



**National Association of State Mental Health Program Directors**  
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## **Assessment #7**

# **Recovery-Oriented Cognitive Therapy: a Theory-Driven, Evidence- Based, Transformative Practice to Promote Flourishing for Individuals with Serious Mental Health Conditions that is Applicable across Mental Health Systems**

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Recovery-Oriented Cognitive Therapy: a Theory-Driven, Evidence-Based, Transformative Practice to Promote Flourishing for Individuals with Serious Mental Health Conditions that is Applicable across Mental Health Systems

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## **Abstract**

Recovery-Oriented Cognitive Therapy (CT-R) is a theory-driven, empirically-supported approach for promoting recovery and resiliency in individuals experiencing serious mental health conditions. This approach can impact individual therapy, group therapy, and the milieu to help individuals access motivation, develop powerful aspirations, and actively pursue the life of their choosing. It begins by identifying times when the individual is at their best, energizing this “adaptive mode,” collaborating to develop and actualize the individual’s aspirations, and building resiliency to empower the individual relative to current challenges (*e.g.*, low energy, limited access to motivation, hallucinations, delusional beliefs, aggressive behavior, or self-injury). CT-R is flexible and can transform the experience of providers and individuals.

This paper will describe the theory, evidence, practice, and implementation of CT-R. This will be illustrated in the experience of seven states that have implemented CT-R. Six states – Georgia, Massachusetts, Montana, Vermont, New Jersey, and New York -- were awarded Transformation Transfer Initiative (TTI) grants for CT-R programming administered by the National Association of State Mental Health Program Directors (NASMHPD) in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA). With the addition of Pennsylvania, the efforts of these states illustrates the flexibility and utility of Recovery-Oriented Cognitive Therapy to produce transformative outcomes.

## Defining the Challenge

Since the early 1960s, there has been a dramatic shift in the site of care for individuals given a serious mental health diagnosis such as schizophrenia, from state hospital into the community (1-3). Over this same time period, recovery has become a mandate for treatment in the United States and abroad. This change in treatment orientation was spurred by the landmark 1999 *Olmstead* decision of the Supreme Court, *The Surgeon General's Report on Mental Health* in 2000, and the 2003 *President's New Freedom Commission Report on Mental Health* (4-6). These changes constitute a paradigm shift in the location – institution to community – and nature of care – from custodial to empowering – consistent with what individuals want – a meaningful and participating life in the community.

Despite these advances, there are many who find themselves incredibly disconnected from others and purpose in life. Many are still in institutions – forensic or civil – even more find themselves alone and isolated in the community. They may have learned not to trust providers. They may have withdrawn into an ‘as good as it gets’ life of quiet desperation, and passing the time. Others may see them as fundamentally different, as broken, as incapable. They may see themselves that way.

Mental health providers may also be at a loss as to how to consistently reach these individuals, whether they be in constant crisis or not interested or feeling unable to engage. How do you promote their recovery, help them discover inner empowerment and get the lives they have always wanted?

Recovery-oriented cognitive therapy, or CT-R, is an approach designed explicitly to help providers and teams work with such individuals. It incorporates a powerful theory of why they live as they do, helping to understand challenges as diverse as low access to motivation, disorganization, paranoid and grandiose beliefs, aggressive behavior, and self-injury. The theory is also a guide to how to pursue a meaningful life and develop recovery and resiliency. The theory translates naturally into practical and highly teachable interventions. There is an evidence-base behind the theory that validates the approach. There are practical and feasible implementation methods that can introduce CT-R into large mental health systems to impact outcomes and improve lives.

## Theory

Dr. Aaron Beck developed the cognitive model nearly 60 years ago (7). This model explains how people get stuck in terms of beliefs about themselves, others, and the future. Individuals given a diagnosis of schizophrenia, for instance, may see themselves as weak, incompetent, incapable; see others as threatening or rejecting; and see their future as uncertain and forbidding (8). These beliefs have force like gravity. It becomes hard to access motivation and easy to be consumed by hallucinations and delusions -- and above all to be held back from the life of one's choosing.

Research and practice now support Beck's theory to help our understanding of depression, anxiety, anger, chronic pain, personality disorders, substance use, and criminality, in addition to hallucinations, delusions, negative symptoms, and many other challenges (9, 10). The cognitive model is extremely useful because no two people have the same challenges; it is a map for understanding and action in a person-centered way.

Building on this usefulness, we have extended the cognitive model to recovery, resiliency, and empowerment – it is a map for how individuals can flourish. We can think of the person's best self; the person they want to be more often. A good person. A helping person. One who is successful. One who others value and love. A person with a future that is full of possibility to make a difference. In CT-R, the cognitive model is our guide to find this best self and help the person live it every day (11).

## **Evidence-base**

### **Science of Beliefs.**

One of Dr. Beck's great contributions, going back to the late 1950s, has been to use research to test out the predictions of his psychological theory (12). How do you know that cognitive model is a good guide? This is part of the evidence supporting CT-R.

### *Negative Beliefs.*

Dr. Beck and I began our development of the CT-R approach by talking with many affected individuals, providers, and family members. When we asked a person why they no longer did the things they used to enjoy (such as basketball or cooking), they said things like: "Why try? I am only going to fail." We labeled these kinds of statements "defeatist beliefs," because the person is protected from failure by being inactive. The strong pull of these safe-keeping attitudes has the unintended effect of cutting the person off from purpose and meaning.

Our interviews also uncovered asocial beliefs – a preference to be alone rather than with other people. For example, "People sometimes think I am shy when I really just want to be left alone." Being with other people can pose challenges; it takes energy and opens one up to the possibility embarrassment, rejection, and other forms of bad treatment. Asocial beliefs conserve energy and keep the person safe because they stick to themselves. But, like defeatist beliefs, there is a big cost. The person still yearns to have a partner, have friends, join a church, participate in community sports, and the like – but can't get started.

*Defeatist studies.* An extensive literature now supports that defeatist beliefs contribute to disconnection and a way of living that produces disability for individuals given a diagnosis of schizophrenia. Dr. Beck and I conducted the first study showing that defeatist beliefs were related to negative symptoms, neurocognitive tests performance, and living a less full life (13). This finding has now been reproduced across the United States and in other countries (14). In a recent study of everyday life, defeatist beliefs cropped up many times during the day, predicting negative symptoms and not being likely to leave one's residence or physically move (15).

Other researchers have shown that those who feel rejected and have no sense of belonging to any social group are much more likely to endorse defeatist beliefs (16). Additionally, when defeatist beliefs weaken people have more success socially, more success at work, getting more of the life they want (17). Developing more accurate beliefs about capability may be a matter of succeeding in tasks performed with other people.

Defeatist beliefs are one of several factors which contribute to poor performance on tests of attention, memory, and problem solving (18). These are all factors that can affect anyone's performance; all can be addressed with psychosocial treatments. The upshot is that individuals given a diagnosis are not fundamentally limited and can succeed; they hold the key to their own potential to contribute (19).

Two studies together show that defeatist beliefs are related to negative symptoms, inactivity, along with difficulties in attention, memory, and problem solving in young people at high risk for developing a psychotic disorder (20, 21). Since a core pursuit of adolescence is being able to contribute to the greater good (22), defeatist beliefs might contribute to the person withdrawing, getting stuck, and feeling painfully separate and unfulfilled.

*Asocial studies.* We have demonstrated that asocial beliefs predicted future choice to not engage in valued activities with others (23). Other researchers have found that improvement in asocial beliefs mediated improvement in negative symptoms and everyday living (24). In a subsequent study, we looked at defeatist and asocial beliefs together and found both independently related to accessing motivation and community participation. If asocial beliefs are high, access to motivation is low, and participation in desired community activities is low. A similar pattern is seen with defeatist beliefs. You can be high in defeatist beliefs, high in asocial beliefs, or high in both types of beliefs at the same time (25). Empowerment in CT-R starts with participation, which increases access to motivation, and provides the opportunity to strengthen more helpful beliefs about capability, success, and togetherness with other people, building activity-sustaining resiliency.

### *Positive Beliefs*

The cognitive model predicts that positive beliefs about the self, others, and the future should be related to better outcomes. In a new study, we have shown elevated positive beliefs predict future community participation, as well as lower negative symptoms and lower positive symptoms (26). Similarly, in a study in which we simulated the therapeutic process of CT-R by collaboratively helping individuals succeed at a task, the best predictors of success were increases in positive beliefs (self, other, future) and the experience of positive emotion (27). This fits with our clinical experience -- positive beliefs and emotion are royal roads to recovery and key targets for CT-R.

### **Validation**

We conducted a clinical trial testing CT-R with individuals having elevated negative symptoms. At the start of the study, if each these participants took a snapshot of their daily life, you would

see cigarette smoke, the television, a case worker, a psychiatrist visit – not a lot of activity. We randomly assigned them to continue their standard treatment in the community or to also receive weekly recovery-oriented cognitive therapy. At the end of 18 months of active treatment, people in the CT-R cohort showed improved functional outcomes, they had enhanced access to motivation, and their positive symptoms were lessened. In real-world terms, the change experienced by the typical person in CT-R was life-altering: from spending all week smoking cigarettes and watching TV, to making a friend, volunteering, starting to return to school, or starting to date (28).

We found that each of these gains was sustained over a six-month follow-up period in which the participants no longer received CT-R. Of interest, people who received the diagnosis 20, 30, 40 years before enrolling in the study still showed significant improvement by the end of the 2-year study period (29). Improving positive beliefs, importantly, best predicted increased community participation for all the people who took part in the study (26). It appears CT-R helps individuals change what they do and how they see themselves, others, and the world in a lasting positive way. Nobody's symptoms are too severe or of too long a duration to get better and get the life they want. Recovery extends to everyone.

### **Approach: What is Recovery-Oriented Cognitive Therapy?**

Theory and evidence are translated into practice. The arrow depicted in Figure 1 illustrates CT-R, capturing forward progress and components of the approach — what we do to produce recovery, resiliency, and empowerment in a straightforward, easily learnable procedure. What works for people is the pursuit of sustained activity that brings them a tremendous amount of meaning. At the heart of CT-R practice, we develop trust, collaborate with the person to develop and realize their purpose or mission in life, drawing attention to the rich meanings that strengthen positive beliefs and neutralize negative ones.

### **Adaptive Mode**

Where to start? A useful concept is the “adaptive mode” (30). Think about someone who is very withdrawn from others, or seems to be focused on voices, or believes they are in danger. When are they not like this? During music therapy group, at a birthday party, or during a sporting event where they are warm, funny, connected, alert, and knowledgeable. The adaptive mode captures this shift in belief, emotion, and action. We can also call it an ‘at their best’ moment. The adaptive mode is a part of everyone, as we all have times we are at our best. In CT-R, we locate this adaptive mode in every single person. Because it tends to be dormant, we energize it, then help the person develop, actualize, and strengthen it.

### **Accessing and Energizing**

It is always a good thing to begin with connection. There is very extensive research that connection is a fundamental human need (31) that extends to everyone – whether they experience mental health challenges or not. Connection is core to our ability to be successful in life.

Connection is frequently lacking in the lives of people given a serious mental illness diagnosis. We see this in congregate living settings such as day rooms in hospital units and programmatic residences in which a lot of people are together but no one is interacting. To borrow a phrase, “they are together alone.” The sources of this palpable disconnection are negative symptoms such as lower energy, difficulty accessing motivation, reduced time with others, less seeking of pleasure, one-word answers, and diminished expressiveness. These negative symptoms are the best predictors of hospitalization over a year’s time (32). Disconnection from others leads to a worsening of challenges (harm to self or others) that leads to hospitalization. This is a downward cycle: Isolation leading to institutionalization leading to further demoralization and marginalization.

A significant number of people given a diagnosis of schizophrenia do not express wanting treatment, wanting a diagnosis, or wanting help. They may be very discouraged, feeling that whatever they are doing is as good as it gets. It is necessary to meet them where they are. This is a matter of accessing their adaptive mode through human connection over shared interests and activities that excite the person.

But accessing the adaptive mode is not enough. We need to recognize “at their best” moments and help to make these happen more often. This is energizing to ensure the person experiences the adaptive mode frequently and predictably. This is about repeatedly developing the connection through shared interests that should involve the individual helping the practitioner and others in some way. The positive social experiences provide ample opportunity to draw conclusions about personal capability, the value of doing things with others, and how activity leads to more energy. This step brings about the recovery dimension of connection.

### **Aspirations and Action**

Becoming more connected, beginning to trust, developing more energy, gaining more access to motivation — all occasion a shift in focus to a life the person really wants, such as owning a home, having a job, starting a family. We use the term “aspirations” for these life targets. Aspirations are big, meaningful, motivating desires. Critical to CT-R is identifying targets for action that have these qualities, really imagining what they would feel like, and eliciting the meaning behind them. By developing the adaptive mode in this way, we operationalize another important recovery dimension and pillar of health – hope.

CT-R is not so much a reflective process as an active process — purpose is lived. Once we know the meaning of a person’s aspirations, we help them realize it every single day through positive, daily action that achieves their highly valued meaning. We do these activities together; we promote doing them with others; we take steps toward aspirations — all to grow a vibrant and flourishing life space. This process of actualizing the adaptive mode brings about another important recovery dimension and pillar of health — purpose.



## **Strengthening Positive Beliefs, Building Resiliency, and Discovering Empowerment**

Experiences are the doorways to meanings. Succeeding interpersonally, making a difference with other people, getting a desired life — these are all opportunities to strengthen positive beliefs. Being capable, lovable, able to enjoy things, can connect; others are appreciative, interested, caring; the future is full of possibility and success. This is a lived best self.

Living one's chosen life is risky and will bring on stressors. When life is more difficult, challenges — such as negative symptoms, hallucinations, delusions, aggression, and self-injury — emerge. Resiliency is about discovering and building up a sense of empowerment with regard to these stressors and experiences. One of the greatest gifts we can collaboratively develop with someone is for them to recognize that when things do not work out, it is not a catastrophe -- not all hope is lost and they can still get what they want. Building resiliency beliefs is another essential part of CT-R that brings about the recovery dimension of personal empowerment

In summary, the cognitive model guides a person-centered, individualized way of understanding how people get stuck and how they thrive. The theory is supported by a diverse set of research studies. The therapy has been validated in a clinical trial. Recovery extends to all, and there are concrete and effective procedures for bringing it about. All individuals have an adaptive mode within them, and everyone who works with them can collaborate to promote flourishing.

## **Implementing CT-R: Improving Staff Skills and Outcomes for Individuals**

Recovery-oriented cognitive therapy embodies a very exciting process of being able to connect with someone, finding within them their deepest values and desires, beginning to realize these values and desires in daily life, and empowering them relative to the challenges that have historically gotten in their way. The approach operationalizes recovery, resiliency, and empowerment. It is easily learned by staff from all levels of education and roles in care, building on what they already know to create new possibilities in care.

Introducing CT-R into a service or system does not require hiring new staff or creating new positions. The successful implementation model (33) is flexible and involves four phases: early collaboration and planning, workshops to deliver basics of theory and practice, consultation to put CT-R into action, and sustainability to keep it going over the long term, making adjustments based upon program evaluation.

### **Phase 1 – Orientation to CT-R implementation**

A successful training effort requires that the stakeholders in the administration understand, buy-in, and help to guide the process. It also requires that supervisors and staff who will be learning CT-R also provide input to the process and become invested enough to give the approach a try. These are the objectives of the first phase of CT-R implementation.

### *System-level Administration*

CT-R experts meet with leadership to develop an understanding of what CT-R is, what it can do, and how it can be implemented. These sessions provide opportunities for CT-R experts to learn the needs of the system. Common system challenges that can be a focus of implementation include individuals who are afraid to leave the hospital, building capacity to enable recovery in the community, and special applications (e.g., residential, early episode teams, forensic). A CT-R training is quite flexible, and the experts and administrators develop a plan delineating the expectations for when and where the training will occur, meetings with local leadership to develop investment in CT-R, explain how it works, and the expected process; also to start gathering information that will inform CT-R training and implementation. Sustainability and measurement of the quality of implementation and outcomes are also a focus.

### *Site-specific staff*

For each site or service involved in the training effort, CT-R experts will hold meetings (remote or onsite) with local leadership (of the hospital, unit, agency, team) to plan the training, conduct a focus group for the staff identified to learn CT-R, and give a general session such as a grand-rounds to familiarize more staff members at the site about the approach.

*Local leadership.* Meetings between the experts and site leadership helps to answer questions about what to expect. If the project involves a selection of staff and focus of the training, the experts can help to provide examples of how different options have fared in different systems in the past. A significant cost to a training is taking people off of the service for the hours of workshop and consultation. Experts can help the leadership set priorities and also to make sure that their staff can fully participate.

*Focus groups.* These sessions include staff selected for the training, administrative leaders, and CT-R experts. The meetings successfully identify staff strengths, points of pride, areas where they would like to improve. The session increases enthusiasm for CT-R, gives staff a chance to provide input into the focus of training, and helps to establish the legitimacy of the experts for the challenges that staff face on a daily basis –mistrust of care providers, low energy, aggressive behavior, beliefs that are hard to understand, self-injury, and disorganization.

*Introduction to CT-R presentation.* A general information session, sometimes referred to as Grand Rounds or Kick-off, can be helpful for orienting and familiarizing the rest of the staff with CT-R and the implementation project. Including the entire facility in the CT-R information session generates additional interest and increases general knowledge of CT-R, and can help to support future expansion of the program.

*Baseline assessment.* Built into the process of implementation is teaching staff to use the CT-R quality assessment (Table 2) to gauge the progress of implementation to ensure that the program is doing CT-R and can sustain it long-term. Experts collaborate with key staff members to

determine the initial level of CT-R. This baseline assessment is the benchmark against which future evaluations of the service can be compared to measure progress and to set aspirations for further improvement.

## **Phase 2 – Workshops**

CT-R experts lead the workshops. The focus is experiential exercises to convey the basics of CT-R. All disciplines can participate -- nursing direct care, social work, licensed counselors, recreational therapists, vocational specialist, psychologist, nurses, psychiatrist, and peer specialist. Trainees complete the workshops with action plans to return to their units, residence, and teams to begin the implementation. Knowledge and skill are improved, along with a raised excitement level to start doing CT-R. Workshop sessions can be scheduled flexibly to account for staffing issues. For some sites, spreading the workshop over several weeks in couple hour increments works best; other sites prefer massing the workshop into two or three consecutive days.

## **Phase 3 – Consultation**

The heart of CT-R acquisition occurs during the consultation period. Consultation consists of regular sessions, often weekly, of one to two hour duration, along with occasional onsite visits. CT-R experts facilitate these consultation sessions, which build upon the know-how imparted in the workshop. Discussion focuses upon specific individuals on the unit, residence, team, or case load. Staff develop recovery maps, make action plans, and then follow up in the next session. Table 1 contains a “how to guide” for completing a recovery map to illustration the process.

Consultation sessions aim to help each staff member learn from each individual discussed and to see the stages of recovery as individuals begin to improve. The sessions also focus on setbacks the individuals might experience and how to turn these to advantage, promoting empowerment and resiliency. Staff that go through consultation often observe that this is a terrific opportunity to make their work with each individual more concerted, coordinated, and intentional.

The consultation sessions can focus on how to include other members of each team to help them acquire the understanding and skill to grow the footprint and effectiveness of CT-R. Sessions can also focus on individual or group therapy, whichever is more relevant for the service. Group therapy consultation session, for example, can help improve the appeal of the groups, enhancing connection and link to purpose and the life each individual is seeking.

Onsite visits by the experts help enhance the positive relationship with staff. These also can be occasion for the experts to observe the CT-R work first-hand, giving feedback or modeling some of the skills. Site visits are also a great time to collaborate on filling out the CT-R quality measure to assess how well the implementation is going and to set future aspirations.

## **Phase 4 – Sustainability**

Discussion of sustainability begins at the start of the CT-R process. Everyone involved can collaborate to keep it going. CT-R can become a part of how the site or service operationalizes care. Continuing internal consultation session can be key to sustaining CT-R. The expert trainers can taper down participation in these sessions as the local team takes it over with their burgeoning know-how. Experts can help when challenges emerge that seem particularly hard to resolve.

The CT-R quality scale is useful in assessing how well the service is doing and for making adjustments and future plans to improve the approach. Maintaining excitement for the approach is part of the sustainability effort. Building it into documentation, care planning, and onboarding of new staff are all part of sustaining the practice. Some sites have developed internal curricula to enhance skill. Others have used media, such as web-based videos, to impart the ideas and skills. Still others have created learning collaboratives to share and develop collective skill. Figure 2 contains the components of sustainability.

### **What CT-R Looks Like in Practice: Seven States of the Art**

Seven U.S. states have undertaken sizable CT-R implementation programs: Pennsylvania, New York, Montana, New Jersey, Vermont, Massachusetts, and Georgia. Six of these states received Transformation Transfer Initiative (TTI) grants in CT-R from the National Association of State Mental Health Program Directors (NASMHPD) in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA). Each state has approached implementation differently, given differing challenges, strengths, and aims. A consideration of each illustrates the flexibility and usefulness of CT-R, as well as providing models for future implementation efforts. Table 3 summarizes CT-R implementation for each state.

#### **Pennsylvania: “Finding the Key to Recovery”**

##### *Implementation*

The Commonwealth of Pennsylvania was first to implement CT-R, beginning with the Department of Behavioral Health and Intellectual disability Services in Philadelphia and later joined by the Pennsylvania Office of Mental Health and Substance Abuse Services. This effort has created a network of care that includes the state hospital, 4 long-term hospital units, 10 programmatic residences, supportive housing, 8 community teams (assertive community, forensic, and specialty care), and outpatient agencies.

Implementation has involved a mix of network-wide and site-specific trainings, including focus groups, workshops, special topics, onsite consultation sessions, and learning collaboratives. All sites use the CT-R quality scale to assess the quality of their implementation and to set goals for improvement.

## *Outcomes*

There have been many benefits of the program:

- Significant reduction or elimination of use of control methods such as seclusion, restraint, and intermuscular injections
- More than 100 individuals returning to the community from state hospital or jail; many inspiring stories of full participation after decades in hospital
- Reductions in jail days and hospital days
- Continuity of care has improved across the network and recovery-promoting practices are being sustained

## *Next Steps*

Many of the providers are going for new levels of autonomy. Building CT-R champions at the service and linking them up across the CT-R network. A significant effort is going into using existing data and developing new data sources to capture the outcomes of staff and individuals in CT-R. This will help the services improve and also recognize that what they are doing is working, helping to improve rationale. There is also an effort to expand the network, to extend CT-R know-how to crisis centers and acute care units.

## **New York: “Piloting System Culture Change”**

### *Implementation*

The New York State Office of Mental Health (NYOMH) spearheaded the CT-R project, which was initially funded through a TTI grant from NASMHPD. More than 700,000 individuals receive care within a large, diverse mental health system that is organized around state hospital facilities called psychiatric centers. NYOMH administration elected to pilot CT-R at one of these facilities, South Beach Psychiatric Center.

Having evolved from a strictly inpatient facility to a system of inpatient and outpatient services for 3,000 individuals living on Staten Island or in Brooklyn, South Beach was an ideal location to focus on continuity of care. Staff from two inpatient units, the hospital treatment mall, a transitional living residence (TLR), an outpatient treatment center, and a mobile crisis team participated in the CT-R training. During the TTI phase of the project, CT-R experts facilitated focus groups, a grand rounds, two workshops, 26 weeks of consultation, and three site visits. South Beach collected outcomes before the training started and then after 6 months of consultation. South Beach used a local champions model of sustainability; these staff members participated in monthly calls with CT-R experts to strengthen and grow CT-R at the facility.

## *Outcomes*

Individuals were selected to receive CT-R who had not been responsive to treatment. Program evaluation findings over a 7-month period of implementation were promising and consistent with the aims of CT-R:

- 50% moved to less restrictive level of care
- loneliness of the group was reduced
- hopefulness increased
- flourishing increased
- functional skills increased

Staff implemented CT-R in a variety of modalities, including milieu, group, and individual therapy. They observed:

- learning new interests and talents of individuals they have worked with for an extended period
- having particular success connecting with individuals who had previously been very isolated and disconnected
- focusing programming activity and opportunities on individuals' interests and skills.
- developing roles for individuals to teach others

### *Next Steps*

The success of the CT-R pilot at South Beach — both staff enthusiasm and individual outcomes — has prompted a larger rollout of CT-R in New York. A total of 17 facilities — forensic and civil — will receive CT-R training over a three-year period. The first year runs from July 2019 through June 2020 and will focus on introducing CT-R in facilities near New York City (“downstate”). The second year, July 2020 through June 2021, will focus on sustaining these facilities and extending the CT-R initiative to facilities in the rest of the state (“upstate”). The third year will be devoted to cultivating autonomy for New York State in sustaining CT-R across the system long-term.

At a kickoff for the new round of training in July 2019, NYOMH Commissioner Ann Sullivan expressed her excitement and enthusiasm for CT-R implementation. She sees CT-R as particularly applicable on inpatient and outpatient teams and for collaborating with people who are getting particularly stuck in their recovery, either in the hospital or community. She called CT-R a culture changer, inspiring the administrations of the facilities to devote the resources to get the training, as it would be well worth the investment.

## **Montana: “Taking Recovery to the Frontier”**

### *Implementation*

A frontier state that has the fourth largest land area in the US but just over 1 million inhabitants, Montana contrasts starkly with New York. The Montana Department of Public Health, Addiction and Mental Health Disorders, and key personnel at Montana State Hospital, collaborated with the CT-R experts on the implementation project, which was funded by a TTI grant from NASMHPD. Long distances and low population density impact individual mental health

presentations, as disconnection and despair are especially prevalent. Service users are spread out – often far from other communities and far from treatment providers.

The CT-R initiative in Montana afforded providers the chance to come face-to-face, collaborate on challenges, and strengthen their connection to each other, while providing a common language and framework that can be implemented anywhere in the state. Continuity of care between the state hospital and community providers was a major emphasis. Trainees were staff at the state hospital, residential programs, community teams, as well as outpatient agency clinicians and state mental health officials. Sustainability of the program involved a train-the-trainer model.

CT-R experts facilitated three workshops, drawing trainees from across the state. Each workshop grew in number of attendees and showed an increase in the amount of time the new experts in Montana were presenting the key CT-R topics. An outpatient agency (Center for Mental Health in Great Falls), two programmatic residences (Anaconda Work and Residential Enterprises or AWARE), and Montana State Hospital (2 groups – one focused on individual therapy, one focused on milieu/club/group programming) participated in 26 hours of consultation with CT-R experts. The consultants also focused 26 hours on the train-the-trainer group, emphasizing specifics of workshop and consultation pedagogy.

The CT-R experts conducted onsite modeling at the state hospital and one of the residences to demonstrate effective methods for eliciting individuals' interests, strengths, and aspirations. The consultants also helped Montana State Hospital develop teaching tools (short presentations on challenges and how to recovery map) for direct care staff who are not able to attend a workshop.

### *Outcomes*

At each level of care, staff reported positive results of CT-R:

- The outpatient agency found a significant increase in their staff satisfaction survey between the start of CT-R initiative and the final month of consultation
- The agency reported more coordinated care, for example, between therapists and vocational specialists. This involved starting employment (one man said: "I feel like a man again!"), *sustaining* work and developing resiliency beliefs in the face of challenges (one woman said: "I can do this; things will likely go better than I imagine they will"), reconnecting with family, reducing substance use, connecting with housemates and making friends, and reducing the expression of delusions.
- Recovery maps also facilitated continuity of care between state hospital and community residence.
- One individual who received CT-R at the state hospital moved from being subjected to constant seclusion/restraint to attending major campus events and performing a meaningful on-unit job. Another individual with medical challenges rediscovered a love of art, cars, and fashion, and renewed hope for the future, spurring a rapid discharge to the community. Yet another who had been overwhelmed with fears related to physical

health concerns became completely transformed when giving piano lessons to staff, leading to positive beliefs, refocusing, and identifying desires for a future outside the hospital.

- There were many clubs, interest- and aspiration-based, developed. Examples included: fashion club, Frisbee golf, a beautification club. An individual who initiated a card-making club, after being crippled by negative symptoms and physical challenges for a lengthy period, was successfully discharged. And individuals receiving CT-R on the milieu, in groups, and in individual work have begun taking advantage of all of these clubs and groups, creating a lively, therapeutic culture with obvious links to the community.

### *Next Steps*

Sustainability of the initial CT-R training has been supported by the train-the-trainer group, as well as local champions at each site that received consultation. Demand for CT-R training has been so great in the state that it exceeded the capacity of the initial group trained as trainers. Montana has initiated a further round of training, explicitly focused on expanding the network of trainers so that communities across the state have access to quality training, consultation, and supervision from local providers.

Beginning in July of 2019, Montana reengaged with CT-R experts to conduct three regionally-based (west, central, and east) groups totaling 40 new trainers. This group of supervisors, nurses, peer specialists, advocates, and therapists (among others) will collectively be part of a network of nearly 50 CT-R trainers in the state of Montana. They represent several organizations and treatment modalities (acute inpatient, family/school-based, outpatient, community teams, residential, individual and group therapy providers, emergency services/crisis response, tribe-based, etc.). After the three-day workshop, this group of trainers have the opportunity to receive consultation calls on their own cases and on the CT-R-based supervision they provide to others over a six-month period. Another aim is the creation of infrastructure to support sustainability of the programming in all its forms, and to support the state's internal trainers. This will include networking learning collaboratives and internal consultation that the state facilitates.

## **New Jersey: “Potentiating Innovative and Powerful Integrative Care”**

### *Implementation*

The Department of Human Services, Division of Mental Health and Addiction Services of New Jersey opted to apply CT-R to an innovative program integrating physical and mental health care — Behavioral Health Homes. These specialty care, community-based teams are comprised of therapists, nurses, doctors, peers, and cases managers. CT-R fits into the mission of these teams by helping each develop formulation-driven ways to reach individuals who are not engaging with the team, as well as the use of recovery mapping to contextualize physical health and mental health challenges in terms of each person's aspirations. The goal was a synergy of mental and physical health outcomes in pursuit of each person's desired life. The project was funded by a TTI grant from NASMHPD.

Four behavioral health homes participated in the CT-R training: Catholic Charities, Hackensack-Meridian, Oaks, and All Access Mental Health (AAMH). CT-R consultants facilitated a three-



day workshop, delivered one day a week over one month's time, and 26 hours of consultation per team. Each home received three site visits from an expert consultant. Sustainability in New Jersey was supported by an elite trainer model. Three trainers at Rutgers University Behavioral Health Care participated fully in the training, including 26 hours of consultation from CT-R experts.

### *Outcomes*

At a panel convened at the end of the project, staff who participated reported the following about the success of the project:

- Within just a few months, individuals who had been using substances for decades stopped entirely and began taking steps toward their chosen values in collaboration with the team, and also began voluntarily attending physical and mental health appointments.
- Individuals who had been previously hesitant to leave their homes at all began walking, shopping, and engaging in their communities.
- Team members were able to have more and longer contacts with individuals, reporting better connection and increased hope in their work, even in some of the most challenging situations. This was attributed to developing a better understanding of challenges they typically did not know how to approach previously, such as delusions.
- Behavioral Health Homes incorporated the Flourishing Scale (34) into their intake, which made outcome measurement clinically relevant. Staff noticed that when individuals said they were not flourishing in a particular area, this led more naturally to a discussion for what was holding them back, what they might do to live the life they want, and how it might be worth collaborating with the team to get there together.
- Sites incorporated the recovery map into the treatment planning process. This ensured that accessing the adaptive mode, aspirations, and important positive and negative beliefs became central to treatment planning.

### *Next Steps*

The Rutgers team has sent a proposal to begin a second round of training in which they will lead workshops, consultation, site visits, and sustainability efforts. The aim of a second round of training would be to increase the number of homes using CT-R, as well as to develop autonomy and sustainability of CT-R in New Jersey to powerfully promote integrative care.

## **Vermont: “Proof of Concept in a Decentralized System in Rural New England”**

### *Implementation*

Vermont presents yet another model of organizing care for individuals with serious mental health conditions. Shifting care to the community from the state hospital has resulted in the creation of 10 regions and 12 designated mental health center providers. The CT-R pilot project in Vermont was a proof of concept in a decentralized system, funded by a TTI grant from NASMHPD. Three

of the designated providers participated fully in the TTI training effort — Clara Martin Center, Washington County Mental Health, and Pathways/Soteria. Two state-run facilities also fully participated—the state hospital (Vermont Psychiatric Care Hospital) and a forensic residence (Middlesex Therapeutic Community Residence). CT-R experts visited the five participating facilities to meet with staff to inform the training. Consultants facilitated three three-day workshops open to providers across the state, as well as held 26 hours of consultation for each of the five sites, and conducted site visits. Sustainability focused on local champions.

### *Outcomes*

At the end of the training period, staff reflected on successes they had seen as a direct result of CT-R. These included:

- finding new ways to engage with individuals with whom they had previously been disconnected
- working more collaboratively, and effectively, with individuals by understanding, exploring, and focusing on aspirations as the main driver for treatment
- trying new strategies empower individuals interested in employment
- developing documentation including CT-R language and strategies to better inform treatment and communicate within teams and across them
- holding internal CT-R consultation groups

### *Next Steps*

Beginning September 2019, Vermont initiated a second round of support of CT-R, funded by a SAMHSA block grant. CT-R experts have introduced the quality measure at each site to assess the CT-R implementation and set goals for improvement. Additionally, they have offered CT-R booster sessions and helped establish an ongoing CT-R learning collaborative. Consultants will also provide additional orientation, training, and consultation for other mental health centers in the state, including applying CT-R principles to forensic and homeless populations..

## **Massachusetts: “Starting a ground swell for CT-R”**

### *Implementation*

The Massachusetts Department of Mental Health (MassDMH) implemented CT-R to improve recovery-promoting treatment in the state system, receiving a TTI grant from NASMHPD to conduct the project. The focus was sites where enhanced skill would facilitate better outcomes for individuals with serious mental health conditions. Participants included staff from two inpatient settings (one long-term, Tewksbury State Hospital, and one acute, Carney Hospital) and four community teams [two Programs of Assertive Community Treatment (PACTs) focused on mental health — Department of Mental Health Brockton PACT and Behavioral Health Network's Forensic PACT — one team focused on homelessness — Eliot Community Services' Project for Assistance in Transition from Homelessness or PATH team] — and one team focused on early episode (Net's Prevention and Recovery in Early Psychosis).

MassDMH recruited two CT-R trainers from a local agency that had successfully piloted CT-R previously. These trainers conducted two three-day workshops, facilitated all 26 consultation sessions with each group, and made all site visits. The Mass CT-R trainers also anchored the sustainability model.

### *Outcomes*

Each service reported positive experiences.

- Clubs organized around the interest of the individuals increase program participation at the state hospital. Staff have shifted their perspectives to looking for potential in each person.
- A PACT team reports a dramatic reduction in ER visits and hospitalizations. Another PACT team found breakthroughs with individuals they had not previously had success.
- A peer specialist on a PATH team reported being able to engage individuals much better – for example a person with a 40-year history of homelessness and intensive daily drinking. The hook was to go fishing. This led to learning that the person was an adept artist – drawing and fishing, all of which resulted in more connection, and a reduction in alcohol use. The peer reported that before CT-R she would have done more talking. Now, she knows to instead engage in meaningful activities together.

### *Next Steps*

Robert Walker of the Massachusetts Department of Health sums up the TTI CT-R process thusly:

What works, and what we are doing in Massachusetts, is to create system change from the bottom up. We have six groups trained, who are implementing it in six different ways, with six different levels of success. I think the big win is we have six groups trying it. We are having a one-day workshop today at the Massachusetts Psychiatric Rehabilitation Association Convention, to start to spread the word. What we need to do in Massachusetts is start a ground swell among the different providers to get them to try it out, and create momentum that way.

## **Georgia “Synergy with Peer Specialists and Infrastructure Development”**

### *Implementation*

Since 2012, Georgia has built capacity in CT-R skill amongst hospital and especially community providers across the state. The focus of the initial work was to help two groups of individuals: those transitioning from long-stay hospital to the community, and those who have difficulty sustaining themselves in the community. Training involved workshops, consultation, site visits, and competency determination in CT-R. Hundreds of providers were trained, helping more than 500 individuals with serious mental health challenges make significant progress in at least one of SAMHSA’s recovery dimensions (35).

The success of this project led Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) to expand the training initiative to adolescents and to develop a center of excellence (COE) for CT-R at Georgia State University. The COE employs highly skilled CT-R trainers (termed *elite trainers*) and staff who continue to sustain those already trained in CT-R, as well as to train new providers to maintain and grow the CT-R network across the state.

In late 2017, DBHDD was awarded a TTI grant from NASMHPD to expand CT-R's impact in the state and beyond. Highlights of this effort included developing a curriculum that Georgia as well as other states, municipalities, and agencies could use for the training of CT-R expert trainers. It also involved a peer specialist CT-R training and the creation of a peer CT-R competency scale.

CT-R expert consultants collaborated with GA COE staff to create both the elite trainer curriculum and peer competency scale. A series of meetings and feedback sessions comprised the process that resulted in the two documents. The Peer training involved a five-day workshop, two site visits, 26 hours of consultation, and competency determination.

### *Outcomes*

*Elite Trainer Curriculum and Peer Competency Scale.* The collaboration produced two documents:

- The elite trainer curriculum document contained training requirements, evaluation scales, and checklists for assessing expertise. The curriculum document is being piloted for feedback by experts inside and outside of Georgia.
- A 12-item peer competency measure assesses CT-R skills using a 6-point scale. The measure includes an instruction page, formatting instructions on how to provide feedback to peers, a definition of terms used throughout the measure, and a page outlining the structure of a CT-R interaction. Two peers who successfully achieved competency in CT-R during the initiative reviewed the completed measure and provided feedback.

*Peer specialist training.* This training was instructive because the Peers collaborated with the trainers to tailor the training to their unique roles. Logistical issues resulted in the consultation being paused half-way through. When the consultation resumed, there was a change of CT-R trainers. The second phase began with the new CT-R trainers – two from the Beck Team and one elite trainer from Georgia -- visiting each of the peer participants at their agency in Georgia assessing desired areas for modification of training and components to maintain.

The outcomes here are worth noting, as the peers excelled in phase 2.

- All six peer specialists reached competency – a score above 40 – on the Cognitive Therapy Rating Scale (36). These high-quality sessions (range = 40 to 51) stayed completely within the peer role. The expert CT-R trainers commented that the peers scored consistently better as a group than most clinicians. Standout items included: (i)

*collaboration* -- offering choices, allowing the individual to be the leader of the dyad, and using their own experience to equalize the relationship and motivate interventions; (ii) *interpersonal effectiveness* -- being genuine, professional, showing concern, and using recovery-oriented language; and (iii) *empathy and understanding in cognitive terms* – developing an understanding in terms of beliefs that guide all interactions.

- Peers reported experiencing a rejuvenation. It was thrilling to focus on each person's desired life, and collaborate with them to make tangible progress, developing resiliency relative to challenges that had historically held them back, and discovering their own empowerment and strength.
- Recovery mapping became essential to the peers' understanding of all individuals on their case load. Peers were able to provide valuable information to other team members. Clinicians, nurses, and case managers could develop better targets appropriate to the focus of their respective scopes of practice.

### *Next Steps*

The peer specialist training was the standout success of the TTI project. With the development of the Peer CT-R Competency Scale, there is a real opportunity to develop and disseminate this synergy between peer skill and role combined with the power of the CT-R model. Excitement from the possibility of peers producing amazing outcomes is palpable. Georgia is considering an expansion of this training effort. Other states with successful peer programs might also consider it.

The elite trainer curriculum is also a step forward. The next thing is to begin to use it to train elite trainers to competency in CT-R, as a systematized way to build training capacity to get more staff trained and more individuals benefiting from CT-R.

### **Conclusions**

The seven state CT-R initiatives add to the growing body of knowledge supporting the applicability and flexibility of CT-R as a viable platform to enable mental health providers to collaborate with individuals with serious mental health conditions in getting the lives they desire. This is a group that has historically been very disadvantaged and unable to find purpose, develop meaningful friendships and partnerships, or participate in the broader world. They find themselves disconnected, walled off from life.

CT-R is a powerful corrective. It has a well-supported and broad-ranging theory and teachable and practical methods, and is applicable to all ages and across persons and challenges. There are very straightforward implementation methods for introducing CT-R and sustaining it long-term. The six TTI grant results, in particular, show that it can work in very diverse settings – long-term and short-term hospitals, programmatic residences, forensic settings, community and specialty care teams, and in group and milieu therapy, using peer specialists or individual therapists.

The success appears independent of locale, from highly urbanized areas to low population density ones, in mental health programs as diversely organized and composed as those in Georgia, New York, New Jersey, Vermont, and Montana.

States, municipalities, and agencies might consider adding Recovery-Oriented Cognitive Therapy to their staff's repertoire for use with individuals who are stuck on their path to recovery. At present, there is a large gap between the lives of those who are given a serious mental health diagnosis and those who are not. More wide-spread dissemination of these methods could close this gap considerably.

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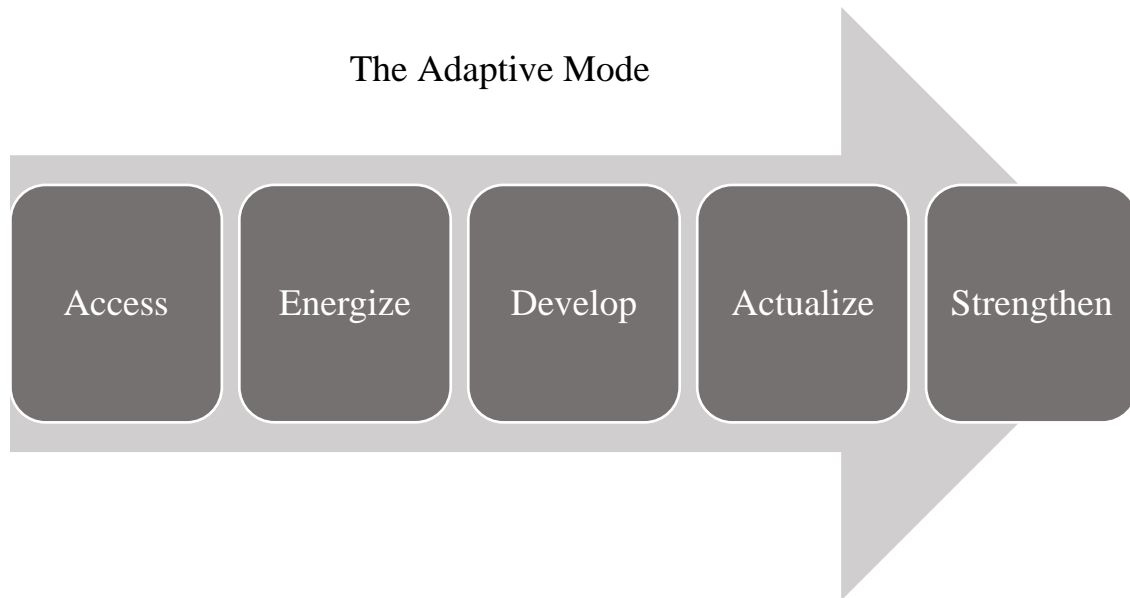
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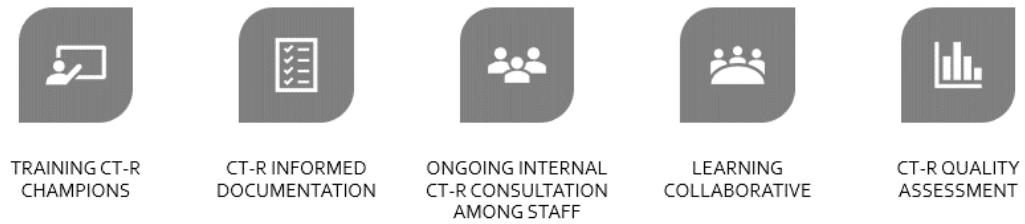


## Figures and Tales

**Figure 1. Recovery-Oriented Cognitive Therapy Model Adaptive Mode**



**Figure 2. Sustainability Model**



Sustainability






**Table 1. Recovery Map How-To-Guide**



<b>Activating the Adaptive Mode – Accessing and Energizing Adaptive Mode</b> <b>Recovery Dimension - Connection</b>	
<b>Interests/Ways to Engage:</b>	<b>Beliefs Activated:</b>
<p>What does a person look like at their best?</p> <ul style="list-style-type: none"> <li>• Shared interests</li> <li>• What can they teach you or help you with?</li> </ul> <p>Develop understanding of when things are going well or what were they doing when they were at their best.</p> <p>Let the individual guide you. Look for a brightening of affect, eye contact, focus, etc.</p>	<p>What positive beliefs are activated when in the adaptive mode? How does a person see themselves? Others? The future?</p> <p>How does the person feel while they are in the adaptive mode?</p> <p>Initially you may have to hypothesize but as you get to know the individual, make sure you test and confirm your hypotheses (e.g. “What does it say about you that you taught me this?”)</p>
<b>Aspirations – Developing the Adaptive Mode</b> <b>Recovery Dimension - Hope</b>	
<b>Goals/Aspirations:</b>	<b>Meaning of Accomplishing Identified Goal:</b>
<p>If everything was how they want it to be, what would they be doing? Getting?</p> <p>All responses accepted without judgment</p> <p>Use questions to distinguish between steps (e.g. discharge) and aspirations (longer range, bigger meaning)</p>	<p>What would be the best part about that [aspiration]?</p> <p>How might they see themselves or others if they achieved their aspiration? How would they feel?</p> <p>Meanings are most important aspect of distant, expansive, or high-risk aspirations</p> <p>Meanings can be actioned everyday, even if aspirations change over time</p>
<b>Challenges</b>	
<b>Current Behaviors/Challenges:</b>	<b>Beliefs Underlying Challenge:</b>
<p>Challenges that are getting in the way of working towards aspirations.</p> <p>Why are they still here in current level of care (symptoms, behaviors, experiences)?</p>	<p>What beliefs might a person hold about self, others, or the future that contributes to the challenge occurring?</p> <p>What feeling(s) might they be experiencing?</p>
<b>Positive Action:</b>	
Based on this, what would you try and why?	

**Table 2. Recovery-Oriented Cognitive Therapy Quality Assessment Domains and Items**

Domain	Items
A. Milieu Factors - CT-R milieu is a lively atmosphere filled with activity and connection with ample opportunities for individuals to engage with others in activities that are connected to their interests.	<ol style="list-style-type: none"> <li>1. CT-R Milieu Programming Frequency</li> <li>2. Individual/Staff Interaction Level</li> <li>3. Connection to Interests and Aspirations</li> <li>4. Opportunities for Roles</li> <li>5. Drawing Conclusions</li> </ol>
B. Community Involvement – provides individuals with many chances to connect to the things that matter to them in the community, regardless of level of care.	<ol style="list-style-type: none"> <li>1. Frequency of Community Involvement</li> <li>2. Connected to Interests and Aspirations</li> <li>3. Opportunities for Roles</li> <li>4. Drawing Conclusions</li> </ol>
C. Treatment Planning - collaboration between treatment providers and individuals, with the plan for treatment is anchored by an individual's aspirations.	<ol style="list-style-type: none"> <li>1. Including Individuals in Treatment Team Meeting</li> <li>2. Activating the Adaptive Mode</li> <li>3. Use of Aspirations to Frame Treatment Plan</li> <li>4. Collaboration in Treatment Planning</li> <li>5. Drawing Conclusions</li> </ol>
D. Transition Planning - individuals and treatment providers begin to discuss transitions to different levels of care as soon as possible. Individuals are actively involved in these discussions and decisions.	<ol style="list-style-type: none"> <li>1. Individual's Participation in Transition Planning</li> <li>2. Connecting Transitions to Aspirations</li> <li>3. Planning for Next Steps</li> <li>4. Building Resiliency Relative to Transitions</li> </ol>
E. CT-R Formulation - sites will develop, review, and revise formulations regularly as they may evolve as individuals become empowered and pursue their aspirations.	<ol style="list-style-type: none"> <li>1. Documented CT-R Formulations</li> <li>2. Completeness of CT-R Formulations</li> <li>3. Strategies and Interventions</li> <li>4. Team-Based Development of CT-R Formulations</li> <li>5. Communication of CT-R Formulation</li> <li>6. Staff Knowledge of CT-R Formulation/Action Plan</li> </ol>
F. Outcomes - CT-R sites have a plan in place to assess outcomes for individuals who are receiving services. These assessments include a focus on aspiration attainment, participation in individually meaningful activities, and satisfaction with the program.	<ol style="list-style-type: none"> <li>1. Outcome Assessment</li> <li>2. Types of Outcomes Assessed</li> <li>3. Use of Outcomes</li> </ol>
G. Staff Factors - a strong CT-R program has a robust training program in place to support new staff as they learn CT-R. Additionally, programs support ongoing improvement of staff CT-R skills by assessing their skills, conducting advanced or refresher trainings, and holding regular consultations.	<ol style="list-style-type: none"> <li>1. Assessment of Staff CT-R Skills</li> <li>2. Training and Integration of New Staff</li> <li>3. Ongoing CT-R Training for Staff</li> <li>4. Internal CT-R Consultation</li> <li>5. Action Plan/Feedback System</li> </ol>

**Table 3. CT-R Implementation in Seven States**

	<b>Focus of Training</b>	<b>Key Outcomes</b>	<b>Next Steps</b>
 <b>Pennsylvania</b>	<ul style="list-style-type: none"> <li>State Hospital: Civil and Forensic</li> <li>Community: 4 long-term hospital units, 10 programmatic residences, supportive housing, 6 assertive community treatment teams, forensic team, specialty care team</li> <li>Sustainability: local &amp; network champions, quality assessment measure</li> </ul>	<ul style="list-style-type: none"> <li>Creation of a network of care based upon CT-R</li> <li>Reduction or elimination of control strategies (seclusion, restraint, injections)</li> <li>More time outside institutions: <ul style="list-style-type: none"> <li>decrease in jail days</li> <li>decrease in hospital days</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Extend network to crisis centers and acute hospital care</li> <li>Develop robust measures of recovery and resiliency at each CT-R service</li> <li>Foster a champions network</li> <li>Expand learning collaborative to strengthen CT-R skills</li> </ul>
 <b>New York</b>	<ul style="list-style-type: none"> <li>2 inpatient units, treatment mall, transitional residence, mobile integration team, outpatient services</li> <li>Individuals who were stuck in their recovery process</li> <li>Promoting continuity of care</li> <li>Sustainability: local champions</li> </ul>	<p>Key findings of program evaluation data:</p> <ul style="list-style-type: none"> <li>50% of a previously non-responsive group moved to less restrictive care</li> <li>loneliness decreased</li> <li>flourishing, hope, and functional skills increased</li> </ul>	<ul style="list-style-type: none"> <li>Three-year plan to implement CT-R across the state in civil and forensic settings, inpatient and outpatient</li> <li>Introduce CT-R quality measurement to gauge implementation and set aspirations by service</li> </ul>
 <b>Montana</b>	<ul style="list-style-type: none"> <li>State hospital staff, community teams, residential programs, outpatient agency</li> <li>Emphasis on continuity of care</li> <li>Sustainability with train-the-trainer model</li> </ul>	<ul style="list-style-type: none"> <li>Staff integrated Recovery Maps into treatment plans, intakes, and referrals which facilitated progress and continuity of care</li> <li>Individuals stepped down into lower levels of care</li> <li>Community agency reported increase in staff satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>Expand network of CT-R trainers across the state</li> <li>Increase capacity for CT-R delivery</li> <li>Extend to Native American communities</li> <li>Families</li> </ul>
 <b>New Jersey</b>	<ul style="list-style-type: none"> <li>4 Behavioral Health Homes</li> <li>Integrated physical and mental health care</li> <li>Train-the-trainer model</li> </ul>	<ul style="list-style-type: none"> <li>Success with substance use and engaging very isolated individuals</li> <li>Quality and length of contacts increased</li> <li>Recovery mapping guides treatment planning</li> <li>Integrated CT-R into individual and group therapy</li> <li>De-escalation with aspirations</li> </ul>	<ul style="list-style-type: none"> <li>A second round of CT-R implementation</li> <li>Include more integrated care providers</li> <li>State's internal trainers take the lead in all aspects</li> <li>Extend CT-R to other services</li> </ul>
 <b>Vermont</b>	<ul style="list-style-type: none"> <li>Community: three regional centers</li> <li>State facilities: forensic residence and hospital.</li> </ul>	<ul style="list-style-type: none"> <li>Increased connection and community participation for previously isolated individuals</li> <li>Employment outcomes improved</li> </ul>	<ul style="list-style-type: none"> <li>CT-R quality scale to guide sustainability and improvement</li> <li>Expand to other mental health centers, forensic involvement, employment, and homelessness</li> </ul>

	<ul style="list-style-type: none"> <li>Continuity of care between state hospital and forensic residence</li> <li>Sustainability: local champions</li> </ul>	<ul style="list-style-type: none"> <li>Developed internal consultation, training, and documentation</li> </ul>	
 <b>Massachusetts</b>	<ul style="list-style-type: none"> <li>Hospital: 1 long-term and 1 acute</li> <li>Community: 4 teams (mental health, forensic, homelessness, early episode)</li> <li>Sustainability: 2 CT-R trainers from a community agency</li> </ul>	<ul style="list-style-type: none"> <li>Culture change at state hospital and on the community teams</li> <li>Reductions in ER visits and hospitalizations and transformations of many individuals</li> </ul>	<ul style="list-style-type: none"> <li>Sustain CT-R in the six services</li> <li>Expand it to other settings</li> </ul>
 <b>Georgia</b>	<ul style="list-style-type: none"> <li>Sustain and expand existing CT-R network</li> <li>Develop a curriculum for training CT-R experts</li> <li>Peer specialists</li> <li>Competency measure for peers</li> <li>Sustainability: Center of Excellence with elite trainers</li> </ul>	<ul style="list-style-type: none"> <li>CT-R trainer curriculum developed with guidelines and evaluation tools</li> <li>All peer specialists reached competency in CT-R</li> <li>A 12-item peer-specific competency measure created</li> </ul>	<ul style="list-style-type: none"> <li>Piloting CT-R trainer competency measure</li> <li>Expand CT-R training of peer specialists, piloting the new competency measure</li> </ul>