Routine Administration of Cognitive Behavioral Therapy for Psychosis as the Standard of Care for Individuals Seeking Treatment for Psychosis: State of the Science and Implementation Considerations for Key Stakeholders

SAMHSA
Substance Abuse and Mental Health Services Administration

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Preface

The Substance Abuse and Mental Health Services Administration (SAMHSA) is committed to advancing personal recovery among individuals with mental illness by supporting recovery-oriented systems of care to provide evidence-based treatments. In recognition of the persistent inaccessibility of cognitive behavioral therapy for psychosis (CBTp), and the accumulated evidence that CBTp can advance recovery among individuals managing psychosis, SAMHSA convened a one-day expert panel meeting on Friday, May 17, 2019, entitled *"Cognitive-Behavioral Therapy (CBT) for Persons with Schizophrenia Spectrum Disorders."* The meeting was attended by subject matter experts and persons with lived experience from across the U.S. and Canada in an effort to examine the key areas of need for redressing the inaccessibility of this life changing intervention (see Contributions page for a complete list of attendees, organizers, and facilitators).

Scope of the Document

Guided by the convening body of the multi-stakeholder panel, SAMHSA is issuing this brief report. A companion document, prepared by the lead authors of this document and published by the National Association of State Mental Health Program Directors (https://www.nasmhpd.org/), provides additional details. Both documents are written for mental health decision-makers and are intended to aid broad scale-up of CBTp across the United States. The intent of this document is to inform stakeholders and decision-makers at various levels of the mental health system ecology of the harmful gaps in the current treatment of persons with schizophrenia spectrum disorders (SSD); relevant factors for CBTp implementation in United States care settings; and policy recommendations to support implementation, dissemination, and long-term sustainment of CBTp service delivery. A more robust discussion of these issues as well as a review of the evidence base for CBTp effectiveness in routine care is available in the complete document. This document summarizes relevant treatment and implementation information for CBTp to support alignment of routine practice with national schizophrenia treatment guidelines[1] pertaining to this intervention.

Ideally, this document will help to advance the adoption of CBTp in a range of care settings. In order to do so, the document endeavors to facilitate the following key outcomes:

1. Increase key decision-makers' awareness of the significant gaps in SSD treatment, as well as how the ideal solution to this problem is the increased adoption of CBTp;

2. Demonstrate to key decision-makers the evidence base for CBTp, its benefits to the service-user, the service providers, and the system as a whole;

3. Set decision-makers who are interested in implementing CBTp up for success by highlighting key considerations in CBTp implementation, suggesting empirically-supported organizational change strategies for CBTp implementation, adoption, and sustainment that can be adapted to particular settings or subpopulations;

4. Identify potential action items to support systemic integration of CBTp in whole-person behavioral healthcare for decision-makers at the federal, state, tribal, and local levels.

Each of these objectives is intended to be applicable to a broad range of stakeholders, but is primarily oriented toward individuals who have decisional capacity for CBTp implementation and sustainment.

SECTION 1

Cognitive Behavioral Therapy: What is it and Why is it Needed?

While progress has been made in the treatment of schizophrenia spectrum disorders (SSD) in the last two decades[1], extant treatments and care delivery approaches have failed to manifest consistent and sustained improvement for many with these disorders.[2]

Cognitive Behavioral Therapy for psychosis (CBTp) is one of a handful of psychotherapeutic interventions that is empirically indicated to address the distress and functional impairment experienced by individuals with SSD. CBTp it is currently the most well-researched psychotherapeutic intervention for individuals experiencing psychosis. Internationally, more than 50 randomized clinical trials, 20 meta-analyses, and four systematic reviews have been conducted on the intervention. The American Psychiatric Association (APA) examined research conducted on CBTp for persons with schizophrenia and classified the overall strength of research evidence as moderate, recommending that individuals with schizophrenia receive CBTp as part of a person-centered treatment.[3] Efficacy and effectiveness trials have examined the effects of CBTp across the illness spectrum, care continuum, therapeutic modalities, and subpopulations.

Evidence supports the use of CBTp for individuals with at-risk mental state, first episode and early psychosis, multi-episode psychosis, medication-resistant psychosis as well as for individuals with co-occurring substance use disorders.[4,5] With regard to individuals at clinical high-risk for psychosis, CBTp can reduce the risk of transitioning to a psychotic episode.[6] Meta-analyses and systematic reviews, which provide a way of assessing findings across independent clinical trials, have found effect sizes typically ranging between 0.3 and 0.4 relative to treatment as usual (most commonly consisting of antipsychotic medications) for positive psychotic symptoms, mood symptoms, reducing hospitalization, improving medication adherence, maintain treatment gains, and enhancing forms of insight.[7-11]

CBTp performs comparably to many antipsychotic medications[12] and is therefore recommended as an adjunctive to pharmacotherapy for individuals who are willing to take medications. CBTp can facilitate symptom reduction for individuals who do not wish to take medications[13] and for those with medication-resistant psychotic symptoms.[14]

CBTp has been customized for delivery in different modalities. In addition to individual therapy, which may take the form of high-intensity/formulation-driven, brief or low-intensity, symptom-specific, or CBTp-informed care, CBTp may also be delivered in group formats, in milieu-based environments, and virtually, using either telehealth, internet-delivered, or mobile health (mHealth) digital application platforms. CBTp is amenable to telehealth and tends to be well-tolerated by service-users.[15,16] Given the importance of therapeutic alliance on deriving therapeutic benefit from psychological treatments for psychosis,[17] the fact that telephonic administration does not seem to hamper client's perceptions of the therapeutic alliance portends well for the utility and effectiveness of remote administration of CBTp.[18] A growing body of research supports the use of web-delivered and application-delivered CBTp concepts and skills to provide clients with continuous access to CBTp-informed care.[19]

SECTION 2

How Does CBTp Advance the Mission of Healthcare Systems?

CBT is a transdiagnostic model indicated in the treatment of more than 60 health conditions and problems of daily living. Both manualized protocols and formulation-based CBT share common educational, motivational, cognitive and behavioral concepts and techniques.

Because CBT for psychosis extends the core principles,

stylistic elements, and adapted interventions of CBT for other presenting problems,[20] practitioners who are trained to administer CBTp are better prepared to meet the needs of all clients who they serve, making training in CBTp a good investment for the behavioral health organization.

Investment in CBTp by organizations or broader public behavioral health systems of care can facilitate both process and outcome goals. Appendix A outlines seven claims about the value of CBTp service delivery to systemic objectives, including alignment of CBTp with Recovery-Oriented Systems of Care (Appendix B).

SECTION 3

Organizational Implementation of CBTp

Given the potential benefits of CBTp to improve the lives of people with SSD and address deficiencies of the current model of care, CBTp has been recommended by the APA [21] and the Schizophrenia Patient Outcome Research Team (PORT)[22] as an adjunctive treatment to antipsychotic medications for SSD. Despite its robust evidence base, inclusion in national schizophrenia practice guidelines, and the proliferation of handbooks and manualized protocols, lack of access to CBTp in the U.S. is pervasive, persistent, and systemic. Only 0.1 percent of the mental health workforce is estimated to have been trained in CBTp,[23] and access of the intervention to mental health consumers in the U.S. is estimated at roughly 0.3 percent.[24]

Implementation refers to efforts designed to get evidence-based interventions into routine practice through effective change strategies. The scientific exploration of theoretical frameworks and strategies for implementing mental health interventions have proliferated in recent years. Developers of this document are agnostic to specific implementation frameworks and support efforts to consolidate constructs and concepts. Key constructs that should be explored in relation to CBTp implementation for a given population or setting include outer implementation context (e.g., payer reimbursement and accountability models) and inner implementation context (e.g., organizational culture, human resources, and readiness for implementation).[25] Other important components to implementation are desired outcomes, intervention characteristics, an empirically-informed training plan, and identification of the individuals who will create, engage, and sustain the implementation process both within the organization and in the outer community or policy-based context. (Appendix C). Organizational factors associated with CBTp adoption and sustainment are explored more fully in the unabridged report. These include inner contextual factors spanning both components and roles of intra-organization implementation and regional and national policies that may contribute to enhanced inter- and intra-organizational integration of CBTp into routine care, such as outer context change facilitators. The remainder of this section will outline CBTp implementation preconditions and recommend empirically-supported strategies for CBTp implementation.

SECTION 3.1

Prerequisites for implementation of APA recommendations

At an agency-level, the minimum requirements for implementation of APA recommendations on inclusion of CBTp include sufficient numbers of properly trained staff, a service model and workflow that allows for implementation of CBTp in a manner consistent with evidence-based methods, and an overall strategy for sustainability of the effort including quality control and resource management. To ensure the success of this enterprise, senior leaders and decision-makers must take ownership of the mission. This can be demonstrated by creating sufficient resources for its implementation, generating buy-in and enthusiasm among staff, practicing effective communication about the ways in which practice change will be facilitated, and identifying—in partnership with managers, service staff, and, if applicable, a service-user advisory group—who will participate and in what capacities. During the planning

stages, thoughtful consideration should be given to the components of the implementation. This includes type of and means to promote desired change and identification of change agents across the organizational ecology such as service-users, providers, managers, executive leadership, and intermediaries. An implementation framework can help guide the change when it reflects careful consideration of both the inner contextual factors (e.g., culture, climate) and outer contextual factors (e.g., reimbursement policies, demand for evidence-based services). Administrators who are seeking consultation or education on EBP implementation may wish to visit the National Implementation Research Network's Active Implementation Hub (https://nirn.fpg.unc.edu/ai-hub), which provides a free, online learning environment with resources intended for a wide range of implementation stakeholders.

Successful implementation begins and ends with sustainment efforts, where CBTp becomes "baked in" to the organizational infrastructure and culture. Sustainment planning must include procedures to monitor and evaluate program deliverables based on the implementation outcomes that are most important to the stakeholders* as well as the clinical outcomes of interest. Evaluation can highlight challenges as well as successes. While both are needed to inform quality assurance and improvement efforts, celebrating successes is critical to maintain momentum and engage others in the organizational change.[26]

* For an orientation to and definitions of implementation outcomes, readers are referred to Proctor et al. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Administration and Policy in Mental Health and Mental Health Services Research, 38(2), 65–76. https://doi.org/10.1007/s10488-010-0319-7

SECTION 3.2

Laying the groundwork for practice transformation

Applying models of change to enhance CBTp adoption. The addition of new mental health services such as CBTp may be met with resistance in systems where change is unwelcomed and/or demand for services is high. Successful implementation can be enhanced by developing and implementing a change model based on the science and evidence of effective change management.[26,27] Change models become implementation roadmaps that guide CBTp adoption. Change models can include planful efforts to engage and empower the stakeholders who are impacted, overcome resistance, develop motivation, and successfully scaffold changes to avoid overwhelming the system. The core elements of many change models highlight the importance of building motivation, creating and disseminating a vision for the future, addressing human components of change, generating and visibly demonstrating executive sponsorship, and considering maintenance and sustainment from the beginning. Taken together, these components meet each individual stakeholder organization where they are and ensure successful implementation of CBTp. Acceptance of and commitment to the maintenance of the program is strengthened through early engagement of a collaborative coalition of stakeholders, including service-users, family members, clinicians, community officials, nonprofit partners, and other local, regional, or state groups who have a vested interest in implementing CBTp, particularly as a component of coordinated psychosis-specific services. These "CBTp champions" can help enable CBTp to become a part of the fabric of the organization.

Organizational readiness. Readiness, defined as the perceived need for change and organization's ability to implement change successfully,[28] predicts implementation success.[29–32] Factors that facilitate readiness include an awareness of the pitfalls and

deficits of the current system, which then fosters a tension and desire for change. Leaders can stimulate this motivation by focusing on "why" a change is necessary by being transparent about the limitations of the current system, the benefits of making the change, and the risks associated with not offering CBTp to those who might benefit. Many of these claims can be found in Appendix B or in the unabridged version of this report.

Develop a mission, vision, and a change plan. In laying the groundwork for their mission, change agents should create and communicate to stakeholders a clear strategic vision for CBTp implementation that aligns with the broader organizational mission and vision, and includes goals and benchmarks for success. These statements are the driving principles of a change effort and, like a "north star," can help coalition members to make decisions, prioritize options, and re-orient should efforts get derailed. A mission statement and vision for the future must be adequately communicated throughout an organization to drive culture change and help explain how CBTp implementation fits into the larger organizational context by filling the gaps between the current state and the ideal future state.

The next step is to generate a change plan that describes how the organization will implement and sustain CBTp. Change plans acknowledge areas that will be impacted by the change, what types of changes are expected (e.g., scheduling, intake, referrals, training, quality control), how they will be managed, as well as facilitators and barriers to change. The most useful change plans provide action steps for what changes will be made by whom and timelines for achieving progress toward these goals. Any planned performance measures or indicators should be clearly described in the change plan. This includes operational details on how and by whom performance will be evaluated and documented, as well as the expected benefits or consequences associated with achievement of milestones. Change plans should undergo regular review and updates based on implementation experience and feedback. Any factors unique to the organization that may influence CBTp implementation should be described in the change plan and accompanied by strategies for how these will be addressed.

The development of a CBTp change plan should collaboratively engage organizational stakeholders likely to be most affected. This can include individuals who receive mental health services for SSD and their family member(s), frontline clinical providers, middle management, technology support staff, and members of the executive leadership team. It is also important to engage payors prior to implementation of any changes. It is helpful to engage experts with experience in service settings similar to your own to review your change plan and allow early troubleshooting and adaptations, prior to implementation.

Leverage existing programs and systems to introduce CBTp. The acceptance of CBTp by personnel and those who receive services is more likely if methods are added to familiar clinic processes rather than developing new systems for service delivery, training, and quality control. For example, add CBTp groups to the existing schedule of available therapy groups or mirror existing methods for quality control methods. As was learned from UK implementation efforts, provide organizational support for applying skills in staff job roles.[33] This can include addressing the need for trained in-house supervisors or accessing consultation from CBTp expert trainers. Invest in recruitment of therapists and other practitioners with prior CBT training and/or experience treating psychosis, and provide professional development for frontline providers without previous therapy training to learn to deliver competent CBTp or CBTp-informed care.[34,35]

Leverage existing technologies. The landmark Institute of Medicine (IOM) report, Crossing the Quality Chasm, concluded that information technology "must play a central role in the design of health care systems if a substantial improvement in health care quality is to be achieved."[36] Progress monitoring measures embedded directly into Electronic Health Records (EHR) enhance measurement-based care practices fundamental to CBTp. Data visualization features that can be shared with service-users enhance accountability, treatment planning, and cognitive and behavioral insights. Digital augmentation of clinical service delivery and training strategies hold tremendous promise for broadly disseminating treatment and training. Technology can

help overcome the constraints of resource-constrained behavioral health settings and enhance access to on-demand CBTp skills for any of the 81 percent of individuals with psychosis who have computer or smartphone access.[37] Indeed, more people with SSD have access to a smartphone than have access to mental healthcare, making deployment of smartphone-enabled delivery of CBTp care practices appealing in and of itself. When combined with teleCBTp or face-to-face CBTp, providers and service-users gain more insight and practice with CBTp coaching. For providers, digital resources that provide performance-based feedback can facilitate both high-quality care and workflow efficiency.

Mobilize the peer workforce. Peer specialists, which are now certified as specialized interventionists in nearly every U.S. state and territory, have been leading the charge for decades in transitioning the mental health system from symptom-focused care to person-centered care. Peer specialists play a pivotal role in re-moralizing clients with SSD by providing their own account of how CBT strategies have advanced their own recovery, engaging clients in activities in the community that are consistent with their own values and goals, and facilitating the transition of CBTp concepts and skills from the clinic to the community.

Engage natural supports. Family members and other natural supports should be engaged in recovery-oriented psychoeducation, oriented to CBTp principles, and receive coaching in high-yield CBTp skills. While this may appear to some to be outside the scope of CBTp, family engagement is an intentional component of recovery-oriented CBTp that yields benefits to the individual, the clinical team, and the family system.

Use an interdisciplinary team approach. CBT is optimally delivered within the context of a multidisciplinary team setting. Coordinated Specialty Care teams, which are typically composed of a prescriber, therapist, vocational specialist, peer or recovery specialist, and case manager, may serve as a model for long-term outpatient psychosis care.[38] Cross-training permits for all members of the team to amplify one another's treatment approaches while maximizing the application of CBT skills and principles across recovery domains.

SECTION 3.3

Empirically supported approaches to CBTp training

CBTp scale-up is limited due to lack of access to CBTp training for behavioral healthcare professionals. Because the critical shortage of clinicians trained in CBTp contributes to the poor population health outcomes for individuals with SSD, CBTp workforce training is a critical intervention target. This section identifies some key considerations pertaining to training providers who can be engaged to deliver CBTp or CBTp-informed care.

Training should be facilitated by a qualified entity or trainer. Settings that are hoping to adopt CBTp can work with Intermediary/Purveyor Organizations (IPOs) and/or experienced, independent trainers. Purveyors (which may be an individual or a group) actively work to implement a practice with fidelity and good effect; whereas intermediary organizations develop, implement, and support multiple best practice programs or services, and build capacity within an organization to sustain such programs.[39] State and federal governments can leverage CBTp-specific IPOs to support broad implementation and dissemination; organizations can work with independent trainers and/or IPOs to identify a training or implementation plan that suits their needs and constraints. The North American CBT for Psychosis Network (www.nacbtp.org) is a membership-based organization that identifies both academically-based and private IPOs as well as independent CBTp trainers.

Employ an implementation approach that meets the needs of the organization and individual learners. There are several approaches to implementing CBTp, including milieu-based treatment, in which all members of an inpatient or residential treatment facility are engaged;[40] implementation of a manualized or formulation-based CBTp intervention; a tiered or stepped care approach,[24] which can leverage providers

across a range of disciplines to offer a menu of CBTp services that are delivered based on service-users' needs and preferences for treatment; or training in a manualized symptom-specific or common elements CBTp-informed approach. Providers should also be trained on psychotic and related symptoms, recovery mindset, and core CBTp concepts and strategies.

Align training practices with empirical support for workforce development. To optimize successful implementation, approaches to training providers should employ best practices in therapist clinical skill development that supplement multimodal didactic training, such as use of role play with peers, live and video-based demonstrations, and ample opportunities for practice and proximal feedback. Training programs are ideally longitudinal, in order to foster competency in direct service delivery, support in-house CBTp supervision to mitigate therapeutic drift, enhance therapist performance, and maintain accountability to CBTp principles and the recovery mindset. There are several examples of training standards from clinical trials being adapted for use in community mental health settings resulting in promising implementation outcomes.[41–44] These methods include recorded practice of therapeutic encounters to facilitate ratings of adherence and competency and use of a train-the-trainer model to support independent sustainment.

SECTION 4

Policy Opportunities

Per available evidence, CBTp is both fiscally sound and effective in facilitating organizational and client goals. The SAMHSA-convened expert panel seeks to champion policies that will support broader scale-up of CBTp in the U.S. as an ingress for systemic transformation that supports access to the more holistic, multidisciplinary, multicomponent care advanced by national practice guidelines. The table in Appendix C proffers policy opportunities that, if actualized, can lead to enhanced CBTp implementation, dissemination, and sustainment. Potential action items outlined in Appendix D are non-exhaustive, mutually inclusive, and are intended to support broad inter-organizational scale-up and sustainment, thereby enhancing access to CBTp among all individuals who have or are at high risk of developing a SSD. Consistent with SAMHSA's "no wrong door" policy, CBTp should be implemented within our mental health systems, and CBTp-informed care at a minimum should be implemented in primary care, correctional and forensic settings, and educational settings.

Summary

CBTp is the most well-researched psychotherapeutic intervention for psychotic disorders, with 30 years of efficacy, effectiveness, and—more recently—implementation trials, meta-analyses, and systematic reviews. CBTp effect sizes for both positive and negative symptoms tend to be comparable to most antipsychotic medications, and prevailing guidance is to offer CBTp alongside medications and preferably within the context of multidisciplinary care teams. Indeed, CBTp is recommended as standard of care in U.S. psychosis practice guidelines, yet, remarkably, fewer than one percent of Americans with a diagnosed psychotic disorder have access to this treatment. As one of the leading causes of disability worldwide, one would be hard-pressed to find another condition for which the health and economic effects are so profound, yet for which well-researched efficacious treatment is so inaccessible. This must change.

It will take a remarkable effort to remediate the inaccessibility of CBTp in the U.S. Leaders in the field of schizophrenia treatment development and delivery have called out the need for innovations in technology and workforce training to overcome the substantial challenges associated with implementation of psychosocial interventions for individuals with SMI.[45] If CBTp is to be brought to scale in the United States, it will require a force multiplier--a combination of factors that will result in an exponential increase of providers in our existing workforce who are competent in CBTp and CBTp-informed care, practicing within settings that enable consistent delivery of psychotherapy to service-users with psychosis. While no country has yet to surmount the complexities and challenges associated with EBT implementation and dissemination, replicable frameworks that have demonstrated success can serve as models for the U.S.[46] The considerations contained in this document are intended to enhance CBTp implementation outcomes within and across complex systems, but change cannot occur without concrete and specific action steps by individuals across the mental health system ecology, families, individuals with lived experience with psychosis and/or CBTp, CBTp researchers, and IPOs.

The panel members hope that this document sparks many productive conversations, and that these conversations extend to other evidence-based treatments and care models.
Redressing treatment scarcities has traditionally required relentless, passionate, bottom-up advocacy coupled with meaningful engagement from key decision-makers who see the addition of services to improve symptom management and overall functioning not only good for those receiving care, but for the overall health of the system. Such a systemic, top-down response is further facilitated by policies that encourage program development, pre-service and workforce training, structuring of services, and quality monitoring to ensure improved service delivery and outcomes. The implementation and policy considerations contained in this position statement are non-exhaustive, but hopefully serve as a helpful resource for administrators and policymakers invested in aligning clinical practice with clinical guidelines. With strategic and committed effort, the U.S. can go from our current reality of fewer than one percent of Americans with a SSD having access to CBTp to 100 percent of Americans having access to this life-changing intervention.

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Appendix A: Value of CBTp service delivery to systemic objectives

Claim	Explanation
CBTp aligns with the mission and values of healthcare organizations.	• Evidence-based treatments (EBTs) such as CBTp are positively correlated with healthcare quality, safety, and client outcomes, and EBTs are known to foster practitioners' active engagement in their clients' care.[47] • Accountable care organizations (ACOs) aim to align care providers and healthcare systems to better serve individuals with chronic illness and complex needs with coordinated, streamlined, and evidence-based services. As ACOs proliferate across the U.S., payment reform has shifted priorities to target outcomes for individual patients and specified patient populations, creating better alignment between reimbursement models and evidence-based treatment for individuals with episodic illnesses. • CBT has been delivered with good effect across a broad range of settings and therefore provides a "common language" across disciplines and across the care continuum, enabling care continuity that may ease the transition across levels of care.
CBTp is a good value.	• Cost analyses of CBTp have been conducted in several countries in which it has been implemented and in at least one U.S. state. Although countries differ in their healthcare systems and payment models, their data provides insights into cost benefits. A complete synopsis of these international data can be found in the full report. Data consistently indicate money saved to the publicly-funded healthcare system, some of which appears to be accounted for by fewer hospitalized days and improved functioning.
CBTp is a critical component of a recovery-oriented system of care.	• Critical to effective execution of CBTp and optimizing outcomes is the belief that psychosis is a common, relatable, and modifiable experience, and that recovery from psychosis is attainable.[48] Not only is the recovery- and strengths-based orientation of CBTp compatible with recovery-oriented systems of care (ROSC), but in the management of persistent psychosis, CBTp should be considered a critical component of a ROSC. Appendix B illustrates the congruence of CBTp and SAMHSA's guiding principles and elements of ROSC.[49] • Finally, good community functioning requires both personal resources and opportunities for engagement and participation. CBTp can be used alongside other interventions and family engagement to build motivation, hope, and skills to set individuals up for successful and sustained community inclusion. CBTp aims to reduce distress and enhance global and specific areas of functioning that are important to the person, thereby serving as a means to concretize recovery. Without explicit emphases on goals that connect people to their communities, staff may not see community engagement as a focal intervention target.[50]
CBTp can enhance culturally-responsive care practices.	• Historically, individuals belonging to cultural minority groups have been at greater risk of misdiagnosis and mistreatment in both the U.S. and abroad. CBTp emphasizes the idea that an individual's experiences must be understood within the appropriate cultural and historical contexts to minimize the risk of pathologizing culturally normative beliefs. Many manualized CBTp protocols explicitly caution against pathologizing culturally normative behavior and beliefs[51] and may therefore serve to advance cultural-sensitivity and humility practices within an organization. • Culturally-adapted CBTp manuals are proliferating, although culturally- and linguistically-responsive CBTp protocols are needed for U.S. communities. The process of individualizing culturally sensitive CBTp protocols in the U.S. must proceed collaboratively between treatment developers, service-users, and cultural leaders.[52] Direct care providers, clinical supervisors, and CBTp intermediaries (e.g., trainers, consultants) should be guided by an awareness of relevant cultural issues, assess and engage the client and—if available—identify natural supports and engage cultural brokers or make technical adjustments to the therapeutic approach, as indicated.

Appendix A: Value of CBTp service delivery to systemic objectives (Continued)

CBTp is compatible with measurement-based care.	• CBTp, like other EBTs, relies on measurement-based care (MBC). MBC is a clinical process in which patient-reported outcome measures are administered at frequent intervals, often at each visit, in order to track progress in treatment. Models of MBC in which feedback from patient-reported outcome measures are discussed with clients, and then used as part of a shared-decision making framework to make changes to the treatment plan, can help to enhance clinical outcomes and engage clients in treatment. • As data from repeated measures in MBC are available, they can be used to modify and refine the clinical formulation over time and can help to prioritize session goals by focusing on what is most important to the client. MBC can be used to engage and empower clients by underscoring successive approximations and facilitating insight into the link between cognitive/behavioral changes and feeling better. • CBTp can serve as a conduit by which evidence-based assessments that are important to the organization can be conducted in which case progress monitoring measures can be aligned with system needs, interests, and values (e.g., recovery measures, symptom measures, consumer satisfaction measures, functioning measures).[53]
CBTp is well-regarded by service-users and families.	• CBTp is regarded as an acceptable intervention to individuals who are referred[54] and by those who have received the intervention.[48, 55] • CBT for psychosis best practice guides the practitioner to involve natural supports in the treatment process, which independently corresponds to improved satisfaction among service-users, reduced hospitalization, reduced perceptions among family of caregiver burden, and enhanced emotional well-being.[56]
Training practitioners in CBTp enhances compassion and competency.	• There is evidence that training in CBTp may help promote the development of prosocial, recovery-oriented attitudes about working with this population.[57] • In the U.S., publicly-funded training initiatives in both transdiagnostic CBT for community behavioral health clients[58] and CBTp for the same population[59] were able to support learners in achieving competence by established standards.[60]

Appendix B: CBTp Compatibility with Recovery Oriented Systems of Care

Elements of recovery-oriented systems of care and services.	Consistent with CBTp or CBTp-informed care?	As evidenced by…
Person-centered	Yes	Treatment goals are established collaboratively. Symptoms are considered treatment targets only when they pose barriers to short- or long-term goals.
Inclusive of family and other ally involvement	Yes	Providers aim to include natural supports for portions of sessions across the treatment course.
Individualized and comprehensive services across the lifespan	Yes	Formulation-based CBTp is individually tailored based on a case formulation. CBTp indicated for psychosis risk states, early psychosis, persistent psychosis, and medication-resistant psychosis.
Systems anchored in the community	Yes	CBTp is intended to maintain community tenure.
Continuity of care	Yes	CBT provides a "common language" across care providers by enhancing focus on increasing adaptive behaviors. Moreover, CBTp is ideally provided across levels of care and settings, including forensic, inpatient, ACT, and outpatient.
Partnership-consultant relationships	Yes	CBTp asserts a nonhierarchical relationship between therapist and client, consisting of "two experts."
Strength-based	Yes	CBTp assesses and leverages strengths, resources, assets, and other protective factors.
Culturally responsive	Yes	CBTp denounces pathologizing culturally normative behavior. Culturally-adapted CBTp manuals are proliferating.
Responsiveness to personal belief systems	Yes	CBTp builds on expanded understanding of unusual beliefs and sensory misperceptions. Experiences are targeted to the extent that they cause distress or impairment.
Commitment to peer recovery support services	Mixed	Partnering with the peer recovery workforce, when available, is highly encouraged, as is linking clients to peer communities, such as the Hearing Voices Network.
Inclusion of the voices and experiences of recovering individuals and families	Mixed	First-person accounts are often, but not systematically, used during the psychoeducation phase of treatment.
Integrated services	Yes	CBTp is ideally included as a component of team-based care, in which cross-training occurs to leverage all members of the clinical team and natural supports in supporting whole-person care.
System-wide education and training	No	Cross-training is not built into the treatment model.[+]
Ongoing monitoring and outreach	Mixed	CBTp relies on measurement-based care practices to ensure accountability to shared treatment targets. CBTp does not emphasize community outreach but may be a component of an evidence-based practice (e.g., Coordinated Specialty Care) that does.

[+] Recovery-oriented cognitive therapy (CT-R)[61] is a more recent adaptation of CBTp that has sought to enhance cross-disciplinary and milieu-based training in recovery-oriented cognitive and behavioral interventions for individuals being treated for a psychotic disorder.

Appendix B: CBTp Compatibility with Recovery Oriented Systems of Care (Continued)

Outcomes driven	Yes	CBTp is both process- and outcomes-driven. CBTp aims to teach the client to reduce their own distress and dysfunction, independent of the therapist. Symptoms are considered treatment targets only when they pose barriers to short- and long-term goals.
Research-based	Yes	CBTp is based on cognitive theory as well as empirically-supported educational, motivational, cognitive, and behavioral strategies. CBTp benefits from 30 years of efficacy, effectiveness, and—more recently—implementation research.
Adequately and flexibly financed	No	In all 50 states, CBTp is currently reimbursed equivalently to non-evidence-based psychotherapy. Public insurance may not reimburse adequately for full therapy hour sessions. Private insurance may not reimburse for the number of sessions that may be required. Value-based payment models are more conducive to CBTp than traditional fee for service.

Appendix C: Policy Considerations for National and Local CBTp Scale-Up

	Policy Considerations at the Tribal, State, and Federal levels.
Promote collaboration within and across government entities to adopt a systematic and intentional approach to CBTp implementation.	Broad-scale CBTp implementation may consist of a federally-spearheaded workforce development initiative to implement a stepped care model—comparable to the IAPT for SMI in the U.K.—to enable rapid access to appropriate services; train providers in CBTp interventions and systems in CBTp implementation; and request program evaluation data to consolidate metrics on service access, treatment delivery, and service-user outcomes. While the U.S. healthcare system functions quite differently from countries that have supported system-wide implementation and sustainment efforts, collaborations among change agents at high levels of federal, state, and tribal government agencies can facilitate innovative solutions to seemingly intractable problems. Furthermore, starting with one of our most disenfranchised, underserved, and vulnerable populations to achieve improved access to evidence-based treatment will serve as a model for implementation of other EBTs and culturally-relevant approaches.
Enact, incentivize, and systematically monitor national guidelines on treatment of SSD.	Federal government entities and funding allocations (e.g., Mental Health Block Grants) are major funding streams for mental health services. Regulations that promote the enactment and monitoring of national practice guidelines for psychosis treatment will enhance CBTp adoption. Utilization of available reimbursement models for psychotherapeutic treatment, including differential reimbursement of evidence-based care, may incentivize statewide, tribal, or regional adoption. As is occurring for other presenting problems (e.g., Opioid Use Disorders) and populations (e.g., children and adolescents), collaboration between SAMHSA and other federal, state, and tribal agencies with payers to support implementation of payment policies that reinforce CBTp service delivery will promote greater compliance with national SSD practice guidelines and serve as a model for other EBTs for SSD.
Provide resources that facilitate training in CBTp within public mental health services.	Local providers can be supported in delivering high-fidelity and culturally-sensitive CBTp by leveraging existing SAMHSA-funded training and technical assistance programs (e.g., www.mhttcnetwork.org; https://smiadviser.org).
Contract with Intermediary/Purveyor Organizations (IPOs) experienced in CBTp implementation.	In order to support broad dissemination and continual professional development needed to sustain high-quality care, states, tribes, and federal entities hoping to support CBTp at the inter-organizational level may wish to seek out an IPO that is experienced in empirically-supported CBTp implementation practices, particularly if this cannot be accessed through SAMHSA-funded initiatives and resources.
Establish a National Network of Psychosis Centers.	Modeled after the National Network of Depression Centers, a National Network of Psychosis Centers could foster connections among members to advance treatment and implementation research, serve as best practice hubs by providing high-quality services to individuals with SSD and their families, and establish and evaluate psychosis stepped care pathways. In addition, such a network could also provide additional regional training infrastructure—particularly within large health systems—that would help to increase the number of CBTp-certified clinicians and trainers.
Encourage CBTp implementation research.	Implementation research can transition our understanding from theoretical frameworks to practical implementation strategies. Unfortunately, most CBTp implementation research derives from the United Kingdom[62,63] and Australia,[64] which have different healthcare systems, cultures, and approaches to population health. Similarly, although there is now a robust body of literature pertaining to frameworks, strategies, and trials of EBT implementation in publicly-funded mental health settings across the country, few pertain to psychological treatments for individuals with SSDs.[58,59] CBTp implementation research will ensure that funders invest limited resources for CBTp implementation based on empirical findings from the U.S. behavioral health system. Strategic partnerships between government, academic, and public behavioral health settings are needed to facilitate rigorous CBTp implementation research.

Appendix C: Policy Considerations for National and Local CBTp Scale-Up (Continued)

	Policy Considerations at Local Mental Health Authority Levels.
Enact, incentivize, and systematically monitor national guidelines on treatment of SSD.	There is often substantial variability between regional behavioral health entities that work to distribute federal flow-through dollars to behavioral health agencies within a state. Consistency in the expectation of and accountability to the provision of evidence-based psychotherapy can promote local alignment with national and state policies promoting EBTs.
Commit to local support of evidence-based treatment for SSD.	Conduct an environmental scan to identify regional facilitators and barriers to EBT implementation.
Create regional partnerships committed to improving care for individuals with SSD in the region.	Regional EBT Advisory Boards and/or Learning Communities may be sensible means to share resources, promote local accountability, agree upon priority interventions and innovations, recommend implementation frameworks and processes, and share information across organizations and service settings. These stakeholder groups should include individual service-users and their families, frontline staff, and organizational leadership. The regional advisory board should ensure connections across settings in which individuals with psychosis are most likely to present, to facilitate more rapid access to appropriate care. This includes but is not limited to educational, correctional, forensic, and primary care settings in addition to mainstream mental health settings, such as outpatient programs, inpatient programs, crisis stabilization units, and Assertive Community Treatment and early psychosis teams.
Encourage collaboration between mental health service providers and clinical training programs.	CBT training should be a required component of graduate training for clinical and counseling professions. In addition, specialized SMI curricula and/or programs can attract more people to this area and support better preparation prior to entering the workforce. Organizations that have implemented CBTp and graduate programs with these educational and training opportunities are reciprocally beneficial, as agencies serving as practicum sites create a pipeline for skill development in CBTp and allow for better penetration of CBTp to their clientele. These investments also facilitate implementation sustainment, higher-quality care, and CBTp-trained supervisors. Such a partnership benefits the professionals-in-training as well, who not only develop more knowledge, competency, and confidence to work with this population, but also are better prepared to meet clinician certification criteria following their training.
Promote a culture and climate that is open to innovation and reinforces good quality care and service-user satisfaction.	The evidence suggests that organizational factors, such as work culture and climate, are more important than individual therapist factors in facilitating or stymying practice change.[65] Effective leadership promotes a clear vision for change and mobilizes and empowers other change agents at the organization to facilitate practice transformation. The mission to improve care by offering and delivering high-quality CBTp or CBTp-informed care, is clear, consistent, and operationally defined.

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