Implementation of CT-R Across a System, Lessons of Success

Welcome, everyone. We're glad to have you with us for this final webinar in the CT-R series. It's been all of January and February now exploring this topic, and we're really excited that you can be with us. We hope that if you have not been able to be with us, that you've taken advantage of the recordings or just know that they are there, and you can access this information at any time. There will be links to that information at the end of the webinar.

A quick orientation to the room in case you have not joined us before.

We are looking at an Adobe Connect webinar platform. And there are different pods or boxes that allow you to do different types of activities. I would point you to look at the Tech and Topic Questions if you have any difficulty with sound or viewing the screen. Those are where your comments should go.

If you have questions for the presenter, anything that has to do with the content, that's where those questions should go as well.

If you want to say hello to each other or have some commentary that you want to add about the content, that can go in the Participant Chat, which is on the left side of your screen.

We also have a Download Materials pod where you can download materials available to you. There is a copy of the RTP newsletter that is on this same topic. A copy of the presentation slides. Some additional resources. A participant certificate. And a hard copy of the Recovery Map that you are going to hear about at the end of this webinar.

You are able to earn CEUs for your participation. To do so, at the end of the webinar, click the link. You'll need to complete a brief quiz, and upon passing that quiz, you will be able to download a certificate and have those CEUs for your records.

As a reminder, the views and opinions and content that is a part of this webinar do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services Substance Abuse and Mental Health Services Administration or the U.S. Department of Health and Human Services. We are very grateful that SAMHSA does provide the funding for the Recovery to Practice initiative and allows us to present this information to you.

Now let me briefly tell you about our presenters today.

We're really happy to have Dr. Arthur Evans, who is the Chief Executive Officer of the American Psychological Association. He assumed that post in March of last year, so it has been almost a year. And this is the leading scientific and professional organization representing psychology in the United States.

However, Dr. Evans is going to be speaking to us about some of his experiences in implementing evidence-based practices which includes CT-R while he was the Commissioner of Philadelphia's Department of Behavioral Health. And what's important to know is the population of Philadelphia is equal to some states. And so it was a huge system. And Dr. Evans will be able to illuminate for us how CT-R helped bridge the gap and how learning about implementation is so critical to the success of even the best evidence-based practices.

Also joining us is Dr. Paul Grant. If you've been in this series before, you are going to be familiar with Paul's voice as he pulls together the focus on implementation with the success of CT-R across systems.

So I am now going to turn this over to Dr. Evans so that he can tell us about the experiences that he had with implementation during his time as the Commissioner of the Philadelphia Department of Behavioral Health.

Dr. Evans, thank you for joining us.

Thank you. And thank you for inviting me to be a part of this.

So, and thank all of you who are on the line. I am going to talk about the work that I did prior to coming to the American Psychological Association when I was Commissioner at the Philadelphia Department of Behavioral Health and Intellectual Disability Services.

When I was there, which I left in 2000 – about a year ago, but I was there for over a decade, from 2004 to last year. And during most of that time, we were engaged in implementing evidence-based practices throughout our service system.

That was done within the context of work that we were doing to transform the system in Philadelphia to focus on recovery for adults and resiliency for children. And that's very important because as I go through the presentation, what you are going to hear is how we used CT-R, but more generally evidence-based practices in general, to help us advance our transformational goals of making recovery the outcome for adults and resilience the outcome for children.

The reason – what I'm going to do is to step back a bit because Paul has talked to you about CT-R from a clinical practice standpoint. I was an administrator, and what we found was that it was not only important to understand the clinical practice issues, but to also understand the organizational and systemic issues – or systems issues, and I'm going to focus on those issues. The rationale being that as an administrator, we could, and we saw this at times, invest sometimes tens of thousands, maybe even hundreds of thousands, of dollars in getting a provider ready to do and implementing an evidence-based practice only to come back in a few years to see that the provider may not be continuing that practice.

And so when we delved into that a little bit, what we found is that often there is high turnover in provider organizations. And there are other organizational barriers that get in the way of the clinicians actually practicing the practice that they have been trained in.

And so the whole premise of what I am going to talk about today is that if you want a successful implementation of CT-R, or any evidence-based practice, for that matter, it's important to pay attention to some of these systemic issues that I'm going to talk about today.

As I mentioned, this work was done in the context of recovery and recovery-oriented systems of care as a framework. It's really important to understand that because for those of you who were around in the early nineties when systems were just beginning to look at the issue of evidence-based practices, there was a lot of talk amongst advocates of moving – who were advocates of moving to recovery orientation that evidence-based practices didn't fit with recovery-oriented care. And in my work in Connecticut prior to going to Philadelphia and in Philadelphia, we took a very strong stand that we felt that evidence-based practices were not only not antithetical to recovery-oriented care, but were essential for providing recovery-oriented care, the rationale being if what we are trying to do is to make sure that people have the best shot at recovery, we need to make sure that they – that we're bringing in the science and the research that can help us achieve those recovery outcomes.

And so the rationale, then, for doing EBPs is simple, from my standpoint. Evidence-based practices are done to increase the likelihood or probability that we are going to achieve the outcomes that we are trying to achieve, and in this case recovery and resilience. And I would go as far to say that if you are not clear that what you are doing is going to improve outcomes for people, to make treatment better, to help people to get better, then that's a practice that you shouldn't move forward with, or evidence-based practice you shouldn't move forward with.

One thing that I do want to point out about this way of thinking is it talks about EBPs not in a categorical sense as good/bad, but in terms of probability. That this will increase the likelihood that we'll get the outcomes. It's not a panacea. And it also leaves room for other things that are outside of evidence-based practices that can also contribute to getting better outcomes. So, for example, including peers and people's lived experience as a part of the overall treatment process, which we know also contributed to getting better outcomes.

So the point here is that EBPs are viewed and from this perspective from the standpoint of being essential, but there are other things that are also essential in making sure that we get good outcomes.

So the conceptual frame is this. That I'm going to talk about this from the standpoint of a system and from a system's perspective. And so the idea here is that what we were trying to achieve in both Connecticut and more recently in Philadelphia, is how do we create an evidence-based system of care versus how do we implement evidence-based practices. And the former idea, the idea of the evidence-based system of care, is that what we're really trying to do is to get the system to think about its work from the viewpoint of what is the evidence, and do we have evidence that what we're doing is working, is effective, and is the best practice for the particular population that we're working with and the people that we're working with.

So that way of thinking about our work was a part of the overall approach.

It's important to think about EBPs in terms of how you achieve larger systems goals. And I'm going to give an example of that. Being clear about how EBPs fit into what you are trying to do from a systems standpoint. I mentioned that we understood EBPs to be an essential part of recovery-oriented care as opposed to a separate kind of concept. One of the things that happens in public systems often is that providers are given a long laundry list of things that they have to pay attention to. Evidence-based practices, recovery, cultural diversity, dual diagnosis. The question is, how do all those things fit together and is there clarity around that, because if there's not, what will happen is that that these will seem like very disconnected, fragmented kinds of approaches, and that can get in the way of successful of implementation.

Thinking about this from a systems change framework is also important. And a developmental approach, which I am going to talk about in a moment, which really has to do with how does our thinking change over time as we're doing this.

So this is some historical context.

You can think about the evolution of evidence-based practices in our work in the field in these ways – this is my way of thinking about it. Early on we had a lot of – most of the scientists focused on the effectiveness of a practice. So the assumption was if we could figure out that a certain practice was effective, that we needed to make it available then through reports and toolkits, and that the emphasis was on disseminating what we had learned. We learned pretty quickly that that wasn't an effective way of getting practices widely spread in our service systems.

Then we moved to where I think we are now, which is more of an implementation/science framework which says, you know what? This is about how do we make sure that we are implementing and using science to help us figure out how to effectively implement practices. And a lot of good work is happening around the country, and I am sure many of you probably know some of the big names around that. But I'm going to go a step further and say that I think that where we need to be is around sustainability science. And I distinguish that from implementation because we can be very successful in implementing a practice, only to come back three or four years later and find that that practice isn't being practiced, and so it raised the question, what are the things that we need to be doing and what are the things that we've learned that can help us ensure that the investments that we're making in CT-R and other evidence-based practices are actually going to be sustained over time.

So that's really the premise of what I'm going to talk about.

Let me just give a little background on how we got started with this.

When I was Commissioner, early on in my tenure I got a call from Dr. Aaron Beck, who – and the conversation went something like this. He said that we know that we have a lot of evidence for cognitive therapy, that it's been done. We have hundreds of studies that show that it works, but we know that it's not very widely practiced in the field. And we talked about developing a partnership where we could really expand the use of CT within the Philadelphia system. So really trying to create a win-win partnership. And that was a very productive relationship over the course of a decade.

The work started very traditionally. We started by going to outpatient mental health programs primarily. Training clinicians. Focusing on fidelity for those clinicians.

And very quickly our work and our thinking evolved. It evolved to the point where we started thinking about other settings, nontraditional settings, where some of these practices had been implemented. We started thinking about other issues beyond training the particular clinicians. And so what I'm going to talk about is how our thinking evolved and what we learned from not only the work with Dr. Beck and his group, but also other purveyors of EBPs who we also worked with.

Because of the emphasis on using empirically-supported treatments in Philadelphia, we created something called a Evidence-based Practice and Innovation Center, which was focused on taking the lessons learned from these various EBP implementations and making sure that we used those lessons learned as we were rolling out additional evidence-based practices.

Over time, we trained hundreds of therapists, dozens of programs, across a variety of EBPs. You can see some of them there, from prolonged exposure and PSCBT for children, to DVT, ecosystemic family therapy. These are just some of the EBPs. And, again, doing this across a variety of settings including inpatient, residential, substance use, mental health. Just trying to increase the use of empirically-supported treatments throughout our systems.

So here are the ten lessons learned. And I'm a David Letterman fan, so I'm going to do it as my Top Ten Lessons Learned from the work that we've done in terms of implementing EBPs, again with the emphasis on sustainability over time.

So number ten is this. That it's important to identify outcomes before the implementation and the training of an EBP begins. The early work, what we found was that we would do the implementation, the training. We would focus on fidelity, all of those kinds of things, making sure that we got it right. Only to then ask the question once we were in implementation, how are we going to measure whether or not we actually are having the impact that we wanted to?

Really at that point it was kind of late. The horse was out of the barn. And we had to do a lot of retrofitting to make sure that we could get the kinds of data that we needed.

And so we started to, and I think this is important, to identify, well, what is it that we are trying to achieve by the implementation of this EBP? How are we going to measure that and to have that system in place before the actual implementation ever begins? It gives one the clarity that one needs in terms of the focus, but it also ensures that – that's the kind of data that you need to evaluate whether or not this was a good investment on the part of the system and the organization. You will have the data to make that determination.

Number two is bill payer and administrative capacity. This is something that probably gets overlooked by a lot of systems. I know that there are people on the call who are either working for states or counties, but they are in some kind of payer role. It's important that payers not only support the use of EBPs, but understand that they have to build their own capacity to understand those EBTs, understand the implications of those EBPs, in order to ensure that as a payer you are making good policies and doing good policies that will help support those EBPs over time. So we found that understanding how we were – because we were doing managed care and a managed care entity – we found that it was important to know how to authorize care for those EBPs.

We also, at some point, began to look at how do we pay differentially for providers who are doing certain EBPs because to do some evidence-based practices really required an investment of additional staff, or additional staff time, or new systems, and if we wanted those providers to be successful, we needed to recognize that in the rates that we were paying. So there are a whole set of issues that are really important, and it's important for the payers, as well as the providers, to have those – that capacity to understand those evidence-based practices.

Number eight, shifting from a training model to a sustainability model. I mentioned that the initial work with Dr. Beck focused on training clinicians. And very quickly we understood that we needed to rethink how we were approaching the work. And to think about how do we build organizational capacity versus training

individuals within the organization. So that if the individuals in the organization left, we – the organization would still have the capacity to deliver the practice.

And so there were a whole set of other things that we started to pay attention to beyond fidelity of the training, or fidelity of the provide the clinician to the training, to thinking about things like supervision, and making sure that – in fact, one of the things that we did is we trained supervisors, clinical supervisors, before we ever trained the clinicians. We started to move in that direction because we knew if we could get the program managers and the clinical directors trained up first, that they would be in a position to provide appropriate clinical supervision, but they would also understand the need to make sure that new individuals that were coming into the program were trained up on that particular practice.

So those kinds of organizational strategies turned out to be really important if you want to see your investment in CT sustained over time.

Another important lesson is to think about EBP implementation from a multilevel developmental perspective. So what does that mean? That means that typically people focus here at the practitioner level. But there is also an organizational level and there is also a systems level. And it turns out that not only is it important to get it right in terms of how you train the practitioner, but there are also these very important organizational and systemic issues that also are important for successful implementation and sustainability.

And – so that's the multilevel. The developmental aspect is that these things change over time. And so there are a set of issues for practitioners, organizations, and systems that you need to think about before the implementation, during the implementation, and then after the implementation. And so if you can just take one – and these are just examples, it's certainly not an exhaustive list of issues – but at the organizational level, a pre-implementation issue is really getting a handle on the organization's capacity to actually implement and deliver the practice.

During implementation we started focusing on issues like programmatic and organizational fit. That turns out to be really important, that these practices really have to fit within the overarching program, and paying attention to that can be very important for sustainability.

And then a post-implementation issue is workforce and capacity. How do you ensure that, and do you institutionalize, how people get trained up once they come into your provider organization so that as people come in, you have institutionalized a way of making sure that those people get trained up on the EBP and that you really create a different kind of culture and organization.

So those are just an example, but thinking at all three levels, thinking how those change over time, turns out to be really important for sustainability.

Number six. Each implementation is different. There are some things that are the same across all EBPs and you have to have it in place. One of the things that we found to be really important is the issue of clinical supervision and having people trained so that they can provide that supervision. But there are a whole set of other issues that vary depending on what the EBP is. Understanding those differences is very important in terms of successful implementation and sustainability.

Number five. Moving beyond provider readiness and general capacity. The issue here is if you look at the implementation literature, the implementation science literature, there is a lot of emphasis on provider readiness, assessing general capacity. One of our lessons learned was that you really have to step beyond that and to think about other issues. So you can have a provider who is actually ready for successful implementation, but there are other issues that may not be in place – or other things that may not be in place that can be barriers. Like data collection. One of the things we found was that often the building blocks for good clinical care that one might assume are in place, are not in place. And if those things are not in place, even if the provider has all of the other elements necessary for a successful implementation, the – those things can be barriers. Some of the things that we found, for example, are data collection, and the ability to collect data systematically and consistently. Or standard assessments. Very important when we were doing the implementation of trauma treatment. How do you determine who

should get that treatment and who is the most appropriate for those kinds of things. If you don't have a standard way of assessing those things, even if you are ready to implement the practice, that can get in the way of that practice being successfully implemented.

Number four, this is another systems issue for my colleagues who are on the line who are at the state level or county level and you are trying to get more practices implemented within your system. So selecting providers wisely turns out to be an important issue. Not all providers are ready to adopt new practices. Some providers have high rates of attrition which will impact. Some providers are better suited for certain EBPs, which is a really important point. Sometimes a provider can be in a certain part of the community, or have a certain client population, demographic, and the practice that is being implemented may not fit well with the people who are coming into that program. And so being very thoughtful about is this provider the right provider for this practice and at this time can be very important.

One other issue that we found to be important is the issue of bandwidth. That sometimes the providers who are doing these kinds of things tend to be early adopters. They tend to be the providers who are doing a lot of the innovations and a lot of the interesting work within the system. And so sometimes providers can actually be ready for a practice, but they just don't have time to do – add anything else to their plate. And so those kinds of things can get missed sometimes but are important for successful implementation.

Number three is build in a system level work with purveyors. You know, I met with Dr. Beck on a monthly basis, and he, when we were doing the implementation of CT-R, it turned out to be a very important part of the implementation because it gave us an opportunity to not only talk about, you know, again, the traditional fidelity to the models and those kinds of things, we started to get into issues like payment, and how do we pay for these services in such a way that we're likely to keep those practices going. So those high-level systems work and thinking, to the degree that you can do that with the purveyors and trainers, helping the organizations and the clinicians to think about some of those issues that need to be addressed can be very important for successful implementation.

Number two, it's a marathon, not a sprint. A very important perspective to have on EBP implementation. Doing this takes time, and doing large-scale change takes time. It's complex. And understanding that thinking about this from a continuous quality improvement framework where what we're trying to do as a system, as a collection of providers who are trying to do the best for the people that we serve, taking that perspective can help with the implementation. And that means that what we're trying ultimately to do is to get a culture shift so that people think in terms of evidence. For example, one of the things we implemented in Philadelphia was whenever we did an RFP, we would ask people, you know, what's the evidence that what you are going to do will be effective for the population. So that kind of cultural systemic change is what we are trying to get at.

And then probably the thing that I enjoyed the most in the work by the time I left the Commissioner's role in Philadelphia, was that we started to use EBPs to address specific systems and organizational challenges. And ultimately I think this is where we want to get. We want to use EBPs in a strategic way. And so by the time I left the Commissioner's position, we were looking at systems problems. It could have been our challenges. It could have been people who were having very long lengths of stay on inpatient units, which is actually what we do CT-R for. It could be people who are homeless who we are getting off of the streets of Philadelphia into a treatment program, so we want those programs to be very effective. Or it could be children who are experiencing trauma, undetected trauma.

So all of those kinds of issues are things for which there are often evidence-based practices that can be deployed to address those issues. And using EBPs in that strategic way really helps to advance the goals of the larger system, to improve the outcomes for people. And it moves us away from thinking about EBPs as just being a nice thing or good thing to do because they have evidence, and they have science, and so forth, to we're using this because we know that this can be used to improve the outcomes and lives of the people that we're working with.

So quick example of how we did that. This is a map of Philadelphia. These are the providers who have been trained in CFCDT and other treatments for the treatment of trauma for children. It took us years to

build out this infrastructure of these providers all over the city. What we did through a federal grant was to begin screening children for trauma in a variety of settings including pediatric settings that children were going to for their primary care. Identifying kids. We identified about ten percent of the kids that we screened as being positive for needing trauma treatment. But then we had the infrastructure to actually send those kids to the appropriate kind of trauma treatment. At the time – when I left Philadelphia, we had screened about 30,000 children in those settings and were able to get, again, ten percent of those kids connected to evidence-based treatment approaches.

So this is an example of why it is important to build out and to make this long-term commitment because it then allows you to take on these big issues that are important o most systems.

So just a summary of a couple of points. One is that the understanding the clinical issues involved in CT-R and other EBPs is important, but it's also very important to have a systems perspective where we're looking at those multiple levels, the practitioner level, the organizational level, the systems level, and how do those issues change over time. It's very important.

It's also important that EBPs are thought about in terms of how do these improve the overall outcomes that we're trying to achieve within our system. And that by doing that, we really have the best shot at improving not only outcomes, but ultimately what we are in the business to do, which is to make people's lives better.

So with that I'm going to end my portion and turn it over to Paul who is going to talk a little more specifically about some of the systems issues from his perspective.

Thank you, Arthur. It's quite an honor to go on after you. Fabulous stuff.

So part of what we were doing, as Arthur was saying before, we were really addressing a set of people who had historically, in Philadelphia and other places, not really – sort of become languished in institutions and things of that sort. And so what I want to talk about in a little bit, about what Arthur was talking about looks like in that context. And it will fit together with the clinical stuff we had talked about before.

So the slide I have up now is the basic model. And the basic model that we would utilize. It fits across settings. So this is sort of one of the links across everything. But just a reminder that for a lot of the people that we're talking about, it's very difficult to initially reach them because they have various defenses they have built up over the years, and they just – they really come out of the flow of things.

And so we talk about finding the adaptive mode, energizing it, and really developing it by looking at their aspirations, and then really actualizing it through their actual action, and strengthening it through various methods or strengthening the positive beliefs and things of that sort.

And this is a model that follows somebody as they move through their recovery. So this can start when they are in a state hospital and can keep going when they are out in the community, really on their own stepping out of services.

Similarly this is kind of a – somewhat of a E.E. Cummings version of a Recovery Map. But basically this is something that we utilize to really achieve continuity of care. Really the opportunity for – teams can share these formulations, and they can also go with the person as they step down levels of care. Making sure to get all the pieces, making sure to update it as we go. And this maps on really nicely to the arrows we talked about before.

This is really – this slide here is really the network of care that we have developed in Philadelphia because one of the things that we realized with Arthur was that we weren't talking so much about one agency. We were really talking about a network. And so over the period of time we applied the principles that Arthur was talking about to this network. And at the top of the figure we have more intensive levels of care. As you step down – as you go down the figure, you have less and less intensive levels of care.

And then, of course, there is support from case management and things of this sort.

But this is sort of – the idea is you can implement recovery-oriented cognitive therapy within this network so that all the providers in this network are actually really synched up in terms of where the person is in their recovery, how to partner with the person, and really how to sort of really help them as they are really slowly not needing as much support and really being able to get the life that they might want.

We've seen people in this program, just to make what Arthur is saying really specific to specific individuals, we have seen people who have been basically in the corner in the hospital talking to themselves that have stepped through this level of care now. And you can find them in the community reconnected with family, playing music at open mic nights, volunteering at area locations like libraries and things of that sort. There's really some amazing things that can happen. So, again, the state hospital is the most restrictive level of care, but being able to start some of this stuff there and provide them with this same framework.

And then also thinking about how do you know that it's working. Arthur talked a lot about the role of data. And data also – while it's very good for administrators, it's very good for people, it's also good for the people who are doing the implementation themselves to sort of see that it's working. And here's something that we innovated where we realized that you could utilize existing data collection to show that an implementation is working.

And so what this slide is trying to show is that nursing staff usually have to check in on everybody every 30 minutes. We found that if they could just identify whether the person was in their room or out of their room participating, that's one way of showing that the programing is improving and that people are coming out of their rooms. And that's what this chart shows. This is one way of using – sort of identifying program evaluation data as a way to actually also illustrate that it's working to staff to give staff more motivation that things are working their way.

One of the things that Arthur got us into is really focusing more on supportive housing, which is a real innovative program that he and many other people across the country have introduced. But sometimes supportive housing comes up a little short for some of the people because they find themselves really isolated. And so we're involved in a program in Philadelphia now that Arthur got us started with to really help people grow their social networks, natural social networks, connect themselves up to resources so that when they hit their own place, rather than feeling more isolated than they did before they actually rally blossom into being sort of a full participant in the community. All in all, the way that looks, church, going to school, volunteering, all of the good stuff.

Similarly with ACT teams. We've done a lot of – and actually ACT teams and the teams that support the supportive housing, actually are all fee for service. And it turns out fee for service is another way that you can get a naturally-occurring metric for determining whether or not it is that your implementation is working.

And I wanted to do is show you this here. This is units from one of the teams that we trained. These are things they have to capture in order to get paid. And what we discovered is that there were a certain number of people for each of the teams that just weren't wanting to engage with us. So with the tools that we have talked about, with recovery-oriented cognitive therapy, these teams were then empowered to be able to reach more of those people. And I think you can see in this graph, over the course of the training, the number of units this team was getting tripled, which is – well nearly tripled. I don't want to exaggerate here. We're just giving you a sense for the way in which the data. And then this information flows back to the team and they can really see that it is really making a remarkable difference.

This is the sustainability science piece of the work we've been working on. Which is really a way of sort of pulling together all the information that Arthur talked about in terms of what are the different factors that are going to allow an agency or a hospital to sustain this programming. And how it is exactly that we can sort of assess where we're at and where we're going. And so we can kind of turn the principles we talked about into actual procedures that we're tracking and ways in which we can move forward. And so I think

this is just an indication of the way in which we can make those things quite realizable for this kind of work with CT-R, but really with any other recovery right to practice.

These measures which look really pale and like they are from the 1970s are just ways in which introducing different simplistic measures into clinical practice for people with serious mental illness that can really enable us to track their outcomes, both the clinical staff and people who are in administrative roles trying to figure out does this work. You probably can't see these, but we have a loneliness scale, for example. We have optimism and pessimism. And these kinds of things are really, really helpful, and they are really quite simple to implement even though they kind of look opaque here.

This isn't the current data that we have, but basically we've been involved in helping a lot of people follow that trajectory I told you about a little bit earlier, which is that they start in the state hospital. Many of them have been there for decades. And how they are out into the community. some of them less long, but whether forensically involved or not, out in the community, beginning to participate, and really starting to have the life that they want. And that really requires really an implementation like this that's really on a network sort of level.

And I think I might stop right there.

So there's just some – this is some of the research support for the approach that we have taken. And then there's some recap of the things that we talked about.

I want to thank all of you for coming along with us on this and being able to share with us these ideas. And I only wish we could hear more from you.

Thank you very much.

Dr. Grant and Dr. Evans, thank you so much for the incredible information that you've shared in a very, very concise period of time. And I know that almost every point that you've made could be its own webinar. And so to kind of do the flyover for us and really whet our appetites for the implications of meaningful implementation is really very important. Because, I mean, we've made this commitment to looking at recovery-oriented cognitive therapy and have spent four webinars on this topic. And we've done so because we know that there is a real need for us to have access to things that are doable in the field and that have meaningful evidence behind it.

There have been some really great discussions happening between the participants, and also questions posed through the second topic question pod. And I would like to try to summarize or touch on as many of these as possible.

So one of the topics that a number of people asked about was there is a tendency to be limited in our scope of what we measure. And that because we only see people at certain points in their recovery, so frequently in crisis or in early recovery, we miss out on how we're able to measure sustained recovery. And then, as you all were wrapping up, you started talking about sustaining the evidence-based practice. And in my mind anyway, I saw this connection between the sustainability of an evidence-based practice being equal to the sustainability of recovery as a concept. And so I'm wondering if you can speak to sustaining connections or identifying data points for after people are in higher levels of care.

And either of you can speak to that.

Are you muted?

I can start, I guess.

Thank you.

Sure. I mean, I think one of the things that I was trying to show is that it's not the same people that will be working with the individual, obviously, as they really sort of step down to lower levels of care, and ultimately, for some of them, step completely out. So I would say – so that – I think what Arthur was

talking about, sustainability within agencies and maybe across them, which is different than the individual actually sustaining their progress and moving forward. I think they are different. I think the two things can definitely support each other and not – but I realize they are actually different – different (inaudible) the question.

Um hmm.

And part of, really, what I think I'm saying is the really positive message that somebody isn't just on an ACT team for life, or somebody isn't just in a residence for life, but they are moving forward in their life. And so that requires a flexible system that can support them at those different levels. And really I would almost say more or less empower them and collaborate with them. I wouldn't say as – support sounds too – too strong, I think, for what their actual experience is on the ground for the most part.

That's helpful. And I know that we will be – that Dr. Evans will be back in just a second. But I wanted to ask, and Paul, actually there were a couple of very concrete questions about CT-R. One is, are the Beck scales available free of charge to be used by clinicians, or how do people access this practice?

So it depends on which scales we're talking about. The most famous ones are actually no longer owned by Dr. Beck but they are actually owned by the Pearson Corporation. And that's the BD – the Beck Depression Inventory and the Beck Anxiety Inventory.

However, some of the other measures that we've talked about are not owned by anybody and they are freely available and we'd be happy to make them available to anyone who would want to use them. Because obviously we developed them with the idea that they would improve – be able to improve practice, improve understanding of what is going on. So it's just the most well-known ones are not in the public domain.

Sure. Sure. And so that's not atypical.

And also another question that we had was where – and Paul, I think you spoke to this actually, but maybe you could illuminate it a bit more – where might CT-R fit in a global continuum of care? Do you see it sitting in a particular section of services? Or how do you see it working across (inaudible) people access?

Well I think – well the way I see it is I think that the basic framework is a pretty good way, if you are working with people who it's difficult to get started with. Or people who don't want to have – who don't think they have an illness, don't want to have an illness, don't want to deal with those sort of psychiatric labels – I think it's a particularly effective practice for that. And certainly I think it works pretty well in the first episode. It works pretty well. And so people who are chronically institutionalized.

So I think the basic framework on this is really useful for making sure you are connecting up with the person and really trying to help them really realize the life that they want.

Then in terms of how you help them with some of the challenges, that's where I see evidence-based practices as plugging in and different ones. You could find that, for example, for somebody your really going to need prolonged exposure or something like that. But we've worked with people or used the basic framework as a way to really connect up with them, find out what's important, and then motivate why it is we might do prolonged exposure, say.

So I see it as a – when you don't have a good way of really sort of getting the recovery thing going, really sort of understanding how you can make resiliency stronger, that's where I see it sitting.

We have – like I was trying to say – in Philadelphia we've tried to focus on a network that really links us to some of the people who have historically been more challenged to get the life that they want. So that's where we focused it in Philadelphia. But in other implementations we have focused more on the early end of it – of the continuum.

Uh huh. And so because recovery-oriented cognitive therapy has been most specifically designed for people who would fit into a diagnosis of schizophrenia, you would see folks earlier in services. And perhaps while needing more support?

Sure. Sure. It's definitely very applicable when there is a lot more need for sure.

Um hmm.

And I just want to let the audience know we're not ignoring Dr. Evans. He's having some phone difficulties, so we're hoping he can join us for some of the Q&A in just a second.

But I also am wondering if there is anything that you can say, Paul, about the training that stands behind CT-R, and kind of the burden of training. Is the approach a certification? Is it exposure? How would you suggest that people prepare to actually use CT-R in practice?

I would say there's a lot of different ways that we've done it depending on the agency, the state, etc. I would say that certainly we have models that involve certification, especially for the individual therapy. We also have consultation models that we have utilized, sort of weekly consultation for supporting teams, either in hospitals or in communities. Also residential settings. And we actually find – we're finding that a team-based approach can produce some pretty amazing outcomes. And I certainly didn't have an opportunity to talk about that a lot here, but there's a couple of places that Arthur has collaborated on with us in Philadelphia that are just doing incredible, incredible work.

So if you have some really motivated people who have got some real desire to do this work and they get their minds around it, some amazing outcomes can be achieved.

That's great.

Dr. Evans, I see that you are now not only able to hear but perhaps speak.

Yes.

And I'm wondering if you have been able to hear some of the conversation and if you have anything to add?

Well, I think one of the big takeaways, and Paul alluded to this in his presentation, is the whole idea of thinking about these things from a systemic standpoint. And so when he talked about, you know, it's one thing for us to do CT-R on an inpatient unit where you have the person who is in the corner not participating, get that person into the community. Well, when you get that person in the community, you want the community provider to also be trained up in that EBP so that you can continue the work and the approach of the work that was started on the inpatient unit.

So thinking about it that way I think really helps the people that we're trying to serve, making sure that they – that we're not thinking about our little box – what I call our little black box – but we're really thinking about the whole experience for the person and ensuring that we get the practices across the whole continuum of care of that person. I think that's a really important point of all of this.

That's very important. And it's been interesting because a lot of the comments and questions that have come in have really been focused on that continuum of care.

And just as we wrap up because we are quickly running out of time for our hour, folks are looking for some very specific information about accessing resources, in particular the public domain measurements. And Paul, I'm wondering if can either tell people how they can access that or if we can get that to disseminate as part of the presentation?

I'll provide you a link. I'll provide you a link.

(Inaudible.)

And I would say, also, if people are interested in some of the background on the larger strategies that Philadelphia was and continues to implement, they can go to the website which is ebhibs.org. And there are things there – resources there like a toolkit on peer services and how to effectively implement peer services. As well as information on the Evidence-based Practice and Innovation Center and so forth. So that could also be an important resource for people who are trying to think about these issues in a systemic way.

Sure. Arthur, would you mind repeating that website –

Website?

Because we are going to type it into the Participant Chat?

Sure. It's ebhids.org.

Super. Thank you.

Sure.

And so we are past our time, and I want to take a quick moment to thank our presenters. We really have to have a way to transfer the knowledge that some people have to the greater audience. And Dr. Grant, Dr. Inverso, who was with us on the first three webinars, Dr. Evans, you all being willing to participate with Recovery to Practice has been very meaningful and rich, and I appreciate your time and your skills.

I want to remind folks that we are committed to providing all of this information from a recovery perspective and that we embrace and support SAMHSA's ten principles and four dimensions of recovery in behavioral health.

And this is really just the tip of the iceberg. And if you have not been on the other webinars in this series, I would suggest that you check those out. Each of them have additional resources attached to them that give you a jumping off place to begin your own study and exploration of these topics. Also ways to connect with other people.

In addition to the webinars that we offer, we have a newsletter that's the companion newsletter on recovery-oriented cognitive therapy and some provides some additional links and an interesting dialogue about how recovery-oriented cognitive therapy is used in practice in real life.

And we're not stopping. We have the rest of the year to continue to bring excellent information to you. Our next series is going to look at engagement and recovery-oriented practices. And I think that it's really important that we look at that and that CT-R actually is a great springboard for us to look more specifically at engagement. And I hope you will join us. We will be sending out emails with the specific dates and times and presenters so you will be able to register.

Remember you can get a CEH, and I know a number of people were asking about if it would apply to their particular profession. And what I would tell you is that the folks that we work with at NADAC have great connections with other professions and that a lot of states and a lot of organizations will honor that hour. And so it's worth following the link.

Thank you so much. Our presenters, it's always great to learn from you. I'm grateful that I get to moderate these calls so that I have the opportunity to continue my learning. Everyone who participated and who joined us on the call, I hope you have a fabulous day so you are able to apply this information [end audio]