POSITION STATEMENT ON THE ROUTINE ADMINISTRATION OF COGNITIVE BEHAVIORAL THERAPY FOR PSYCHOSIS AS THE STANDARD OF CARE FOR INDIVIDUALS SEEKING TREATMENT FOR PSYCHOSIS

Sarah L. Kopelovich, PhD[*]
Monica Basco-Ramirez, PhD
Meaghan Stacy, PhD
Harry Sivec, PhD

[*] Dr. Kopelovich received staff support from Jennifer Blank, BA at the University of Washington.

Table of Contents

Preface

In recognition of the persistent inaccessibility of cognitive behavioral therapy for psychosis (CBTp) in the United States (U.S.), and the accumulated evidence that CBTp can advance recovery among individuals managing psychosis, this document is intended 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); empirical evidence supporting CBTp across settings, modalities, and subpopulations; relevant factors for CBTp implementation in U.S. care settings; and to echo the policy recommendations supporting implementation, dissemination, and long-term sustainment that were made in the Substance Abuse and Mental Health Services Administration (SAMHSA) brief report of the CBTp expert panel convened on May 17, 2019. This document was authored by the lead contributors to the SAMHSA (2021) guide *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*. This lengthier exposition intends to expound upon the evolution and definition of CBTp, its evidence base, and the implementation and policy recommendations provided in the SAMHSA guide in an effort to advance the adoption of CBTp. Together, these complimentary documents endeavor to meet the following key functions:

1. Increase key decision makers' awareness of the significant gaps in SSD treatment that make the current mental health system untenable, 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 and CBTp investors but is primarily oriented toward players who have decisional capacity for CBTp implementation and sustainment, whether that pertains to a unitary agency or a state. It is important to note that this position statement and administrator guide cannot adequately do justice to each of these aims. Rather, this document, in tandem with the SAMHSA (2021) guide, is intended to develop awareness and a desire to incite adoption among decision makers; to enhance recognition that CBTp is increasingly desired by service users and their families; and to affirm CBTp's alignment and compatibility with other principles of high-quality treatment, such as measurement-based care, person-centered and recovery-oriented care, culturally-sensitive practices, and inclusion of natural supports. Ultimately, this product is intended to plant seeds of change that will be pursued by local and federal change agents who recognize the inadequacies of the current care model and will work to advance the adoption of CBTp in a range of care settings across the U.S.

Section 1: Psychosis and the Current Model of Care

Psychosis is a core symptom of the group of disorders known as the schizophrenia spectrum disorders (SSD), which include schizophrenia, schizoaffective disorder,

schizophreniform disorder, and delusional disorder. Collectively, these conditions are regarded by many as the abandoned illnesses.[1] Roughly three percent of the U.S. population will experience psychosis at some point in their lives, and, each year in the U.S., 100,000 adolescents and young adults will experience their first psychotic episode.[2] Individuals diagnosed with SSDs face stigma related to misconceptions about psychosis and its treatability, barriers to treatment, high rates of homelessness and institutionalization, fractured social and familial relationships, high rates of medical and psychiatric comorbidities, and premature mortality. Individuals with a SSD diagnosis die 28.5 years earlier than their peers, on average.[3] The personal and societal economic effects of these disorders are profound. Individuals with a SSD diagnosis are 2.4 times more likely than those without the diagnosis to experience homelessness, and one quarter of adults with a serious mental illness (SMI)[†] live below the poverty line.[4,5] On a national scale, the cost of schizophrenia to the U.S. economy was $155 billion in 2013, or $44,773 per individual with the diagnosis[6]. While it is tempting to attribute the economic and functional impact of these disorders to the disease itself, it is critical to bear in mind three factors that are associated with the high economic toll and poor functional outcomes:

(1) *Poor access to care*: Fewer than half of all Americans with SMI have access to care.[7] Access to care is substantially poorer among people of color with SMI. Racial disparities in access to care are evident even among the more recently implemented First Episode Psychosis coordinated specialty care (CSC) teams.[8] The access point to care for many Americans with a serious mental health condition tends not to be in behavioral health

[†] The term "Serious Mental Illness" is applied to individuals over age 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities (SAMHSA, 4/30/20). The primary diagnoses include the Schizophrenia Spectrum Disorders, severe bipolar disorder, and severe major depression.

settings. In the U.S., individuals with SMI are three times more likely to access treatment in a forensic or correctional facility than a behavioral health facility.[9]

(2) *Inadequacies of the predominant models of care*: Among those who do access treatment, only two percent of individuals have access to empirically supported therapeutic approaches.[10] Antipsychotic medications represent the mainstay of treatment in the U.S., and are often administered as a stand-alone intervention.[11] While antipsychotic medications are effective for many in treating acute psychotic episodes,[12] there are several drawbacks to relying solely on medications to treat this complex set of conditions. Medications are costly,[13] and are associated with a myriad of side effects, many of which can have deleterious effects on one's physical health, functioning, and quality of life (e.g., lethargy, sexual dysfunction).[14] Discontinuation rates are high, with 60–80 percent of individuals prescribed antipsychotic medication discontinuing their use at least once.[15] Even with an optimal pharmacotherapeutic regimen, most people will continue to experience break-through symptoms.[11,16] While medications are an important element of recovery for many, the scope of the needs of persons with serious mental illness extends beyond psychiatric and medical symptoms.[17,18] Wellness, self-defined recovery, and flourishing within one's community requires agency and self-determination. Social, political, and healthcare contexts have repeatedly created and subsequently dismantled the structures that could enhance access to effective, comprehensive, recovery-oriented services. CSC packages are increasingly available to individuals experiencing new-onset psychosis, but remain inaccessible to those who do not meet the strict admission criteria for these programs.[19] For individuals with recurrent or persistent psychosis, their only other option for multidisciplinary team-based care that approximates CSC may be to meet

the high bar for admission to an Assertive Community Treatment (ACT) team. Team-based care models like CSC and ACT incorporate the elements of care found to be most effective at holistically treating SSDs, and should be the standard of care for all.[20] These elements include evidence-based psychotherapy, family interventions for psychosis, supported employment and education services, peer support, case management, and medication management.

(3) *Social determinants of health*: In the U.S., SSDs are disproportionately diagnosed in immigrants, people of color, and among those who are raised in low-income urban neighborhoods.[21-23] Despite the fact that these populations disproportionately experience adverse mental health outcomes, resources are not disproportionately allocated to address these needs. Indeed, as stated above, people of color are not only less likely to have access to treatment, but are also less likely to receive evidence-based care.[24] Predictors of receiving guideline-concordant care include being white, female, severely ill, and having mental health insurance coverage.[24] Moreover, culturally- and linguistically-responsive care can offset health disparities, but is rarely available. Race, socioeconomic status, and arrest history are among the most prominent social determinants of access to any evidence-based care for psychosis.[25]

With appropriate care and support, the majority of people who experience a psychotic episode will recover fulfilling, meaningful lives in the community.[26,27] Federal efforts are underway to improve care for individuals with SMI and their families. SAMHSA's Strategic Plan 2019-2023 prioritizes addressing SMI as well as serious emotional disturbances in young people (Priority Area 2) and prioritizes the fortification of health practitioner training and education (Priority Area 5). Moreover, the strategic plan highlights opportunities for

collaboration with both federal (e.g., Centers for Medicare & Medicaid Services) and regional agencies as well as private payers to support implementation of payment policies that can sustain evidence-based practices. The National Institute of Mental Health's 2020 Strategic Plan for Research seeks to strengthen research-practice partnerships to expedite adoption, sustained implementation, and continuous improvement of evidence-based mental health services (Objective 4.2) and emphasizes the importance of developing innovative service models to dramatically improve the outcomes of mental health services received in diverse communities (Objective 4.3). The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), commissioned as part of the 21st Century Cures Act to codify recommendations to federal departments in the coordination and administration of mental health services for adults with SMI, recommends widespread implementation of evidence-based and effective practices for individuals with SMI (Recommendation 3.10) and enhanced funding to cover the full range of psychological, biomedical, and social services needed for holistic care (Recommendation 5.2).

Section 2: Establishing Recovery, Fulfillment, and Community Inclusion as Care Priorities

Organizational entities that serve individuals with complex needs often struggle to align their care models with their values as an organization. This quandary may be exacerbated by the expectations and restrictions imposed by payers and other external entities to whom they are accountable. The construct of *recovery*, as defined by individuals with lived experience with mental health conditions, rarely conforms to concrete health metrics, but rather can be considered as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[28] Robert Stewart, an individual with lived experience with community mental health treatment, and Dr. Jeffrey Geller, an academic psychiatrist and president of the American Psychiatric Association (2020-2021), aptly

describe recovery as "resilience in one's daily living with symptoms."[29] The idea that recovery is not synonymous with symptom remission has been well-covered in other outlets. This perspective emphasizes the dignity of the person and the belief that individuals who experience psychosis can better their own world.[30]

Rather than focusing on an illness state, which is implicit in the term *recovery*, a flourishing orientation emphasizes the desired outcome of living well in the community, with *purpose*, *connection*, *safety,* and *self-determination for one's health and well-being*. Thus, the term *flourishing* may more aptly describe the objective of living with agency and self-determination in the community. The cognitive behavioral therapist, supported by other members of the care team and the individual's natural supports, guides the individual in identifying their values and goals and then targeting, in the treatment, factors that are interfering with the flourishing life in the community that the individual craves. Commonly, individuals' own discouraging beliefs about themselves and their prospects are themselves the primary barriers to goal attainment and value-based living. In particular for individuals who experience psychosis, stigma and self-stigma contribute to beliefs and expectations related to their recovery prospects. Viewing symptoms as challenges or obstacles rather than the sole focus of care, as CBTp encourages, facilitates the destigmatization that engenders personal and social acceptance critical to community inclusion.

"(CBTp) has had a positive impact and is really helping me to move forward. It helps with overcoming voices and looking at my experience. It's very helpful in changing the way that I think about my experience."
-- Former CBTp client

Section 3: Cognitive Behavioral Therapy: What is it and Why is it Needed?

While progress has been made in the treatment of SSDs in the last two decades, extant treatments and the process by which they are delivered have failed to manifest consistent and sustained improvement for many with these disorders. Historically, the dominant approach to conceptualizing psychosis has been from a biomedical perspective, in which core psychotic symptoms are not viewed as amenable to psychological interventions. Pharmacotherapy with atypical antipsychotics have remained the front-line intervention in the management and long-term treatment of SSDs.[31,32] Unfortunately, roughly 60 percent of individuals with a SSD diagnosis will experience persistent or residual psychotic symptoms despite optimal pharmacologic regimens.[33] National Medicaid data indicate that antipsychotic polypharmacy is often used to enhance clinical response[34] despite the lack of empirical efficacy of this approach and the increased risk associated with compounded medication side effects. In addition, inconsistent adherence to the prescribed regimen is more common than not.[35,36] The shortcoming of administering antipsychotics as a stand-alone approach to treating SSDs is well-documented.[37,38] Rehabilitative psychotherapy has demonstrated reduced risk of relapse and re-hospitalization, promotes recovery, and is cost effective.[39,40] CBTp is one of a handful of psychotherapeutic interventions that is empirically indicated to address the distress and functional impairment experienced by individuals with SSDs.

Section 3.1: What is Cognitive Behavioral Therapy?

Cognitive therapy was first conceived as a psychological intervention in the case study of a person being treated by Dr. Aaron T. Beck, who was receiving inpatient care and experiencing paranoid and guilt delusions.[41] Dr. Beck developed cognitive therapy as a structured intervention that employs an information processing model to understand and treat psychopathology. Since the publication of the first book articulating the theory and mechanics of

cognitive therapy,[42] the model has been expanded to more fully explain the interplay between cognitive symptoms such as distorted thinking, problematic behavior patterns, and emotional reactions within the context of biological and social forces and vulnerability to stress that occurs in SSD.[43] Given the focus on offering concrete skills to address these symptoms, cognitive behavioral therapy (CBT) has become the dominant psychological approach to conceptualizing and treating emotional and behavioral disturbances.[44] The cognitive model asserts that our thoughts, behaviors, and emotions are interconnected, and that making changes to one or more of these facets of experience can correspond to more adaptive, healthful living. CBT emphasizes the importance of meaning-making cognitions (e.g., judgments, assumptions, beliefs) in the formation and maintenance of mental health symptoms.

CBT is a short-term, skills-focused form of talk therapy that is applicable to a wide range of psychiatric diagnoses and problems of daily living. It employs educational, motivational, cognitive, and behavioral strategies based on a tailored formulation of an individual's personal history, symptoms, problems, strengths and resources.[45] Key among these elements are engagement strategies intended to ensure a collaborative therapeutic process and a collaboratively-generated problem and goal list to enable the practitioner and client to work toward shared goals. Elicitation of the clients' personal narratives about their problems and experiences informs the treatment plan through identification of cognitions that have led to distressing emotions and maladaptive (unhelpful) behavioral patterns that perpetuate distress and impairment. Clients are empowered to learn effective self-help and illness management skills to help change the way they think, feel, and behave as a means of relieving symptoms, reducing impairment, and improving overall functioning and quality of life. In enhancing technical

transparency and agency over the treatment, CBT revolutionized psychotherapy by empowering the client to facilitate his or her own recovery.

Section 3.2: What is CBT for psychosis?

Like CBT for other presenting problems, CBT for psychosis is a time-limited talk therapy that helps individuals identify and evaluate the way they are interpreting and reacting to their experiences. The concept of recovery as a movement and mind-set is foundational for CBTp. The assumptions and guiding principles associated with recovery, such as acceptance, commonness of experience, hope, recognizing strengths, and promoting empowerment were influential in developing the adaptations to CBT that eventually led to CBTp.[46] For instance, recent ethnographic research has demonstrated that positive psychotic symptoms (e.g., delusions and hallucinations) lie on a continuum with typical human experience, and are therefore amenable to the same CBT techniques used to treat other forms of psychological distress.[47] For example, paranoia is an extreme form of anxiety, perpetuated by information processing errors that occur when we are emotionally activated. Thus, CBTp strives to teach the individual to identify, evaluate, and then make an informed decision to either modify or accept thoughts and assumptions. This approach capitalizes on the unique strengths, resources, and interests of the individual. Over time, CBTp has come to include a range of approaches that can be adapted to individuals in a flexible manner according to their primary goals and the symptoms that are interfering with goal attainment. For instance, recent iterations of CBTp have emphasized mindfulness, self-compassion, and acceptance of distressing thoughts and experiences in recognition that these can serve as antidotes to shame, self-criticism, poor tolerance for uncertainty, and feelings of dyscontrol that can accompany psychosis.

Over the course of the last 30 years, CBTp has become the most well-researched psychotherapeutic intervention for individuals experiencing psychosis. It is typically delivered in a structured, stage-wise manner, consisting of engagement, assessment, intervention, and wellness planning. The intervention is ideally customized to suit the individual needs, strengths, and challenges of each service user. The main instrument of change in CBTp involves articulating, evaluating, and reappraising distressing experiences and concerns. This is achieved by helping the individual to identify the sources of distress (e.g., an interpretation that a voice is all-powerful or all-knowing), and responses to stressful experiences that are perpetuating distress (e.g., using drugs or alcohol, over-use of avoidance techniques). The therapist coaches the individual to form more helpful appraisals and to adopt a repertoire of goal- and value-consistent behaviors.

Unlike biomedical approaches, which aim to abate the symptoms themselves, the primary goal of CBTp is to reduce distress and impairment related to psychotic experiences in order to enable the individual to achieve personally valued goals.[43,48] In line with this focus, psychotic and psychotic-like experiences (e.g., hearing voices) are framed as occurring in a minority of the general population, but not inherently pathological. Rather, these experiences are conceptualized as problematic to the extent that they cause the individual undue distress and affect their functioning. Voice hearers often report immense relief once they formulate an understanding of their voice-hearing experience. For example, one voice hearer reported during a course of CBTp, "*I realize now that they are my most critical self. I don't have to listen to everything they say*."

All CBTp approaches require that the individual expresses distress or impairment in some facet of their lives. Having some degree of insight and desire for treatment are factors that correspond with a positive response to CBTp. Motivational enhancement is a complementary

approach that is often used to prepare the individual to engage in CBTp and adopt new behaviors by identifying and articulating values, goals, and obstacles, particularly if individuals disagree with their diagnosis of record.

Section 3.3: What does the empirical evidence suggest about the benefits of CBTp?

The clinical presentation of primary psychotic disorders can be highly variable. Similarly, despite the fact that core CBTp principles and elements have been identified by experts,[49] CBTp protocols may differ quite a bit from one another due to the fact that CBTp is often individualized based on the individual's needs and preferences for treatment as well as conceptual breadth of the intervention itself. As a result of such heterogeneity of the therapeutic methods employed, research participants' primary symptoms and personal goals for treatment, and primary outcomes of interest, CBTp has been difficult to study.[50] It is not yet known which components of the intervention are most effective for which chief complaints. Nevertheless, formulation-based CBTp, as well as low-intensity and symptom-specific CBTp interventions tend to demonstrate improved efficacy in reducing clinical symptoms than is observed for either inactive or active comparators.

Internationally, more than 50 randomized clinical trials, 20 meta-analyses, and four systematic reviews have been conducted on the intervention. 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.[18,51] With regard to individuals at clinical high-risk for psychosis, CBTp can diminish the risk of transitioning to a psychotic episode.[52] 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.[53-57] CBTp performs comparably to most antipsychotic medications,[58] and is therefore recommended as an

"CBTp has been really useful for keeping me balanced. Prior to this method of therapy, I had other therapists, but a lot of that treatment — not to dis them — did not have the same positive results that CBTp did. My therapy has been a mix of data analysis (looking at my mood chart and stuff like that) and talk therapy. The talk therapy doesn't feel palliative because I have gained skills that I hope to use for a long time."
-- Former CBTp Client

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[59] and for those with medication-resistant psychotic symptoms.[18] When compared to a therapeutic control condition in both general reviews and targeted studies, CBTp shows greater advantage on positive symptoms.[53,56,60] A recent cumulative meta-analysis evaluating the effects of formulation-driven CBT on delusions and hallucinations concluded that the evidence base has been sufficient and stable since 2015 and 2016, respectively.[61] Smaller yet still significant effects are observed for negative symptoms.[62] CBTp appears well-suited to targeting anhedonia and amotivation by focusing on modifying anticipatory pleasure. Owing to the flexible nature of CBTp, recent modifications such as an emphasis on activation and modification of defeatist beliefs found in Recovery-Oriented Cognitive Therapy , are being explored as options to enhance the efficacy of CBTp on negative symptoms.[63,64] A primary limitation of the existing research base on CBTp is its overly-narrow focus on symptoms at the expense of individuals' functional recoveries and perceived well-being.

CBTp protocols have evolved over the decades from broad approaches targeting a range of psychotic and mood symptom constellations, to targeted, symptom-specific protocols.[65] Targeted CBT interventions focus on specific mechanisms or symptoms (e.g., sleep disturbance, worry), tend to be manualized, may require fewer sessions, and may require less advanced therapeutic training. Although targeted studies are relatively nascent, a recent systematic review found that symptom-based approaches could improve efficacy by delivering more targeted formulations and interventions.[66]

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. Most group CBTp studies report positive results, with some reporting immediate (post-treatment) effects on symptoms as well as on psychosocial dimensions, such as self-esteem, coping, social support or social functioning; and some studies finding that treatment effects persisted up to one-year follow-up.[67,68] Group cohesion, among other therapeutic group processes, yield the strongest therapeutic effects. Groups that are too brief, that try to transpose individual CBTp to a group format, that do not use trained group therapists, that accept new participants on a rolling basis, or that require that participants change groups or therapists frequently are less likely to develop a strong sense of cohesion that appear

"It's amazing to see the difference. Previously she wasn't showering; was completely isolated. She's showering now; she has a new way of thinking about her voices. She's talking about getting a job. We have to turn people away sometimes for the group. They want to come even if they don't hear voices or have schizophrenia. It's amazing to watch people connect with the material, with each other. It's an amazing group."
-- Kate McNulty, RN, regarding her CBTp inpatient group

necessary for symptom improvements.[69] Younger individuals, such as those presenting with a first episode of psychosis, may derive more benefit from group CBTp than individual therapy.[70]

CBTp is amenable to telehealth and tends to be well-tolerated by service users.[71,72] Given the importance of therapeutic alliance on deriving therapeutic benefit from psychological treatments for psychosis,[73] the fact that telephonic administration does not seem to hamper clients' perceptions of the therapeutic alliance portends well for the utility and effectiveness of remote administration of CBTp.[74] 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. The effectiveness of these interventions is accumulating, and emerging evidence suggests that it is enhanced by professional support.[75] Unfortunately, a few of the apps with the strongest evidence that have been designed specifically for users with serious mental illness are not yet publicly available. Two application-based interventions that have amassed the most clinical research to-date are FOCUS[76] and PRIME.[77] Both have demonstrated efficacy, clinical effectiveness, and high rates of user engagement in randomized trials. Facilitated by strategic partnerships between industry and research institutions, digital augmentation of human-delivered care is being developed and deployed at a furious pace, but funding and intellectual capital must be extended to enhancing care for individuals with SSDs and their support networks.[78]

Section 4: How Does CBTp Advance the Mission of Healthcare Systems?

Individuals with serious mental illnesses such as SSD constituted 68 percent of the individuals served by state mental health authorities in Fiscal Year 2015 (www.nri-inc.org). Psychosis frequently co-occurs with psychiatric and medical comorbidities as well as other challenges, such as sleep disturbances and social skills deficits. 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,[49] 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.

Claim 1: CBTp aligns with the mission and values of healthcare organizations.

Most health care systems aim to provide person-centered care with excellence in quality, service, and access. The individuals' goals and humanity/personhood are central to service delivery. Evidence-based treatments (EBTs) are positively correlated with healthcare quality, safety, and client outcomes, and EBTs are known to foster practitioners' active engagement in their clients' care.[79] Leaders in implementation science make a compelling business case for evidence-based strategies as well: "As healthcare systems work under increasingly dynamic and resource-constrained conditions, evidence-based strategies are essential in order to ensure that research investments maximize healthcare value and improve public health".[80] Healthcare systems and funders are particularly attuned to the problems of EBT access and availability. 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. Finally, CBT has been delivered with good effect in long-term residential

treatment facilities, forensic hospitals, intensive outpatient programs, outpatient programs, Assertive Community Treatment teams, correctional facilities, schools and universities, and in primary care. CBT therefore provides a "common language" across disciplines and across the care continuum, enabling care continuity that may ease the transition across levels of care.

Claim 2: CBTp is a good value.

Cost analyses of CBTp have been conducted in most major countries in which it has been implemented. An analysis of cost data in Ontario, Canada suggests that adding CBTp to usual care in the management of adult schizophrenia would save an estimated $15–$35 million to Ontario's publicly funded healthcare system over a five-year period.[81] In the United Kingdom (U.K.), the National Institute for Clinical Excellence (NICE; 2014) undertook a cost analysis to assess whether the costs to the National Health Service (NHS) of providing individually-administered CBT in addition to standard care was offset by future savings resulting from reduced relapse and hospitalization.[82] The analysis revealed that offering CBT plus standard care to service users with SSDs yielded net cost savings of £989 (roughly $1,263 U.S. dollars) per person. Van der Gaag and colleagues (2011) conducted a randomized clinical trial in which they investigated the costs associated with CBT in the Netherlands.[83] CBT was associated with better clinical outcomes than treatment as usual (183 days of normal social functioning vs. 106 for standard care) but statistically similar costs over the 18-month period of investigation. The authors calculated a cost of £3,928 (approximately $5,016 U.S. dollars) per additional day of normal functioning gained, which suggested that CBTp had social economic benefits over standard care. This finding is echoed by studies that have found higher rates of employment following a course of CBT.[84,85] In the U.S., Washington State examined cost-benefits per CBTp participant, including the estimated cumulative net benefits per participant beyond the initial

investment in the service.[86] The analysis estimated total benefits to taxpayers and the participant as exceeding net program costs by $13,337, and details a 61 percent likelihood that CBTp will produce benefits greater than the costs.

"People living with challenges related to psychosis have traditionally been underserved and told the only effective care is medications. CBTp gives people options and empowers them to take control of their lives and symptoms. Building a workforce capable of providing this intervention with federal block grant dollars has been imperative for our state. We have focused on including CBTp in many of our new service delivery systems to help reach people who have traditionally been underserved."
-- Matthew Gower, MBA. Behavioral Health Administrator, Washington State Health Care Authority

Claim 3: CBTp is a critical component of a recovery-oriented system of care.

CBTp is more than a constellation of techniques. 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.[87] 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. Table 1 illustrates the congruence of CBTp and SAMHSA's guiding principles and elements of ROSC.[88]

Table 1: Degree of overlap between CBTp and ROSC

Elements of recovery-oriented systems of care and services.	Element 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 is 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.

Elements of recovery-oriented systems of care and services.	Element consistent with CBTp or CBTp-informed care?	As evidenced by…
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.
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 and team-based care payment models are more conducive to CBTp than traditional fee for service.

‡ Recovery-oriented cognitive therapy (CT-R)[64] 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.

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.[89]

Claim 4: CBTp can enhance culturally-responsive care practices.

Racial and ethnic minorities with a SMI tend to receive poorer quality of care, report lower satisfaction with professional mental health services, and have higher rates of early service termination than their White counterparts. The engagement and assessment processes that are integral to CBTp are intended to ensure that CBTp is personalized to each individual in order to maximize treatment effectiveness. It is critical for clinicians to work toward cultural sensitivity through understanding and acknowledging their own cultural lens and to conceptualize each individual's experiences within their relevant contexts (social, familial, cultural, historical).

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. Historically, individuals belonging to cultural minority groups have been at greater risk of misdiagnosis and mistreatment in both the U.S. and abroad. Many manualized CBTp protocols explicitly caution against pathologizing culturally normative behavior and beliefs,[44] 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.[90] Research demonstrates that, when a collaborative process of developing a culturally- and linguistically-adapted CBTp protocol is followed, service users benefit.[91,92] Practitioners should seek to understand cultural factors that influence therapeutic participation and worldviews. 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—identified natural supports, and engage cultural brokers or make technical adjustments to the therapeutic approach, as indicated.

Claim 5: 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. CBTp requires competencies in both structured and narrative assessment to aid in the development of symptom maintenance formulations and to develop a more comprehensive formulation that encompasses the breadth of clinical and psychosocial complexities. As data from repeated measures in MBC are available, they can be used to modify and refine the 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 also serve as a conduit by which evidence-based assessments that are important to the organization can be conducted, as CBTp interventionists typically have weekly or biweekly contact with clients. Progress monitoring measures should be aligned with system needs, interests, and values (e.g., recovery measures, symptom measures, consumer satisfaction measures, functioning measures). In doing so, aggregated MBC data may confer secondary and tertiary gains in addition to the primary benefits to the client. For instance, MBC may facilitate professional development at the provider level, quality assurance at the clinic level, and value-based payments at the system level. The latter is particularly important for the future of the mental health system, as the inability to demonstrate the value of mental health treatments to payers may be contributing to persistent underfunding, the results of which negatively impact access to services and patient outcomes, thereby reinforcing payers' misperceptions that mental health services yield a poor return on investment. Aggregated intervention data can interrupt this cycle by signifying the value of mental health treatments.[93]

Claim 6: CBTp is well-regarded by service users and families.

CBTp is regarded as an acceptable intervention to individuals who are referred[94] and by those who have received the intervention.[87] For example, in two different satisfaction surveys of service users, between 80 percent[95] and 96 percent[96] of those who completed a course of CBTp reported that they were satisfied or very satisfied with their psychotherapeutic treatment. Miles and colleagues (2007) noted that specific aspects of CBT, rather than the non-specific therapeutic factors, predicted overall satisfaction.[95] Service users have described the experience of CBTp sessions as collaborative and report positive perceptions of therapists.[96–98] In addition, service users report that CBTp is helpful in increasing knowledge and acceptance, improving coping skills, and facilitating change.[97–99]

CBTp 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.[100]

"Learning CBTp therapy has positively impacted my interactions with my family member as well as my own sanity. This was able to occur within just 24 hours. It has helped me to identify that the dominant messaging that is within our society about psychosis not being treatable with anything other than medication, is false. I have heard from so many people this message along the way of trying to help my loved one, including the medical professionals. The phrase and the charge to "expect recovery" has changed my perspective and approach completely. After one day of training I was able to have an interaction with my loved one that helped create a positive restart in our relationship. This emotional connection had not occurred for months. I received hope from the evidence-based information and CBTp training. This is what family members, caregivers, and especially already trained medical professionals need to embrace and learn to make a positive change within our very broken and archaic health care systems."

-- Jerusha Jerome, Family Member, Washington

Claim 7: 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.[101] For example, training providers in CBTp and CBTp-informed strategies has been associated with improved perceptions of treatment,[102] with staff feeling more knowledgeable and optimistic about treatment[103] and with providers feeling more empathetic toward individuals who experience psychosis.[104]

"[After receiving training in CBTp] I have more empathy; I have more understanding. The fear is not there anymore. I relate to clients as people first, not their diagnosis. And that makes me more effective in working with them as well. It has had a pretty immense impact on my professional development even with people who do not have schizophrenia spectrum disorder."

-- Stephani Carlton, MA, LMHC, Supervisor at Frontier Behavioral Health, Washington

---

In the U.K., where the NHS have funded system-wide training initiatives, Jolley and colleagues (2015) reported that clients who received CBTp from therapists who achieved competent fidelity ratings showed good clinical outcomes on both affective and psychotic

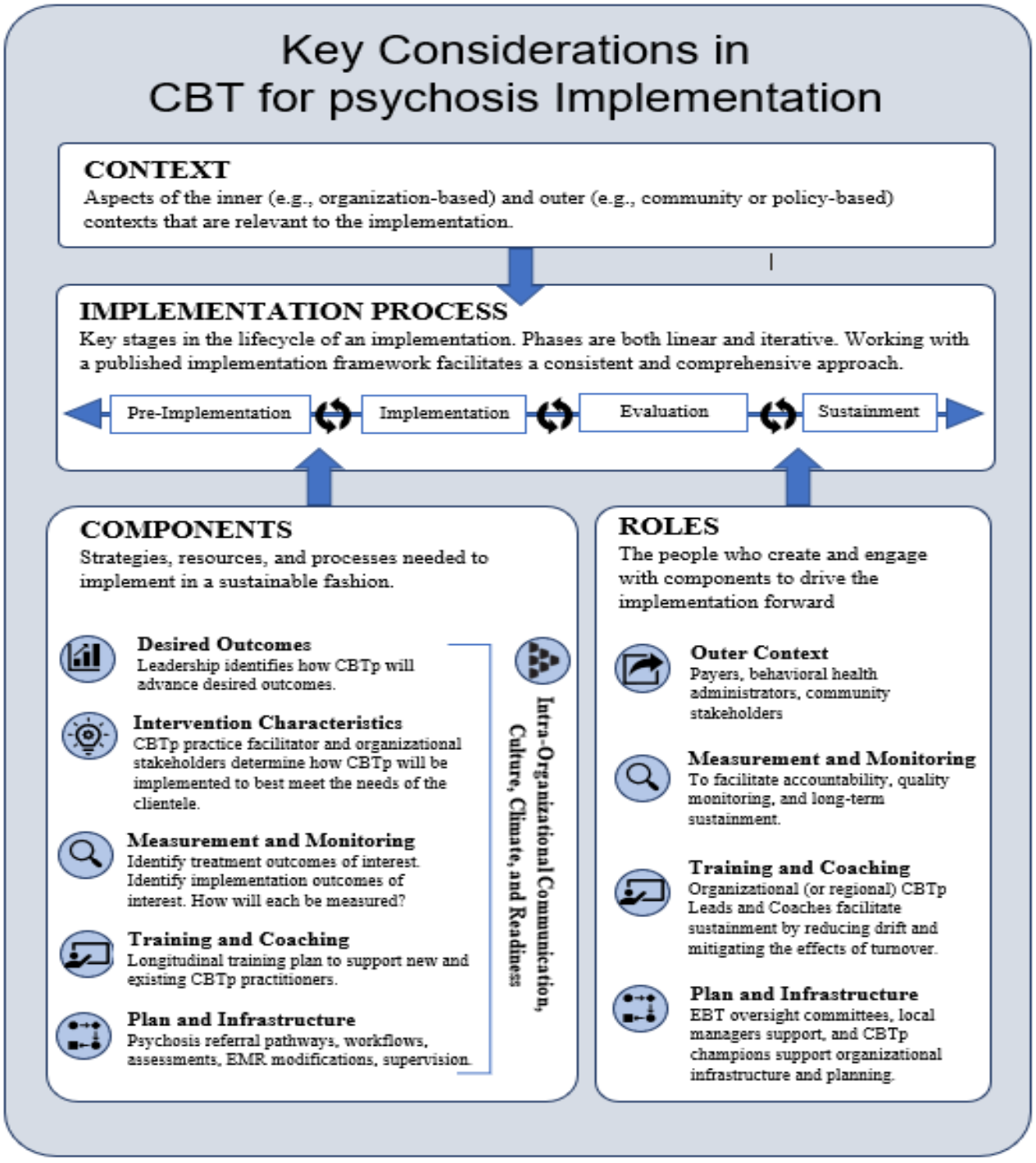
symptoms.[105] In the U.S., publicly-funded training initiatives in both transdiagnostic CBT for community behavioral health clients[106] and CBTp for the same population[107] were able to support learners in achieving competence by established standards.

Section 5: Implementation at the Organizational Level

CBTp has long-been included in SSD and psychosis practice guidelines in both the U.S. and abroad, but guidelines seldom generate systemic conformity to prescribed practices. For instance, in the U.K., schizophrenia treatment guidelines were first published by NICE in 2002.[108] Subsequently, the NHS mandated that CBTp be offered to clients within seven days of a diagnosis of SSD. The mandate resulted in substantial investments in national implementation and training of multiple health disciplines in CBTp protocols, yet there remains substantial variability in penetration rates between trusts,[109] and the NHS is not yet in full compliance with NICE guidelines. That said, while access to CBTp remains limited across the U.K., systemic investments in programs and personnel have facilitated uptake that vastly outpaces uptake in the U.S.[110,111] This is due, at least in part, to a federal government-funded initiative, Increasing Access to Psychological Therapies (IAPT), which has central leadership as well as regionally-based training, workforce development, quality monitoring, and research. The investment has included a massive workforce development initiative to train providers, implement a stepped care model to enable rapid access to appropriate services, and maintain a comprehensive monitoring and evaluation system that collects performance data on service access, treatment delivery, and service user outcomes. The NHS estimates that the costs of the service is fully recovered in savings to the government associated with service users' functional recoveries and reduced expenditures on healthcare.[112]

Implementation refers to efforts designed to get evidence-based interventions into routine practice through effective change strategies. The scientific exploration of theoretical implementation frameworks and activities have proliferated in recent years and are instructive to the persistent and pernicious CBTp science-to-practice dilemma. 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).[113] 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 context (see Figure 1). This document does not endeavor to explore each of the factors associated with these domains for CBTp implementation in the U.S., but will instead speak more broadly to organizational factors associated with CBTp adoption and sustainment. These include inner contextual factors spanning both components and roles of intra-organization implementation (Section 5) 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 (Section 6).

Figure 1. Key Considerations in CBTp Implementation[§]



[§] Figure 1 was adapted from Hirsch, W. (2019) *Implementer's Starter Kit, Second Edition*.

Section 5.1: Where are we now?

Given the potential benefits of CBTp to improve the lives of people with SSDs and address deficiencies of the current model of care, CBTp has been recommended by the American Psychiatric Association (APA)[114] and the Schizophrenia Patient Outcome Research Team (PORT)[115] as an adjunctive treatment to antipsychotic medications for SSDs. Despite its robust evidence base, inclusion in national schizophrenia practice guidelines, and the proliferation of practical handbooks and manualized protocols, lack of accessibility to CBTp in the U.S. is pervasive, persistent, and systemic. According to currently published estimates, only 0.1 percent of the U.S. mental health workforce is estimated to have been trained in CBTp,[116] and accessibility of the intervention to mental health consumers is estimated at roughly 0.3 percent.[117]

Section 5.2 Prerequisites for implementation of PORT recommendations

At an agency-level, the minimum requirements for implementation of PORT 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 evidence-based practice implementation may wish to visit the National Implementation Research Network's Active Implementation 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 engaging others in the organizational change.[118]

With regard to "roles" (see Figure 1), acceptance of and commitment to the maintenance of the program is strengthened through 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

[**] 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

champions" can help with the early identification and attention to social, political, financial, or other factors that may negatively or positively influence CBTp implementation and sustainment and help secure the necessary community and organizational resources and infrastructure to enable CBTp to become a part of the fabric of the organization.

Section 5.3: 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.[118,119] Change models for new psychosocial treatments are roadmaps that guide the process of implementing new services and 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 components 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.

Organizational readiness. Readiness, defined as the perceived need for change and the organization's ability to implement change successfully,[120] predicts implementation success.[121–124] Indicators of organizational readiness include favorable attitudes toward adopting new behaviors such as EBTs. 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.

Develop a mission, vision, and a plan to achieve them. In laying the groundwork for their mission, change agents, such as organization leaders, should create and communicate to stakeholders a clear strategic vision that includes goals and benchmarks for success. A compelling mission statement provides an explanation of what an organization does and why it exists and summarizes their vision for the future. 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 cultural 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.

Plan for organizational change. Following successful creation and communication of an organizational mission statement, 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 SSDs 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 before implementation.

Section 5.4: Structural mechanics of effective CBTp 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, CBTp groups should be added to the existing schedule of available therapy groups or mirror existing methods for quality control methods. As was learned from U.K. implementation efforts, organizational supports for applying skills in staff job roles are critical to quality assurance and sustainment.[125] This could be delivered by agency supervisors or by CBTp expert trainer-consultants. When possible, organizations should invest in recruiting therapists and other practitioners with prior CBT training and/or experience treating psychosis or provide professional development to providers without previous therapy training to learn to deliver competent CBTp or CBTp-informed care.[126,127]

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."[128] 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 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.[129] Indeed, more people with SSDs 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 can facilitate performance-based feedback to facilitate both high-quality care and workflow efficiency.

Enhance awareness among referral providers. In countries where CBT is more commonly offered to individuals with psychosis, such as in Great Britain, treatment providers are more likely to be aware of CBTp. For instance, in West Southampton, England, researchers[130] contacted all service users with a SSD diagnosis, conducted a chart review, and interviewed their treating psychiatrists. Nearly half of service users who had SSD and had been in contact with mental health services were referred to CBTp by a member of their treatment team. Even as early as 2005, when the New Southampton audit was conducted, CBTp was

viewed as appropriate and potentially beneficial for a wide range of service users. Conversely, pessimistic views of the prospect that CBTp will yield positive outcomes may reduce motivation to refer to CBTp, as recommended by practice guidelines.[131]

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 SSDs 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 skills training. 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. CSC 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.[20] 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 5.5: 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 SSDs, CBTp workforce training is a critical 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.[132] 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;[102] implementation of a manualized or formulation-based CBTp intervention; a tiered or stepped care approach,[117] 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.[133–136] 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 6: Policy Considerations

CBTp is, per available evidence, both fiscally sound and effective in facilitating organizational and client goals. The SAMHSA-convened expert panel sought 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. This section reviews the policy considerations reported by SAMHSA to enhance CBTp implementation, dissemination, and sustainment for policymakers at the tribal, state, and federal level, as well as regionally within a state. Potential action items outlined here 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.

Policy Recommendations 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.
Create specialty preservice training in the treatment of persons with SMI	Graduate programs in clinical and counseling fields should place greater emphasis on providing students with education and training in evidence-based psychotherapies for individuals with a SMI. The Council for Serious Mental Illness (SMI) Psychology (http://www.psychtrainingsmi.com/) provides a training curriculum, guidelines, a competency measure, and other resources to support specialization and certification in SMI treatment.
Certification of CBTp practitioners	Certifying organizations define standards for clinical practice of CBT. CBTp certification provides an assurance of knowledge, training, and experience to service users, families, employers, and other practitioners. The North American CBTp Network is not a credentialing body, but is working to recommend certification processes and grandparenting procedures.

Policy Recommendations at the Tribal, State, and Federal Levels. (Continued)	
Enact, incentivize, and systematically monitor national guidelines on treatment of SSD.	Federal government and joint federal/state insurance (e.g., Medicaid), and grant programs (e.g., Mental Health Block Grants) represent important opportunities to support evidence-based mental health services. Regulations that promote the enactment and monitoring of national practice guidelines for psychosis treatment will enhance CBTp adoption. Quality assurance organizations, such as the National Committee for Quality Assurance, should be engaged in the development of standards concerning process of multi-component care inclusive of CBTp.
Exploration of differential rate structure for evidence-based treatments.	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 federal, state, and tribal agencies with payers to support payment policies that reinforce CBTp service delivery—particularly in the context of team-based care—may promote greater compliance with best practice guidelines and serve as a model for other EBTs for SSD.
Provide resources that facilitate training in CBTp within public behavioral health services.	Local providers can be supported in delivering high-fidelity and culturally-sensitive CBTp by leveraging existing training and technical assistance programs (e.g., www.mhttcnetwork.org; https://smiadviser.org). Training should be directed toward a range of healthcare providers and practitioner allies (e.g., families and peers) to enable complimentary approaches of CBTp-informed care as well as administration of formulation-based cognitive behavioral therapies.
Contract with 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. Implementation targets and performance metrics should be in alignment with systems' respective missions and strategic plans related to the care and management of the individuals with psychosis whom they serve.

Policy Recommendations at the Tribal, State, and Federal Levels. (Continued)	
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 psychosis treatment and implementation research, serve as best practice hubs by providing high-quality services to individuals with SSDs and their families, and establish and evaluate psychosis 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 U.K.[105,137] and Australia,[138] 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.[106,107] CBTp implementation research will support strategic investment of 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.
Inform and engage national advocacy organizations.	Partnerships with mental health advocacy organizations (e.g., National Alliance on Mental Illness, Mental Health America) can facilitate consumer demand for CBTp and more effectively engage decision-makers in supporting CBTp dissemination.
Create an SMI treatment educational campaign for administrators and policymakers.	An educational campaign targeting key decision-makers within federal and local systems should accompany this document in an effort to address misconceptions that CBTp is a nascent intervention, lacks empirical support, or is contraindicated for psychotic disorders.
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 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.

Policy Considerations at Local Mental Health Authority Levels. (Continued)	
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 behavioral health service providers and preservice 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 that collaborate with graduate programs to provide practicum sites can 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.[139] 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.

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 of 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.[140] If CBTp is to be brought to scale in the U.S., 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.[141] The considerations contained in this document and the SAMHSA companion report 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 these documents spark many productive conversations, and that these conversations extend to other evidence-based treatments and care models for individuals with psychosis.

The current global drive is to refine intervention protocols that hold the promise of easier implementation and wider dissemination to improve access in frontline services.[142] In practice, this can take many forms, including (but not limited to) symptom-specific protocols, stepped care, common elements protocols, and augmenting in-person care with CBT digital health tools. These training and treatment delivery strategies are being studied and implemented both domestically and abroad. In addition to protocol adaptations, training approaches such as those that leverage multiple disciplines within the clinical team, extend CBTp-informed care training to non-therapists, incorporate digital health tools for learners, and incentivize learners and/or systems, are also innovative approaches to enhancing CBTp uptake at the hyperlocal level. More research is needed to better ascertain core versus adaptable components of the intervention itself, key implementation strategies that are setting- or population-specific, and key strategies to train, retain, and support the workforce that has the highest degree of contact with individuals with SSDs.

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 improved service delivery. 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.

References

1. Schizophrenia Commission. The abandoned illness: A report from the Schizophrenia Commission. *Rethink Mental Illness* (2012).
2. RAISE Questions and Answers; Questions & Answers about Psychosis. *National Institute of Mental Health* https://www.nimh.nih.gov/health/topics/schizophrenia/raise/raise-questions-and-answers.shtml#3.
3. Olfson, M., Gerhard, T., Huang, C., Crystal, S. & Stroup, T. S. Premature Mortality Among Adults With Schizophrenia in the United States. *JAMA Psychiatry* 72, 1172–1181 (2015).
4. Center for Behavioral Health Statistics and Quality (CBHSQ). *2018 National Survey on Drug Use and Health: Detailed Tables*. (2019).
5. Folsom, D. P. *et al.* Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *Am. J. Psychiatry* 162, 370–376 (2005).
6. Cloutier, M. *et al.* The Economic Burden of Schizophrenia in the United States in 2013. *J. Clin. Psychiatry* 77, 764–771 (2016).
7. McAlpine, D. & Mechanic, D. Utilization of specialty mental health care among persons with severe mental illness: The roles of demographics, need, insurance, and risk. *Health Serv Res* 35, 277 – 292. (2000)
8. Oluwoye, O. *et al.* Racial-Ethnic Disparities in First-Episode Psychosis Treatment Outcomes From the RAISE-ETP Study. *Psychiatr. Serv.* 69, 1138–1145 (2018).
9. Substance Abuse and Mental Health Services Administration. *IMHO Survey*. (2004).
10. Interdepartmental Serious Mental Illness Coordinating Committee. *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their*

Families and Caregivers. https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf (2017).

11. Lally, J. & MacCabe, J. H. (2015). Antipsychotic medication in schizophrenia: a review. *Br. Med. Bull. 114,* 169–179.
12. Leucht, S. *et al.* (2012). Antipsychotic drugs versus placebo for relapse prevention in schizophrenia: a systematic review and meta-analysis. *Lancet, 379*, 2063–2071.
13. Stahl, S. M. & Grady, M. M. (2006). High-cost use of second-generation antipsychotics under California's Medicaid program. *Psychiatric Services, 57*, 127–129.
14. Cascade, E., Kalali, A. H., Mehra, S. & Meyer, J. M. (2010). Real-world data on atypical antipsychotic medication side effects. *Psychiatry, 7*, 9–12.
15. Fervaha, G., Agid, O., Takeuchi, H., Foussias, G. & Remington, G. Effect of antipsychotic medication on overall life satisfaction among individuals with chronic schizophrenia: findings from the NIMH CATIE study. *Eur. Neuropsychopharmacol.* 24, 1078–1085 (2014).
16. Meltzer, H. Y. Treatment of the neuroleptic-nonresponsive schizophrenic patient. *Schizophr. Bull.* 18, 515–542 (1992).
17. Geller, J. L. The First Step in Health Reform for Those with Serious Mental Illness: Integrating the Dis-Integrated Mental Health System. *J. Nerv. Ment. Dis.* 203, 909–918 (2015).
18. Burns, A. M. N., Erickson, D. H. & Brenner, C. A. Cognitive-behavioral therapy for medication-resistant psychosis: a meta-analytic review. *Psychiatr. Serv.* 65, 874–880 (2014).
19. Dixon, L. What It Will Take to Make Coordinated Specialty Care Available to Anyone

Experiencing Early Schizophrenia: Getting Over the Hump. *JAMA Psychiatry* 74, 7–8 (2017).

20. Goldman, H. H. Coordinated Specialty Care: An Impetus to Improve All Mental Health Services? *Psychiatr. Serv.* 71, 415 (2020).
21. Bresnahan, M. *et al.* Race and risk of schizophrenia in a US birth cohort: another example of health disparity? *Int. J. Epidemiol.* 36, 751–758 (2007).
22. Laurens, K. R. *et al.* Common or distinct pathways to psychosis? A systematic review of evidence from prospective studies for developmental risk factors and antecedents of the schizophrenia spectrum disorders and affective psychoses. *BMC Psychiatry* 15, 205 (2015).
23. Schwartz, R. C. & Blankenship, D. M. Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World J Psychiatry* 4, 133–140 (2014).
24. Wang, P. S., Berglund, P. & Kessler, R. C. Recent care of common mental disorders in the United States: Prevalence and conformance with evidence-based recommendations. *J. Gen. Intern. Med.* 15, 284–292 (2000).
25. Dixon, L. *et al.* Variables associated with disparities in treatment of patients with schizophrenia and comorbid mood and anxiety disorders. *Psychiatr. Serv.* 52, 1216–1222 (2001).
26. Bellack, A. S. Scientific and consumer models of recovery in schizophrenia: concordance, contrasts, and implications. *Schizophr. Bull.* 32, 432–442 (2006).
27. Lambert, M. *et al.* Rates and predictors of remission and recovery during 3 years in 392 never-treated patients with schizophrenia. *Acta Psychiatr. Scand.* 118, 220–229 (2008).
28. Substance Abuse and Mental Health Services Administration. Recovery and Recovery Support. https://www.samhsa.gov/find-help/recovery.

29. Stewart, R. J. & Geller, J. L. Personal accounts: recovery is resilience in the face of symptoms. *Psychiatr. Serv.* 65, 975–976 (2014).

30. Deegan, P. E. Recovery and empowerment for people with psychiatric disabilities. *Soc. Work Health Care* 25, 11–24 (1997).

31. Kopelovich, S. & Wood, K. Schizophrenia Spectrum and Other Psychotic Disorders: Treatment. *The SAGE Encyclopedia of Abnormal and Clinical Psychology* vol. 6 (2017).

32. Rector, N. A. & Beck, A. T. Cognitive behavioral therapy for schizophrenia: an empirical review. *J. Nerv. Ment. Dis.* 189, 278–287 (2001).

33. Robinson, D. G., Woerner, M. G., McMeniman, M., Mendelowitz, A. & Bilder, R. M. Symptomatic and Functional Recovery From a First Episode of Schizophrenia or Schizoaffective Disorder. *American Journal of Psychiatry* vol. 161 473–479 (2004).

34. Cotes, R. O., Goldsmith, D. R., Kopelovich, S. L., Lally, C. A. & Druss, B. G. Characteristics of Medicaid Recipients Receiving Persistent Antipsychotic Polypharmacy. *Community Ment. Health J.* 54, 699–706 (2018).

35. Kane, J. M., Kishimoto, T. & Correll, C. U. Non-adherence to medication in patients with psychotic disorders: epidemiology, contributing factors and management strategies. *World Psychiatry* 12, 216–226 (2013).

36. Velligan, D. I., Sajatovic, M., Hatch, A., Kramata, P. & Docherty, J. P. Why do psychiatric patients stop antipsychotic medication? A systematic review of reasons for nonadherence to medication in patients with serious mental illness. *Patient Prefer. Adherence* 11, 449–468 (2017).

37. Holmes, M. V. *et al.* Association between alcohol and cardiovascular disease: Mendelian randomisation analysis based on individual participant data. *BMJ* 349, g4164 (2014).

38. Swerdlow, N. R. Are we studying and treating schizophrenia correctly? *Schizophr. Res.* 130, 1–10 (2011).

39. Lazar, S. G. The cost-effectiveness of psychotherapy for the major psychiatric diagnoses. *Psychodyn. Psychiatry* 42, 423–457 (2014).

40. Chien, W. T., Leung, S. F., Yeung, F. K. & Wong, W. K. Current approaches to treatments for schizophrenia spectrum disorders, part II: psychosocial interventions and patient-focused perspectives in psychiatric care. *Neuropsychiatr. Dis. Treat.* 9, 1463–1481 (2013).

41. Beck, A. T. Successful outpatient psychotherapy of a chronic schizophrenic with a delusion based on borrowed guilt. *Psychiatry* 15, 305–312 (1952).

42. Beck, A. T. *Depression: Clinical, experimental, and theoretical aspects*. (Hoeber Medical Division, Harper & Row, 1967).

43. Kingdon, D. G. & Turkington, D. Cognitive therapy of schizophrenia: Guides to evidence-based practice. *New York: Guilford* 234–239 (2005).

44. Beck, A. T. A 60-Year Evolution of Cognitive Theory and Therapy. *Perspect. Psychol. Sci.* 14, 16–20 (2019).

45. Tai, S. & Turkington, D. The evolution of cognitive behavior therapy for schizophrenia: current practice and recent developments. *Schizophr. Bull.* 35, 865–873 (2009).

46. Association, A. P., Jansen, M. A. & Others. Recovery to practice initiative curriculum: Reframing psychology for the emerging health care environment. *Washington, DC: American Psychological Association* (2014).

47. Freeman, D. & Garety, P. Helping patients with paranoid and suspicious thoughts: a cognitive–behavioural approach. *Advances in Psychiatric Treatment* 12, 404–415 (2006).

48. Rector, N. A., Stolar, N., Grant, P. & Beck, A. T. *Schizophrenia: Cognitive Theory,*

Research, and Therapy. (Guilford Press, 2011).

49. Morrison, A. P. & Barratt, S. What are the components of CBT for psychosis? A Delphi study. *Schizophr. Bull.* 36, 136–142 (2010).
50. Thomas, N. What's really wrong with cognitive behavioral therapy for psychosis? *Front. Psychol.* 6, 323 (2015).
51. Valmaggia, L. R., Tabraham, P., Morris, E. & Bouman, T. K. Cognitive Behavioral Therapy Across the Stages of Psychosis: Prodromal, First Episode, and Chronic Schizophrenia. *Cogn. Behav. Pract.* 15, 179–193 (2008).
52. V. Hardy, K. & Loewy, R. Cognitive Behavioral Therapy for Adolescents at Clinical High Risk for Psychosis. *Adolesc. Psychiatry* 2, 172–181 (2012).
53. Wykes, T., Steel, C., Everitt, B. & Tarrier, N. Cognitive behavior therapy for schizophrenia: effect sizes, clinical models, and methodological rigor. *Schizophr. Bull.* 34, 523–537 (2008).
54. Jauhar, S. *et al.* Cognitive–behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *Br. J. Psychiatry* 204, 20–29 (2014).
55. Mehl, S., Werner, D. & Lincoln, T. M. Does Cognitive Behavior Therapy for psychosis (CBTp) show a sustainable effect on delusions? A meta-analysis. *Front. Psychol.* 6, 1450 (2015).
56. van der Gaag, M., Valmaggia, L. R. & Smit, F. The effects of individually tailored formulation-based cognitive behavioural therapy in auditory hallucinations and delusions: a meta-analysis. *Schizophr. Res.* 156, 30–37 (2014).
57. McDonagh, M. *et al.* Treatments for adults with schizophrenia: A systematic review (AHRQ Publication No. XX-EHCXXX-EF). *Agency for Healthcare Research and Quality*

(2017).

58. Andrade, C. Antipsychotic Drugs in Schizophrenia: Relative Effects in Patients With and Without Treatment Resistance. *The Journal of Clinical Psychiatry* vol. 77 e1656–e1660 (2016).

59. Morrison, A. P. *et al.* Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial. *Lancet* 383, 1395–1403 (2014).

60. Garety, P., Bentall, R. P. & Freeman, D. Research evidence of the effectiveness of cognitive behavioural therapy for persecutory delusions. *Persecutory Delusions* 329–350 (2008) doi:10.1093/med:psych/9780199206315.003.0016.

61. Turner, D. T., Burger, S., Smit, F., Valmaggia, L. R., & van der Gaag, M. (2020). What constitutes sufficient evidence for case formulation-driven CBT for psychosis? Cumulative meta-analyses of the effect on hallucinations and delusions. *Schizophrenia Bulletin, 46*(5), 1072-1085.

62. Turner, D. T., van der Gaag, M., Karyotaki, E. & Cuijpers, P. Psychological interventions for psychosis: a meta-analysis of comparative outcome studies. *Am. J. Psychiatry* 171, 523–538 (2014).

63. Grant, P. M., Reisweber, J., Luther, L., Brinen, A. P. & Beck, A. T. Successfully breaking a 20-year cycle of hospitalizations with recovery-oriented cognitive therapy for schizophrenia. *Psychol. Serv.* 11, 125–133 (2014).

64. Grant, P. M., Huh, G. A., Perivoliotis, D., Stolar, N. M. & Beck, A. T. Randomized trial to evaluate the efficacy of cognitive therapy for low-functioning patients with schizophrenia. *Arch. Gen. Psychiatry* 69, 121–127 (2012).

65. Hagen, R., Turkington, D., Berge, T. & Gråwe, R. W. *CBT for psychosis: A symptom-based approach*. (Routledge, 2013).

66. Lincoln, T. M. & Peters, E. A systematic review and discussion of symptom specific cognitive behavioural approaches to delusions and hallucinations. *Schizophrenia Research* vol. 203 66–79 (2019).

67. Granholm, E. *et al.* Randomized controlled trial of cognitive behavioral social skills training for older people with schizophrenia: 12-month follow-up. *J. Clin. Psychiatry* 68, 730–737 (2007).

68. Lecomte, T., Leclerc, C. & Wykes, T. Group CBT for Early Psychosis—Are There Still Benefits One Year Later? *Int. J. Group Psychother.* 62, 309–321 (2012).

69. Lecomte, T., Leclerc, C., Wykes, T., Nicole, L. & Abdel Baki, A. Understanding process in group cognitive behaviour therapy for psychosis. *Psychol. Psychother.* 88, 163–177 (2015).

70. Saksa, J. R., Cohen, S. J., Srihari, V. H. & Woods, S. W. Cognitive behavior therapy for early psychosis: a comprehensive review of individual vs. group treatment studies. *Int. J. Group Psychother.* 59, 357–383 (2009).

71. Daker-White, G. & Rogers, A. What is the potential for social networks and support to enhance future telehealth interventions for people with a diagnosis of schizophrenia: a critical interpretive synthesis. *BMC Psychiatry* 13, 279 (2013).

72. Santesteban-Echarri, O., Piskulic, D., Nyman, R. K. & Addington, J. Telehealth interventions for schizophrenia-spectrum disorders and clinical high-risk for psychosis individuals: A scoping review. *J. Telemed. Telecare* 26, 14–20 (2020).

73. Goldsmith, L. P., Lewis, S. W., Dunn, G. & Bentall, R. P. Psychological treatments for early psychosis can be beneficial or harmful, depending on the therapeutic alliance: an

instrumental variable analysis. *Psychol. Med.* 45, 2365–2373 (2015).

74. Mulligan, J. *et al.* An exploration of the therapeutic alliance within a telephone-based cognitive behaviour therapy for individuals with experience of psychosis. *Psychol. Psychother.* 87, 393–410 (2014).
75. Mohr, D. C., Cuijpers, P. & Lehman, K. Supportive accountability: a model for providing human support to enhance adherence to eHealth interventions. *J. Med. Internet Res.* 13, e30 (2011).
76. Ben-Zeev, D. *et al.* Mobile Health (mHealth) Versus Clinic-Based Group Intervention for People With Serious Mental Illness: A Randomized Controlled Trial. *Psychiatr. Serv.* 69, 978–985 (2018).
77. Schlosser, D. A. *et al.* Efficacy of PRIME, a Mobile App Intervention Designed to Improve Motivation in Young People With Schizophrenia. *Schizophr. Bull.* 44, 1010–1020 (2018).
78. Ben-Zeev, D. & Atkins, D. C. Bringing digital mental health to where it is needed most. *Nat Hum Behav* 1, 849–851 (2017).
79. Melnyk, B. M., Fineout-Overholt, E., Giggleman, M. & Choy, K. A test of the ARCC© model improves implementation of evidence-based practice, healthcare culture, and patient outcomes. *Worldviews Evid. Based. Nurs.* 14, 5–9 (2017).
80. Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J. & Kilbourne, A. M. An introduction to implementation science for the non-specialist. *BMC Psychol* 3, 32 (2015).
81. Health Quality Ontario. Cognitive Behavioural Therapy for Psychosis: A Health Technology Assessment. *Ont. Health Technol. Assess. Ser.* 18, 1–141 (2018).
82. National Institute for Health and Care Excellence. *Costing Statement: Psychosis and Schizophrenia in Adults: Treatment and Management*. (2014).

83. van der Gaag, M., Dennis Stant, A., Wolters, K. J. K., Buskens, E. & Wiersma, D. Cognitive–behavioural therapy for persistent and recurrent psychosis in people with schizophrenia-spectrum disorder: cost-effectiveness analysis. *Br. J. Psychiatry* 198, 59–65 (2011).

84. Gumley, A. *et al.* Early intervention for relapse in schizophrenia: results of a 12-month randomized controlled trial of cognitive behavioural therapy. *Psychol. Med.* 33, 419–431 (2003).

85. Lysaker, P. H., Bond, G., Davis, L. W., Bryson, G. J. & Bell, M. D. Enhanced cognitive-behavioral therapy for vocational rehabilitation in schizophrenia: Effects on hope and work. *J. Rehabil. Res. Dev.* 42, 673–682 (2005).

86. Washington State Institute for Public Policy. *Cognitive behavioral therapy (CBT) for schizophrenia/psychosis Adult Mental Health: Serious Mental Illness*. (2019).

87. Brabban, A., Byrne, R., Longden, E. & Morrison, A. P. The importance of human relationships, ethics and recovery-orientated values in the delivery of CBT for people with psychosis. *Psychosis* 9, 157–166 (2017).

88. Sheedy, C. K. & Whitter, M. Guiding principles and elements of recovery-oriented systems of care: What do we know from the research? HHS Publication No.(SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment. *Substance Abuse and Mental Health Services Administration* (2009).

89. Zippay, A. Staff Approaches to Facilitating Neighborhood Connections Among Individuals with Serious Mental Illness Living in Shared Community-Based Housing. *Journal of Psychosocial Rehabilitation and Mental Health* 5, 127–137 (2018).

90. Rathod, S., Kingdon, D., Phiri, P. & Gobbi, M. Developing culturally sensitive cognitive

behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behav. Cogn. Psychother.* 38, 511–533 (2010).

91. Habib, N., Dawood, S., Kingdon, D. & Naeem, F. Preliminary Evaluation of Culturally Adapted CBT for Psychosis (CA-CBTp): Findings from Developing Culturally-Sensitive CBT Project (DCCP). *Behavioural and Cognitive Psychotherapy* vol. 43 200–208 (2015).
92. Naeem, F. *et al.* Brief culturally adapted CBT for psychosis (CaCBTp): A randomized controlled trial from a low income country. *Schizophr. Res.* 164, 143–148 (2015).
93. Fortney, J. C. *et al.* A Tipping Point for Measurement-Based Care. *Focus* 16, 341–350 (2018).
94. Kingdon, D., Rathod, S., Weiden, P. & Turkington, D. Cognitive Therapy for Schizophrenia. *Journal of Psychiatric Practice* vol. 14 55–57 (2008).
95. Miles, H., Peters, E. & Kuipers, E. Service-User Satisfaction with CBT for Psychosis. *Behav. Cogn. Psychother.* 35, 109–116 (2007).
96. Lawlor, C. *et al.* Service user satisfaction with cognitive behavioural therapy for psychosis: Associations with therapy outcomes and perceptions of the therapist. *Br. J. Clin. Psychol.* 56, 84–102 (2017).
97. Wood, L., Burke, E. & Morrison, A. Individual cognitive behavioural therapy for psychosis (CBTp): a systematic review of qualitative literature. *Behav. Cogn. Psychother.* 43, 285–297 (2015).
98. Mankiewicz, P. D., O'Leary, J. & Collier, O. That hour served me better than any hour I have ever had before": Service users' experiences of CBTp in first episode psychosis. *Counselling Psychology Review* 33, 5 (2018).

99. Berry, C. & Hayward, M. What can qualitative research tell us about service user perspectives of CBT for psychosis? A synthesis of current evidence. *Behav. Cogn. Psychother.* 39, 487–494 (2011).

100. Pitschel-Walz, G., Leucht, S., Bäuml, J., Kissling, W. & Engel, R. R. The Effect of Family Interventions on Relapse and Rehospitalization in Schizophrenia—A Meta-analysis. *Schizophr. Bull.* 27, 73–92 (2001).

101. Sivec, H. J., Kreider, V. A. L., Buzzelli, C., Hrouda, D. R. & Hricovec, M. M. Do Attitudes Matter? Evaluating the Influence of Training in CBT-p-Informed Strategies on Attitudes About Working with People Who Experience Psychosis. *Community Ment. Health J.* (2020) doi:10.1007/s10597-020-00611-w.

102. Chang, N. A., Grant, P. M., Luther, L. & Beck, A. T. Effects of a recovery-oriented cognitive therapy training program on inpatient staff attitudes and incidents of seclusion and restraint. *Community Ment. Health J.* 50, 415–421 (2014).

103. Berry, K., Barrowclough, C. & Wearden, A. A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behav. Cogn. Psychother.* 37, 39–48 (2009).

104. McLeod, H. J., Deane, F. P. & Hogbin, B. Changing staff attitudes and empathy for working with people with psychosis. *Behav. Cogn. Psychother.* 30, 459–470 (2002).

105. Jolley, S. *et al.* A pilot evaluation of therapist training in cognitive therapy for psychosis: therapy quality and clinical outcomes. *Behav. Cogn. Psychother.* 43, 478–489 (2015).

106. Creed, T. A. *et al.* Implementation of transdiagnostic cognitive therapy in community behavioral health: The Beck Community Initiative. *J. Consult. Clin. Psychol.* 84, 1116–1126 (2016).

107. Kopelovich, S. L. *et al.* Statewide Implementation of Cognitive Behavioral Therapy for Psychosis Through a Learning Collaborative Model. *Cogn. Behav. Pract.* 26, 439–452 (2019).

108. National Institute for Clinical Excellence. *Schizophrenia. Core interventions in the treatment and management of schizophrenia in primary and secondary care*. (2002).

109. Ince, P., Haddock, G. & Tai, S. A systematic review of the implementation of recommended psychological interventions for schizophrenia: Rates, barriers, and improvement strategies. *Psychology and Psychotherapy: Theory, Research and Practice* vol. 89 324–350 (2016).

110. Haddock, G. *et al.* An investigation of the implementation of NICE-recommended CBT interventions for people with schizophrenia. *J. Ment. Health* 23, 162–165 (2014).

111. Colling, C. *et al.* Identification of the delivery of cognitive behavioural therapy for psychosis (CBTp) using a cross-sectional sample from electronic health records and open-text information in a large UK-based mental health case register. *BMJ Open* vol. 7 e015297 (2017).

112. Layard, R. *How Mental Illness Loses Out in the NHS A report by The Centre for Economic Performance's Mental Health Policy Group*. https://ideas.repec.org/p/cep/cepsps/26.html (2012).

113. Damschroder, L. J. *et al.* Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement. Sci.* 4, 50 (2009).

114. Lehman, A. F. *et al.* Practice guideline for the treatment of patients with schizophrenia, second edition. *Am. J. Psychiatry* 161, 1–56 (2004).

115. Dixon, L. B. *et al.* Schizophrenia Patient Outcomes Research Team (PORT). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophr. Bull.* 36, 48–70 (2010).

116. Mueser, K. *et al.* A call to action 10 years on: Training US therapists in CBT for psychosis. *Panel presentation at the 49th Association for Behavioral and Cognitive Therapies: Chicago, IL http://www.abct.org/conv2015/docs/General_Sessions_2015. pdf* (2015).

117. Kopelovich, S. L., Strachan, E., Sivec, H. & Kreider, V. Stepped Care as an Implementation and Service Delivery Model for Cognitive Behavioral Therapy for Psychosis. *Community Ment. Health J.* 55, 755–767 (2019).

118. Kotter, J. P. *Leading Change*. (Harvard Business Press, 2012).

119. Hiatt, J. *ADKAR: A Model for Change in Business, Government, and Our Community*. (Prosci, 2006).

120. Barrett, J. H., Haslam, R. A., Lee, K. G. & Ellis, M. J. Assessing attitudes and beliefs using the stage of change paradigm—case study of health and safety appraisal within a manufacturing company. *Int. J. Ind. Ergon.* 35, 871–887 (2005).

121. Amatayakul, M. EHR? Assess readiness first: there's no denying interest in electronic health records is increasing. *Healthc. Financ. Manage.* 59, 112–114 (2005).

122. O'Connor, E. J. & Fiol, C. M. Creating readiness and involvement. *Physician Exec.* 32, 72–74 (2006).

123. Kirch, D. G. *et al.* Reinventing the academic health center. *Acad. Med.* 80, 980–989 (2005).

124. Kuhar, P. A. *et al.* The Cleveland Clinic's Magnet Experience. *Orthopaedic Nursing | The International Leader in Education, Practice & Research* 23, 385 (2004).

125. Jolley, S. *et al.* Increasing access to psychological therapies for people with psychosis:

predictors of successful training. *Behav. Res. Ther.* 50, 457–462 (2012).

126. Mueser, K. T., Bond, G. R., Drake, R. E. & Resnick, S. G. Models of community care for severe mental illness: a review of research on case management. *Schizophr. Bull.* 24, 37–74 (1998).

127. Garety, P. A. *et al.* Training the Frontline Workforce to Deliver Evidence-Based Therapy to People With Psychosis: Challenges in the GOALS Study. *Psychiatr. Serv.* 69, 9–11 (2018).

128. Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the quality chasm: A new health system for the 21st century*. (National Academies Press, 2001).

129. Firth, J. *et al.* Mobile Phone Ownership and Endorsement of 'mHealth' Among People With Psychosis: A Meta-analysis of Cross-sectional Studies. *Schizophr. Bull.* 42, 448–455 (2016).

130. Kingdon, D. G. & Kirschen, H. Special Section: A Memorial Tribute: Who Does Not Get Cognitive-Behavioral Therapy for Schizophrenia When Therapy Is Readily Available? *Psychiatric Services* vol. 57 1792–1794 (2006).

131. Prytys, M., Garety, P. A., Jolley, S., Onwumere, J. & Craig, T. Implementing the NICE guideline for schizophrenia recommendations for psychological therapies: a qualitative analysis of the attitudes of CMHT staff. *Clin. Psychol. Psychother.* 18, 48–59 (2011).

132. Proctor, E. *et al.* Intermediary/purveyor organizations for evidence-based interventions in the US child mental health: characteristics and implementation strategies. *Implement. Sci.* 14, 3 (2019).

133. Riggs, S. E. & Creed, T. A. A Model to Transform Psychosis Milieu Treatment Using CBT-Informed Interventions. *Cogn. Behav. Pract.* 24, 353–362 (2017).

134. Lopez, M. A. & Basco, M. A. Effectiveness of cognitive behavioral therapy in public

mental health: comparison to treatment as usual for treatment-resistant depression. *Adm. Policy Ment. Health* 42, 87–98 (2015).

135. Turkington, D. *et al.* High-yield cognitive behavioral techniques for psychosis delivered by case managers to their clients with persistent psychotic symptoms: an exploratory trial. *J. Nerv. Ment. Dis.* 202, 30–34 (2014).
136. Poole, J. & Grant, A. Stepping out of the box: broadening the dialogue around the organizational implementation of cognitive behavioural psychotherapy. *J. Psychiatr. Ment. Health Nurs.* 12, 456–463 (2005).
137. Jolley, S. *et al.* Opportunities and challenges in Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI): evaluating the first operational year of the South London and Maudsley (SLaM) demonstration site for psychosis. *Behav. Res. Ther.* 64, 24–30 (2015).
138. Dark, F. *et al.* Implementing cognitive therapies into routine psychosis care: organisational foundations. *BMC Health Serv. Res.* 15, 310 (2015).
139. Glickman, A., Weiner, J. & Beidas, R. *Transforming mental health care through implementation of evidence-based practices*. (2020).
140. Drake, R. E., Bond, G. R. & Essock, S. M. Implementing evidence-based practices for people with schizophrenia. *Schizophr. Bull.* 35, 704–713 (2009).
141. Johns, L. *et al.* Improving Access to psychological therapies for people with severe mental illness (IAPT-SMI): Lessons from the South London and Maudsley psychosis demonstration site. *Behaviour Research and Therapy* vol. 116 104–110 (2019).
142. Peters, D. H., Tran, N. T., Adam, T. & World Health Organization. *Implementation Research in Health: A Practical Guide*. (World Health Organization, 2013).