Recovery-Oriented Cognitive Therapy (CT-R): Operationalizing Hope and Purpose in Mental Health Care

Beck Institute Center for Recovery-Oriented Cognitive Therapy

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National Association of State Mental Health Program Directors
Annual Meeting
Washington DC

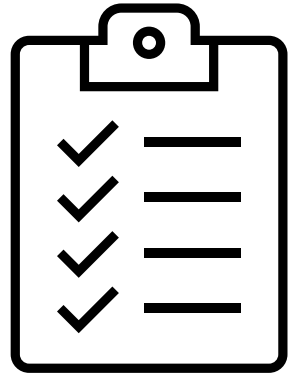
July 26, 2025

About Beck Institute

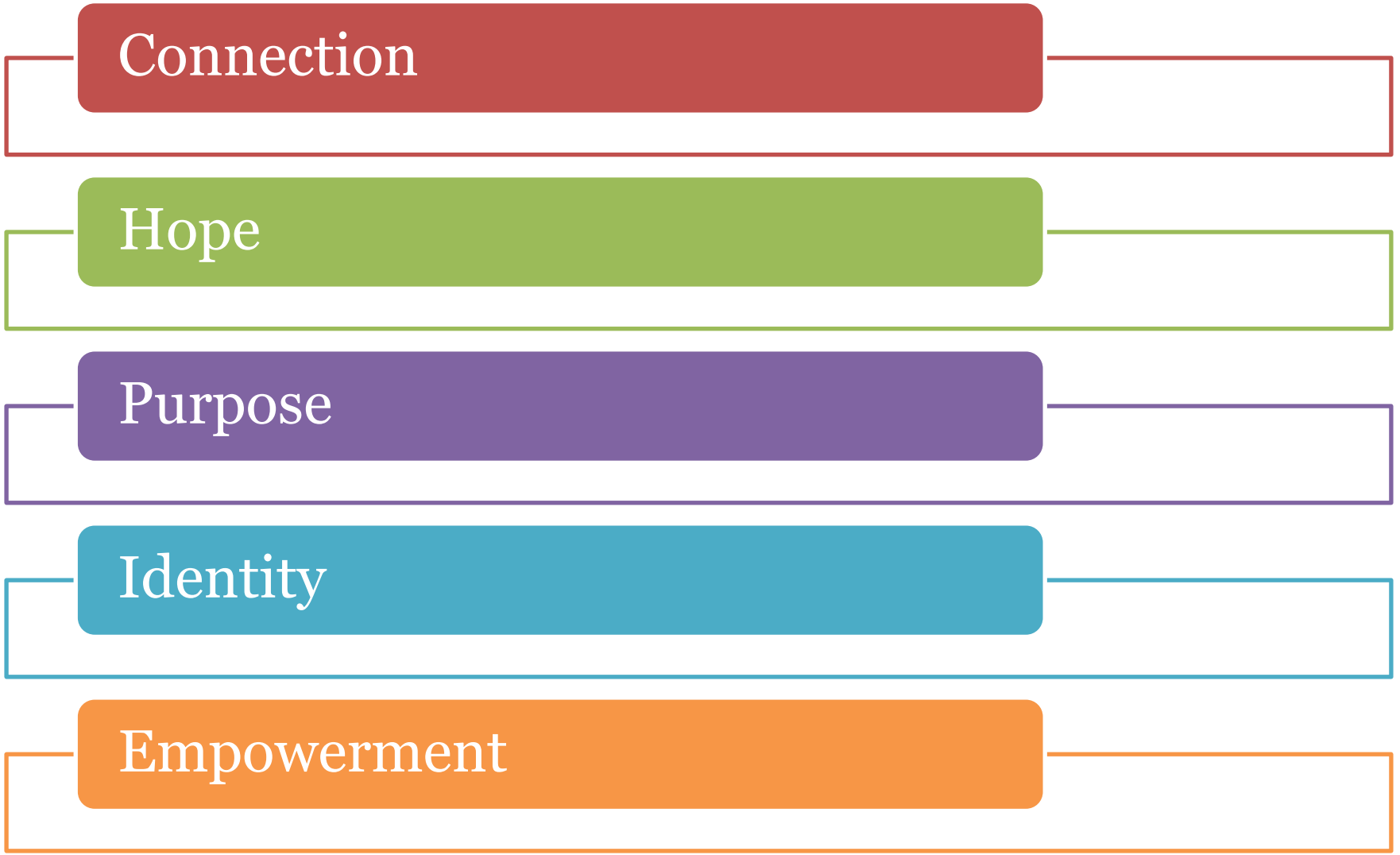
Beck Institute is a 501(c)3 nonprofit organization with the mission of *improving lives worldwide through excellence in CT-R and CBT.* We offer training and dissemination of Recovery-Oriented Cognitive Therapy and Cognitive Behavior Therapy to health and mental health professionals and paraprofesssionals around the world.

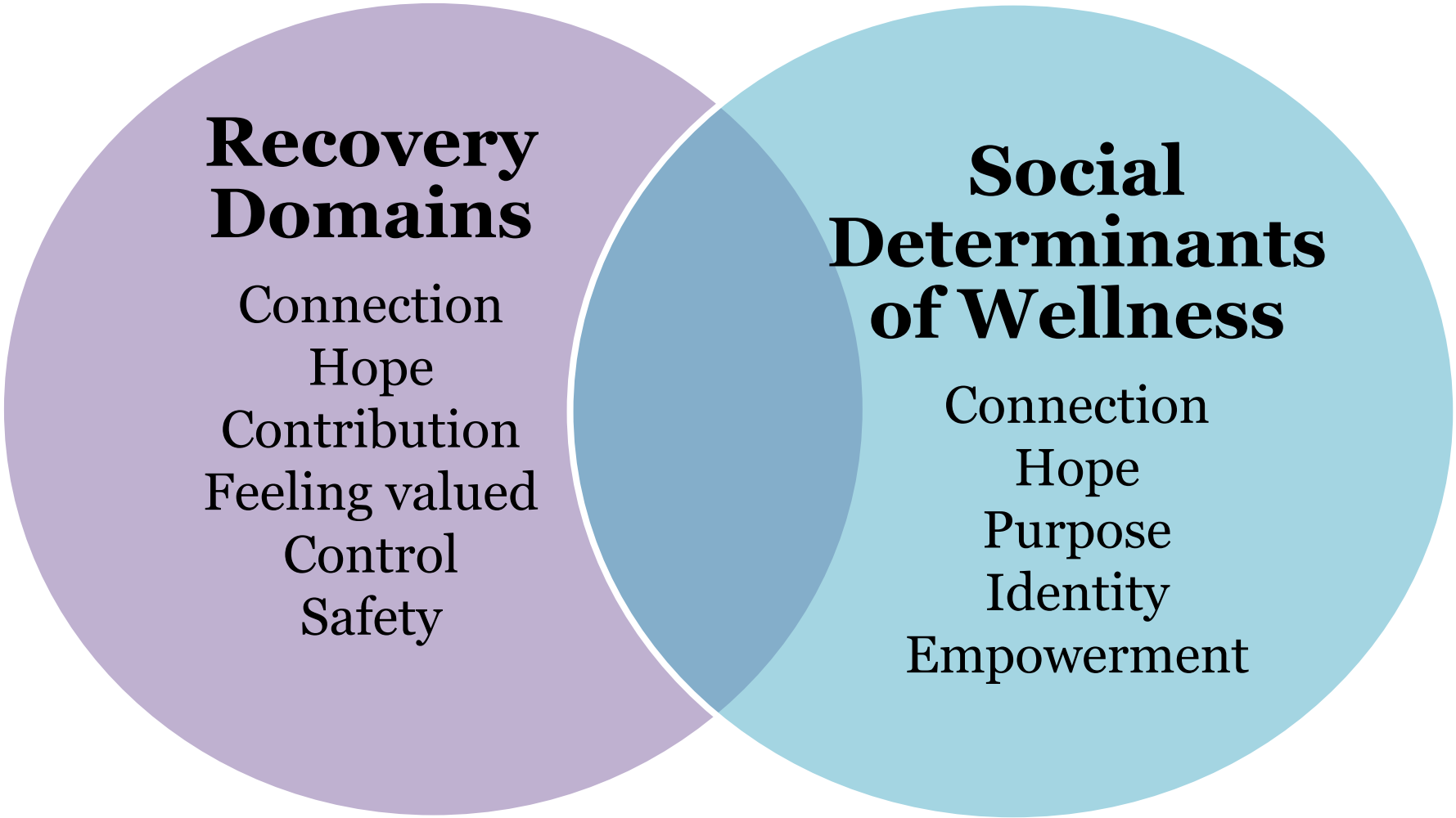
Agenda

- Meeting the challenge: Social determinants of health & recovery
- Setting the scene with CT-R
- Application & implementation
- Where we've been & lessons learned



Social Determinants of Wellness




Recovery Domains
Connection
Hope
Contribution
Feeling valued
Control
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Hope
Purpose
Identity
Empowerment

A Challenge: Dropout and Non-Engagement

Schizophrenia Bulletin vol. 35 no. 4 pp. 696–703, 2009
doi:10.1093/schbul/sbp046
Advance Access publication on June 2, 2009

Disengagement From Mental Health Treatment Among Individuals With Schizophrenia and Strategies for Facilitating Connections to Care: A Review of the Literature

Julie Kreyenbuhl[1–3], Ilana R. Nossel[4], and Lisa B. Dixon[2,3]

[2]Division of Services Research, Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD; [3]Department of Veterans Affairs Capitol Healthcare Network (VISN 5) Mental Illness Research, Education and Clinical Center, Baltimore, MD; [4]Department of Psychiatry, Columbia University College of Physicians and Surgeons, New York, NY

dence that efforts to enhance client-centered communication and promote individuals' active involvement in mental health treatment decisions can also improve engagement in treatment.

Key words: treatment dropout/serious mental illness/

Treatment engagement of individuals experiencing mental illness: review and update

Lisa B. Dixon, Yael Holoshitz, Ilana Nossel

Columbia University Medical Center; Division of Mental Health Services and Policy Research & Center for Practice Innovations, New York State Psychiatric Institute, New York, NY, USA

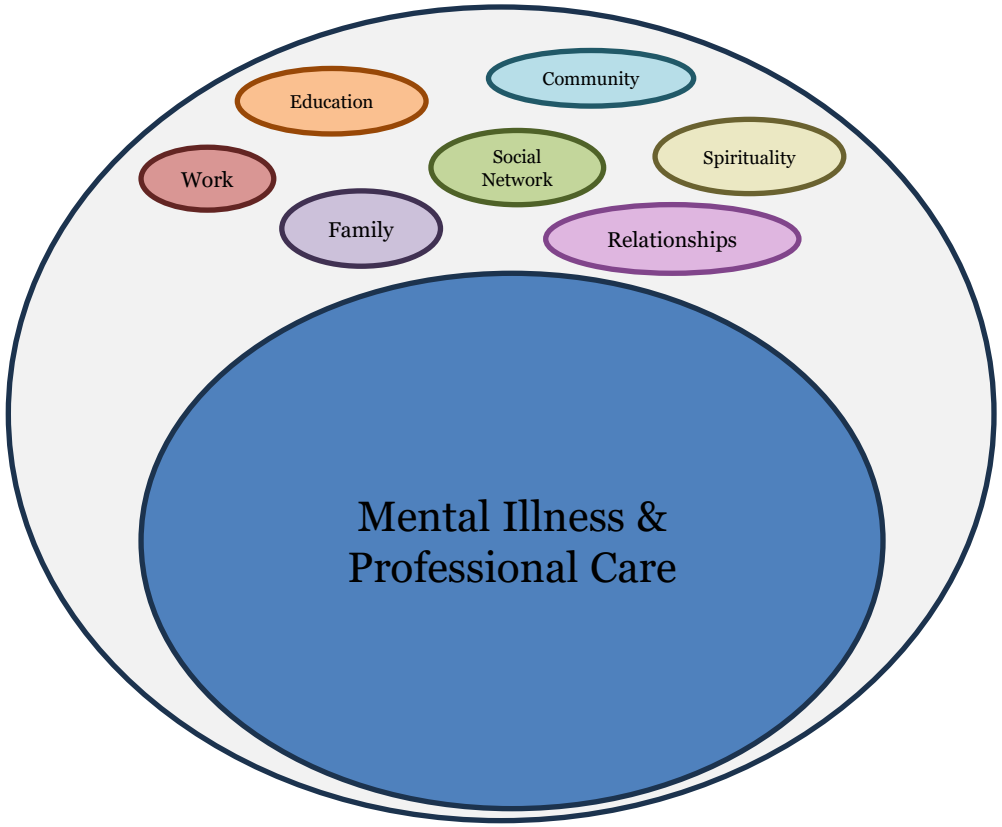
Treatment engagement

- Up to 1/3 of individuals with serious mental health challenge disengage from treatment
- A median rate of 58% do not follow up with first outpatient appointment following discharge from inpatient

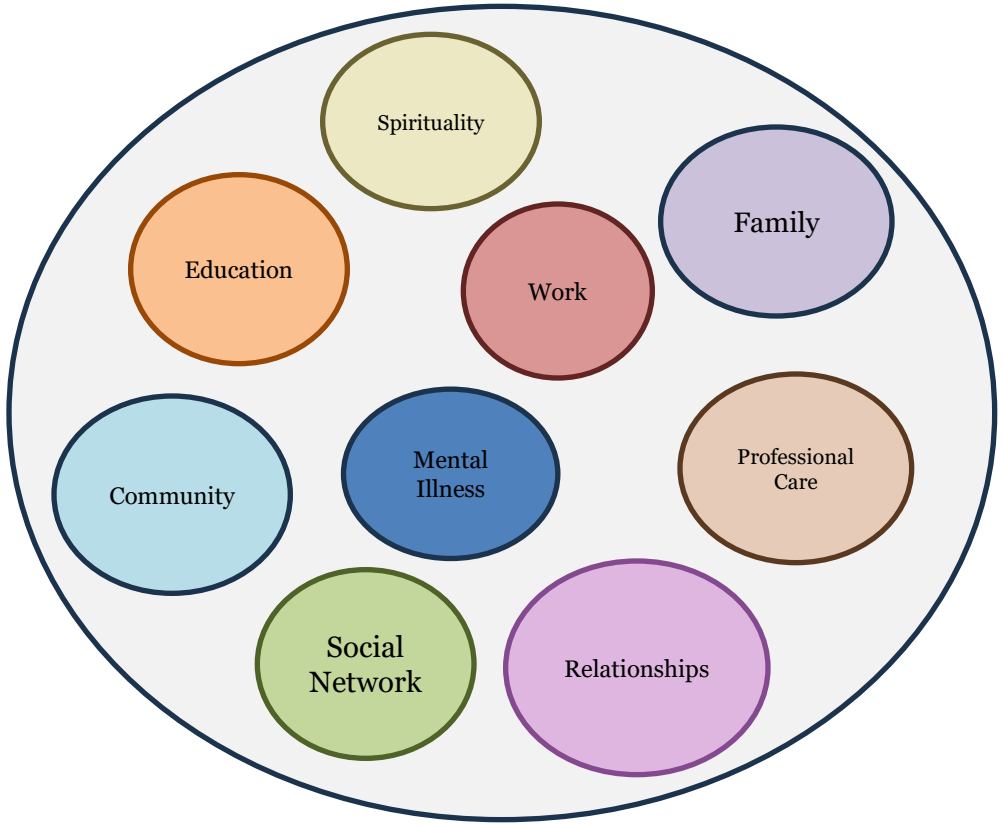
Recommendations towards patient centered care

- Recovery-orientation
- Collaborative
- Person-centered care
- Using strategies to meet the individual's needs
- Peer support
- Cultural context

What Work Can Look Like…

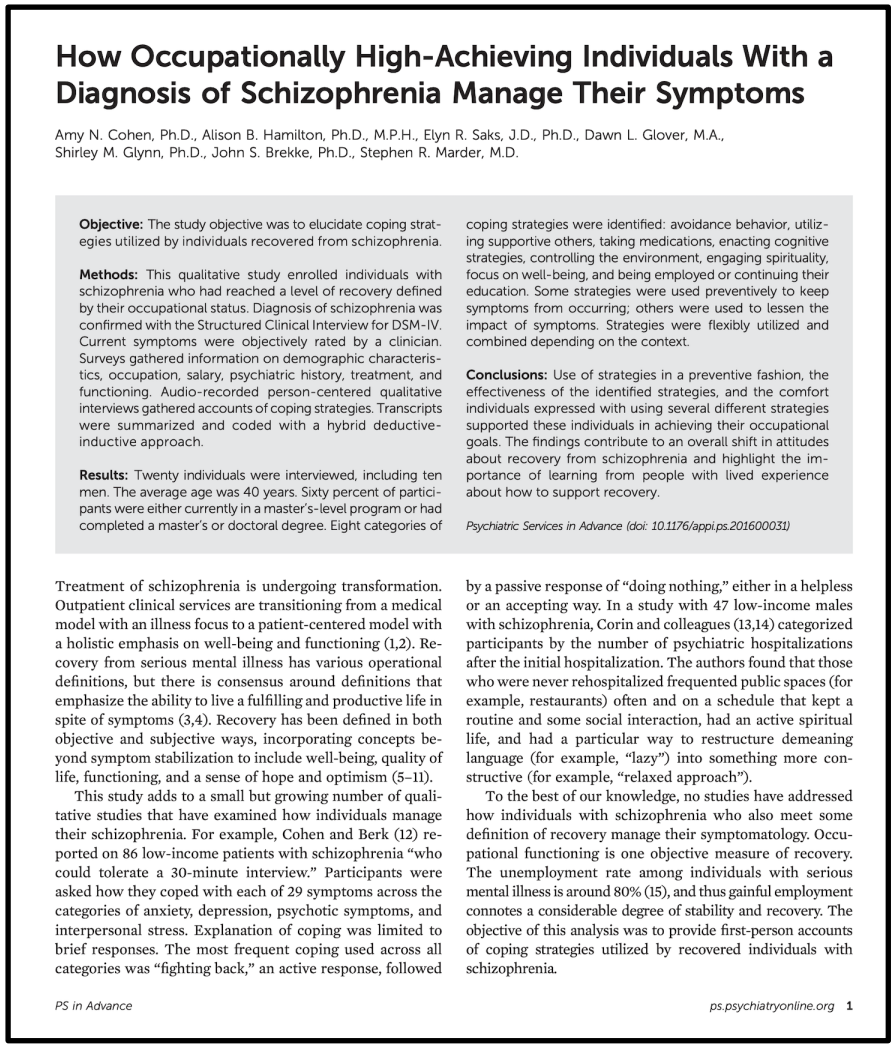


Person with lived experience:
Perception of Care



Person with lived experience:
Preferred Focus

Elyn Saks



How Occupationally High-Achieving Individuals With a Diagnosis of Schizophrenia Manage Their Symptoms

Amy N. Cohen, Ph.D., Alison B. Hamilton, Ph.D., M.P.H., Elyn R. Saks, J.D., Ph.D., Dawn L. Glover, M.A., Shirley M. Glynn, Ph.D., John S. Brekke, Ph.D., Stephen R. Marder, M.D.

Objective: The study objective was to elucidate coping strategies utilized by individuals recovered from schizophrenia.

Methods: This qualitative study enrolled individuals with schizophrenia who had reached a level of recovery defined by their occupational status. Diagnosis of schizophrenia was confirmed with the Structured Clinical Interview for DSM-IV. Current symptoms were objectively rated by a clinician. Surveys gathered information on demographic characteristics, occupation, salary, psychiatric history, treatment, and functioning. Audio-recorded person-centered qualitative interviews gathered accounts of coping strategies. Transcripts were summarized and coded with a hybrid deductive-inductive approach.

Results: Twenty individuals were interviewed, including ten men. The average age was 40 years. Sixty percent of participants were either currently in a master's-level program or had completed a master's or doctoral degree. Eight categories of coping strategies were identified: avoidance behavior, utilizing supportive others, taking medications, enacting cognitive strategies, controlling the environment, engaging spirituality, focus on well-being, and being employed or continuing their education. Some strategies were used preventively to keep symptoms from occurring; others were used to lessen the impact of symptoms. Strategies were flexibly utilized and combined depending on the context.

Conclusions: Use of strategies in a preventive fashion, the effectiveness of the identified strategies, and the comfort individuals expressed with using several different strategies supported these individuals in achieving their occupational goals. The findings contribute to an overall shift in attitudes about recovery from schizophrenia and highlight the importance of learning from people with lived experience about how to support recovery.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.201600031)

Treatment of schizophrenia is undergoing transformation. Outpatient clinical services are transitioning from a medical model with an illness focus to a patient-centered model with a holistic emphasis on well-being and functioning (1,2). Recovery from serious mental illness has various operational definitions, but there is consensus around definitions that emphasize the ability to live a fulfilling and productive life in spite of symptoms (3,4). Recovery has been defined in both objective and subjective ways, incorporating concepts beyond symptom stabilization to include well-being, quality of life, functioning, and a sense of hope and optimism (5–11).

This study adds to a small but growing number of qualitative studies that have examined how individuals manage their schizophrenia. For example, Cohen and Berk (12) reported on 86 low-income patients with schizophrenia "who could tolerate a 30-minute interview." Participants were asked how they coped with each of 29 symptoms across the categories of anxiety, depression, psychotic symptoms, and interpersonal stress. Explanation of coping was limited to brief responses. The most frequent coping used across all categories was "fighting back," an active response, followed by a passive response of "doing nothing," either in a helpless or an accepting way. In a study with 47 low-income males with schizophrenia, Corin and colleagues (13,14) categorized participants by the number of psychiatric hospitalizations after the initial hospitalization. The authors found that those who were never rehospitalized frequented public spaces (for example, restaurants) often and on a schedule that kept a routine and some social interaction, had an active spiritual life, and had a particular way to restructure demeaning language (for example, "lazy") into something more constructive (for example, "relaxed approach").

To the best of our knowledge, no studies have addressed how individuals with schizophrenia who also meet some definition of recovery manage their symptomatology. Occupational functioning is one objective measure of recovery. The unemployment rate among individuals with serious mental illness is around 80% (15), and thus gainful employment connotes a considerable degree of stability and recovery. The objective of this analysis was to provide first-person accounts of coping strategies utilized by recovered individuals with schizophrenia.

Meaningful activity

Valuable connection

Empowerment for stress

Mental & Physical Health

JAMA Psychiatry | Original Investigation

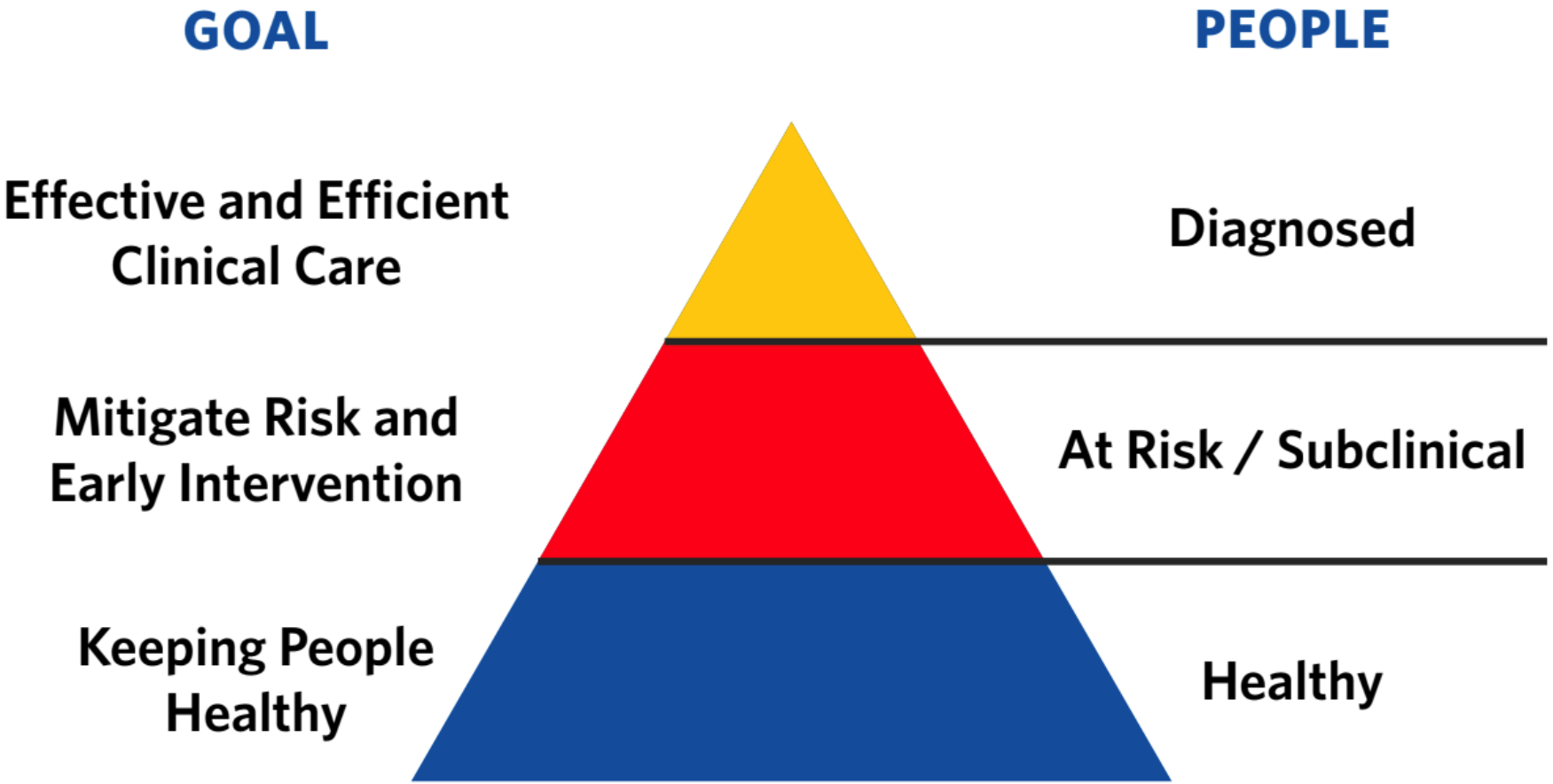
Association of Recent Stressful Life Events With Mental and Physical Health in the Context of Genomic and Exposomic Liability for Schizophrenia

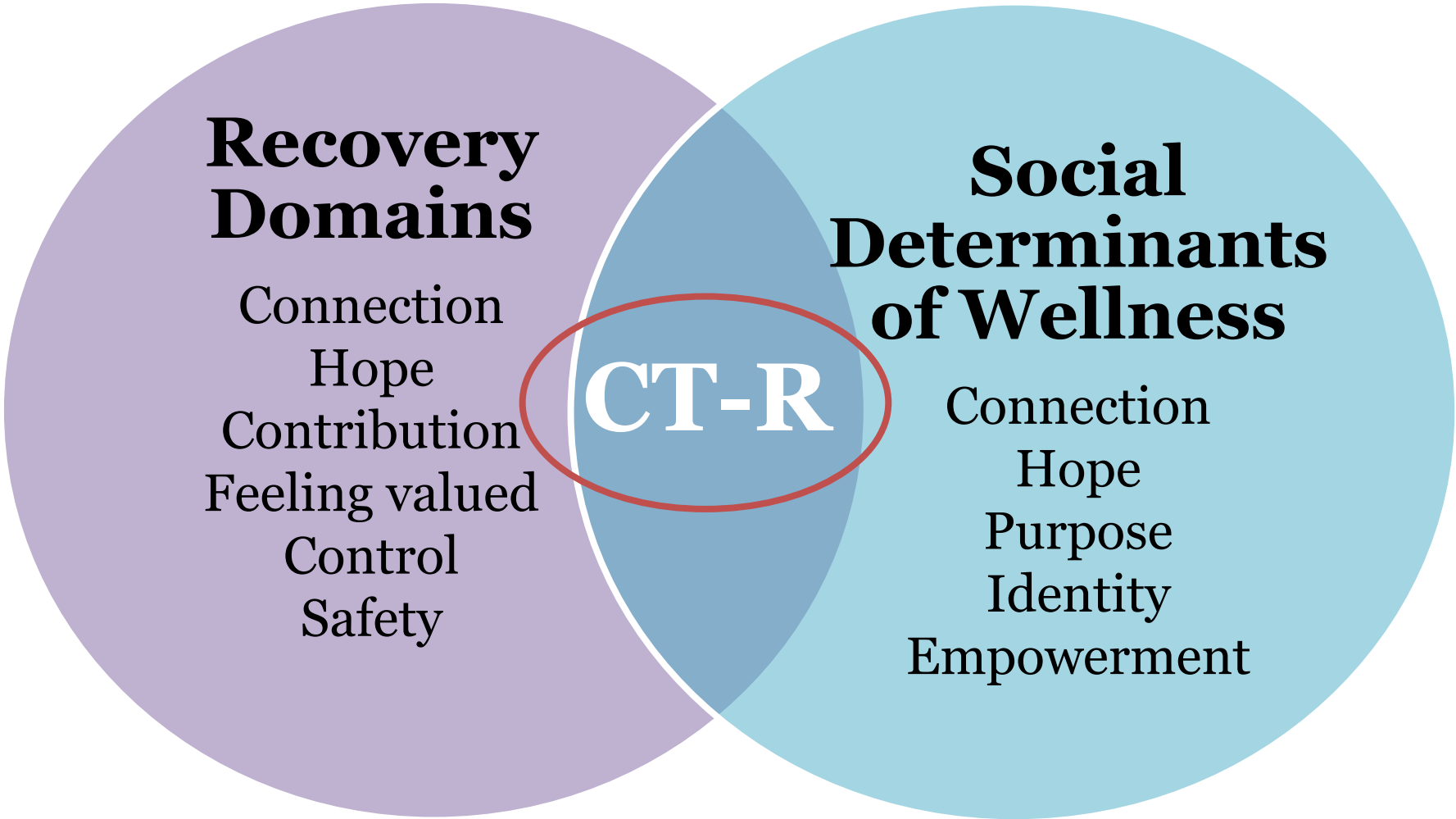
Lotta-Katrin Pries, MSc; Jim van Os, MD, PhD; Margreet ten Have, PhD; Ronde Graaf, PhD; Saskia van Dorsselaer, MSc; Maarten Bak, MD, PhD; Bochao D. Lin, PhD; Kristel R. van Eijk, PhD; Gunter Kenis, PhD; Alexander Richards, PhD; Michael C. O'Donovan, MD, PhD; Jurjen J. Luykx, MD, PhD; Bart P.F. Rutten, MD, PhD; Sinan Guloksuz, MD, PhD

Stressful life events (SLE's) were linked to poorer mental and physical health outcomes

Mitigating environmental risk throughout the lifespan can have a significant impact on improving mental and physical health outcomes

Pries, Van Os, et al. Association of Recent Stressful Life Events With Mental and Physical Health in the Context of Genomic and Exposomic Liability for Schizophrenia. JAMA Psychiatry. 2020;77(12):1296-1304. doi:10.1001/jamapsychiatry.2020.2304


GOAL
PEOPLE
Effective and Efficient Clinical Care
Diagnosed
Mitigate Risk and Early Intervention
At Risk / Subclinical
Keeping People Healthy
Healthy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CT-R and Addressing Risk

Known to have a strong association with recidivism

"Big Eight" Risk Factors
Criminal History
Antisocial Personality Pattern
Antisocial Cognitions
Criminal Companions
Substance Abuse
Poor family/marital relationships
Poor educational/vocational achievement
Lack of prosocial leisure activities

Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation*, *6*, 1-22.

CT-R: A Unique Approach

Person-Centered & Whole Person

- ✓ How people and families get stuck
- ✓ How they thrive

Flexible (all scopes of practice, across settings)

Active & Practical

- ✓ Cultivate connection, belonging, hope, purpose, and empowerment
- ✓ Collaborate to actively sustain these objectives

How Do We Empower with CT-R?

- Learn about and access each person's "best self" (adaptive mode)
- Engage people in meaningful daily connections and activities within their community/setting
- Explore broader "aspirations" or desires for the future
- Collaborate to plan or take steps towards a desired future
- Navigate any challenges that may arise within each person's life
- Collaborate to notice progress, success, positive moments, and to build resilience

How Does CT-R Work?

CBT

Identify situation-specific negative thoughts (e.g., I failed)

→

Evaluate accuracy of thinking (e.g., "What is an alternative explanation?")

→

Correct thinking to decrease challenging behaviors or responses

CT-R

Adaptive mode activates positive beliefs (e.g., I am capable, I am a good person)

→

Strengthen positive beliefs (e.g., "what does it say about you that you accomplished that?")

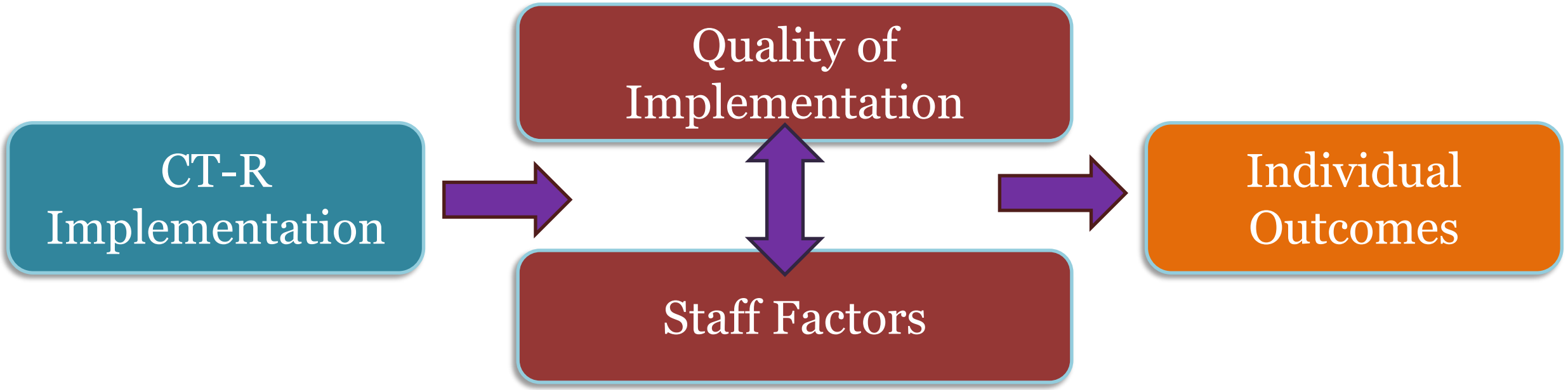
→

Adaptive mode becomes predominant (positive beliefs more accessible; negative beliefs neutralized)

CT-R Application Across Roles & Settings

- Therapeutic impact
  - Individual, group, or family therapy, telehealth
- Programmatic interactions & activities
  - Formal or informal milieu-based interactions
- Treatment and community-based team approach
  - Provides a multidisciplinary framework for a unified approach to care
- Case management & treatment planning
  - A way to understand challenging behaviors & how to empower in a strengths-based way

Model of CT-R Implementation



CT-R Impact

Individuals Empowerment	Go from feeling defeated to thriving, from being disengaged to participating in the community, taking action towards a life of their choosing, developing resiliency in the face of challenges
Staff Self-Efficacy	Build upon their understanding, experience, skill, and knowledge. Enhance collaboration, teamwork, innovation and problem solving.
Organizations Culture Change	Community-based, residential, inpatient and justice-based programs create and sustain environments in which everyone has a hand promoting recovery and resilience
Systems Enhanced Care	Systems operationalize recovery, resiliency, and promote continuity of care as a person increases their involvement in the community

Where to Find CT-R & Who Uses It

Systems:

- Pennsylvania (Philadelphia, Pittsburgh)
- New York
- New Jersey
- Vermont
- Georgia
- Kentucky
- Missouri
- Montana
- Massachusetts
- Nevada
- California
- Florida
- Guam
- Puerto Rico

Settings:

- Forensic inpatient units*
- State hospitals*
- Jails and prisons*
- Problem-solving courts*
- ACT (fidelity, non-fidelity), FACT Specialty care teams*
- Community-based competency restoration teams*
- Acute inpatient units
- Residential services*
- Temporary housing & shelters
- Outpatient clinics
- Sex offender treatment programs*

* Indicates forensic programming

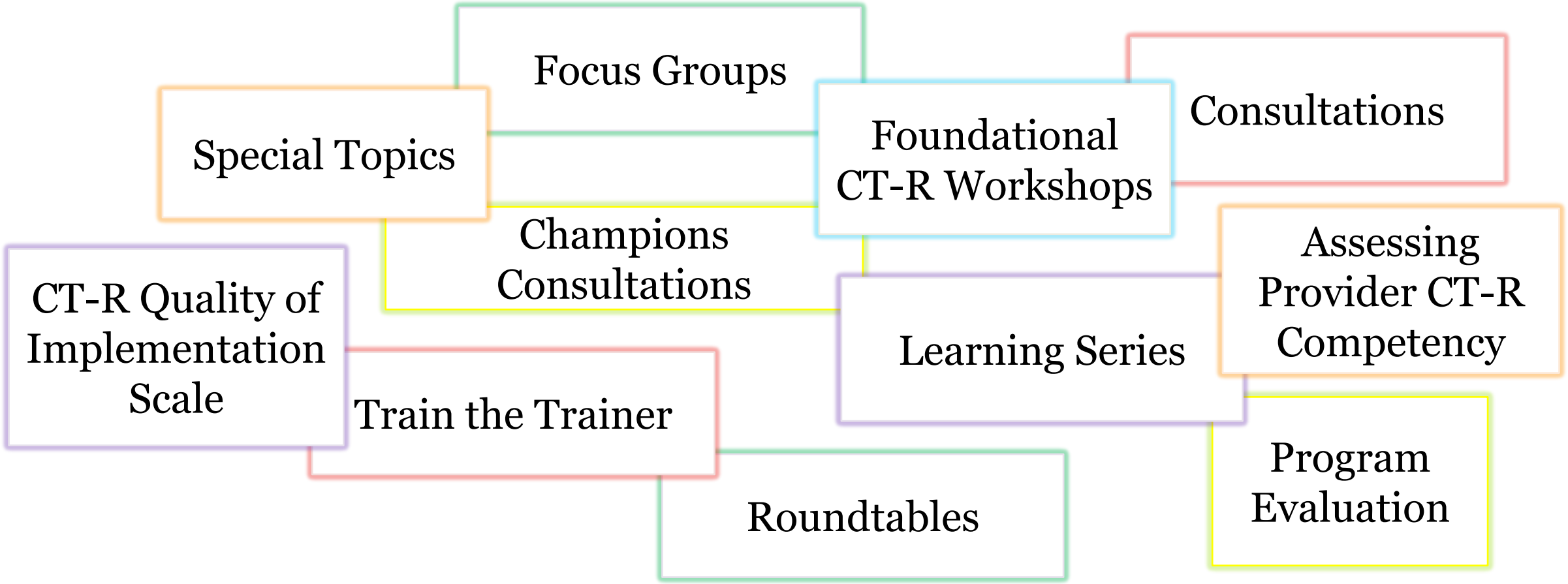
Disciplines:

- Psychologists
- Psychiatrists
- Therapists
- Drug and alcohol counselors
- Social workers
- Case managers
- Nurses
- Direct care staff
- Peer specialists
- Occupational therapists
- Corrections Officers
- Court officials
- Parole, probation, pretrial officers
- Outreach workers

What Implementation Collaboration Can Look Like

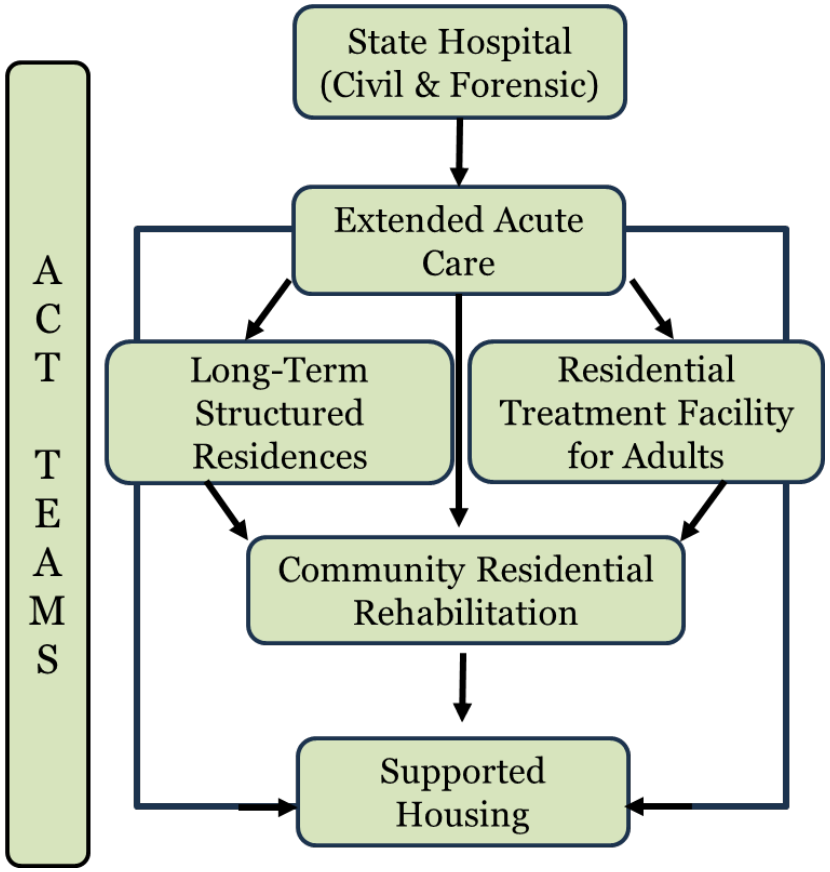
- Workshop/ Training
- Consultation/ Technical Assistance
- Resource Development
- Sustainability Planning & Outcome Collection

Training Components



Pennsylvania: How it Started

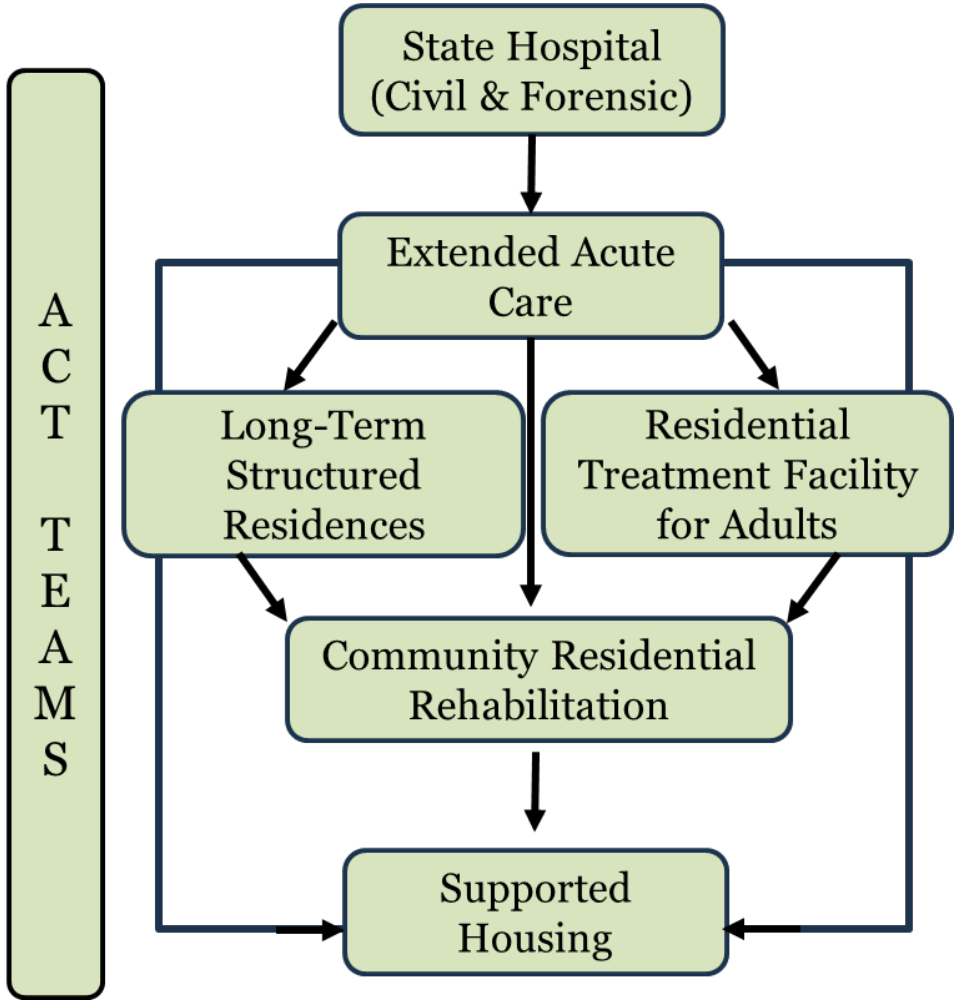
ACLU
AMERICAN CIVIL LIBERTIES UNION



CT-R in Pennsylvania

Training Settings

- 3 State Hospitals
- 2 Extended Acute Units
- 12 Long-Term Structured Residences (LTSRs)
- 3 Residential Treatment Facilities (RTFAs)
- 2 Assertive Community Teams (ACT)
- Community Residential Rehabilitation (CRR)



Lessons Learned in Pennsylvania

Benefits of training across systems to support continuity of care

Development of training resources to orient new staff (addressing turnover) promote sustainability

Creating CT-R network of programs

Positive outcomes for individuals receiving CT-R services with these programs

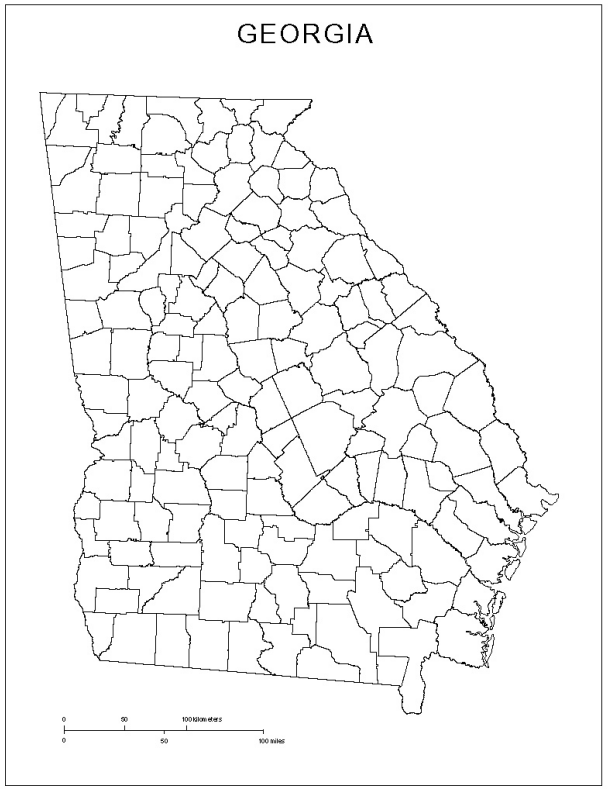
Georgia: How it Started

Catalyst: Department of Justice (DOJ) lawsuit

- *Beginning focus*: state hospital and community providers
- *Later focus*: community providers
- Emphasis on training individual providers to competency in CT-R using the CTRS

TTI grants

- Elite Trainer curriculum, CT-R Peer Competency Scale
- Peer Specialist Training



CT-R in Georgia

Overview

Phase 1: State hospitals and community-based providers (e.g., ACT teams)

Phase 2: Youth and young adults

Training Numbers

- ~800 staff received CT-R training
- 82% (of 200) clinicians achieved CT-R competency

Sustainability

CT-R Center for Excellence at Georgia State University (GSU)

- 3 *elite trainers* provide CT-R workshops, consultation and certification/recertification
- Equivalence: elite trainers = CT-R team (competency rates)

Lessons Learned in Georgia

It is possible to train individual providers to achieve competency in CT-R

Specially trained staff can sustain the practice of CT-R within a system and can achieve similar results (e.g., scores on the CTRS)

Feasibility of CT-R to enhance the effectiveness of peer specialists

Recovery is measurable and possible: 69% of individuals showed improvement on at least one recovery dimension over 6 months of CT-R

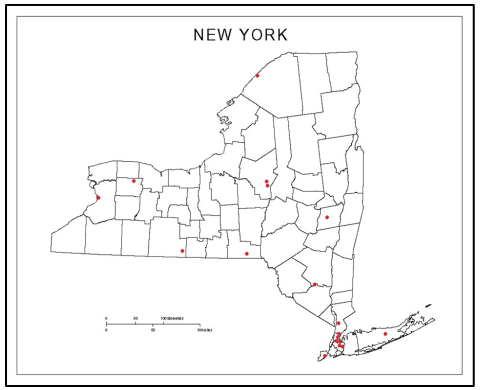
New York: How it Started

TTI Grant

- Pilot at South Beach Psychiatric Center

Expanding within the system

- Worked directly with NYOMH over the next three years



- Creedmoor Psychiatric Center
- Kingsboro Psychiatric Center
- Rockland Psychiatric Center
- Kirby Forensic Psychiatric Center
- New York State Psychiatric Institute
- Pilgrim Psychiatric Center
- Bronx Psychiatric Center
- Mid-Hudson Forensic Psychiatric Center
- Manhattan Psychiatric Center
- Capital District Psychiatric Center
- Central New York Psychiatric Center
- Greater Binghamton Health Center
- Elmira Psychiatric Center
- Buffalo Psychiatric Center
- Rochester Psychiatric Center
- Hutchings Psychiatric Center
- Mohawk Valley Psychiatric Center
- St. Lawrence Psychiatric Center
- South Beach Psychiatric Center
- Oakview & Bridgeview STARC

CT-R in New York

Overview

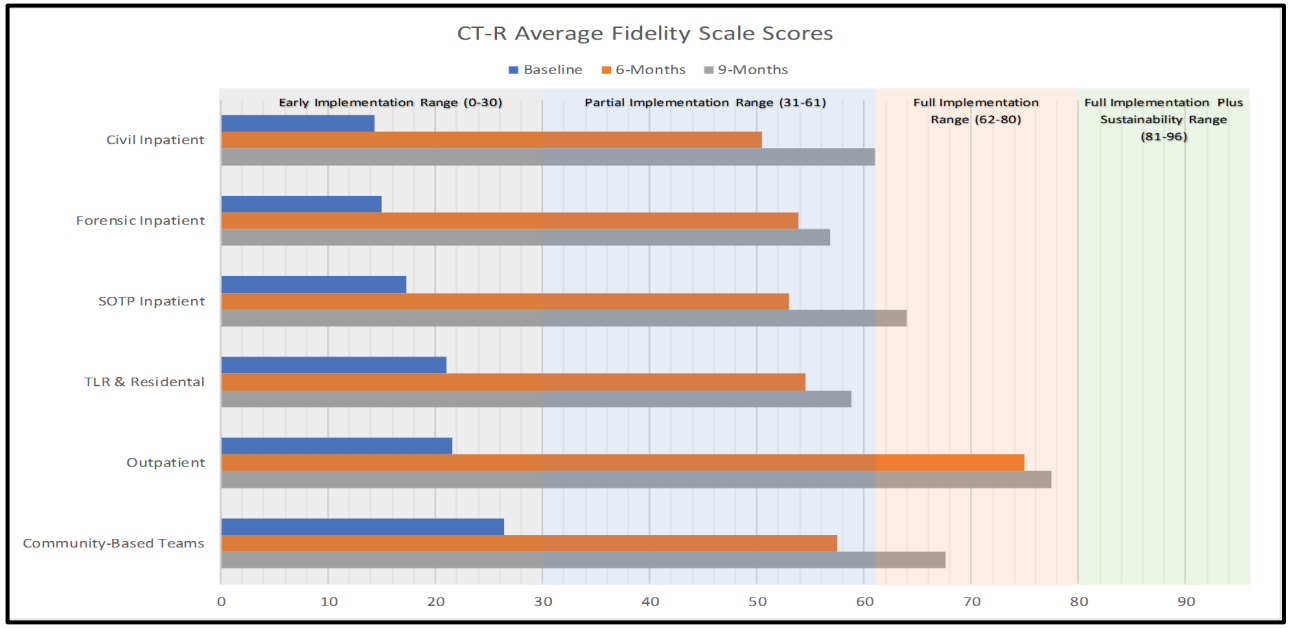
- 19 Psychiatric Centers
- 34 Inpatient Units
- 9 Residences
- 8 Outpatient Clinics
- 4 Community Based Teams

Training Numbers (2022)

- 922 mental health staff participated in CT-R workshops
- 440 engaged in 39 weeks of consultation

Training Numbers (2023)

- 933 mental health staff participated in CT-R trainings



CT-R in New York

Sustainability

- CT-R network shared access to
  1. Onboarding training materials
  2. Opportunities to learn from each other
- Site-specific CT-R champions
- CT-R *elite trainers* to continue to support the practice of CT-R with workshops, consultation, and certification/recertification

Lessons Learned in New York

Focus on multidisciplinary roles and integrating CT-R within a staff member's scope of practice

Assessing CT-R implementation at a program level (in addition to assessing individual providers competency)

Pilot of site-specific CT-R champions as a model for sustainability

Creation of CT-R based inpatient and residential units

New Jersey: How it Started

NASMHPD TTI grants

- Behavioral health homes
- Peer support project

Center of Excellence SAMHSA grant

- Year 1: Expand to all 22 counties, community behavioral health, train Rutgers-based elite trainers
- Year 2: Re-entry from incarceration, continuity of care from state hospital, nursing home care, sustainability

CT-R in New Jersey

Overview

Phase 1: Behavioral health homes

Phase 2: Peer providers

Phase 3: Community provider agencies and development of the Center of Excellence

Training Numbers for Phase 3 (2023)

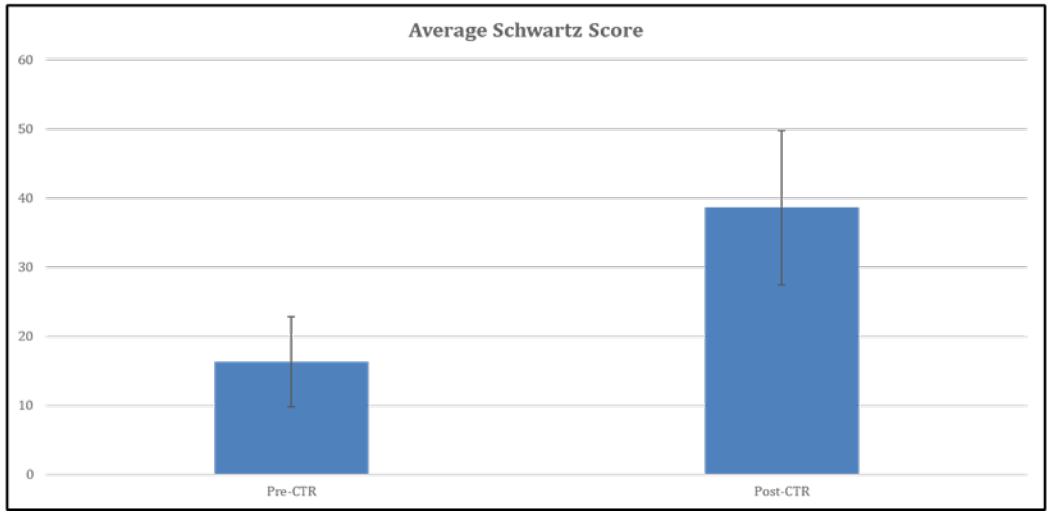
- Number of agencies participating: 14
- Programs participating: 30
- 281 staff members trained

Talking about movies and watching trailers together online → picking a movie for movie club

Learning an individual's favorite recipes → creating a cookbook with others

Visiting a virtual museum or looking at pictures of art → going to a museum or joining an art class

Playing basketball in the courtyard → getting a basketball team together



CT-R in New Jersey: Sustainability

- Development of a New Jersey CT-R Center for Excellence in 2023
- Rutgers University elite trainers
- Website
- Building up the CT-R network by providing additional resources (e.g., On-Demand CT-R Orientation material for onboarding new staff, network wide learning opportunities)
- Continue to offer to train sites to use the CT-R Quality of Implementation Scale and to assess provider CT-R competency

Lessons Learned in New Jersey

Replication and expansion of peer specialist involvement

Successful collaboration with teams that focus on integrating mental and physical health care

Diversity and innovation of treatment programs

Sustaining the elite trainer role

Considerations & Lessons Learned

1. Sustainability
2. Workforce turnover
3. Non-psychologists and paraprofessionals
4. Measurement (fidelity and impact)

Thank you!!

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NEW YORK STATE | Office of Mental Health

Recovery Oriented Cognitive Therapy

In New York State Operated Services

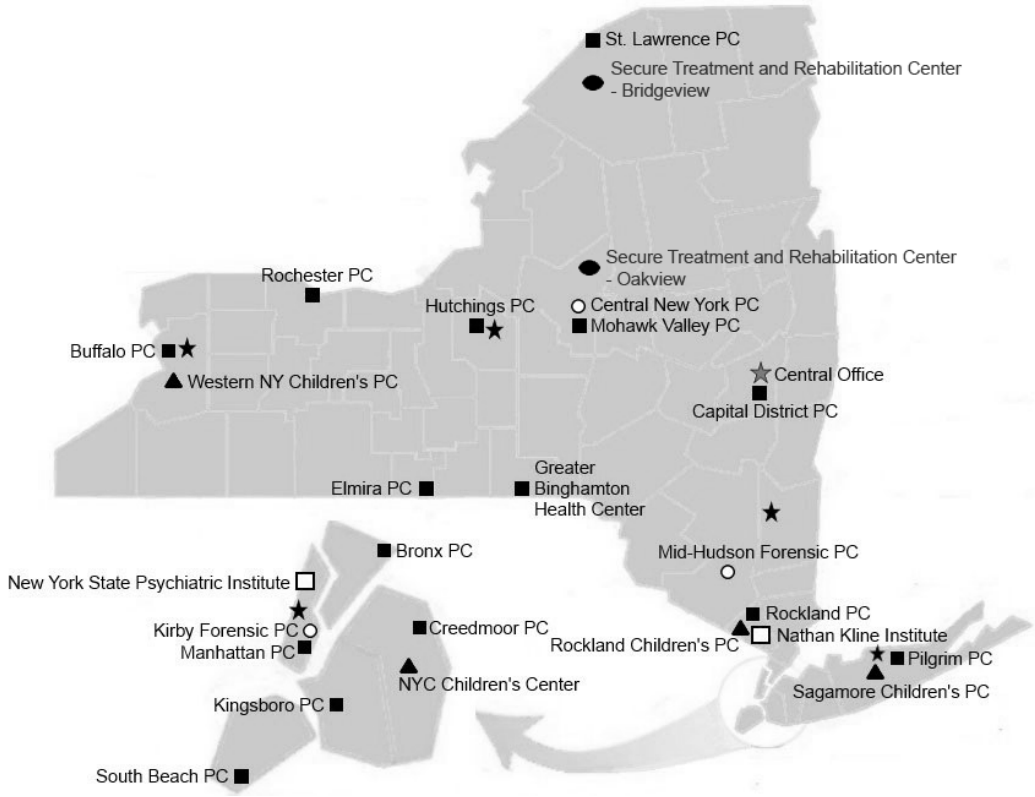
Julie Burton
Chief Recovery & Resilience Officer

JULY 29, 2025

Implementation

Transformation Transfer Initiative-NASMHPD

- In late 2017 New York State was one of six states awarded TTI funds through the National Association of State Menta Health Program Directors to provide Recovery-Oriented Cognitive Therapy (CT-R) training at one of our facilities.
- NYS OMH has since expanded use to all 19 State Operated Adult Civil and Forensic facilities



Facility Work

- Facility CT-R Champions were identified to serve as point person and expert
- Inpatient units were identified for participation
- Staff were trained
- Outcome measurements were explored

Project Scope of Work and CT-R Implementation at NYS Psychiatric Centers

- Consultation Calls occurred with the facility teams and the Beck Center team, on site or remotely
- Coordination Calls occurred with trainers and key administrators to evaluate progress of implementation
- Ten knowledge builders created as learning modules available to community providers

Impact

Impact on Individuals

- New understanding and sharing, activating staff along with individuals
- Benefit across unit and facility, beyond just the person actively engaged in CT-R
- Increase confidence and innovation in staff performance, especially those engaged in applying for competency

A Goldfish

- Mr. G. 60-year-old male
- Diagnosed with Schizophrenia, unspecified personality disorder, avoidant food intake, multiple substance use disorders + comorbid medical conditions
- Physical aggression as a discharge barrier
- Love of animals

A Zillion Dollars

- Mr. MA engaged in CTR for 5-6 weeks
- Grandiose, no interest in medications
- Oppositional behavior of urinating and defecating on floor
- Desire to be helpful

Thank you for your time!

Any questions, please contact:

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Chief Recovery and Resilience Officer
Julie.Burton@omh.ny.gov

NEW YORK STATE | Office of Mental Health

Georgia BECK Initiative

Brenda Cibulas, APRN, BC, CGP
Executive Director, Division of Behavioral Health
Georgia Department of Behavioral Health and Developmental Disabilities

D·B·H·D·D
Georgia Department of Behavioral Health & Developmental Disabilities

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH & WELLBEING
strengthening pathways for resilient communities and lifelong wellness

Today’s agenda

Partnership and Implementation

CT-R Training and Certification

Outcomes

Funding

Project Goals for BECK Initiative

- To promote recovery and increased quality of life for individuals served by using the evidence-based practice of CT-R as a standard of care within DBHDD network
- To promote the sustained implementation of CT-R within the DBHDD network
- To improve the professional lives of providers in the DBHDD system

CT-R Partnership

CT-R training is underway in two DBHDD departments:

1. The Office of Adult Mental Health, and
2. The Office of Children, Young Adults and Families.

There are three CT-R Programs:

1. Beck Initiative
2. GA LIGHT(Listening, Inspiring, and Guiding Healthy Transitions)
3. OCYF

The Center of Excellence for Behavioral Health and Wellbeing (formally Children's Behavioral Health), is providing ongoing training and evaluation to assess fidelity to the model, treatment impact, and long-term sustainability of CT-R in Georgia.

D·B·H·D·D

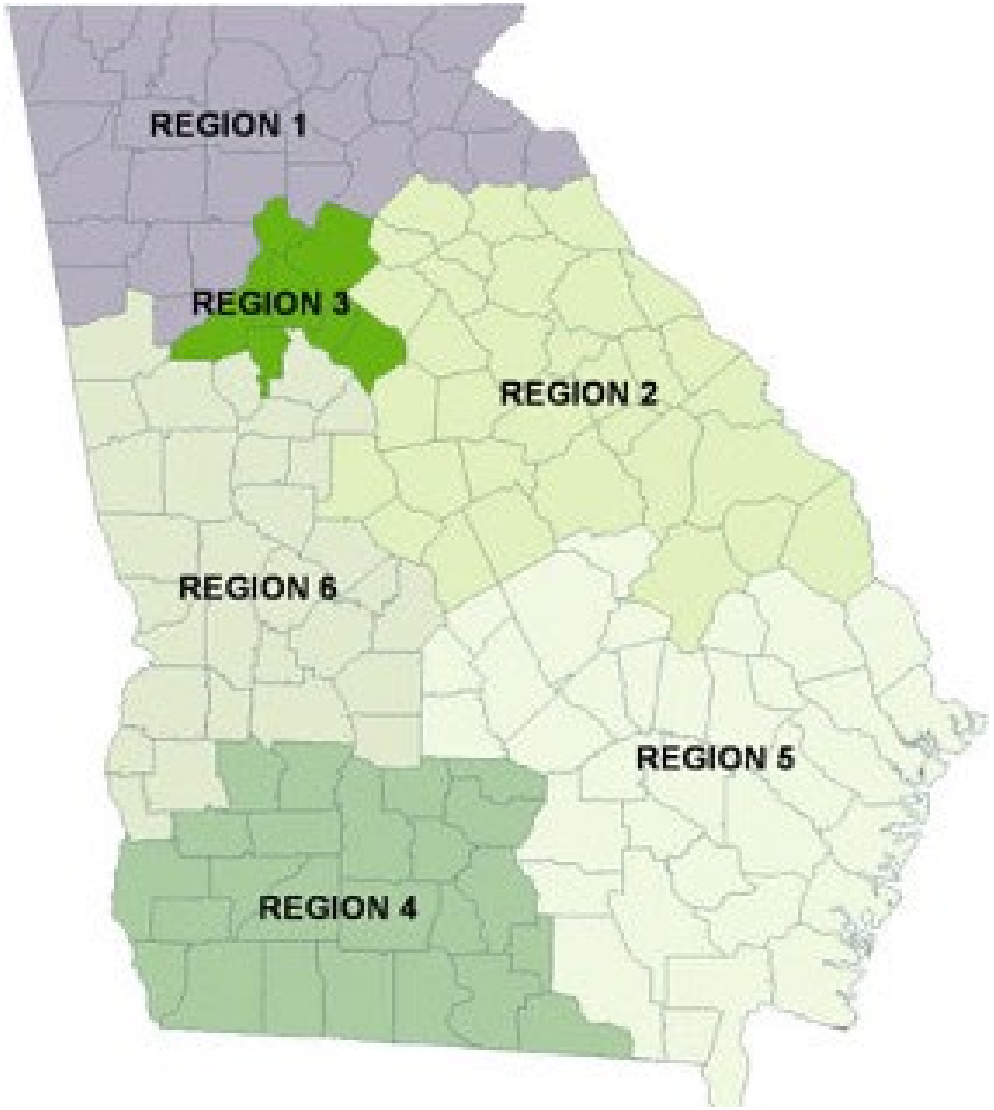
Georgia Department of Behavioral Health & Developmental Disabilities

CENTER OF EXCELLENCE FOR BEHAVIORAL HEALTH & WELLBEING

strengthening pathways for resilient communities and lifelong wellness

Implementation Efforts

- Training by Region
- Across the continuum of care
  - ACT, CST, ICM, Outpatient
  - Residential Case Management
  - CSU Staff
  - School-based mental health
  - Wraparound Care (IC3, MC3)
  - First Episode Psychosis Team
- Providers across the behavioral health spectrum
  - Clinicians, Certified-Peer Specialists, Case managers, Prescribers, Nurses



Beck Initiative

Project Overview

- The Georgia Beck Initiative delivers evidence-based, recovery-focused treatment for individuals with a range of mental health challenges, from severe to less acute but impactful conditions.

Professionals

- Interdisciplinary care teams (ACT, CST)
  - Outpatient Clinicians
  - Case managers
  - Certified Peer Specialists
  - Prescribers

Clients/Consumer Population

- Adults 18 and older
  - Serious mental health challenges
  - Substance misuse
  - Unhoused individuals
  - Frequent hospitalizations

GA LIGHT

Project Overview

- The LIGHT-ETP program, funded by SAMHSA, supports emerging adults experiencing first-episode psychosis through early detection, rapid access to coordinated care, and recovery-focused, youth-friendly services.

Professionals

- Coordinated Specialty Care Teams
  - Clinicians
  - Case managers
  - Certified Peer Specialists
  - Prescribers
  - Vocational/Educational Specialist

Clients/Consumer Population

- Emerging Adults 16-30
  - First-Episode Psychosis
    - Symptoms lasting at least one week
    - Symptom onset within the last two years

Office of Children, Young Adults, and Families

Project Overview

- The Office of Children, Young Adults & Families (OCFY) supports Georgia's System of Care for uninsured or SSI Medicaid youth and families accessing public behavioral health services. CT-R is an evidence-based practice to support professionals working with youth facing mental health challenges and crises.

Professionals

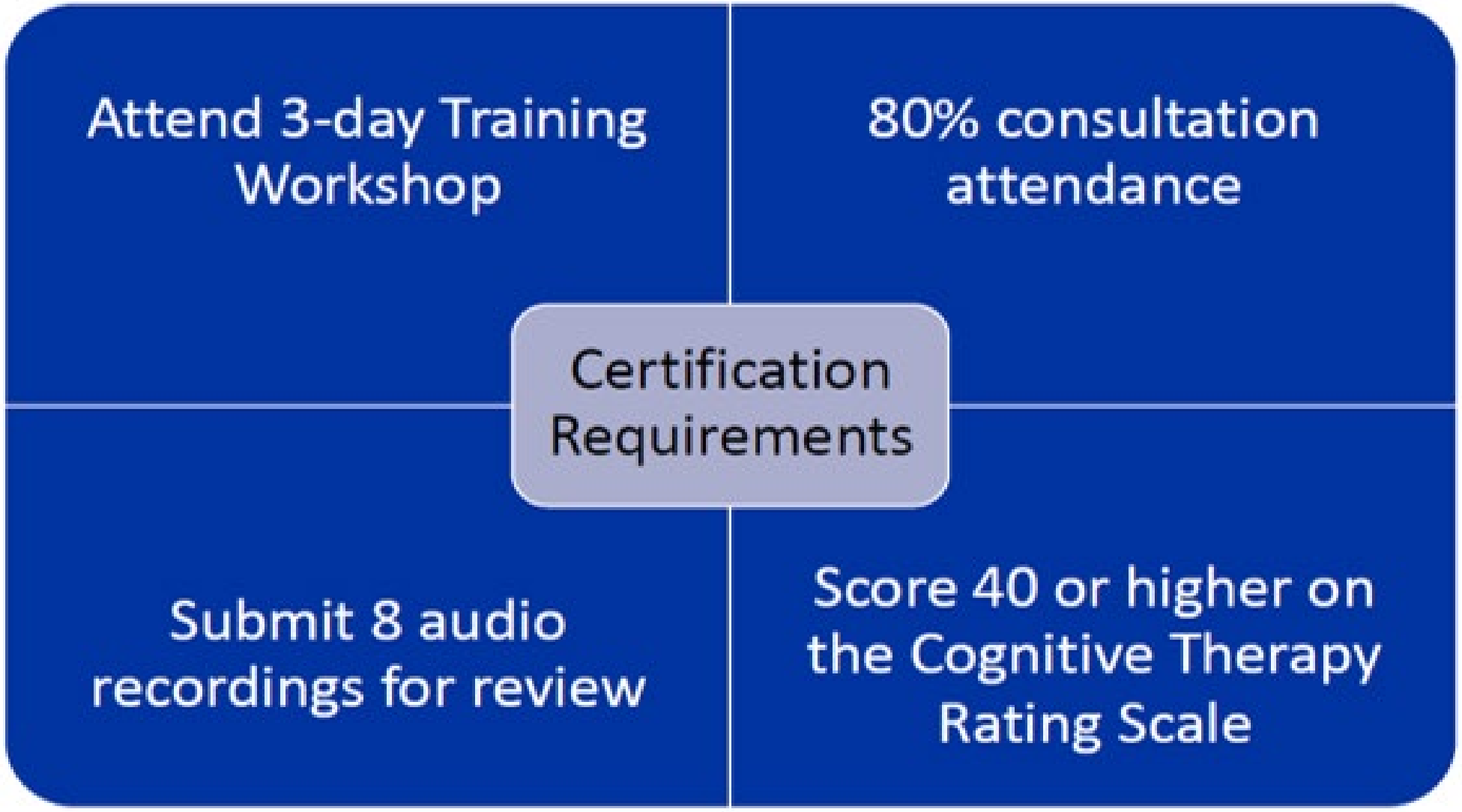
- Care coordination teams (IC3, MC3, Wraparound)
- Clinicians
- Case managers
- Certified Peer Specialists
- Prescribers
- Vocational/Educational Specialist

Clients/Consumer Population

- Youth and Young adults under 18 years of age
  - Emerging mental health challenges
  - Serious mental health challenges
  - At-risk for out of home placement
  - Behavioral challenges

CTR- Training Composition

Certification Requirements



BECK Initiative

Outcomes

Georgia BECK Initiative (2015 – Present)

Community Service Boards Represented

Training Workshops

Type of Providers Trained:

Team Lead (ACT/CST)
Clinician
Intensive Case manager
Residential case manager
Residential Director
Crisis Unit discharge planner
Crisis Unit clinician
Vocational/Rehabilitation specialist
Substance use counselor
Certified Peer Specialist
Physician Assistant
Psychiatric Nurse Practitioner
Case Manager
Transitional discharge coordinator (ACT)

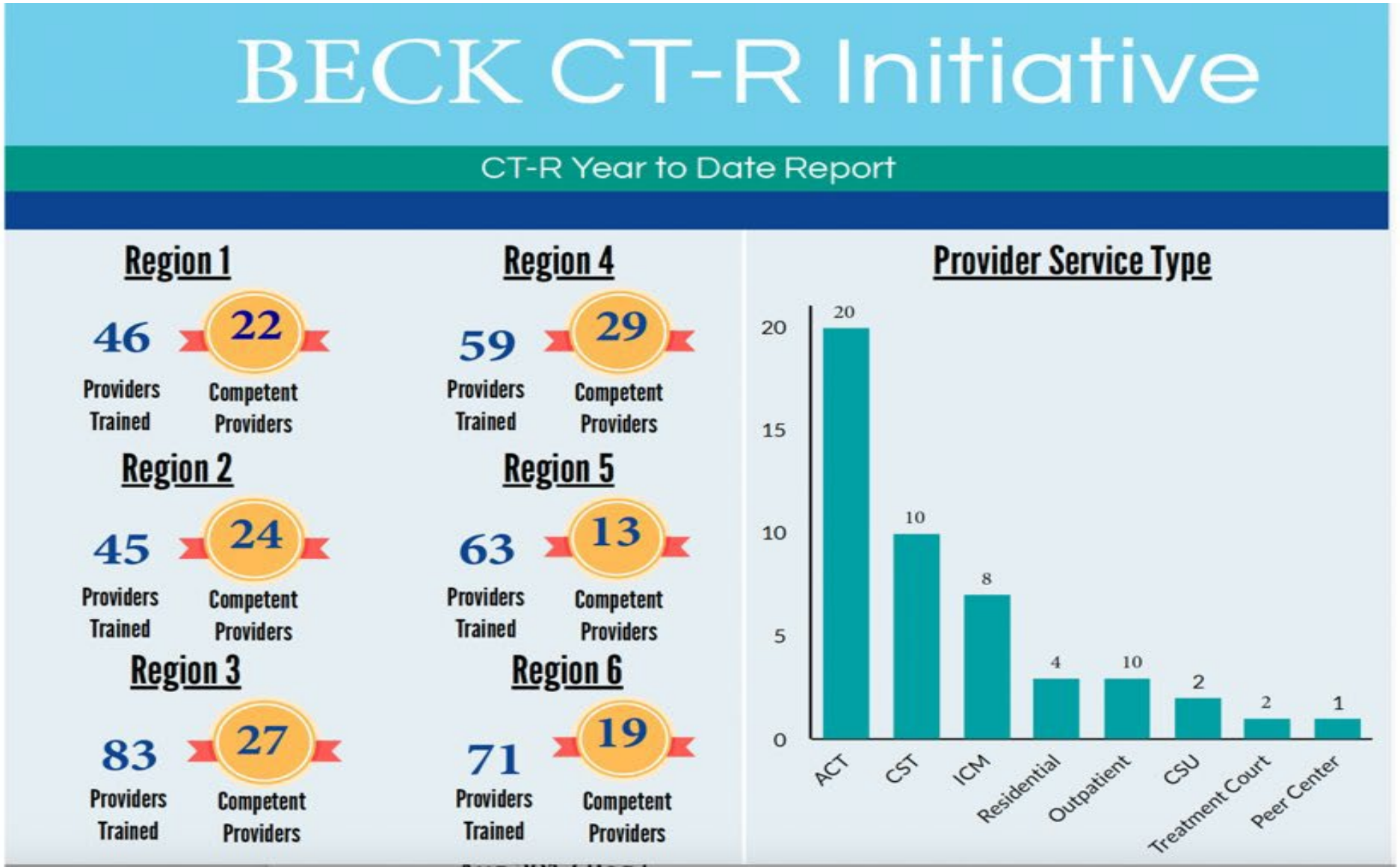
Trained in CT-R

Participated in Consultation

CT-R Competent

*Providers currently in consultation are not reflected here.

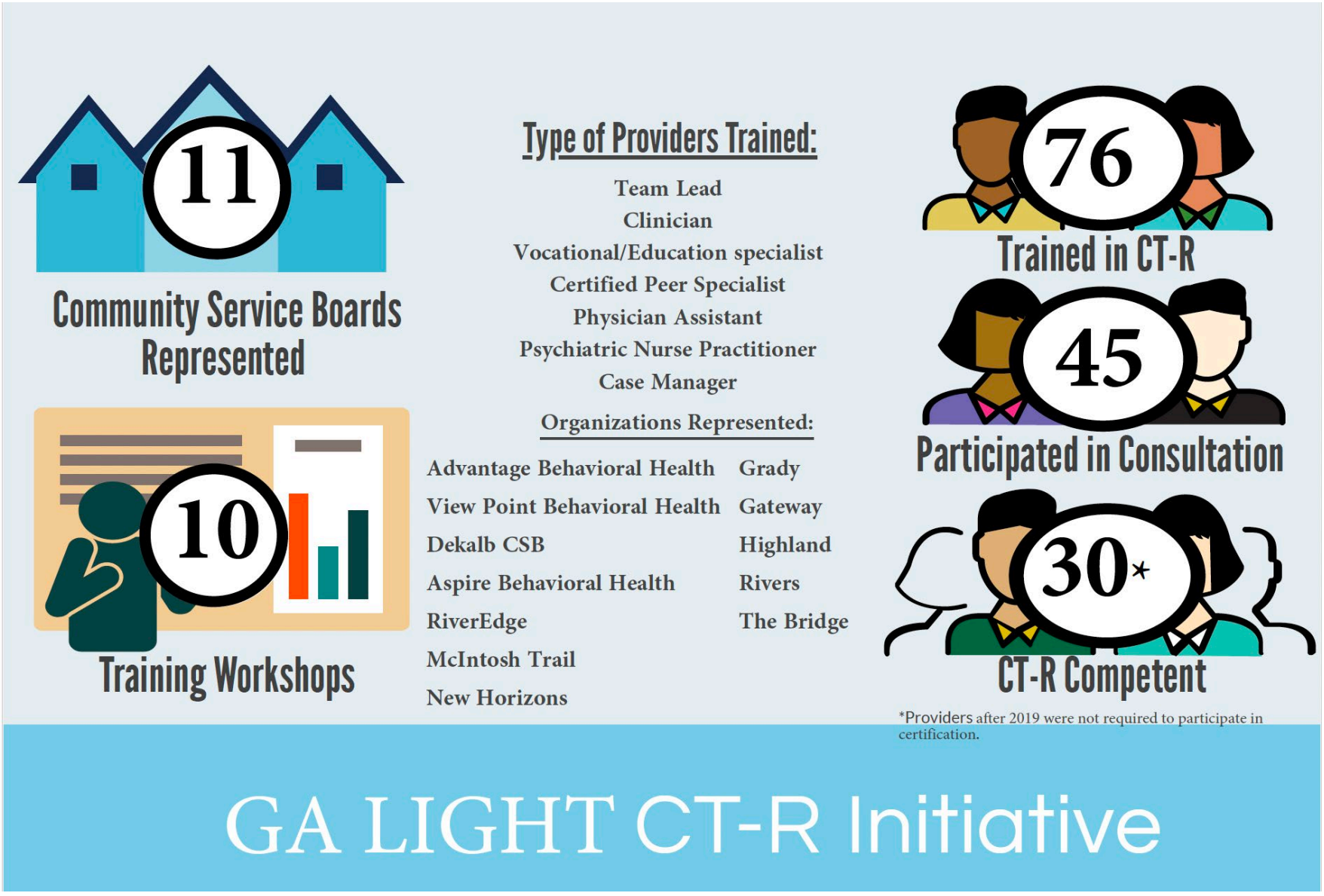
CT-R Report (2015 – Present)



GA Light

Outcomes

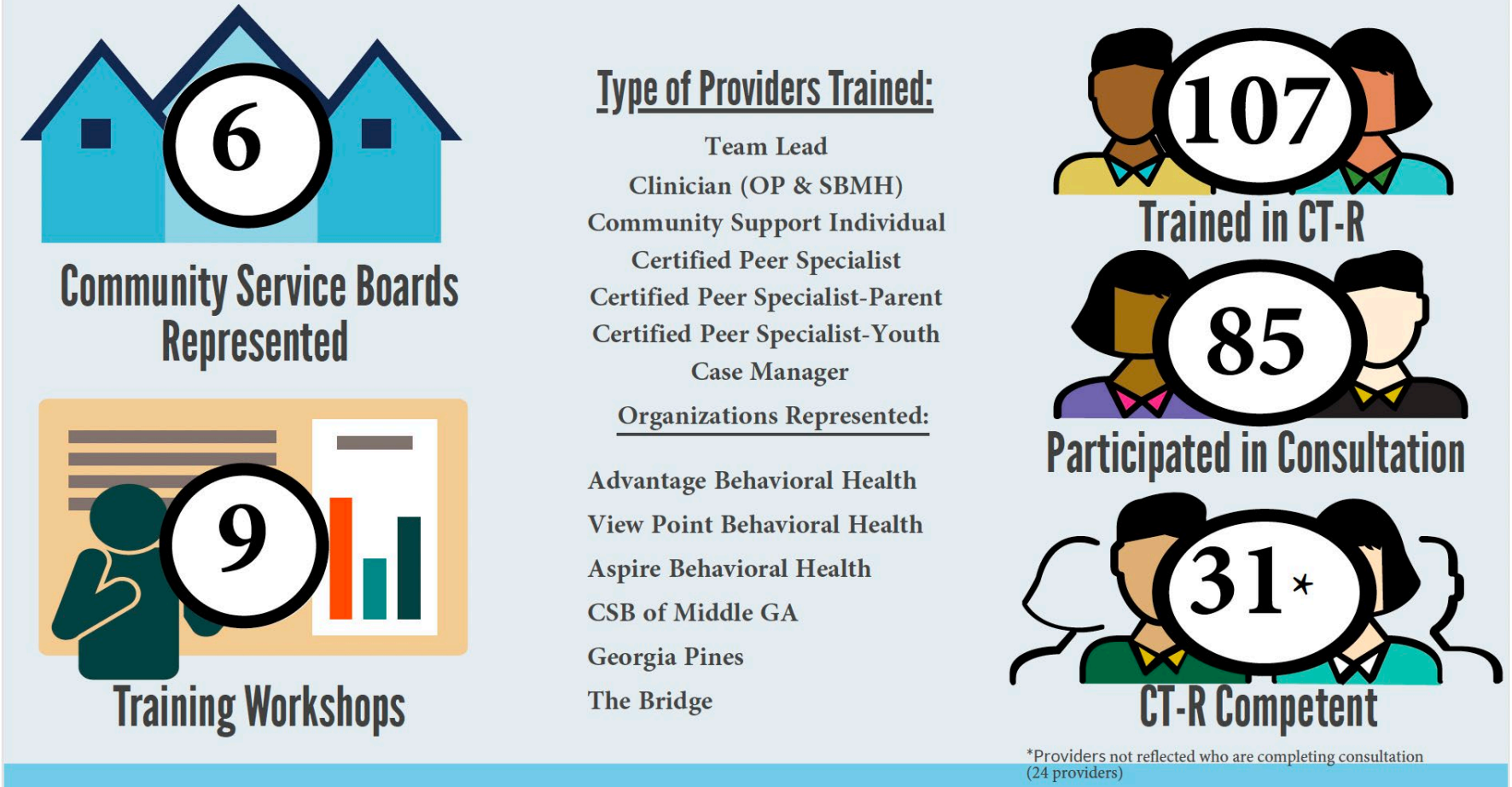
GA LIGHT CT-R Training (2016 – 2023)



Office of Child, Youth and Families

Outcomes

OCYF CT-R Training Initiative (2023-Present)



Attitudes

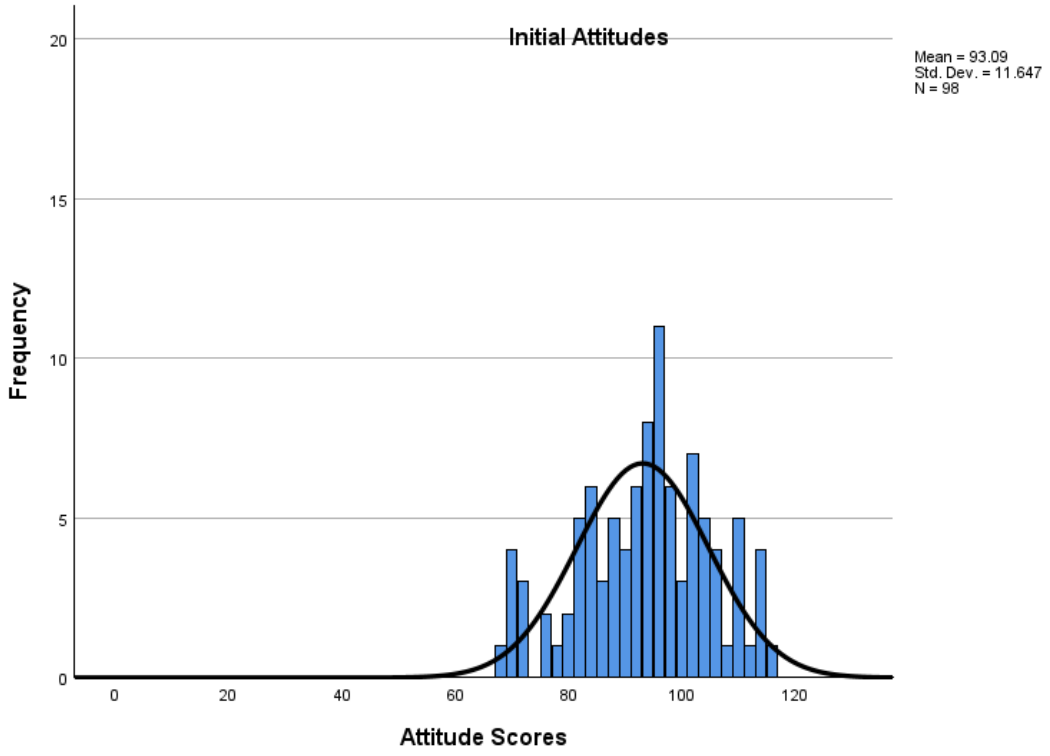
High significant improvement

The following measures of attitude improved at a **high level of statistical significance** following the training ($p<0.01$)*

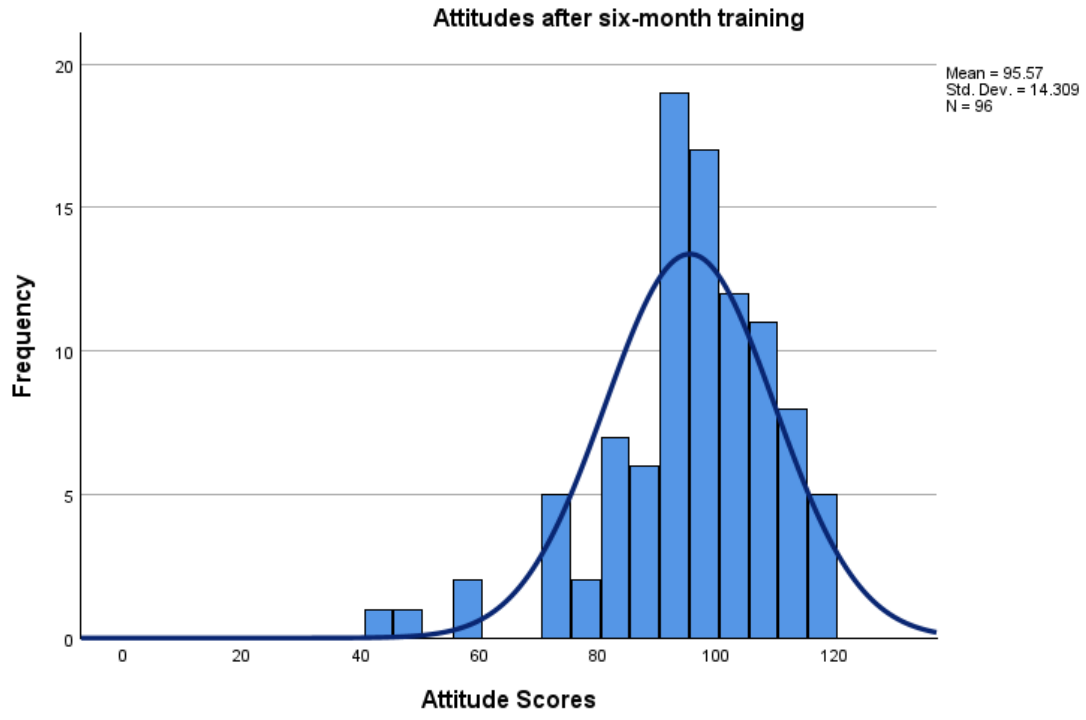
- Confidence in sufficient knowledge of psychosis
- Ability to imagine the experience of psychosis
- Belief in cognitive-behavioral therapy as an effective treatment for psychosis
- Satisfaction with working with people with psychosis

Changes in Attitudes

Initial Attitudes



Attitudes after 6-months of Training



Measures of Burnout

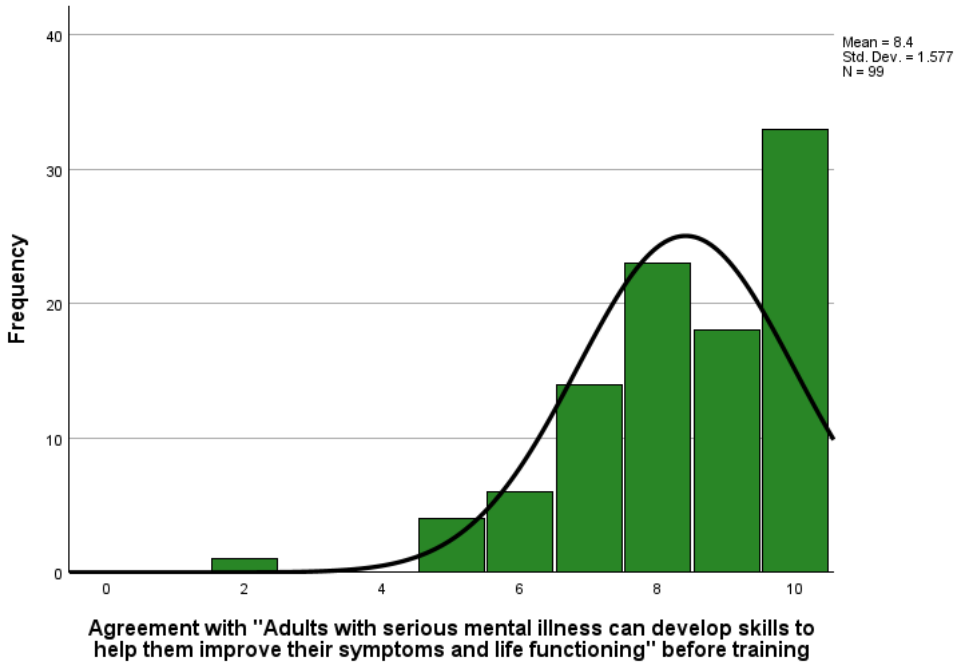
Highly significant improvement: Burnout

- The measures of general burnout improved at a **high level of statistical significance** following the training ($p<0.01$)*
    - Reduction in the feeling that working with people all day long requires a great deal of effort.

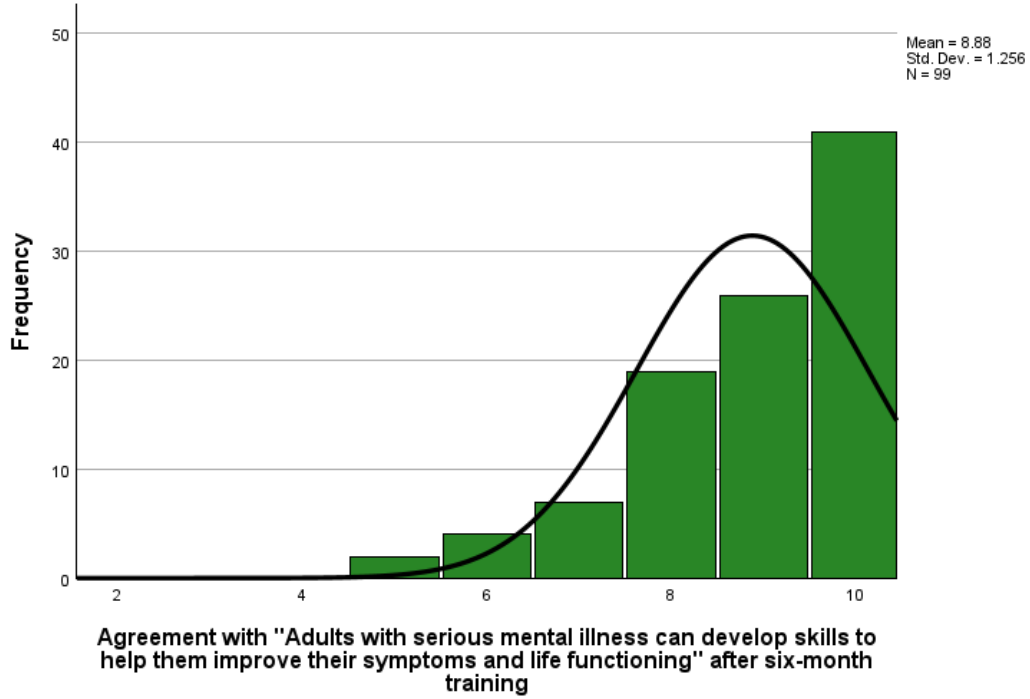
Efficacy

Efficacy in adults' ability to build skills to improve their symptoms and life functioning

Efficacy prior to training



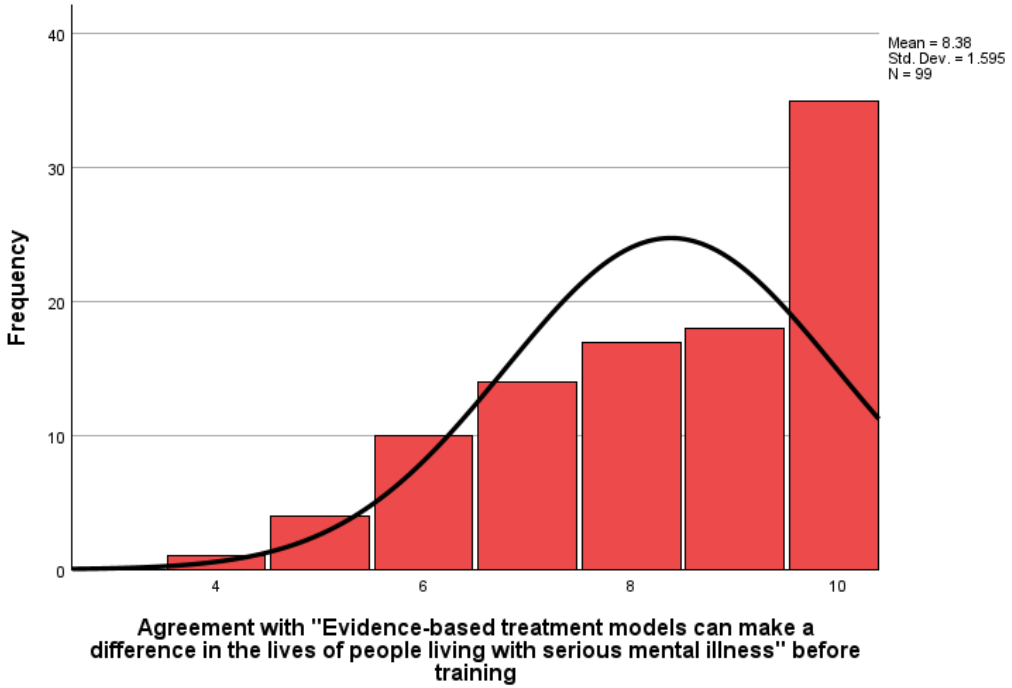
Efficacy after 6-months of training



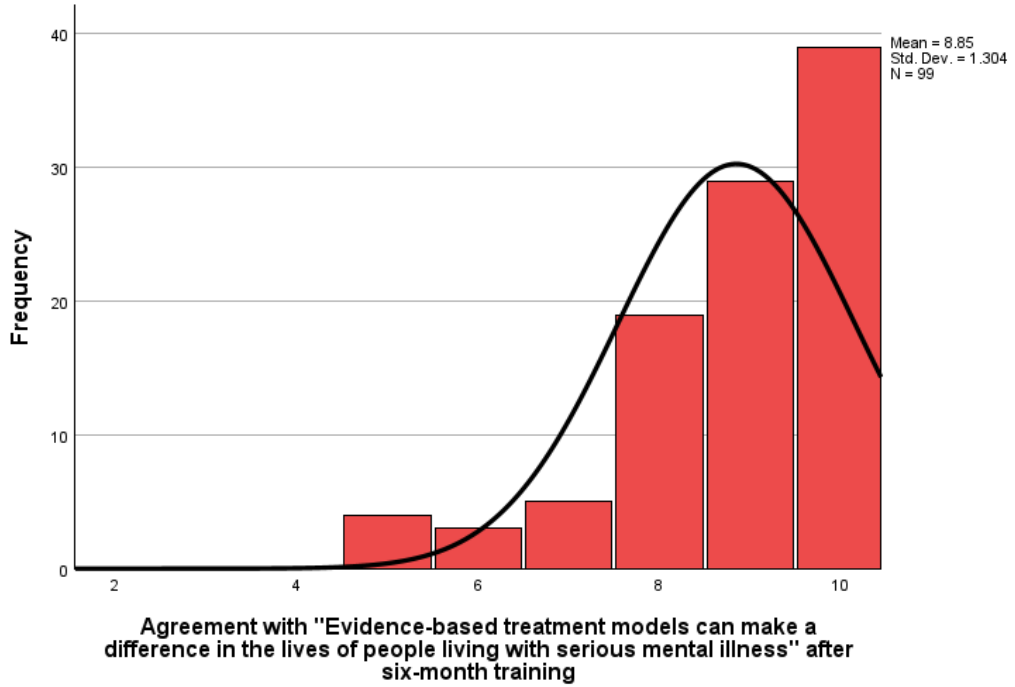
Providers' **efficacy** in adults' ability to **build skills** to improve their symptoms and life functioning **very significantly improved** after the training ($p<0.01$)

Efficacy in evidence-based treatment's impact on SMI

Efficacy in EBT on SMI prior to training



Efficacy in EBT on SMI after 6-months of training



Providers' **efficacy** in EBT's ability to make a difference with SMI **very significantly improved** after the training ($p<0.01$)

Funding Sources

AMH

- Funding for CT-R is supported with state dollars
- Current cost of AMH contract = $269,333 annually

OCYF

- Funding for GA LIGHT and OCYF is also supported with state dollars.
- Current cost of OCYF contract = $206,394

TTI

- GSU and DBHDD applied for TTI funding in 2018
- Funds awarded for TTI grant $245,733.29

What if I want to bring this to my state?

CT-R Implementation

- Needs Assessment-Determine greatest population needs (youth at risk for psychosis, adults with SMI, etc.)
- Partnership with state-level behavioral health authority
- Funding source-Federal, state, or community-level funding
- Training and Supervision-by Certified Trainers
- Evaluation-Client and Provider level data collection
- Sustainability Plan-Some states have developed internal curricula and learning collaboratives to enhance skills and knowledge. Train the Trainer model to ensure that sustainability efforts continue.

Georgia CT-R Initiative

Georgia Health Policy Center

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D·B·H·D·D

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D·B·H·D·D

Georgia Department
of Behavioral Health
& Developmental
Disabilities

BE D·B·H·D·D
BE COMPASSIONATE
BE PREPARED
BE RESPECTFUL
BE PROFESSIONAL
BE CARING
BE EXCEPTIONAL
BE INSPIRED
BE ENGAGED
BE ACCOUNTABLE
BE INFORMED
BE FLEXIBLE
BE HOPEFUL
BE CONNECTED
BE D·B·H·D·D