# The Evidence Based Treatment Centers of Seattle

*Bringing the Scientist Practitioner Model to Life*

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*Evidence Based Treatment Centers of Seattle / University of Washington*

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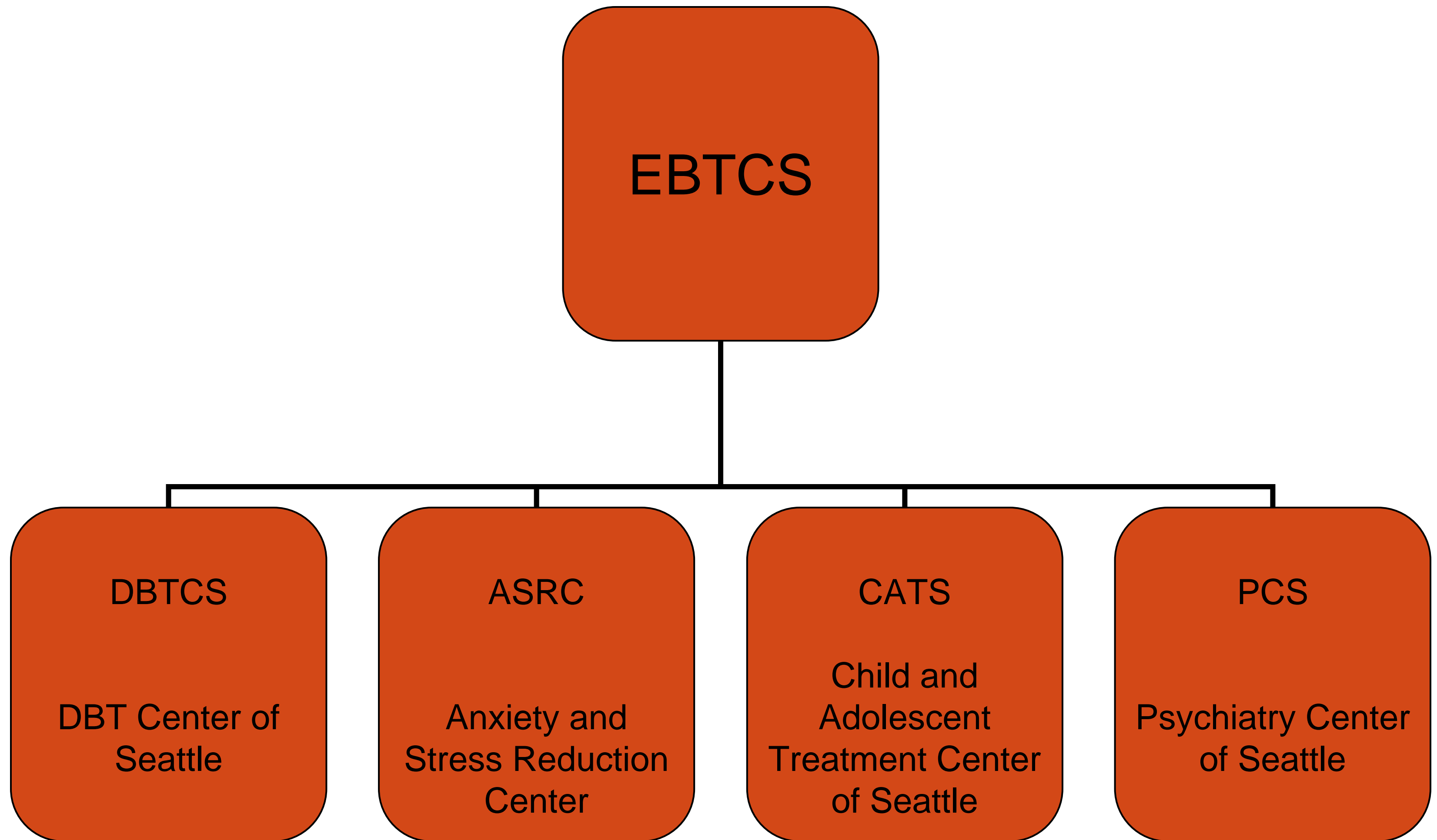
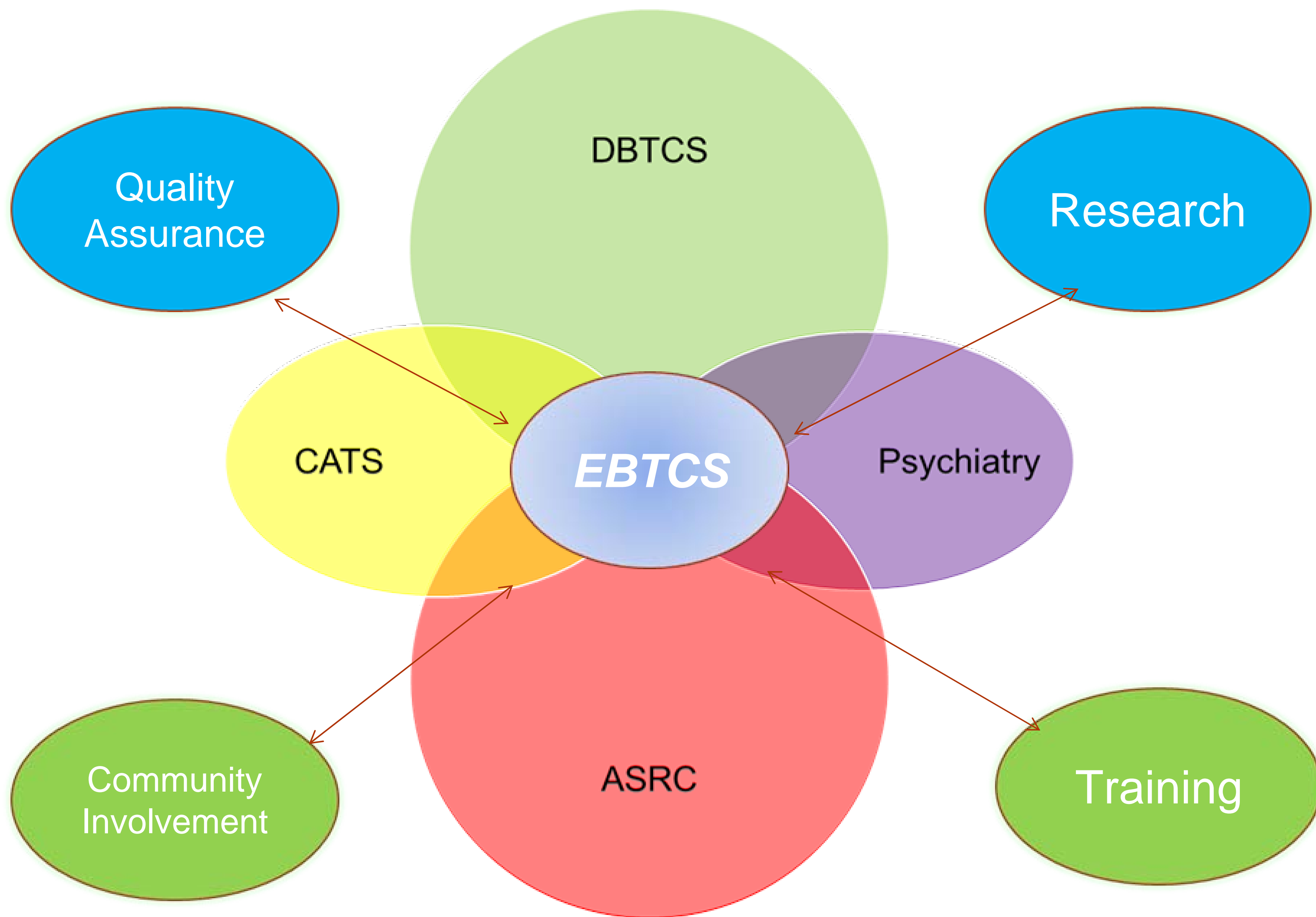
# Symposium topics

- Describe the Evidence Based Treatment Centers of Seattle (EBTCS) model of implementing the scientist practitioner vision
- Clinical Focus: Sustaining adherent implementation of evidence based treatments in a large private practice setting
- Research Focus: Maintaining focus and involvement in science over the long haul in a community setting

# EBTCS Clinical programs



# *The Evidence Based Treatment Centers of Seattle*



# What EBTs are implemented?

***DBT***: DBT

***ASRC***: Exposure and response prevention, CBT

***CATS***: Behavioral parent training, multimodal treatment (behavior therapy, skills training, and parent management training) for kids with ADHD.

***Psychiatry***: Evidence based psychopharmacology, collaborative care

*All programs: Use a strategy guided by the evidence base when confronted with treatment failure/resistance, lack of remission, sub-clinical issues*

# Building an Evidence Based Treatment Center

- Going from "good to great"
  - Founders/directors
  - Postdoctoral fellows
  - Staff

- **First Who, Then What:** "*When we began the research project, we expected to find that the first step in taking a company from good to great would be to set a new direction, a new vision and strategy for the company, and then to get people committed an aligned behind that new direction….We found something quite the opposite…" Jack Collins*

# Implementing EBTs: critical structures

- Key driver to ongoing implementation: ***a self-germinating culture***

- **Critical seeds of this culture:**
  - Weekly program specific and clinic wide team meetings
  - Allowing organic change/growth driven by talented staff
  - Organizational commitment to research / quality assurance

# Emphasis on the team: specialty centers

- Weekly program specific meetings
  - Influenced by DBT model, although each program is distinct and follows its own path according to formal and informal leadership within the program (ASRC, ASRC/Child, psychiatry, DBT)
  - Support, consultation, culture are fostered here
  - Leadership at times is very active to maintain focus on evidence-based practice
  - Over time, the culture promotes itself
    - Initiative towards evidence based practice is highly valued and reinforced / other approaches are considered and rigorously questioned

# Emphasis on the team: EBTCS

- Weekly CE meetings
  - EBTCS leadership provides structure and organization
  - EBTCS staff, postdocs, and community partners lead and connect with each other within the CEs
  - Varies from outside speakers, internal trainings, team meetings, journal club, etc.

# Organic growth

- EBTCS has committed to growth as opportunities arise that fit the vision
  - Driven by talented people who have a vision
  - Allows for internal promotion and opportunity
  - Growth is driven by "getting the right people on the bus"
  - Organization committed to adaptation: not getting to stagnant/rigid
  - Specialty clinics make each other and the whole better
    - Training
    - Psychiatry
    - CATS
    - Eating disorders

# Organizational commitment to research

- Investment in structures
  - Database
  - IRB
  - Literature and books
  - Training
  - Postdoc time

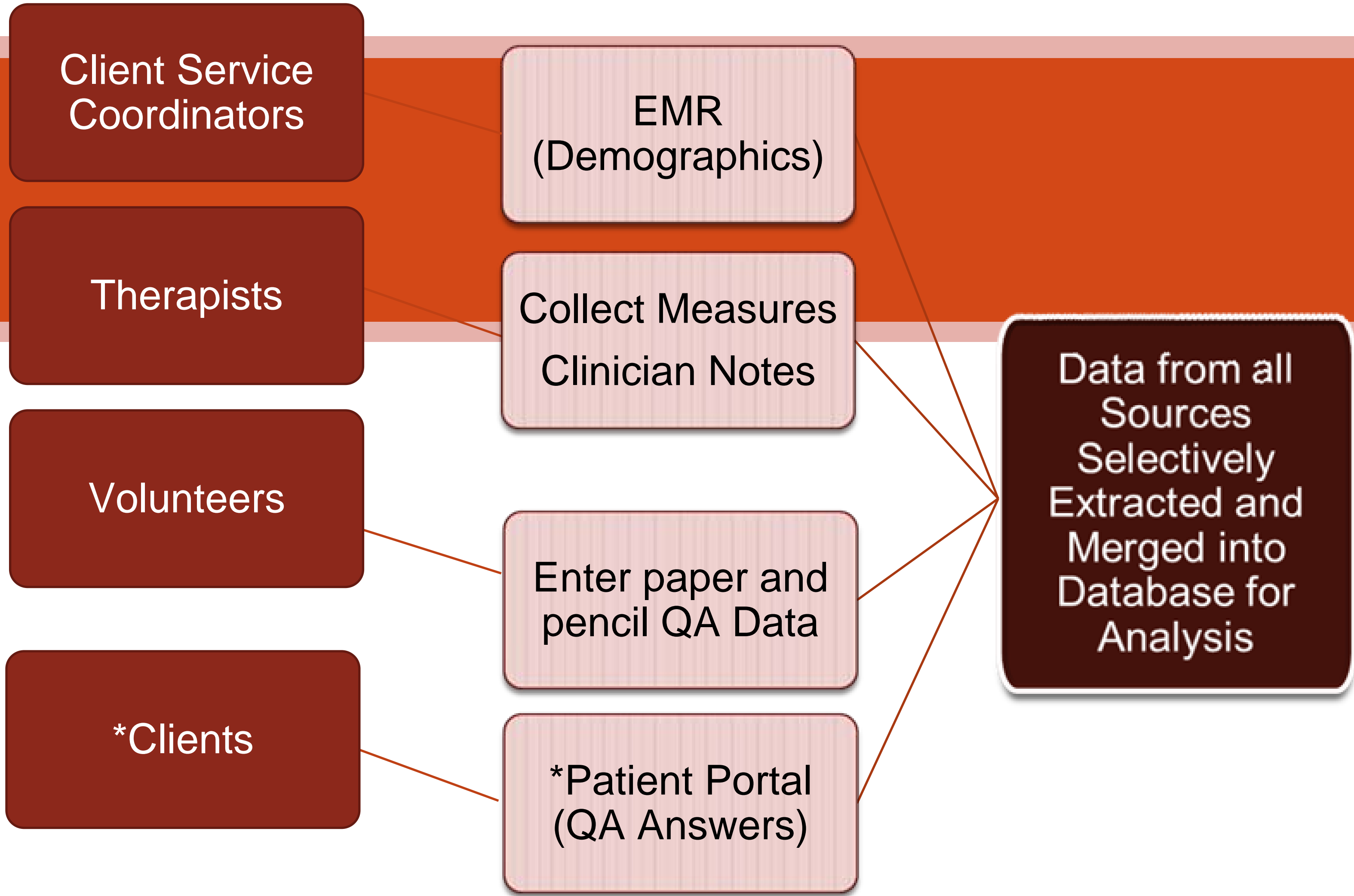
- Great effort made to create an atmosphere that makes research sustainable in a community setting like ours
  - Learning through trial and error

# Quality Assurance QA Program

- Launched in 2005
- Values clinical excellence and science
- 3 goals of the program:
  - Monitor client progress
  - Program evaluation
  - Research

# Assessment

- Time points
- Self-report
- Brief (up to 5 questionnaires)
- Measures: free, validated, common
- Over 1000 clients now consented to research study


Client Service Coordinators
Therapists
Volunteers
*Clients
EMR (Demographics)
Collect Measures
Clinician Notes
Enter paper and pencil QA Data
*Patient Portal (QA Answers)
Data from all Sources Selectively Extracted and Merged into Database for Analysis

# Examples: Adult DBT Program and Child ASRC programs

- Adults in DBT program
  - OQ (Outcome Questionnaire)
  - DERS (Difficulty with Emotion Regulation Scale)
  - BEST (Borderline Evaluation of Symptoms Over Time)
  - SBQ-Pretreatment (Suicidal Behaviors Questionnaire)
  - Skills Training Rating Form (Therapist and Client)
  - **Disorder specific measure added by therapist (e.g., PDSS for panic disorder)

- Children in ASRC program
  - CBCL (Child Behavior Checklist – parents)
  - SCARED-P and SCARED - C (Child Anxiety Related Emotional Disorders)
  - **Disorder specific measures added by therapist (e.g., C-YBOCS for OCD)

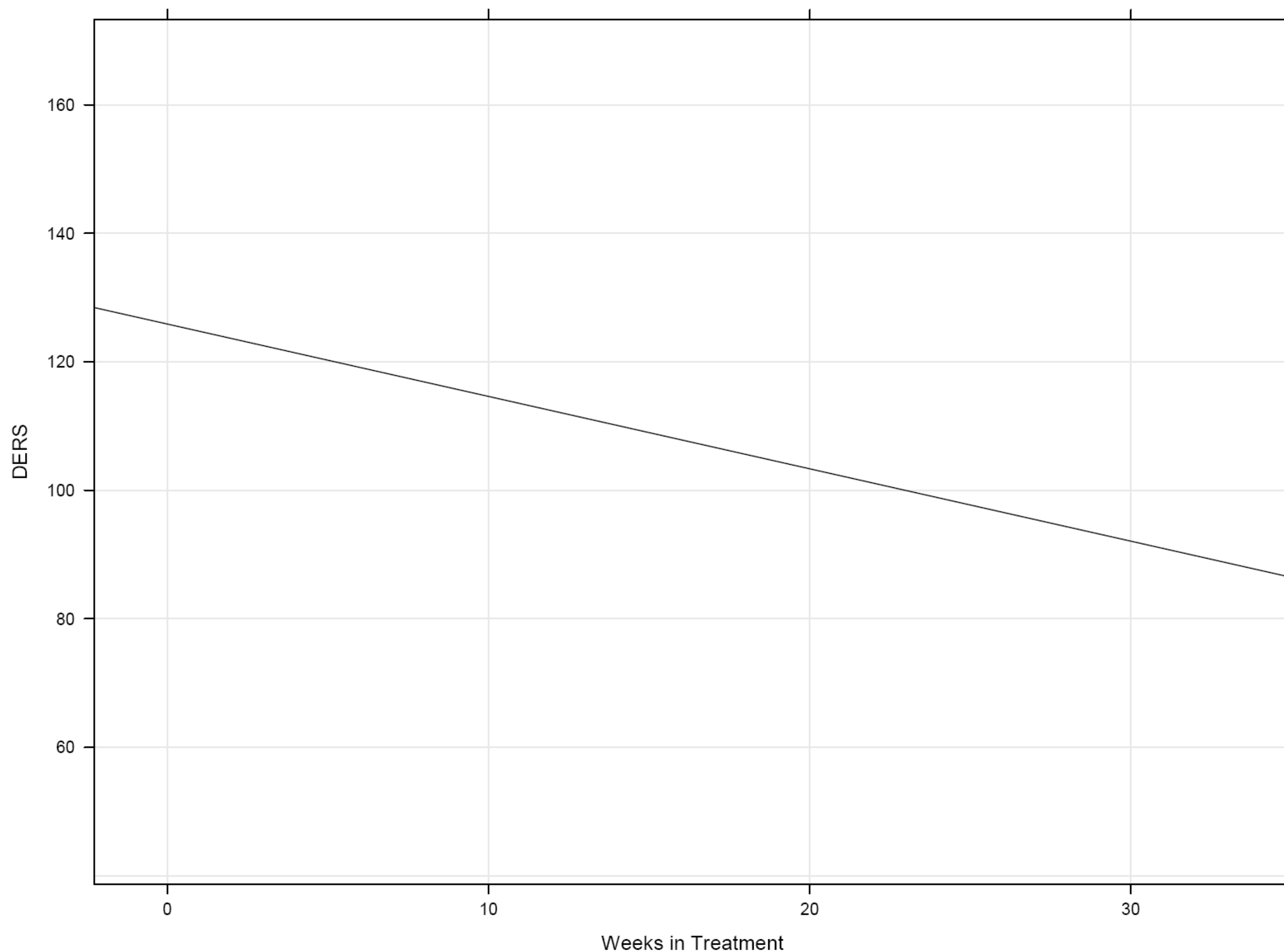
# Problems we've encountered

- Keeping clinicians motivated
- Technology to support tracking and data storage
- Measures
- Occasional client resistance
- Meaningful feedback to clinicians and clients
- Staff to monitor the program and score data

# What makes it successful?

- Scheduling
- Reminders
- Having a QA team
- UW volunteers
- Behavioral Principles
- Graphing
- Having the right people “on the bus”

# DERS change: first 6 mos of DBT

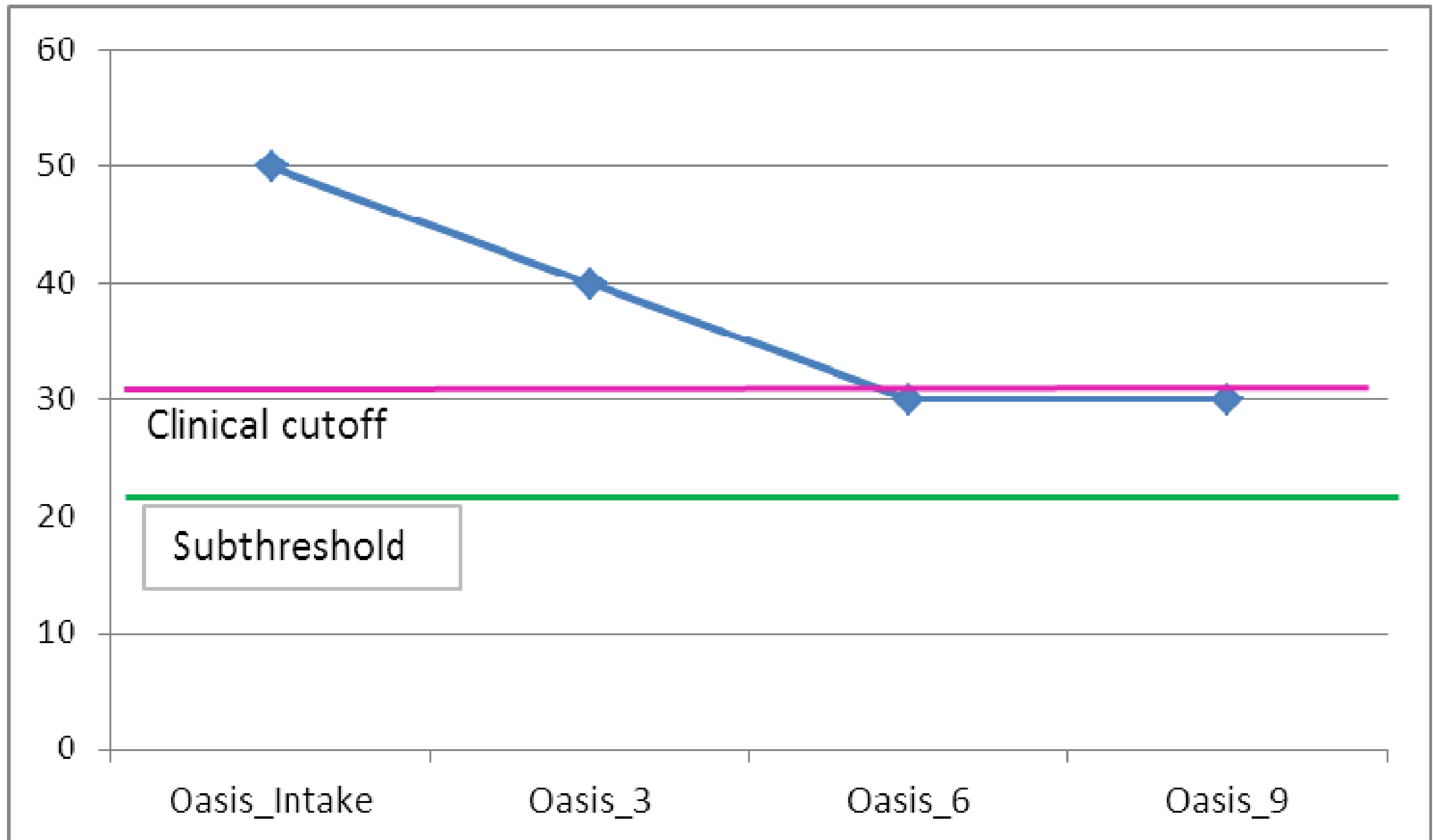


# Current status and future directions

- Beginning stages of evaluating data
- Some data on 554 in DBT
- 3-5 poster presentations 2007-2011
  - WPA, ABCT, ISITDBT
  - Included two factor analyses (DERS, OASIS) and clinical outcomes

- Challenge: research in a messy setting
- Transferring to online system

# Example OASIS feedback graph



# Record data during session

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## Patient Health Questionnaire (PHQ)

Greetings **Steve Smith**!

Over the last 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest of pleasure in doing things | | | | |
| 2. Feeling down, depressed, or hopeless | | | | |
| 3. Trouble falling or staying asleep, or sleeping too much | | | | |
| 4. Feeling tired or having little energy | | | | |
| 5. Poor appetite or overeating | | | | |
| 6. Feeling bad about yourself–or that you are a failure or have let yourself or your family down | | | | |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | | | | |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite–being so fidgety or restless that you have been moving around a lot more than usual | | | | |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | | | | |

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PHQ-9 | Medications | Allergies | Interval History | Side Effects | Compliance | Vital Signs | MSE | Lab Results | Assessment | Diagnosis | Plan | Signable Note

## Patient Self-evaluation

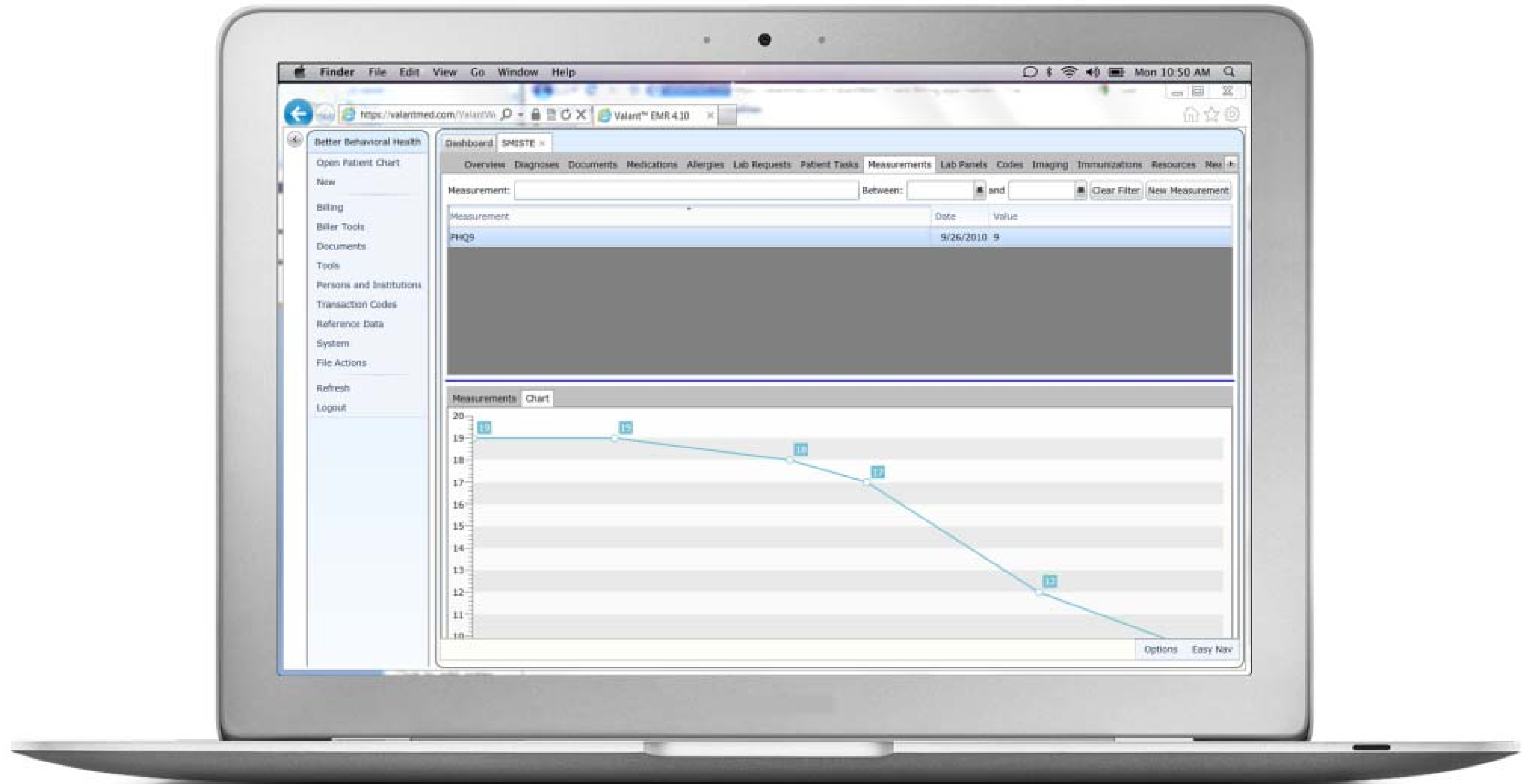
Based on answers to the PHQ-9, over the prior two weeks, the patient endorsed feeling down, depressed, or hopeless for several days, having trouble falling or staying asleep, or sleeping too much more than half the days, feeling tired or having little energy for several days, feeling bad about themselves, or that they were a failure or have let themselves or their family down for several days, having trouble concentrating on things, such as reading the newspaper or watching television for several days, moving or speaking so slowly that other people could have noticed, or the opposite, being so fidgety or restless that they have been moving around a lot more than usual more than half the days, having thoughts that they would be better off dead, or of hurting themselves in some way for several days.

The patient denied having problems with feeling little interest or pleasure in doing things, having a poor appetite or overeating over the past two weeks.

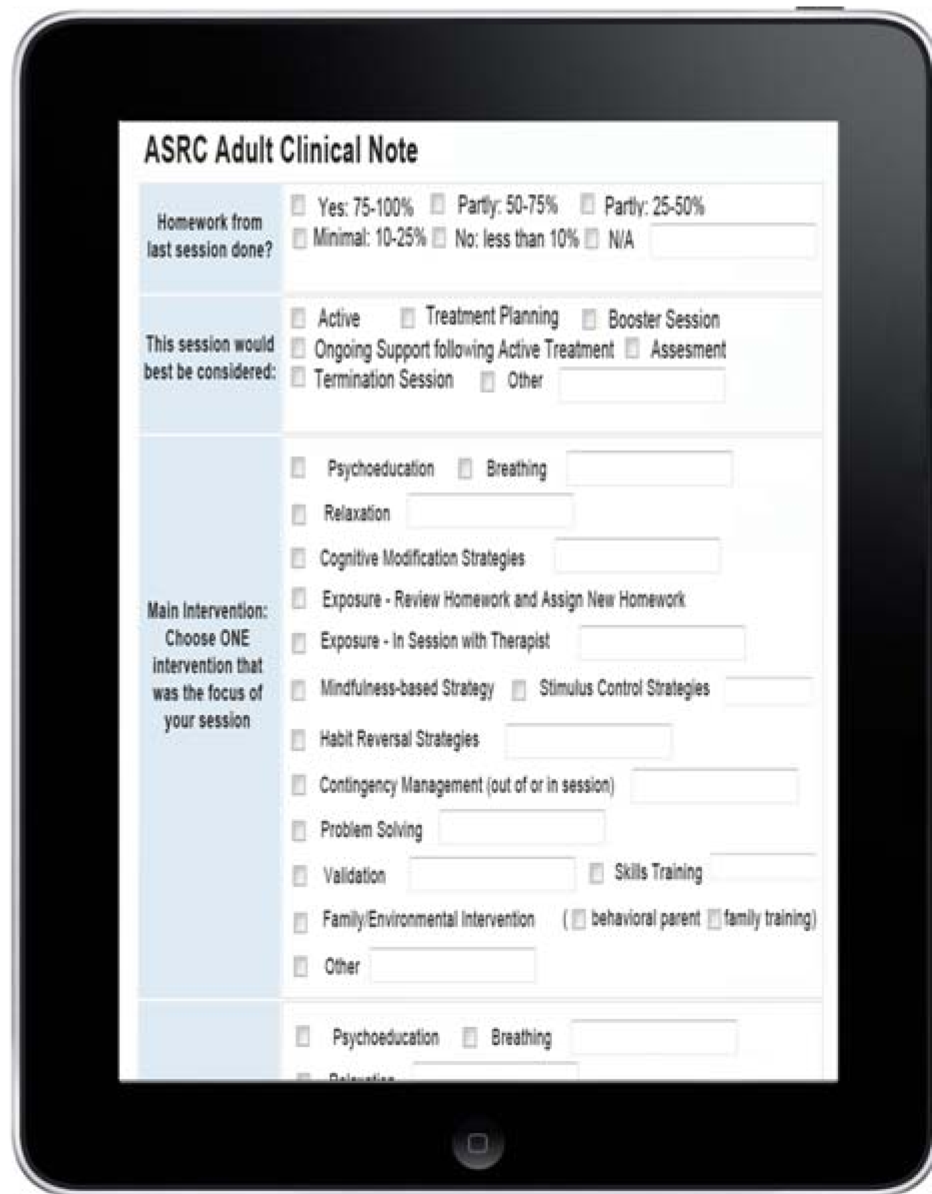
## PHQ-9 Results

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|

# Graph and review after session



# Recording Outcomes



**ASRC Adult Clinical Note**

| | |
|---|---|
| Homework from last session done? | ☐ Yes: 75-100% ☐ Partly: 50-75% ☐ Partly: 25-50%<br>☐ Minimal: 10-25% ☐ No: less than 10% ☐ N/A |
| This session would best be considered: | ☐ Active ☐ Treatment Planning ☐ Booster Session<br>☐ Ongoing Support following Active Treatment ☐ Assesment<br>☐ Termination Session ☐ Other |
| Main Intervention: Choose ONE intervention that was the focus of your session | ☐ Psychoeducation ☐ Breathing<br>☐ Relaxation<br>☐ Cognitive Modification Strategies<br>☐ Exposure - Review Homework and Assign New Homework<br>☐ Exposure - In Session with Therapist<br>☐ Mindfulness-based Strategy ☐ Stimulus Control Strategies<br>☐ Habit Reversal Strategies<br>☐ Contingency Management (out of or in session)<br>☐ Problem Solving<br>☐ Validation ☐ Skills Training<br>☐ Family/Environmental Intervention (☐ behavioral parent ☐ family training)<br>☐ Other |
| | ☐ Psychoeducation ☐ Breathing |

# Recording Outcomes

## ASRC/CATS Child and Adolescent Clinical Note

| | |
|---|---|
| Homework from last session done? | ☐ Yes: 75-100% ☐ Partly: 50-75% ☐ Partly: 25-50%<br>☐ Minimal: 10-25% ☐ No: less than 10% ☐ N/A |
| This session would best be considered: | ☐ Active ☐ Treatment Planning ☐ Booster Session<br>☐ Ongoing Support following Active Treatment ☐ Assesment<br>☐ Termination Session ☐ Other |
| Main Intervention: Choose ONE intervention that was the focus of your session | **CBT Strategies**<br>☐ Assessment<br>☐ Psychoeducation ☐ Breathing<br>☐ Relaxation<br>☐ Cognitive Modification Strategies<br>☐ Exposure - Review Homework and Assign New Homework<br>☐ Exposure - In Session with Therapist<br>☐ In vivo<br>☐ Imaginal<br>☐ Mindfulness-based Strategy ☐ Stimulus Control Strategies<br>☐ Habit Reversal Strategies<br>☐ Contingency Management (out of or in session)<br>☐ Problem Solving<br>☐ Validation ☐ Skills Training |

Thanks from everyone at EBTCS!