnership

Felton Research & Training: In collaboration with Dr. Kate Hardy created CBTp training for PREP model at Felton Institute 5 sites 2006 – present

CIBHS: California Institute for Behavioral Health Solutions - leaders in California in implementing EBPs across the State using the CDT (Community Development Team) model

Insight in the UK: a collaborative of trainers developed the model and “evidence base” on CBTp for SMI
Insight Projects

- Beijing (Anding Hospital) - inpatient psychiatrists trained to deliver CBT for schizophrenia (Li, 2013)
- Rome (La Sapienza) - inpatient nurses trained in CBT techniques for psychosis (Biondi, 2012).
- Ohio (BEST centre) - Support workers trained in CBT techniques (Munetz et al, 2013).
- Valencia - CBT and fMRI (Sanjuan, 2011)
- Dublin - 3 CMHTs trained in CBT schizophrenia.
- Insight project UK - >300 mental health professionals trained.
- Chicago - early intervention team trained in CBT to improve adherence (Weiden, 2013).
- New York - 20 psychiatrists trained in CBT psychosis (Garrett et al, 2009)

CBTp training: The Vision

- To increase accessibility for clients to CBTp across California and beyond
  - Master Level clinicians
  - Case Managers – High Yield Techniques
- To train whole teams in CBTp to ensure full integration and utilization and engage all levels of the organization in sustaining the model
- To provide evaluation and on-going feedback on the provision of competent CBTp by clinicians
- To develop long-term sustainability through local champions and train the trainer models
ACCESS Model (Wiltsey-Stirman et al. 2010)

Model developed to support implementation of EBPs in community mental health settings

- **Assess and Adapt**
- Develop effective and feasible training
- **Convey the basics**
  - Increase knowledge
- **Consult**
  - Transfer knowledge to practice & facilitate continued learning
- **Evaluate**
  - Evaluate use of EBP and provide feedback
- **Study outcomes**
  - Collect outcome data to inform future training decisions
- **Sustain**
  - Support continued implementation (train the trainer)
Convey the Basics

- Intensive small group training for identified individuals and whole teams
- Provision of key knowledge and skills required for practice of CBTp
- Blended format combining learning styles to maximize learning capacity
  - Didactic
  - Experiential (role play)
  - Video examples
  - Refer to own clinical examples (positive and negative outcomes)

Intensive CBTp training

- Theory
- Manualized
- All techniques demonstrated in live role play/DVD
- All techniques practiced
- Improvement measured by independent role play score and written exam
CBTp for Case Managers

- Engaging and normalising
- A-B-C or mini-formulation of voices / delusions
- Improving coping strategies
- Reality testing voices and delusions
- Improving concordance
- Self-esteem/schema work
- Relapse prevention

Consult

- Important element in implementation of EBPs
- Increases likelihood that knowledge and skills acquired in training will be transferred to clinical practice (Miller et al., 2004)
- Develop non-judgmental and supportive atmosphere
- Identify appropriate training cases
- Explore difficulties implementing EBPs
Supervision

• Local
  – Local face-to-face group supervision
  – Community Development Team (CDT) model for administrative calls monthly
• Distance
  – Skype
  – Vidyo

Evaluate Work Samples

• Crucial component of training to competence
• Address clinician apprehension regarding evaluation
• Support clinician in discussing recording of sessions with clients
• Session rated using competency rating scales
  – Learning facilitated if clinician reviews and rates own tapes also
• Deliver specific feedback regarding session and areas of strength and areas to improve
Cognitive Behavioral Therapy for Psychosis: An Introduction

Kate Hardy, Clin. Psych.D

Objectives

• Describe the general principles of CBT for Psychosis

• List key research demonstrating the effectiveness of CBTp

• Summarize the role formulation plays in developing a collaborative understanding of psychotic symptoms
• Goals for the day?

• Barriers to implementing CBTp?

What is CBT anyway?
What is CBT?

- How you think leads to changes in how you feel and what you do
- Thinking includes how you think about:
  - Yourself
  - The world
  - Other people
- Here and now focus draws upon past experiences to explain how beliefs are formed
How does CBT apply to psychosis?
History of CBTp

First described by Beck (1952)

However…
Largely overlooked as an intervention for psychosis

– Prominence of biological/medical models
– Studies in the 80’s that reported talking therapies as damaging to people with psychosis
– Long held assumption psychosis lies outside of realm of ‘normal psychological functioning’

Psychosis exists on a continuum

Stress  Drugs  Trauma  Sleep deprivation  Life experiences

No psychosis   Psychosis
CBT for psychosis

Focus is on **reducing the distress** caused by **positive symptoms** including hallucinations and unusual thoughts

**Thoughts**
- Interpretation of the event that causes distress rather than the event itself
- Need to check the accuracy of the interpretation

**Behaviors**
- How are current behaviors maintaining the problem?
- Need to check the helpfulness of current behaviors

---

CBT for psychosis

**Other target areas:**
- Symptoms of depression and anxiety
- Past traumatic events
- Social skills
- Negative symptoms including lack of motivation
- Problem solving and decision making
- Developing coping skills
- Relapse prevention planning
Is there any evidence that CBTp is useful?

Evidence Base for CBTp

- Highly acceptable to consumers (Morrison et al, 2004)
- Reduces positive symptoms, negative symptoms and increases functional outcomes (Wykes et al, 2008)
- Reduced days in hospital (Jolley et al, 2003)
**Evidence Base for CBTp**

- Sarin et al. (2011)
  - CBTp had delayed impact with most improvement at follow up
- Kumari et al. (2011)
  - CBTp led to significant clinical improvement and decreased activation in brain areas associated with threat perception
- Stafford et al. (2013)
  - CBT for those at risk of psychosis prevents transition to psychosis at 12 months
- Morrison et al. (2014)
  - CBTp without antipsychotic medication
  - Mean PANSS scores significantly lower in CBTp group compared with TAU

**Recommendations**

- CBTp should be offered adjunctive to medication management
    - Patient Outcomes Research Team (PORT)
  - NICE (2013)
    - Psychosis and Schizophrenia in Children and Young People
  - NICE (2014)
    - Psychosis and Schizophrenia in Adults
Meta-analysis debate

- Juahar et al. (2014)
  - Applied stringent masking to analysis and exploration of publication bias
  - CBT has an effect on 'schizophrenic symptoms in the “small” range'
- Burns et al. (2014)
  - Meta-analysis for medication resistant positive symptoms
  - ES 0.47 (positive symptoms) & 0.52 (general symptoms) at end of treatment
  - 'patients with medication resistant positive symptoms may derive more benefit from an adjunctive psychotherapy… than from adjunctive medications'
- Turner et al. (2014)
  - Comparison of psychosocial treatments for psychosis
  - CBT significantly more effective in reducing positive symptoms than other PSI (befriending and supportive counselling)
  - Social skills training more effective in reducing negative symptoms

Evidence Base Summarized

- CBTp effective in reducing positive symptoms, negative symptoms, general symptoms
- Evidence to suggest most effective in UHR, early phase psychosis and stable chronic symptoms (Birchwood et al, 2014)
- More research required on:
  - ‘active ingredients’ of CBTp
  - Identification of predictive client characteristics
  - Number of required sessions
Indispensable CBTp Interventions
CBTp techniques for all

1. Engagement and befriending
2. Embracing curiosity and normalizing
3. Recognizing and managing stress
4. Understanding distressing voices and beliefs

Engagement and Befriending
Common Barriers to Engagement

Incomprehensible/disorganized
- Stay with the client and remain curious
- Information elicited may lead to fuller formulation
- Provide structure

Silent
- Remain patient
- Be aware of cognitive impairment and internal distraction

Over talkative
- Structure the session
- Attempt to interrupt (use humor)

Kingdon and Turkington (2008)

Engagement and befriending

- Essential to developing therapeutic relationship
- Ongoing process throughout therapy
- May require increased amounts of befriending depending on symptoms
  - Paranoia
  - Hallucinations
  - Severe Negative Symptoms
Engagement Issues

• Befriending
  » Focus on neutral non-threatening topics
  » No active formulation or treatment
  » Non confrontational
  » Empathic
  » Supportive
  » Accepting
  » Non colluding

• Assertive engagement techniques

Engagement Issues

• Non confrontational
  » Avoid confrontation but avoid collusion also
  » Show interest in the subject with non judgmental questioning

• Pacing
  » May need to be at a slower pace with simple achievable goals set for each session
  » Use aids to help client to follow session (white board etc)
  » Be aware of internal distracters that may impact on clients ability to concentrate
Pacing of CBTp

Ensure pacing matches client pace
- Once a week vs. multiple sessions per week

Prepare for paranoia?

Engagement Issues

- Word perfect accuracy and consistency
  » Maintain consistency throughout sessions
  » Open acknowledgement of inconsistencies from therapist
  » Use of client’s language without collusion

- Tactical withdrawal
  » If increase in agitation or distress move from topic to neutral non threatening topics developed through befriending
  » Agree to disagree on topic
Important to Remember:

• It is ok to be flexible and creative in sessions
  – Go for a walk, talk about shared interest, break for a game
• Do not have to adhere to strict CBT structure

ABOVE ALL NEED TO BE RESPONSIVE TO THE CLIENT

Engagement Exercise

Split into groups of 3 or 4
Embracing Curiosity: Normalizing and Questioning

Normalization

• CBT is inherently normalizing
  – We all experience negative thoughts
  – We all engage in unhelpful thinking
  – We all use coping strategies that aren’t always the most healthy choices

• Allows for normalizing of psychotic symptoms as well
Psychosis exists on a continuum

Normalization of psychotic symptoms

“Normalization is the antidote to stigma”

– Avoid catastrophizing
  • Mental Illness is a common experience (1 in 4 people)
  • Psychosis can affect anyone regardless of age, ethnicity, gender, SES
  • Large number of people can overcome symptoms
  • Symptoms may be viewed positively in different cultures

Normalizing experiences – not dismissing them
  • Check in how the information is received (invalidating?)
Normalizing: How

• Encourage people to research and read personal recovery stories
  – Elyn Saks
  – John Nash
  – Eleanor Longden
  – Rufus May
• Develop agency library of recover stories?

Normalizing: How

• Connect with other people experiencing psychosis
  – Intervoice
  – Psycope.co.uk
  – Paranoia.com
Normalizing: How

• Research prevalence of symptoms (depression, hearing voices, paranoia, etc.)
  – 15-20% population experience frequent paranoid thoughts without significant distress
  – 3-5% population have more severe paranoia (Freeman, D. 2006)
  – 5% of population hear voices (Tien 1991)
  – People hear voices without seeking mental health services (Romme & Escher 1989)
  – 9% people hold delusional beliefs (van Os, 2000)
  – Common to see or hear loved one following bereavement (Grimby 1993)

Normalizing: How

• Normalizing hallucinations in Schizophrenia
  – Sleep deprivation
  – Bereavement
  – Abuse/trauma
  – Hostage situations
  – Hypnogogic/hypnopompic hallucinations
  – Stress
  – Drugs
  – Voice hearing
Tips for Curious Questioning

• Be curious
• Don’t make assumptions
• Be open to different explanations
• Explore all possibilities
• Ask questions

What questions/assumptions might you have about the following statement?

– I am being persecuted by a man who can control satellites
– The devil has possessed me and I have no control over my actions or thoughts
– My wife is plotting to have me killed because I know about her illegal money laundering scheme
Recognizing and managing stress

Stress Bucket

Adapted from UNSW Counseling Services & Carver et al., 1989
Applying for college
Hearing voices
Exams coming up
Parents arguing

Stress Bucket

Go for a walk
Play video game for one hour
Talk to voices
Stay up all night playing video games

Buffer Zone
Stress Level

Adapted from UNSW Counseling Services & Carver et al., 1989
Understanding distressing voices and beliefs – Formulation

Formulation

• Stress Bucket
• Mini Formulation
• Morrison’s Interpretation of Intrusions
Clinical Vignette

Sam comes to your session very anxious. He describes an experience this morning where he could hear his neighbors talking about him and making threatening comments leading him to conclude that he was not safe. He became very afraid and anxious and instead of doing his laundry as planned he stayed in his room all morning.
Develop a mini-formulation for Sam using the information in the clinical vignette

Mini Formulation

Hears a threatening voice

“The people across the hall are talking about me”

Scared, Anxious

‘I am not safe’

Stays in room, Isolates
Morrison’s (2001) Model of Psychosis

- Positive symptoms are conceptualized as intrusions into awareness
- The interpretation, rather than the intrusion, causes distress and disability
- Symptoms are maintained by mood, arousal and mal-adaptive cognitive-behavioral responses (e.g. avoidance)

Formulating Psychosis

(Morrison, 2001)

Additional Clinical Information

In later sessions Sam describes some of his early experiences. He discloses he was regularly bullied at school including an incident where a boy, whom he thought was his friend, ‘turned on him’ and joined his bullies. He was berated and criticized by his father for low grades.
Using the additional information develop a formulation including Sam's past experiences and possible rules/beliefs he may have as a result of these.

Formulating Psychosis

What happened
Hears mocking and taunting

How I make sense of it
The people across the hall are talking about me

Beliefs about yourself and others
I'm a failure.
I'm different.
Others can't be trusted.

Life Experiences
Poor grades in school
Bullied at school
Critical father

How do you feel when this happens?
Talk to voices.
Stay in room.
Isolate.

What do you do when this happens?
Talk to voices.
Stay in room.
Isolate.

How does it make you feel?
Scared.
Hopeless.

(Morrison, 2001)
Developing a formulation: In action!

Using formulation to inform intervention
Mini Formulation

Hears a threatening voice

“The people across the hall are talking about me”

Scared, Anxious

‘I am not safe’

Stays in room, Isolates

Working with unusual thoughts

- **Exercise in pairs:**
  1. Partner 1: think about a fact about yourself that you know to be true i.e. eye color, hair color, place of birth (stay away from religion/politics)
  2. Partner 2: do everything you can to argue the opposite (no, I don’t think that is true + evidence to the contrary)
  3. Switch roles
  4. Reflection: what was it like to have a fact disputed? How did it feel? How did you respond?
Cognitive Intervention: Exploring the evidence

Thought: the people across the hall are talking about me (90%)

<table>
<thead>
<tr>
<th>Evidence For</th>
<th>Evidence Against</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Belief:

Alternative possibility:

Using curious questioning

What would you want to know to explore the evidence for and against the statement ‘the voices I hear are those of my neighbors talking about me’?
Cognitive Intervention: Exploring the evidence

<table>
<thead>
<tr>
<th>Thought: the people across the hall are talking about me (90%)</th>
<th>Evidence For</th>
<th>Evidence Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>They said my name</td>
<td>They’ve never actually directly spoken to me</td>
<td></td>
</tr>
<tr>
<td>I feel afraid when I am around them</td>
<td>The noise was a whisper and not a shout</td>
<td></td>
</tr>
<tr>
<td>I’ve heard shouting from that room before</td>
<td>When I recorded the voice and played back the tape there wasn’t anything there</td>
<td></td>
</tr>
</tbody>
</table>

Belief: the people across the hall are talking about me (40%)

Alternative possibility: I am hearing an auditory hallucination (60%)

Voices: behavioral interventions

- Distraction e.g. music (listening), playing the guitar, attention shifting, art, walk, pets, writing, DVD, computer games.

- Focussing e.g. sub-vocalization, deep slow breathing, rational responding, schema work.

- Meta-cognitive e.g. detached mindfulness, acceptance.
Mini Formulation

Hears a threatening voice

“l am hearing an auditory hallucination”

Deep breathing
Reassure self
Listen to music

Less anxious

“The voices can’t hurt me”

Collaboratively exploring beliefs

• Behavioral Experiments
  – Have to be carefully developed to be win-win
  – Should be meaningful to the client and test a belief/behavior that is important to them
  – Should also take into account all the things that can go wrong with the experiment
  – Should be prepared to consider the possibility that the belief is correct (and what you will do if that is true)
### Behavioral Experiment

#### Thought to be tested:

<table>
<thead>
<tr>
<th>Belief in thought (0-100%)</th>
<th>Before experiment</th>
<th>After experiment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experiment</th>
<th>Likely problems</th>
<th>Strategies to deal with problems</th>
<th>Expected outcome</th>
<th>Actual outcome</th>
<th>Alternative thought</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Behavioral Experiment

#### Thought to be tested: My neighbors are talking about me

<table>
<thead>
<tr>
<th>Belief in thought (0-100%)</th>
<th>Before experiment</th>
<th>After experiment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experiment</th>
<th>Likely problems</th>
<th>Strategies to deal with problems</th>
<th>Expected outcome</th>
<th>Actual outcome</th>
<th>Alternative thought</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use MP3 recorder to record sounds in room for 1 hour. Write down the time I hear people talking.</td>
<td>Might not hear anything</td>
<td>Try again another day</td>
<td>Kate and I will be able to hear the voices on the recording</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Might forget to do this</td>
<td>Write a reminder and keep it on the computer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Behavioral Experiments

• In small groups develop an experiment to test out the following:
  – My food is being poisoned by a satellite
  – I emit a foul smell
  – Everyone can hear my thoughts
  – Everyone knows who I am because they have seen a derogatory video that was made about me

Behavioral Experiment Development:
In action!
WORKING WITH “BIG” DELUSIONS

Delusional Systems

- Development of a systematised delusion is understandable and treatable.
- Evidence for schema vulnerability in these patients.
Working with delusional systems

• Delusional systems do not respond to reality testing.
• Work on stress or rumination.
• Absorb and contain psychosis and ask questions.
• Use less structure.
• Do timeline and look for memories or images linked to hot cognitions or inference chain.
• Do schema level work on underlying belief and affect.

A word on trauma....
Multiple Pathways to Trauma and Psychosis

Pre-existing trauma leading to later psychosis

Trauma as consequence of psychosis

Traumatic event as proximal trigger for psychosis

Pathways to trauma

Pre-existing trauma

- Patients with psychosis 2.72 times more likely to have been exposed to childhood adversity (Varese et al. 2012)
Pathways to trauma

Trauma as proximal cause of psychosis

• Symptoms of PTSD can exacerbate stress, leading to a psychotic experience (Mueser et al. 2002)

• 70% of voice hearers developed their hallucinations following traumatic event (Romme and Escher 1989)

Pathways to trauma

Trauma as a result of psychosis

– Trauma can result from hospitalization or even the experience of the psychotic symptoms themselves (Frame & Morrison, 2001; McGorry et al., 1991; Morrison et al., in press; Shaw et al., 2001)
Trauma and psychosis: clinical considerations

• We SHOULD be asking all individuals about potential traumatic experiences
  – If we don’t routinely ask, the information is rarely freely volunteered (Read and Fraser 1998)

• Clinicians should be trained in how to ask about trauma and respond to trauma disclosure
  – One of the primary reasons people don’t ask is fear (Read et al. 2007)

• Interventions should address trauma (if appropriate)
  – Consider skill building and distress tolerance initially (especially with younger clients?)
  – Utilize existing trauma protocols (PE + EMDR)
    • Dutch T-TIP study
Culture and CBTp

The need to incorporate culture

- The community perspective
  - High number of ethnic minorities and first generation immigrants in Bay Area
  - Criticism from community clinicians that CBTp ‘not applicable’ to their culturally diverse client population
  - Misperception of CBTp as tools and skills only
  - Misperception of CBTp as ‘explaining away’ cultural experience
Incorporating culture

- “We believe that a therapist who uses a ‘color-blind’ approach to therapy is a therapist with an ethnically based disability” (Harper and Iwamasa, 2000)

- CBTp acceptable for BME with culturally appropriate adaptation (Rathod, 2010)

- CBTp through ‘cultural lens’

Framework for CBTp through a cultural lens

1. Identify culturally related strengths and supports.
2. Use the client’s list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.
3. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.

(Hays, 2009)
Case example

• 17 year old Afro-Caribbean female (Rena)
• Lived on small Caribbean island with adopted family
• Reported seeing witches coming out of her cupboard from age 8
• Family understood this experience in context of belief in the spirit world prevalent to the island and consistent with family beliefs
• Initially sought alternative treatments specific to local culture

Case example cont.

• Decrease in functioning and increase in symptoms led family to seek westernized treatment
• Came to PREP SF (2010) for three months of CBT treatment (28 sessions total) and medication management
• Presenting complaint
  – Auditory and visual hallucinations in form of demons taunting and mocking her
Case example cont.

- Cultural strengths based focus
  - Skilled in crystal healing, yoga,
  - Identification of a ‘spirit guide’ or angel. Positive and supportive influence. Consistent with family beliefs.

Collaboratively developed formulation

What happened
Hears voice mocking and taunting

How I make sense of it
The demons are disrespecting me

Beliefs about yourself and others
I’m bad.
I’ve got to take care of myself

What do you do when this happens?
Shout at demons, punch out at them, irritable with family

Life experiences
Abandoned by biological mother
Bullied by cousins

How does it make you feel?
Scared
Angry +

(Morrison, 2009)
Collaboratively developed re-formulation

What happened
Hears voice mocking and taunting

How I make sense of it
They are just being rude. I have my angel on my side

Beliefs about yourself and others
I've had some bad things happen but I am strong. I'm not on my own

What do you do when this happens?
Ignore demons, do yoga

Life experiences
Abandoned by biological mother
Bullied by cousins

How does it make you feel?
Relieved, powerful

Applied framework for CBTp through a cultural lens

1. Identify culturally related strengths and supports.
   - Yoga, crystal healing, spirit guide
2. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.
   - "I'm not on my own", "I am strong"
3. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.
   - Practice yoga and healing, enlist angel to help her dismiss voices

(Morrison, 2009)

(Hays, 2009)
CBTp Implementation Framework:

CIBHS Community Development Team (CDT) Model
Objectives

• Increased understanding of the benefits of implementation support to facilitate greater adherence and fidelity to CBTp
• Increased understanding of how organizational and system supports impact successful implementation
• Demonstrate an increased understanding of how data may facilitate needed changes in practice

CBTp Training and Implementation Protocol

• Pre- Implementation Planning Meeting (in-person or webinar, conference call)
• Training Coordination - logistical coordination of training events
• Three-Day Initial Clinical Training
• Weekly Clinical Supervision Calls (1 hour) for 6 months
• Review of 6-8 audio-tapes using CTS-R coding for fidelity and adherence monitoring
Implementation (cont.)

- Monthly Administrator Calls (for technical assistance & peer-to-peer learning support)
- Evaluation Protocol and Strategy - measure effectiveness of practice at client level
- Data Coordination and Collection
- Bi-annual Program Performance Dashboard Reports
- Two-Day CBTp Booster Training

Fidelity

- Random audiotape selection
  - Multiple sessions
  - Different clients
- Viz-Health
- Fidelity measures
  - CTS-R
  - CTS-Rpsy
CTS-R

- Item 1: Agenda Setting and Adherence
- Item 2: Feedback
- Item 3: Collaboration
- Item 4: Pacing and Efficient Use of Time
- Item 5: Interpersonal Effectiveness
- Item 6: Eliciting of Appropriate Emotional Expression
- Item 7: Eliciting Key Cognitions
- Item 8: Eliciting and Planning Behaviors
- Item 9: Guided Discovery
- Item 10: Conceptual Integration
- Item 11: Application of Change Methods
- Item 12: Homework Setting

Prevention & Recovery In Early Psychosis (PREP)

FLOWCHART FOR ACHIEVING AND MAINTAINING COMPETENCE IN CBT FOR PSYCHOSIS (CBTp)

Developed by Kate Hardy, Clin.Psych.D, Pamela Greenberg, MFT and Erika Van Buren, Ph.D.
**CDT Context and Goals**

- The CDT model is a strategy or approach for increasing the dissemination and use of evidence-based practices (EBP), in everyday public mental health settings
- It is focused on EBP programs, models, and interventions
- It is about implementing (establishing) and sustaining, with model-adherence or integrity or fidelity

---

**Why the CDT (Community Development Team) Model?**

- Need for evidence-based implementation
  - There are currently (at least) 61 different models in the literature that support implementation of behavior change in community-based settings

![Flowchart showing Quality of Intervention, Quality of Implementation, and Positive Outcomes]
What is the Community Development Team Model (CDT)?

- The CDT model is a strategy or approach for increasing the dissemination and use of evidence based practices (EBPs), in everyday public mental health settings.
- It is focused on EBP programs, models, and interventions.
- It is about implementing (establishing) and sustaining high-quality clinical interventions, with model-adherence, integrity, and fidelity.
- It recognizes and carefully considers key drivers or environmental-organizational barriers and strengths that can inhibit or stimulate the effective uptake of practice (NIRN Drivers).
- Process that utilizes peer-to-peer learning as a primary strategy of system preparation and change to support effective practice.

Overview and History of the CDT

- Initial support for the creation of CIBHS infrastructure to support adoption and implementation of EBPs in California was through the Zellerbach Family Foundation in 1998.
- CDT Created by CIBHS in early 2000 with funding support through the California Department of Mental Health.
- Large Scale utilization of the model was initiated in the early-2000s via CIBHS support of Los Angeles County Department of Mental Health regarding implementation of a Range of EBPs as part of the effort to increase efficacious services to foster youth with SMI.
Why Implementation support and not just training?

- Practicing without fidelity can lead to worse outcomes than usual practice.
- Promotes retention of knowledge, preservation of skills, and clinical innovation (while exposing and eliminating “bad habits”).
- Provides data and evaluation strategy which allows for practice improvements in “real time.”
- Protects the ‘investment” in the practice-practitioners are able to facilitate client improvement, more skillfully/quickly.

Why CDT?

- Three (of 61) implementation models have strong support of their effectiveness.
  - Community Development Team (CDT), CIBHS.
  - Availability, Responsiveness, Continuity (ARC), Glisson and colleagues.
  - Interagency Collaborative Teams (ICT), Aarons & colleagues.
- All 3 are multicomponent strategies.
Research Support for the CDT

- The only implementation support model to be subjected to a randomized-controlled trial (funded by NIMH).
- SAMHSA NREPP Featured Implementation Model.
- Determined to be effective at achieving its intended goal:
  
  **The sustainable adoption of a model-adherent evidence-based practice**

Current EBPs in California Supported by the CDT Model

- Functional Family Therapy (FFT)
- Aggression Replacement Training (ART)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Cognitive Behavioral Therapy for Psychosis (CBTp)
- Motivational Interviewing (MI)
Historical CDT Projects

- Aggression Replacement Training ®
- CBT for Depression
- Depression Treatment Quality Improvement
- Early Detection and Intervention for the Prevention of Psychosis (*in development*)
- Functional Family Therapy
- Incredible Years
- Trauma Focused Cognitive Behavior Therapy
- Managing and Adapting Practice
- Multidimensional Family Therapy
- Multidimensional Treatment Foster Care
- Multisystemic Therapy
- Triple P Parenting
- (High Fidelity) Wraparound

Development Team Features

- Clinical training
  - *Provided by model developers or their designees*
- Organizational supports
  - *Provided by CIBHS or County CDT staff*
  - Implementation planning
  - Administrators calls
  - Program performance evaluation supports
  - Individualized technical assistance
- Peer-to-peer assistance
Organizational Support

- Implementation planning
  - Thorough understanding of the model, training protocols, and key implementation supports
- Individualized technical assistance
  - Address system and program level issues
- Program performance/outcome evaluation
  - Tracking service delivery
  - Preparation of database (Excel)
  - Analysis, interpretation and reporting of outcomes
- Monthly peer-to-peer administrators “champions” conference calls
  - Share successes, raise concerns, and offer solutions

NIRN Implementation Drivers (Fixsen, et al)
Challenges

Challenges concerning utilization of implementation support:

• Added Costs
• Greater administrative time investment
• Potential “negative hit” regarding billable time
• Can be more difficult to “sell” to fiscal decision makers

Business Case

• Fits “Quality as a Business Strategy” (Langley et. Al) construct
• Increased ability to report measurable impact of effectiveness for client population
• Increased organizational readiness to implement quality services that will increase positive outcomes for clients and satisfy the demand of upcoming payment reform models
QBS

- Basic Elements of the Strategy:
  - A foundation of continuous matching of products and services to a need through design and redesign of processes, products, and services.
  - An organization that performs as a system to achieve this matching with the need as the target.
  - A set of methods to insure that changes result in real improvements to the organization.

*Same credit for following slide

Why Quality as a Business Strategy?

Understand the Need
(i.e., interventions targeting trauma)

Define Quality (relative to the need)
(Usual or undefined care vs. EBP)

Improve Quality
- Improve the whole system
- Design a new product
- Redesign an existing product
- Design a new process
- Redesign an existing process

One or more will happen:
- Decrease fixed costs
- Decrease variable costs
- Increase productivity
- Increase value (better outcomes for youth and families)

Joy in Work
Increase Profits
Increase Market Share

Everybody Wins
These three questions provide the framework for all improvement

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement?

“Model for Improvement”

Dimensions of Quality

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>MEANING OF DIMENSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Performance</td>
<td>Primary operating characteristics</td>
</tr>
<tr>
<td>2. Features</td>
<td>Secondary operating characteristics, added touches (not included in other dimensions)</td>
</tr>
<tr>
<td>3. Time</td>
<td>Time waiting, cycle time, time to compensate a service</td>
</tr>
<tr>
<td>4. Reliability</td>
<td>Extent of failure-free operation over time</td>
</tr>
<tr>
<td>5. Durability</td>
<td>Amount of use before replacement is preferable to repair</td>
</tr>
<tr>
<td>6. Uniformity</td>
<td>Low variation among repeated outcomes of a process</td>
</tr>
<tr>
<td>7. Consistency</td>
<td>Match with documentation, forecasts, or standards</td>
</tr>
<tr>
<td>8. Serviceability</td>
<td>Resolution of problems and complaints</td>
</tr>
<tr>
<td>9. Aesthetics</td>
<td>Relating to the senses such as color, fragrance, fit or finish</td>
</tr>
<tr>
<td>10. Personal Interface</td>
<td>Punctuality, courtesy and professionalism</td>
</tr>
<tr>
<td>11. Flexibility</td>
<td>Willingness to adapt, customize, or accommodate change</td>
</tr>
<tr>
<td>12. Harmlessness</td>
<td>Relating to safety, health, or the environment</td>
</tr>
<tr>
<td>13. Perceived Quality</td>
<td>Inferences about other dimensions; reputation</td>
</tr>
<tr>
<td>14. Usability</td>
<td>Relating to logical and natural use; ergonomics</td>
</tr>
</tbody>
</table>

STUDY OUTCOMES

• Determine appropriate evaluations to inform future trainings
• Outcomes may include:
  – Symptoms
  – Functioning
  – Therapeutic relationship
  – Client/Clinician satisfaction
  – Competence
• Assessments should:
  – Not add unnecessary burden to the client or clinician
  – Inform treatment planning and clinical decision making

Outcomes: Examples

• Positive Symptoms (QSAPS)
• Negative Symptoms (QSANS)
• Depression (PHQ-9)
• Anxiety (GAD-7)
• Functioning (Role and Social)
• Mania (AMRS)
• Medication Adherence (MARS)
• Working Alliance (WAI)
• Client Satisfaction
SUSTAIN

• Ongoing internal consultation
• Booster training/consultation
• Dissemination of updated materials
• Train the trainer model
• Identification of agency (and local) champions for CBTp
• Statewide CBTp network?

QUESTIONS?
Contacts

Percy Howard, LCSW
Chief Program Officer, CIBHS
916-501-0989
phoward@cibhs.org
www.cibhs.org

Melissa Moore, Ph.D.
Director, Felton Institute Research and Training Division
415-823-1336
mmoore@felton.org
www.feltonresearch.org