MBT Implementation and Quality Assurance

Dawn Bales & Joost Hutsebaut
September 7th, 2015
Anna Freud Centre, London

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MBT-Nederland

MBT-onderzoekslijn &
MBT-onderzoeksconsortium

MBT-Onderzoeksconsortium: Jan van Busschbach, Jan Henk Kamphuis, Patrick Luyten, Jac Dekker, Roel Verheul, Dawn Bales

MBT-Onderzoekslijn: Dineke Feenstra, Joost Hutsebaut, Annelies Laurenssen, Maaike Smits, Hester van Eeren

Thanks to the Viersprong

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Implementation becomes the issue

- Knowledge is increasingly available
  - Evidence based treatment methods: MBT, SFT, TFP, DBT, STEPPS, CAT,…
  - Guidelines (APA, NICE, Trimbos)

<u>Governmental position anno 2012</u>:

‘Knowledge is available, it’s up to the field to start implementing’

- Accent shifts towards implementation:
  - How to implement (MBT) safely?
  - How to assure high quality treatment throughout the running of the program?

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Implementation Barriers

1. The *first* problem concerns the slow and cumbersome implementation of these treatments.

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Slow & Cumbersome Implementation

- On average it takes on average 17 years to turn 14 % of scientific knowledge to the benefit of patient care (Shattuck)

- Example: first published study MBT: 1999
- MBT in APA guidelines 2001; in NICE 2009; in Multidisciplinary Guidelines for PDs in the Netherlands: 2008
- Study Trimbos in NL: 2011 (Hermens, van Splunteren, van de Bosch, Verheul)
  - only 1/5 treatment seeking BPD-patients receives psychotherapy (treatment of choice according to the guidelines)
  - How many BPD patients receive an evidence based psychotherapy?
  - How many BPD-patients receive a well conducted evidence based psychotherapy?

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Emerging field:
Implementation science

- The study of methods to promote the integration of research findings and evidence into healthcare policy and practice

- It seeks to understand the behavior of healthcare professionals and other stakeholders as a key variable in the sustainable uptake, adoption, and implementation of evidence-based interventions

- At the National Institutes of Health, the National Center for Advancing Translatinal Science (NCATS) aims to transform the translational science process so that new treatments and cures for disease can be delivered to patients faster

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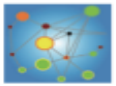
Hutsebaut et al. International Journal of Mental Health Systems 2012, 6:10
http://www.ijmhs.com/content/6/1/10



INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS

CASE STUDY Open Access

The implementation of mentalization-based treatment for adolescents: a case study from an organizational, team and therapist perspective

Joost Hutsebaut[1,4*], Dawn L Bales[1], Jan JV Busschbach[1,2] and Roel Verheul[1,3]

Abstract

Background: Reports on problems encountered in the implementation of complex interventions are scarce in psychotherapy literature. This is remarkable given the inherent difficulties of such enterprises and the associated safety risks for patients involved.

Case description: A case study of the problematic implementation process of Mentalization- Based Treatment for Adolescents (MBT-A), a new therapy for 14 to 18 year old youngsters with severe personality disorders, is presented. The implementation process is described and analyzed at an organizational, team and therapist level.

Discussion and evaluation: Our analysis shows that problems at all three levels contributed and interacted to make the implementation cumbersome and hazardous.

Conclusion: The implementation of complex psychotherapeutic programs for difficult patients could benefit from a structured attention to processes at multiple levels. We therefore propose a new comprehensive heuristic model of treatment integrity. This new model includes organisational, team and therapist adherence to the treatment model as necessary components of treatment integrity in the implementation of complex interventions. The application of this new model of treatment integrity potentially increases the chance of successful implementations and reduces safety risks for first patients enrolling in a new program.

Keywords: Implementation, Treatment integrity, Personality disorders, Adolescents, Mentalization-Based Treatment

Background

The last two decades have yielded new and promising interventions for the treatment of borderline personality disorder (BPD). For example, several studies support the effectiveness of various psychosocial interventions for BPD in adults, including Mentalization-Based Treatment (MBT) [1], Dialectical Behaviour Therapy (DBT) [2], Schema-Focused Therapy (SFT) [3], Transference-Focused Psychotherapy (TFP) [4], Systems Training for Emotional Predictability and Problem Solving (STEPPS) [5] and Cognitive Behaviour Therapy (CBT) [6]. These results have typically been obtained under optimal (experimental) conditions, including extensive supervision, adherence monitoring, and above average organizational support. It is less clear how these evidence-based programs are actually implemented in regular practice. Given the many challenges associated with treating BPD patients and the complexity of these interventions, this issue might be particularly relevant to this patient group. Therefore, it is not only important to report about what works, but also to share experiences on how to implement these promising interventions. However, despite its obvious relevance, reports of (problems in) the dissemination of complex psychosocial interventions seem almost absent in the psychotherapy literature. In fact, we couldn't find a single article describing implementation failures of a psychotherapy treatment program. It is unlikely that this absence of reports reflects actual absence

Unsuccesful implementation: lessons learned

- We understood the failed implementation of inpatient MBT-A as resulting from an interaction between three levels:
  - Organization:
    - Insufficient support for the new program within the whole institution
    - Organizational fences prevented an optimal use of available expertise
    - Incomplete implementation plan given the complexity of the innovation
  - Team:
    - Difficulties to change team culture
    - Lack of leadership
    - Issues of inconsistency, due to a lack of experience and a large team size
    - Lack of supervision ‘on the spot’ by a therapist experienced in the model
  - Therapists:
    - Lack of experience in the model creating doubts and uncertainty among professionals
    - No selection of personnel prior to starting

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The implications

- The MBT-A case raises important issues:
  - Do these findings reflect more universal issues in the implementation of MBT (or PD treatment programs in general) or do they simply reflect a very specific problem in a very specific context?
  - How are evidence based treatment programs disseminated and implemented in regular clinical practice?
  - What are the factors determining success of implementations?

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Determinants of success and failure in the implementation of Mentalization Based Treatment (MBT) for severe borderline personality disorder: an explorative multiple case study

- A multiple case study design using a *sequential exploratory strategy*
  - in which a qualitative study (phase 1) is followed by a (partial) quantitative study (phase 2)

- Phase 1:
  - *Participants* included were departments of mental health care institutions in the Netherlands that intended to implement the full MBT DH or IOP (Bateman and Fonagy, 1999, 2004, 2009)
  - *Semi-structured interviews* with managers and principal therapists of 7 MBT units in 6 institutions
  - Phase 1 resulted in 7 narrative reconstructions detailing the relevant determinants of the implementation trajectory in a narrative and interactional way.

- Phase 2:
  - *Participants*: 12 expert reviewers, extensive experience in two areas (i.e. the treatment of BPD patients and/or management of BPD treatment programs not restricted to MBT)
  - *Review questionnaire:* A questionnaire was developed to review the reconstructions.

Tabel 1: multiple case study:
Summary of outcome and determinants of each case

Case	Outcome of implementation	Determinants
A	**Negative** (stop of the program, high expenses, high burden for personnel, high turnover of personnel)	• Organizational split between 'care' and 'cure' treatment programs • Lack of support from within the organization • Upsetting discussions within the unit and overt fights over leadership • Lack of role differentiation • Felt incompetence by nurses • Splits between management and team
B	**Positive** for as well PH (of lower dosage) as IOP (few drop outs, gradually more severe BPD patients, acceptable burden among team members)	• Clear institutional support, involvement of all experts from the organization • Active leadership • Strong team, complementary personalities • Sufficient budget for training • Gradual development towards better adherence and engagement of more severe BPD patients
C	**Negative**: program stopped, high absence through illness, high turnover, loss of money	• Top-down implementation • Lack of support in (existing) team • High levels of conflict before the start • Differences in training and motivation between groups and within groups • Unit split between 'team on model' and 'team off model' • Team split between disciplines • Reorganization, leading to a change in support by key managerial persons • Split between management and team / hostility
D	**Negative**: program has stopped at time of writing (high turnover of personnel; dissatisfaction of patients, non-profitability of program)	• Choice of new program by select group and top-down implementation • Split between management and team • Isolation of the team within the institution

Hutsebaut, Bales (2015, submitted): **determinants of success and failure in implementation of MBT**

Tabel 1: multiple case study:
Summary of outcome and determinants of each case (2)

Case	Outcome of implementation	Determinants
E	**Mixed:** PH groups are still running, but there are still financial losses; IOP group never started	• Broad support within organization; MBT in line with mission of institution • RCT provided support to continue program • Direct involvement of first line of management • Program insufficiently embedded within institution, leading to lack of referrals • Strong co-leadership
F	**Positive** (quick expansion of the unit; mission to include 'difficult' patients was accomplished; few incidents and drop outs; good outcome results)	• Strong support from management board, at the start and during the whole period • MBT fulfilled mission of institution to involve new and difficult patients • Partial lack of support, but unit was physically isolated • Strong leadership • Small and cohesive team • Personnel recruited based upon capacities and motivation
G	Positive for IOP **Mixed** for PH (high burden among team members, high level of drop out, many crisis-like incidents, forma complaints)	• Hurried implementation, no implementation plan • Temporary splits between management and trainers; role confusion • Lack of protocols for dealing with crisis • Difficulties within the team to keep reflective stance • Diverting from the model by team • Lack of experience

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Results support hypothesis of interaction of three levels?

	Range	Average
Case A	4-5	4,8
Case B	4-5	4,4
Case C	4-5	4,8
Case D	3-5	4,6
Case E	3-5	4,2
Case F	3-5	4,4
Case G	3-5	4,1
		4,5

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Results: Contribution of each level

	Organization	Team	Therapist
Case A	4,8	3,9	2,4
Case B	3,8	4,5	3,8
Case C	4,1	4,4	3,3
Case D	4,1	3,8	3,1
Case E	3,9	4,9	3,8
Case F	4,4	4,0	3,9
Case G	3,6	3,8	3,8
Average	4,1	4,2	3,4

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Results: generic critical factors

Factor	X
Commitment and support within the organization	8
Leadership	7
Therapist selection (competence and affinity with MBT and patient population)	7
Training & supervision	5
Highly structured project-based implementation according to implementation plan	5
Availability of MBT expertise	3
Sufficient budget	3
Team size	2

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Results: additional barriers and facilitators of success/failure

Additional critical factors:
Severity of patient population
Phasing the implementation
Team culture: changing an existing team versus starting with a new team
Extra incentives, (i.e. An RCT)
Charismatic leadership
Competence to manage destructive team processes
Maintaining mentalizing, positive team spirit: flexibility , playfulness and motivation of therapists

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Toward a Quality System for MBT: critical success factors for implementation

Level	Organization	Team	Therapist
Critical Success Factors	•Commitment of the organization to fully implement MBT •Long term financial commitment •Continuity and stability at management level •Structured, project-based implementation •Short and direct lines between team and management •Creating and maintaining a well balanced and mentalizing team (mentalizing environment) •Maintaining contact stakeholders •Organization of unit (clear program structure, defined roles and responsibilities, etc.)	•Clear and supportive leadership •MBT expertise availability: supervision structure •Consistency: ability of team to deliver treatment in consistent manner •Coherency: team utilizes theoretically coherent MBT framework to tailor interventions •Selection of therapists: competenties & affinity •Creating and maintaining a well balanced and mentalizing team (practice what you preach) •Experienced support from 'above' •Team size (6- max 12)	•Have skills, competencies and characteristics necessary to treat BPD patients from a MBT-model •Willing to change old habits and learn a new approach •Adherence to the model: adherence and competence to the model in individual and group sessions •Follow a process-oriented and goal-focused approach in treatment, including focus on commitment and (self-) destructive behavior

Summary of Results

- Our results testify of the *complex* nature of implementing evidence based psychotherapy programs in regular mental health centers institutions
  - In all cases the course of implementation was influenced by an interaction of critical factors at the organizational , team and therapist level

- Our findings indicate that *all* implementation processes in all institutions had problems

- In less than half (43%) of the seven cases evaluated, implementation succeeded (29%), leaving the majority of cases (57%) with (completely or partially) failed implementation processes.

- Problems in the implementation process are highly correlated with:
  - The targeted patient population (less severe = less problems)
  - The dosage of treatment (higher dosage = more problems)

- Mere the dissemination of knowledge (training and supervison) is not enough toensure a safe and effective implementation of MBT

Implementation Barriers

1. The *first* problem concerns the slow and cumbersome implementation of these treatments.

2. The *second* problem is the often neglected issue concerning the quality of the implementation of evidence based psychotherapy models (Hutsebaut, Bales, Busschbach, & Verheul, 2012).

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Unclear Quality of Implementation

- NICE guidelines (2009): 'the quality of a psychological intervention depends on therapists having the skills and the organizational support to replicate the intervention found to be effective in research settings'
- Psychotherapists perform poorly in the application of scientific knowledge (Baker, McFall & Shoham, 2007)
- Large differences between optimal (experimental) conditions and sub-optimal conditions in daily clinical practice
  - in (structural) supervision, education / training level of therapists, climate in the organization and structure of programs (Henggeler, et. al. 2004)
- Dissemination often leads to lower treatment outcomes

- Curtis, Ronan & Borduin (2004): effect size MST van .81 naar .26
- DBT clear; but also in MBT we are finding a drop in reported effectiveness…
- Etc.

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Implementation Barriers

1. The *first* problem concerns the slow and cumbersome implementation of these treatments.

2. The *second* problem is the often neglected issue concerning the quality of the implementation of evidence based psychotherapy models (Hutsebaut, Bales, Busschbach, & Verheul, 2012).

3. The *third* issue regarding the implementation is even more complex when the scope of implementation is expanded to the maintenance of treatment results.

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Once effective, always effective?

- Even when a program has been implemented properly, including effective treatment outcomes during the phase of implementation, it remains unclear how these results can be maintained in the long run.

- Organizations and teams are dynamic entities: teams might experience a high turnover of personnel; organizations change; team leaders, managers and experts can change jobs; new incoming team members have an impact upon team dynamics, etc.

- What is the effect of these dynamics on the (proven) effectiveness of a treatment program ?

- This issue of maintenance of treatment results

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Study: The impact of organizational changes on treatment outcome of dayhospital Mentalization-Based Treatment (MBT)

Situation:

- MBT successfully implemented in NL (Bales, et. al 2012, 2014)
- Significant organizational changes in a relatively short period of time between augustus 2008 en maart 2010
  - Expansion of MBT unit; start of national MBT training program; problematic implementation of an adolescent MBT program, reorganization at the Viersprong, the management structure changed, merging of adult MBT unit with the adolescent MBT unit, tripling personel, many new, inexperienced therapists, new, inexperienced manager, unit's supervisor and trainers were partially deployed elsewhere and less available
- Defined 'pre-reorganization' cohort and a 'post-reorganization' cohort

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New Study: the impact of organizational changes on treatment outcome of dayhospital Mentalization-Based Treatment (MBT)

Aim:

1. What is the impact of these major organizational changes on (the maintenance of) treatment effectiveness?
   - By comparing the treatment outcome of 'pre-reorganization' cohort and 'post-reorganization' cohort.
2. Can (possible) changes in outcome possibly be explained by the impact of the reorganization on the adherence at organizational, team and therapist level?
   - By comparing adherence to the model at organizational, team and therapist level of 'pre-reorganization' cohort and 'post-reorganization' cohort.

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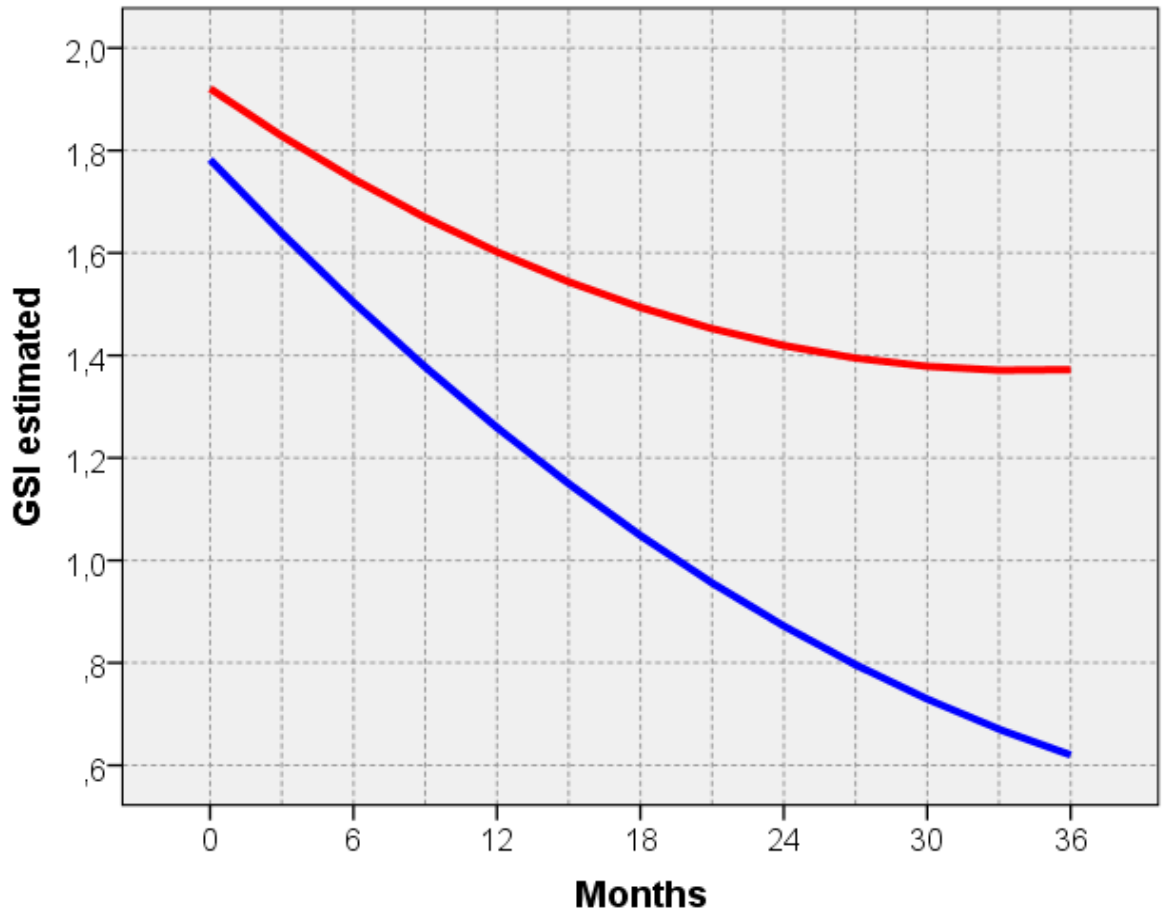
Results: differences between (PRE) and (POST) reorganization cohort in the course of treatment outcomes



PRE:
pre reorganization

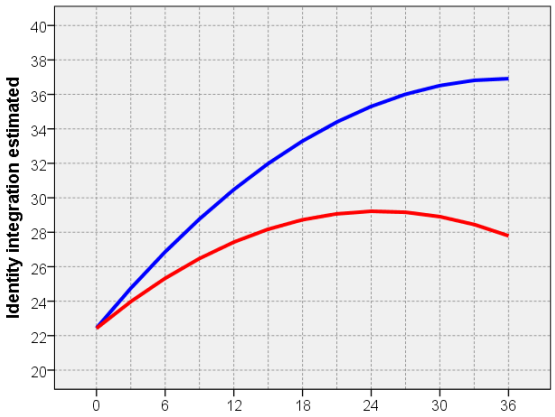
POST:
post reorganization

1½ jaar:
d = 0.42
p = 0.07

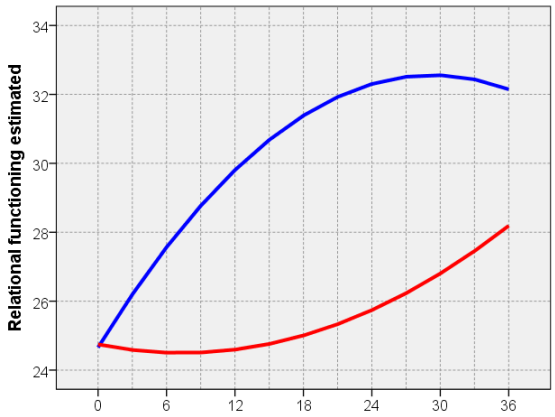
3 jaar:
d = 0.82
p = 0.07

Bales, et. al (2015, submitted): **The impact of major organizational changes on treatment outcome**

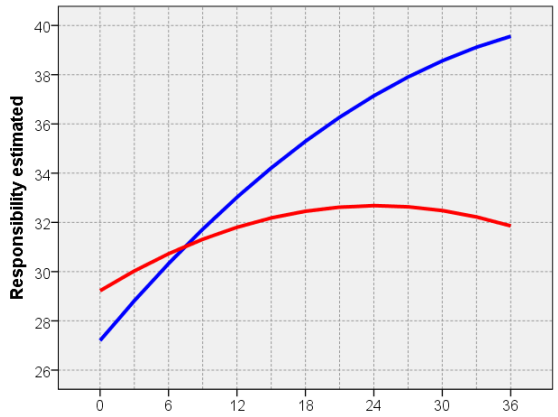
Results: differences between (PRE) and (POST) reorganization cohort in the course of treatment outcomes



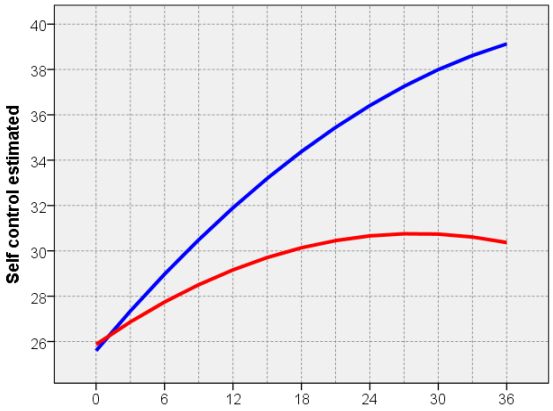
Identity integration
1½ jaar: d = 0.51, p = 0.005
3 jaar: d = 1.03, p = 0.005



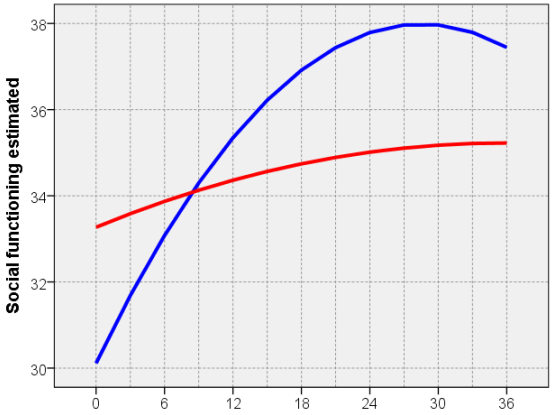
Relational functioning
d = 0.82, p = 0.002
d = 0.51, p = 0.117



Responsibility
d = 0.71, p < 0.001
d = 1.42 p < 0.001



Self-control
1½ jaar: d = 0.63, p = 0.008
3 jaar: d = 1.17, p = 0.008



Social concordance
d = 0.79, p < 0.001
d = 0.80, p = 0.029

PRE reorganization cohort
POST reorganization cohort

Bales, et. al (2015, submitted): **The impact of major organizational changes on treatment outcome**

New Study: the impact of organizational changes on treatment outcome of dayhospital Mentalization-Based Treatment (MBT)

Aim:

1. What is the impact of these major organizational changes on (the maintenance of) treatment effectiveness?
   - By comparing the treatment outcome of 'pre-reorganization' cohort and 'post-reorganization' cohort.
2. Are (possible) changes in outcome possibly related to the impact of the reorganization on the adherence at organizational, team and therapist level?
   - By comparing adherence to the model at organizational, team and therapist level of 'pre-reorganization' cohort and 'post-reorganization' cohort.

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Consensus ratings on Adherence at organizational, team and therapist level

	Cohort 1 (PRE)	Cohort 2 (POST)
Organisation		
Commitment and support within the organization to fully implement MBT	7	4
Structured project-based implementation	6	2/3
Sound financial management	7	4
Continuity in management	7	2/3
Organization of MBT unit (clear structure, defined roles and responsibilities, etc.)	6	2
Stability in the organization	5	3
Staff selection based on competences regarding treating BPD patients, MBT competence, team composition, affinity with treatment model	7	1

1=very poor; 2= poor; 3= acceptable; 4= Adequate; 5= Good; 6= Very good; 7= excellent

Bales, et. al (2015, submitted): **The impact of major organizational changes on treatment outcome**

Consensus ratings on adherence at organizational, team and therapist level

	Cohort 1 (PRE)	Cohort 2 (POST)
Team		
Well balanced team composition	6	2/3
Team size (8-12)	6	1
Leadership (clear leadership as supported by the whole team)	6	3
Team cohesion: secure, open, cohesive team	7	2
Mentalizing environment: open, responsive, mentalizing atmosphere	6	2/3
Availability of MBT expertise at the unit	6/7	2/3
MBT training and supervision	5/6	2/3
Consistency: ability of the team to deliver treatment in consistent manner	6	2/3
Coherency: team utilizes theoretically coherent (MBT) framework to tailor interventions	6	2/3
Continuity	6	2
Structure: Program structure, clear definition of roles and responsibilities	6	2

1=very poor; 2= poor; 3= acceptable; 4= Adequate; 5= Good; 6= Very good; 7= excellent

Bales, et. al (2015, submitted): **The impact of major organizational changes on treatment outcome**

Consensus ratings on adherence at organizational, team and therapist level

	Cohort 1 (PRE)	Cohort 2 (POST)
Therapist		
MBT experience with the model	4	2
Adherence to the model: adherence and competence with the model in individual sessions and group sessions	6	2/3
Commitment among all team members to MBT-model	7	3

1=very poor; 2= poor; 3= acceptable; 4= Adequate; 5= Good; 6= Very good; 7= excellent

Bales, et. al (2015, submitted): **The impact of major organizational changes on treatment outcome**

Conclusions & Implications

1. Succesful implementation of evidence based treatment programs for severe BPD patients in every day practice is complex and determined by several organizational, team and therapist factors

Implications/suggestions:

- Structured project–based implementation is necessary for new treatment programs; based on a thorough diagnostic analysis of relevant key factors at organizational/team/therapist level

- research on the effectiveness of these implementation strategies : implementation science

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Emerging field:
Implementation science

- The study of methods to promote the integration of research findings and evidence into healthcare policy and practice

- It seeks to understand the behavior of healthcare professionals and other stakeholders as a key variable in the sustainable uptake, adoption, and implementation of evidence-based interventions

- Intent is to investigate and address major bottlenecks (e.g. social, behavioral, economic, management) that impede effective implementation, test new approaches to improve health programming, as well as determine a causal relationship between the intervention and its impact

- At the National Institutes of Health, the National Center for Advancing Translatinal Science (NCATS) aims to transform the translational science process so that new treatments and cures for disease can be delivered to patients faster

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Conclusions & Implications

3. It is naive to make assumptions about the effectiveness of a psychotherapeutic model if the context of implementation and maintenance is not taken into account;
4. Organizations and teams are dynamic entities that constantly change, impacting upon the implementation and/or maintenance of the quality of the delivered treatment

Implications:

- Manuals, training and supervision alone are not enough; to ensure quality a *consistent monitoring and feedback system is necessary* to keep therapist, team, and organizations 'on model'
- The Quality Assurance System for MBT is developed to monitor and adjust the relevant factors in order to optimize organization, team and therapist functioning (treatment integrity)

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Contact

- Website:
  - www.mbtnederland.nl

- Email:
  - Dawn.Bales@mbtnederland.nl
  - Joost.Hutsebaut@mbtnederland.nl

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Conclusions

- The implementation of evidence based treatment programs for severe BPD patients in every day practice is complex and determined by several organizational, team and therapist factors

- The labels (MBT, SFT, DBT, etc.) we attach to our treatment programs doesn't necessarily tell us anything about the effectiveness of the treatment program in regular clinical practice
- It's probably not enough to 'know' a treatment model in order to 'deliver' the treatment as intended
- An urgent issue in our field is how we can optimize the efficacy of our treatment models once they are implemented in real day practice
- We lack studies on critical success factors for implementation and maintenance of evidence based models in the PD field
- We hope to have made a start addressing these issues in the development of the MBT quality system

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Conclusions Joost & Dawn

- Behind the **MBT** 'label on the door', many mental health care institutions struggle to implement a (MBT) treatment programs in a **safe and effective** way
- Struggles originate from a multitude of factors at organizational, team and therapist level
- New treatment programs should be implemented stepwise, based upon a thorough diagnostic analysis of relevant key factors at organizational/team/therapist level
- Implementation is a continuous process including hard work
- What is needed are strategies to guide implementation and (much) more research on the effectiveness of these strategies
- Organizations and teams are dynamic entities that constantly change, impacting upon the implementation and/or maintenance of the quality of the delivered treatment: continuous monitoring is necessary

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Summary treatment outcome MBT

Is MBT effectief?

- RCT Deeltijdbehandeling (1999, Engeland)
- Partiële replicatie (2012, Nederland)
- RCT MBT vs. TAU (201?, Nederland)

Zijn de effecten blijvend?

- 18 maanden follow-up study (2001, Engeland)
- 8 jaar follow-up study (2008, Engeland)
- 10 year follow-up study (2015, NL in ……)

Cost (-effectiveness) of MBT?

- Kosten studie (2003, Engeland)

Does MBT work in other dosages?

- RCT MBT IOP vs. SCM (2009,Engeland)
- RCT MBT-DOS (start 2013, baseline article submitted, NL)
- RCT Jorgenson (….)

Discussion: implications

1. Training and supervision typically focus upon therapist skills, while these seem not to be most important to make implementations successful
2. New treatment programs should be implemented stepwise, based upon a thorough diagnostic analysis of relevant key factors at organizational/team/therapist level
3. Implementation is a continuous process including hard work
4. What is needed are strategies to guide implementation and (much) more research on the effectiveness of these strategies
5. Organizations and teams are dynamic entities that constantly change, impacting upon the implementation and/or maintenance of the quality of the delivered treatment: continuous monitoring is necessary
6. The Quality Assurance System for MBT is developed to monitor and adjust the relevant factors in order to optimize organization, team and therapist functioning (treatment integrity)

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Conclusies en implicaties 1

- Er is veel kennis over effectieve behandelingen!
- Kloof tussen wetenschap en dagelijkse klinische praktijk: implementatiekloof
- Methode is niet doorslaggevend
- Deze studies benadrukken kritische rol van *de context* waarbinnen therapie effectief is
- Belang van organisaties:
  - Die gestructureerd, projectmatige implementeren
  - Waar draagvlak is voor het programma en doelgroep
  - Die voldoende budget vrijmaken voor implementatie, opleiding en supervisies
- Belang van goed samengestelde en functionerende teams:
  - Leiderschap
  - Duidelijke afbakening rollen en taken
  - Met een goede ‘teamspirit’; open, betrokken, reflectief, gemotiveerd en flexibel
- Belang van de goede therapeuten op de goede plek
  - Persoonlijke eigenschappen en competenties
  - Affiniteit met doelgroep en werkwijze

Conclusies en implicaties 2

- Organisaties blijven dynamische entiteiten
  - veel veranderingen in zorgstelsel en financiering
- Rommelige organisaties geven rommelige behandelresultaten!
- Naast implementatie is de *borging van kwaliteit* op langere termijn van behandelprogramma's en behandelresultaten essentieel
- Hoe? Hoe kun je zorgen voor een gunstige context? Dat de voorwaarden waarbinnen therapeuten hun werk doen goed zijn?
  - Opleiden managers (niet meer, maar betere managers die begrijpen dat randvoorwaarden belangrijk zijn voor kwaliteit en dat goedkoop duurkoop is)
  - Zorgverzekeraars opleiden (af van korte termijn denken en meer lange termijn denken)
  - Kwaliteitssystemen met continue monitoring en feedback
  - Verder onderzoek : wat zijn belangrijke factoren die de context bepalen waarbinnen therapie effectief is?

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Discussion: general conclusions

1. Problems with implementing (intensive) MBT-programs are rather common

2. Implementation problems arise from a complex interplay of factors, with organizational and team factors being most important

3. Experts mention several key issues:
    1. General support within the organization / budget / facilitating by creating necessary conditions
    2. Leadership within the team
    3. Ability to manage destructive team processes and keep up team morale
    4. Selection of competent team members
    5. Stepwise and systematic implementation and management of risks

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Conclusions Joost Preliminary conclusions

- Behind the **MBT** ‘label on the door’, many mental health care institutions struggle to implement a (MBT) treatment programs in a **safe and effective** way
- Struggles increase when dealing with extremely complex (B)PD patients in a highly dosed treatment setting (inpatient or day hospital)
- Struggles originate from a multitude of factors at organizational, team and therapist level
- Our field definitely needs to pay attention to developing strategies to implement treatment programs, particularly when treating the most difficult patients

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New study

- N=8 implementation trajectories in 8 different departments in 6 different organizations
- Design 1:
  - Multiple case study using qualitative interview data from semi-structured implementation interviews
  - Respondents: 2 from each department: 1 from management level and 1 principal therapist, involved in the implementation of the MBT-programs
  - Analysis: for each implementation case both interview transcripts were summarized in a narrative, detailing the interaction of factors at stake in the implementation. Each narrative was corrected by both respondents and was given to a panel of blind raters who score the rate of success and the relevant returning patterns of critical factors and interactions between them in each case. They will also be asked to generate from the narratives a list of generic critical 'success factors'.
- Design 2:
  - Original respondents will be asked to score the relevance of each success factor in their case
  - A panel of experts will be asked the same

Some preliminary results

- Based upon an inspection of the ratings
  - ‘In depth’ inspection of the implementation process reveals that no implementation was ‘spotless’
    - In 4 cases the program has been stopped or discontinued for a longer period of time
    - In 1 case, there are still doubts about continuation (due to reasons external to the implementation process)
    - In 2 cases, implementation was successful, but still with problematic episodes
  - Problems in the implementation process are highly correlated with:
    - The targeted patient population (less severe = less problems)
    - The dosage of treatment (higher dosage = more problems)
  - Problematic cases all show a highly similar pattern of interactions between all three levels

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Some preliminary results

- At organizational level:
  - insufficient support within the organization
  - financial difficulties
  - discontinuation in managers and organizational instability
  - managerial problems
- At team level
  - unbalanced team composition
  - leadership problems (roles unclear, unsupported, inadequate, etc.)
  - inability to keep reflective/mentalizing stance within the team leading to ´splits´ within team
  - often critical, non-mentalizing attitude towards mistakes
  - insufficient MBT expertise, knowledge, supervision during implementation
- At therapist level
  - difficulties in dealing with aggression and crisis
  - ambivalent commitment among all team members to learn and keep adherent to the model

Critical factors in implementation of MBT

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- Aanvullende punten implementation science

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MBT Netherlands

- 2012: start of MBT- Netherland, expertise center
  - Formal collaboration with the Anna Freud Centre (Anthony Bateman)
  - Mission: enhancing/assuring quality of care in MBT-programs in the Netherlands
    - Dissemination of expertise through training, supervision and congresses
    - Development of a *MBT Quality System*
    - Offering support with the implementation of new MBT-programs and adaptations of MBT
    - Stimulating research

- Installation of Registration system for MBT therapists in 2013

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Quality assurance
maintaining Effectiveness of MBT program

- Not only Implementation is an important issue,
- But also once implemented: how do you ensure equally/more effective mbt programs?
- So far, we haven't even yet talked about efficacy or effectiveness of the implemented programs…

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Why a MBT quality system?

1. Effect sizes drop with the dissemination of a treatment program; and in regular ‘maintenance’ period?

- Curtis, Ronan & Borduin (2004): effect size MST in efficacy studies is .81, in effectiveness studies .26

- Henggeler (2004): large difference in (ongoing) clinical supervision, training level of therapists, organizational climate, organization and program features

- Weisz & Kazdin (2003): ‘treatments that cannot cope with these real world factors may not fare so well in practice, no matter how efficacious they are in well-controlled laboratory trials’

- NICE guidelines: ‘the quality of a psychological intervention depends on therapists having skills and the organizational support to replicate the intervention found effective in research settings’

- Our own study

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- Organisatie dias

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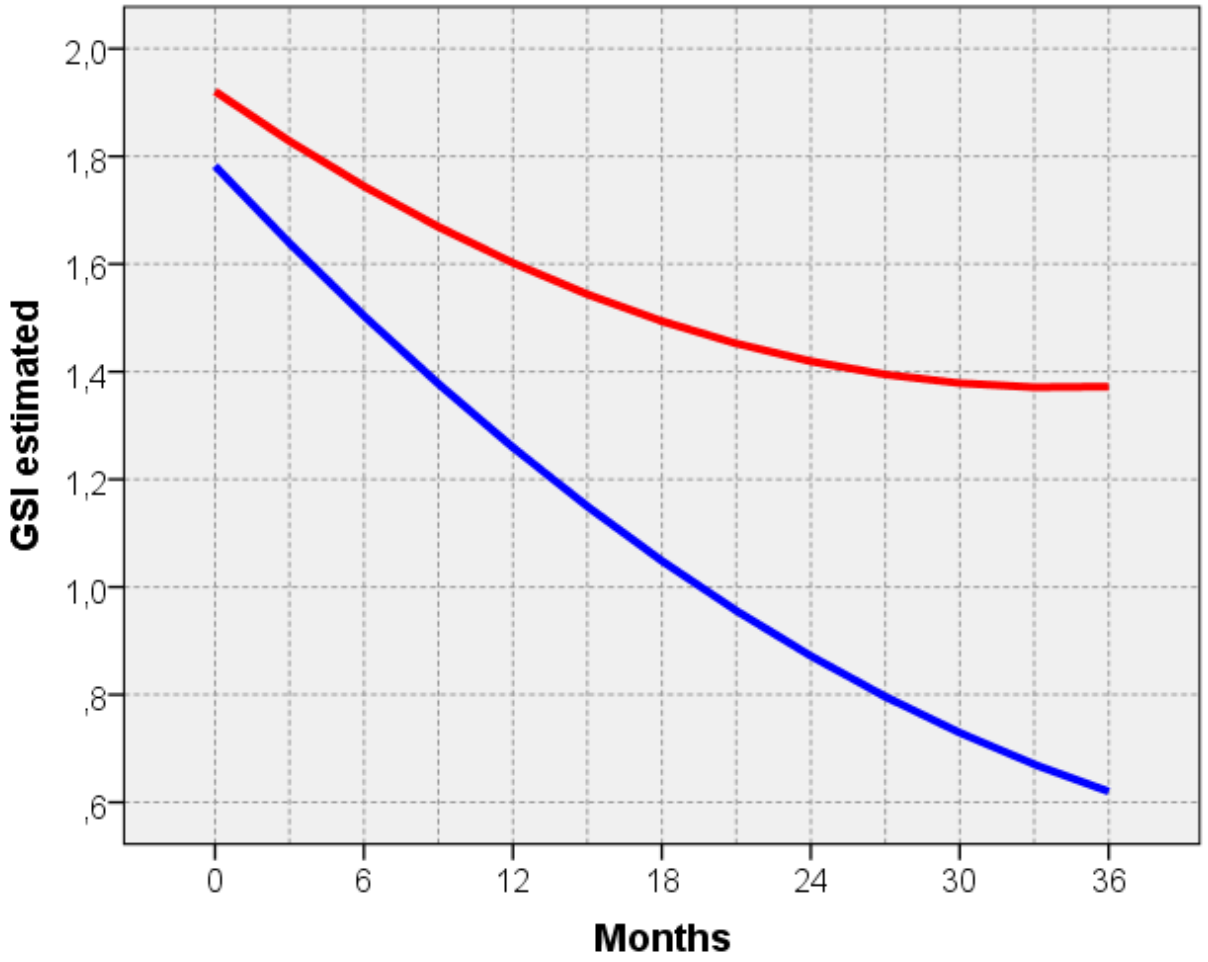

Bad cohort
Good cohort

1½ years:
d = 0.42
p = 0.07
3 years:
d = 0.82
p = 0.07

Source: 'The impact of major organizational changes on treatment outcome of day hospital Mentalization-Based Treatment (MBT)'

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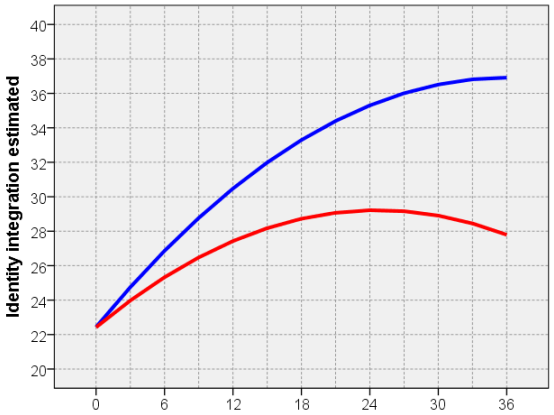
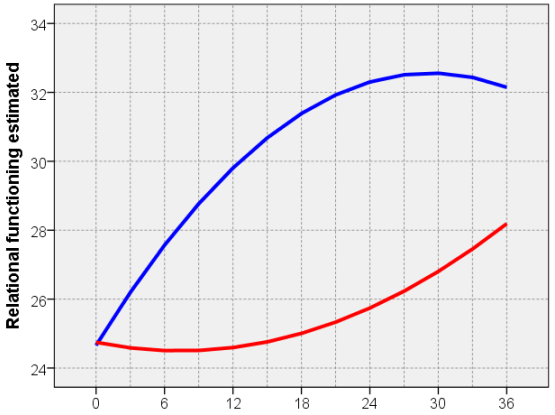
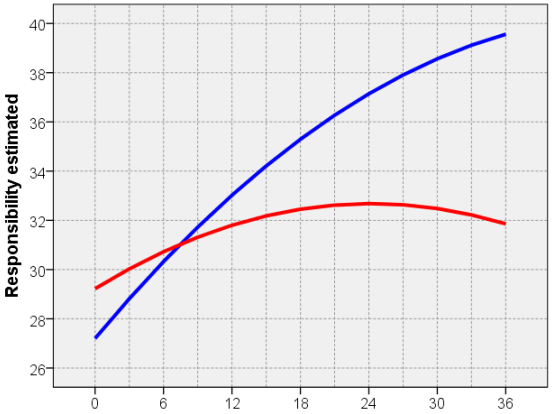


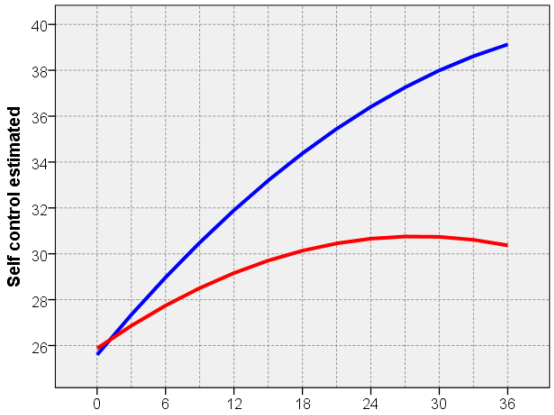
Identity integration
1½ years: d = 0.51, p = 0.005
3 years: d = 1.03, p = 0.005



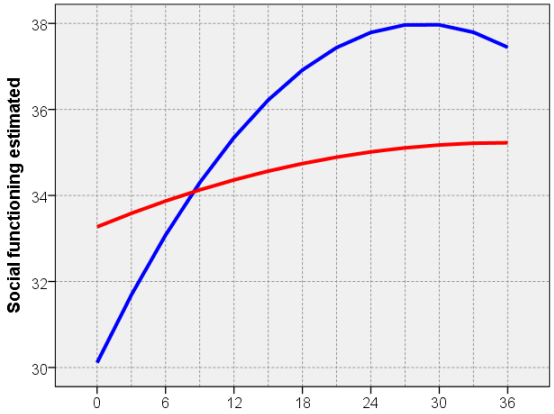
Relational capacities
d = 0.82, p = 0.002
d = 0.51, p = 0.117



Responsibility
d = 0.71, p < 0.001
d = 1.42 p < 0.001



Self control
1½ years: d = 0.63, p = 0.008
3 years: d = 1.17, p = 0.008



Social concordance
d = 0.79, p < 0.001
d = 0.80, p = 0.029

Bad cohort
Good cohort

Source: 'The impact of major organizational changes on treatment outcome of day hospital Mentalization-Based Treatment (MBT)'

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Meer organisatie dias

- Plus aanvullende dias
- Die conclusies ondersteunen
- Leuke voorbeelden

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- Verwijzing quality manual

- But manual is not enough…..

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Why a quality system?

6. Because we know that even simple monitoring systems can generate large effects….

Monitoring the behavior of professionals by applying a simple checklist reduces infections to virtually none ……

In Multisystemic Therapy, a quality system has proved to be very helpful to improve implementation and patient outcome…..

Lessons from hand hygiene

- In 2009, 6,7% of patients in a Dutch hospital caught an infection during their stay at the hospital (PRECIEZ)
- The beneficial effect of washing hands in preventing infections has been demonstrated by at least **9 randomized studies** (Pratt, 2001)
- All professionals are aware of the importance of washing hands to prevent infections
- A study on 47 departments of 3 major hospitals, counting **3500 observations** of nurses and doctors, revealed that (only) **37%, 33% and 19%** of the professionals followed the basic guidelines on infection prevention (Brink-Huis, 2010)
- Professionals are not aware of this: a review study based upon 17 individual studies revealed an inverse relationship between their own judgment of the level of care they offered and the judgment based upon objective sources
- Monitoring the behavior of professionals by applying a simple checklist reduces infections to virtually none

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MBT Quality system

MBT Quality system will help:

- Successful implementation of MBT programs
- Maintain quality of ongoing MBT programs

How?

- By optimalizing assumed workingmechanisms of MBT
- By enhancing and optimalizing therapist competence
- By working on and optimalizing team and organization conditions

MBT QS consists of:

- Manuals
- Trainingstructure
- Programsupervision structure
- Monitoring and feedback system

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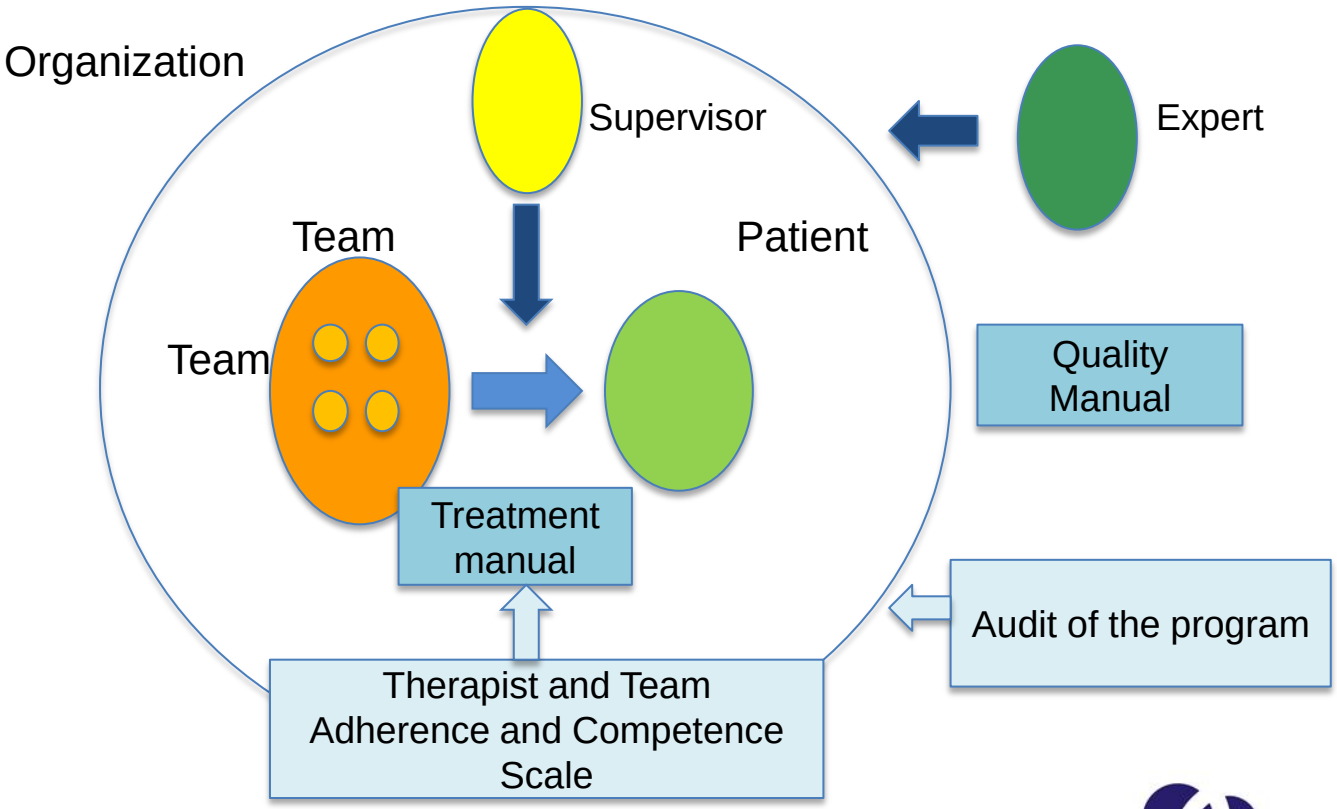
MBT Quality System



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Manuals

- At therapist level
  - Manual
  - Protocol
- At team level
  - Manual
  - Handbook
  - Quality manual
  - Protocol
- At organization level
  - Quality manual
  - Protocols

Structure of protocol & example

MBT NL-protocol	Crisishantering				
Versie	Status	Datum	Auteur/eigenaar	geldig tot	Locatie document
1	*Vastgesteld*	*13-11-2012*	*MBT Nederland*	13-11-2013	*Sharepoint*

Doel

Crisissen die te maken hebben met affectoverspoelingen of impulscontroleverlies zijn nauw verweven met BPS. In een crisissituatie is het vaak lastiger om een mentaliserende focus te behouden. Daardoor kunnen crisissen aanleiding geven tot ondoordachte en soms schadelijke interventies van hulpverleners. Een duidelijk omschreven procedure en signaleringsplan (inclusief crisisafspraken) biedt houvast voor patiënt en hulpverleners bij het hanteren van crisissen.

Definitie crisis

Een crisis is een situatie waarin patiënt controle over zichzelf dreigt kwijt te raken of kwijt is. Het is belangrijk om onderscheid te maken tussen in crisis raken, in crisis zijn en in crisis zijn geweest. Voorbeelden van soorten crisissen:

1. acute (inclusief verandering van chronische) suïcidaliteit en recente suïcidepoging;
2. ernstige vormen van automutilatie;
3. agressie / dreiging homicide / gevaar voor anderen;
4. impulsief en/of chaotisch gedrag dat kan leiden tot gevaar voor zichzelf of anderen
5. ernstig acute psychiatrische ziektebeelden (zoals een psychose, ernstige depressie, ernstige angsttoestand);;
6. levensbedreigende lichamelijke toestand (inclusief intoxicaties) .

Algemene principes

Bij het hanteren van crises gelden de volgende algemene principes:

- De verantwoordelijkheid voor het hanteren van crises wordt zoveel mogelijk bij de patiënt gelaten. Dit geldt ook voor het nemen van de beslissing om een crisisopname aan te vragen.
- Het signaleringsplan vormt de leidraad voor het hanteren van de crisis
- Naastbetrokkenen en hulpverlenende instanties die een eventuele rol spelen bij het hanteren van de crisis, zijn op de hoogte van de afspraken en beschikken over het signaleringsplan
- Een belangrijk doel is om schadelijke interventies te vermijden
- Crisissen worden zo 'spaarzaam' mogelijk gehanteerd: patiënten worden aangemoedigd om zelf actief gebruik te maken van het signaleringsplan om crisissituaties te hanteren; lukt dat onvoldoende, dan kunnen ze (binnen kantoortijd) bellen voor een telefonisch crisisgesprek; blijkt dat nog steeds onvoldoende, dan kan een extra crisisgesprek op de afdeling georganiseerd worden. Pas in laatste instantie wordt een crisisopname als interventie gebruikt. Maar ook daar wordt het besluit daartoe zoveel mogelijk bij de patiënt gelaten.
- Is er sprake van onhanteerbare crisis buiten kantoortijd, dan kan de route tot crisisopname worden gevolgd. Ook in dat geval blijft de verantwoordelijkheid voor een besluit tot aanvraag van crisisopname zoveel mogelijk bij de patiënt.

Onderdelen van een signaleringsplan (inclusief crisisafspraken)

Met iedere patiënt wordt bij aanvang van het MBT-programma een **signaleringsplan (inclusief crisisafspraken)** opgesteld. Dit plan is beschikbaar bij: patiënt zelf, naaste(n) van betrokkene, MBT-team, huisarts, huisartsenpost, PAAZ of een ander instelling waar opnameafspraken mee gemaakt zijn, eventuele opnameplaats buiten de regio. Patiënten worden aangeraden het plan steeds bij zich te hebben.

Een signaleringsplan bevat minimaal de volgende vijf aspecten:

- Signalen (intern en extern) van een (opbouwende) crisissituatie bij de patiënt
- Acties die de patiënt zelf kan ondernemen in een crisissituatie
- Acties die anderen (naastbetrokkenen, hulpverleners) kunnen ondernemen in een crisissituatie,
- Informatie voor de huisarts of andere hulpverleners die de patiënt in een crisis zien

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Structure of protocol & example

MBT NL protocol	Voortraject MBT en MBT-A				
Versie	Status	Datum	Auteur/eigenaar	Geldig tot	Locatie document
1	*Vastgesteld*	*28 mei 2013*	*MBT Nederland*	*28 mei 2014*	*Sharepoint*

Inleiding

Het voortraject is de fase na de intake en aanmelding, vanaf het oriënterend gesprek (OG) tot instroom in de intensieve behandelfase. Het doel van dit protocol is om de doelstellingen, programmacomponenten, taken en verantwoordelijkheden van het voortraject uniform te beschrijven.

Doelen voortraject

Het voortraject heeft verschillende doelstellingen:

1. Overbrugging van de wachttijd tot instroom in intensieve behandelfase
2. Stabiliseren van problematiek bij aanmelding
3. Bevorderen van commitment aan de behandeling
4. Starten met crisismanagement
5. Psycho-educatie over mentaliseren en MBT-behandelprogramma

Fasen in het voortraject

Het voortraject zelf bestaat uit twee fasen:

1. Wachtlijstoverbrugging
2. Voorbereidingstraject

Daaraan voorafgaand is er nog een fase na aanmelding bij de unit om de indicatie te bevestigen.

Van aanmelding tot voortraject
Patiënten kunnen zowel intern als extern verwezen worden voor een MBT-behandeling. In beide gevallen is het belangrijk dat de indicatie gecheckt wordt en dat de patiënt voldoende informatie krijgt zodat een geïnformeerde keuze voor de behandeling kan worden gemaakt. Dat gebeurt in het Oriënterend gesprek (OG).

- Indicatiecriteria MBT

MBT richt zich op adolescenten (vanaf 15.5 jaar) en volwassenen (vanaf 17.5 jaar) met een borderline

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Structure of protocol & example

De volgende criteria gelden:

- Oriënterend gesprek (OG)

Inclusiecriteria	Exclusiecriteria
Tenminste 5 BPS-trekken via de SCID-II	Autismespectrumstoornissen; chronisch psychotische stoornissen; organische aandoeningen die ernstig interfereren met het vermogen om te mentaliseren.
Reisafstand: binnen 60 minuten zelfstandig naar de therapielocatie kunnen reizen.	As I stoornissen die ernstig interfereren met de mogelijkheden van de patiënt om in behandeling te kunnen zijn (vb dusdanig middelengebruik dat patiënt niet nuchter kan zijn voor de therapiesessies). In deze uitzonderlijke gevallen zal het noodzakelijk zijn om de voorwaarden te creëren dat patiënt aanwezig kan zijn; een sequentiële of parallelle behandeling voor betreffende as I stoornis in voortraject is dan aangewezen.
	IQ< 80 Onvoldoende beheersing van de Nederlandse taal.

Het oriënterend gesprek wordt ingepland nadat een patiënt verwezen werd naar het MBT-programma. Doelen van het oriënterend gesprek zijn:

- Checken van de in- en exclusiecriteria;
- Bieden van informatie over de aard van de behandeling en van het behandelprogramma;
- Inventariseren van mogelijke aandachtspunten voor het voortraject (commitmentproblemen, suicidaliteit, problemen met zelfstandig reizen, overige bestaande hulpverlenerscontacten, andere maatschappelijke en klinische problemen);
- Informatie geven over wetenschappelijk onderzoek;
- Informatie geven over verdere procedure.

Het protocol 'Oriënterend gesprek' geeft meer informatie over doelstellingen en opzet van het OG. Aan het einde van het OG wordt voor een week later het advies en plaatsingsgesprek afgesproken om van beide kanten (behandelteam en patiënt) de indicatie definitief te bevestigen en verdere afspraken te maken.

Afstemmen behandelverantwoordelijkheid

Met de verwijzer moet duidelijk afgestemd worden wie, wanneer de behandelverantwoordelijkheid heeft. MBT-unit neemt behandelverantwoordelijkheid over de patiënt vanaf het psychiatrisch onderzoek en wanneer medicatiebeleid overgenomen is, tenzij expliciet anders overeengekomen met de verwijzer/huisarts.
Indien patiënt niet direct in het voorbereidingstraject kan starten, maar in wachtlijstoverbrugging komt, is het wenselijk om behandelverantwoordelijkheid bij de huisarts/verwijzer te houden.

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Training and supervision structure

- Individual therapist level:
  - Training
  - Inwerkprogramma
  - Supervision until level of MBT practitioner

- At team level:
  - Installation programsupervisor
  - Continuous teamsupervision/intervision
  - Programsupervision

- At organization level:
  - Implementation Consultation
  - Consultation of programsupervisor
  - Consultation of management

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Monitoring and feedback system

- At patiënt level
  - Treatmentplan evaluations
  - ROM
- At therapist level
  - Patiënt adherence measures & adherence measures
  - Therapy proces checklist
  - Audit
- At team level
  - Programsupervisor consultation
  - Audit
- At organization level
  - Management consultation
  - audit

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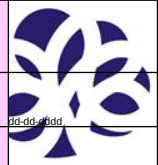
MBT-V Peeltijd			NAAM PATIËNT	NAAM PATIËNT	NAAM PATIËNT	NAAM PATIENT	NAAM PATIENT:		NAAM PATIENT:	NAAM PATIENT:	NAAM PATIENT:	NAAM PATIENT:
MBT Voortraject	**OP**	**Joost**						**Dawn**				
Supervisor voortraject			Manon	Manon	Manon	Manon	Manon		Manon	Manon	Manon	Manon
Individueel therapeut voortraject			Joost Hutsebaut	Joost Hutsebaut	Joost Hutsebaut	Joost Hutsebaut	Joost Hutsebaut		Dawn	Dawn	Dawn	Dawn
Individueel sociotherapeut voortraject			Liesbeth	Monique	Monique	Liesbeth	Liesbeth		Liesbeth	Monique	Monique	Liesbeth
psychiater			Milka	Milka	Milka	Milka	Milka		Milka	Milka	Milka	Milka
Orienterend gesprek (OG): Informatie MBT-behandeling meegeven			dd-dd-dddd	15-04-13	15-03-13	8-03-13	22-04-13		9-08-12	12-11-12	dd-dd-dddd	dd-dd-dddd
Afstemmen behandelverantwoordelijkheid met verwijzer en huisarts			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		8-10-12	nvt	6-09-12	6-09-12
datum start voorbereidingstraject			x	x	x	x	x		x	x	x	x
Sign. Plan, crisisafspraken getekend door therapeut			dd-dd-dddd	15-04-13	15-03-13	8-03-13	22-04-13		9-08-12	12-11-12	dd-dd-dddd	dd-dd-dddd
Individueel behandelplan getekend voor gezien			dd-dd-dddd	15-04-13	15-03-13	8-03-13	22-04-13		12-11-12	26-11-12	22-10-12	22-10-12
Afdelingsregels MBT getekend			dd-dd-dddd	15-04-13	15-03-13	8-03-13	22-04-13		12-11-12	26-11-12	12-11-12	12-11-12
Toestemmingsformulieren (inclusief beeldmateriaal)			dd-dd-dddd	15-04-13	15-03-13	8-03-13	15-04-13		12-11-12	26-11-12	22-10-12	22-10-12
Psychiatrisch onderzoek												
telefonische contact met huisarts: medicatie en crisisproctocol												
Vragenslijst Sociale Omstandigheden												
Huisbezoek												
Startdatum MBT-i												
eerste versie signaleringsplan (1 - 2 maanden na start IS gesprekken)												
eerste versie behandelplan doel 1,4, 5 (1 - 2 mnd. na start voortraject)												
MBT Intensieve behandeling												
Supervisor intensieve behandeling			naam	naam	naam	naam	naam				Manon	Manon
Individueel therapeut intensieve behandeling			naam	naam	naam	naam	naam		naam	naam	Anouk	Anouk
Individueel sociotherapeut intensieve behandeling			naam	naam	naam	naam	naam		naam	naam	Jan	Jan
psychiater			Anke	Anke	Anke	Anke	Anke		Anke	Anke	Anke	Anke
Startdatum intensieve behandeling			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	19-11-12	19-11-12
Individueel behandelplan binnen max. 3 mnd (compleet), getekend			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		*dd-dd-dddd*	*dd-dd-dddd*	*18-02-13*	*18-02-13*
Signaleringsplan binnen max. 3 mnd. (compleet) getekend			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	25-05-13	25-05-13
Datum signaleringsplangesprek			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	23-05-13	23-05-13
Eventueel: aanvullende modulen (MBT-F, MBT-P) en/of aanvullende behandelingen (bv. verslavingszorg, relevante medische zorg)												
Individueel behandelplan na max. 9-12 maanden aangepast, focus op afronden, afscheid			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	dd-dd-dddd	dd-dd-dddd
Startdatum nabehandeling			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	dd-dd-dddd	dd-dd-dddd
Onderdelen nabehandeling op maat												
Individueel behandelplan nabehandeling (2 doelen) getekend			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	dd-dd-dddd	dd-dd-dddd
In BHP afgesproken fequentie IS/IT gesprekken (datum BHP en nieuwe frequentie aanvullen, oude laten staan)												
IT-frequentie minder dan 1 x per 6 weken, medicatie terug naar huisarts			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	dd-dd-dddd	dd-dd-dddd
Brief "MBT Medicatieoverdracht aan huisarts" (bij contact minder dan 1 x per 6 weken)			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	dd-dd-dddd	dd-dd-dddd
Formulier einde behandeling bij ontslag ingevuld & brief			dd-dd-dddd	dd-dd-dddd	dd-dd-dddd		dd-dd-dddd		dd-dd-dddd	dd-dd-dddd	dd-dd-dddd	dd-dd-dddd



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Dawn Bales & Joost Hutsebaut

September 7th, 2015

Anna Freud Centre, London

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Effectiveness of (MBT) – a matched control study comparing MBT with other psychotherapies

- Study aim: what is the effectiveness of day hospital MBT when compared to other psychotherapeutic treatment settings?
- Study population, 2 naturalistic cohorts
  - N=29 BPD patients assigned to MBT
  - N=175 BPD patients assigned to OPT
    - Outpatient (23%)
    - Day hospital (38%)
    - Inpatient treatment (39%)
    - SFT, TFP, DBT, integrative psychotherapy
- Baseline and follow-up-data on psychiatric symptoms (SCL-90) and personality functioning (SIPP)
- Design: matched-control design.

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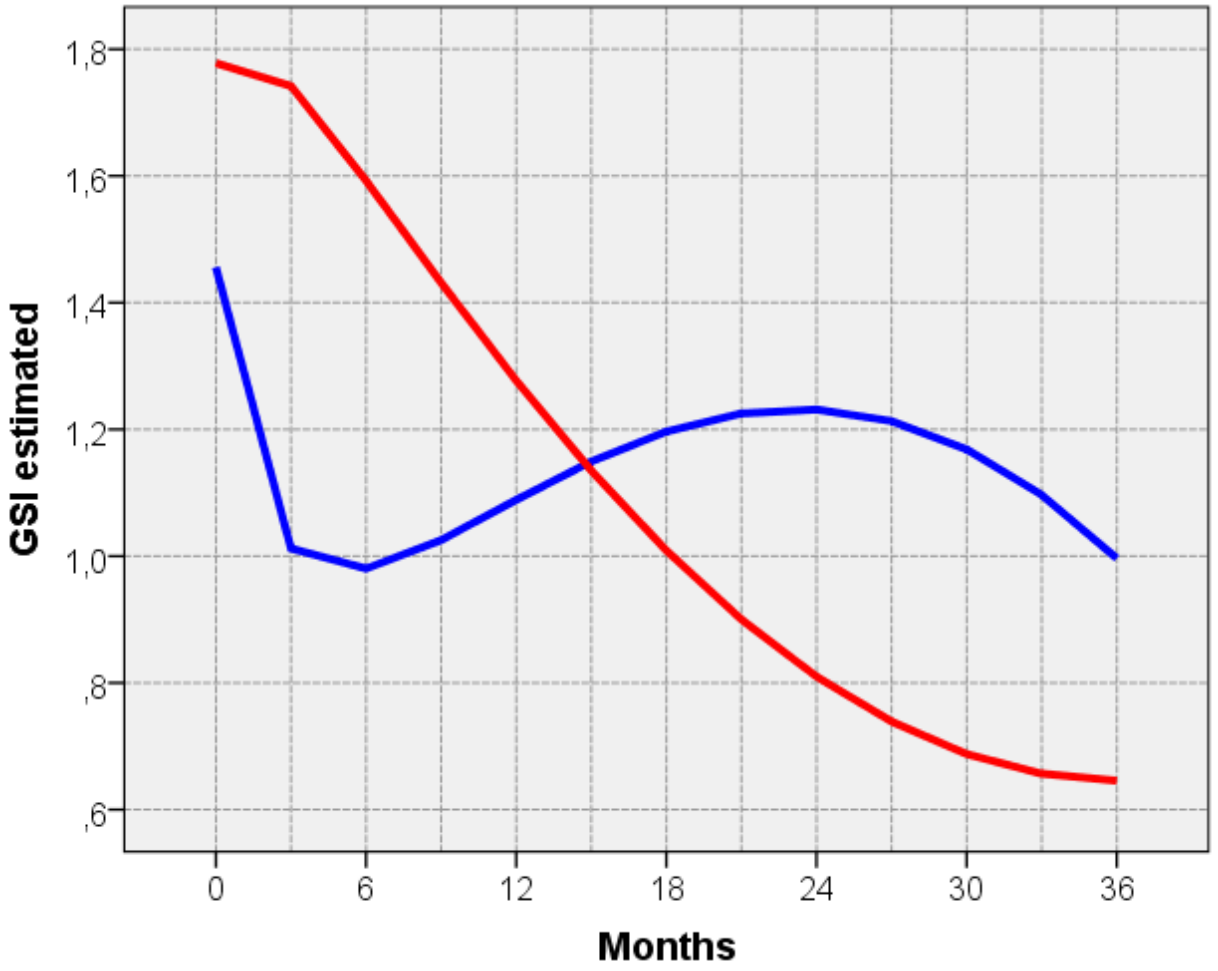

MBT

OPT

1½ years:
d = 0.71
p = 0.006
3 years:
d = 0.85
p = 0.0018

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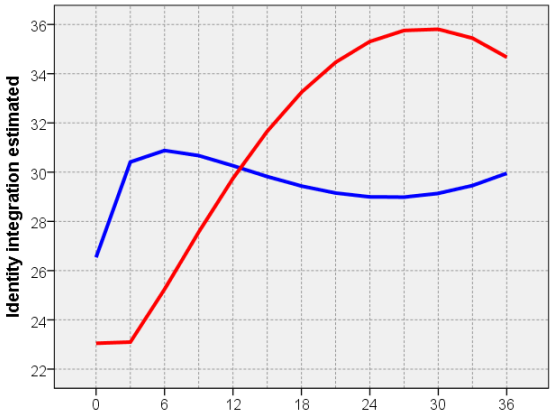
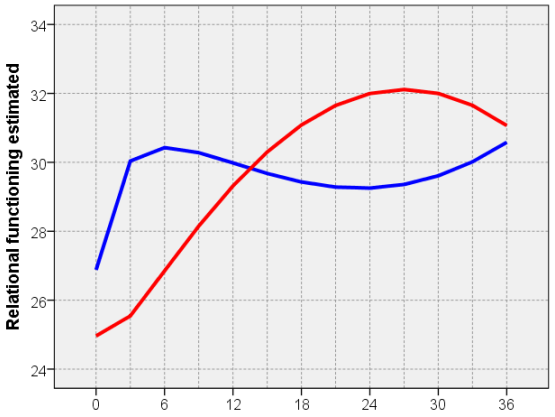


Identity integration

1½ years: d = 0.88, p = 0.002

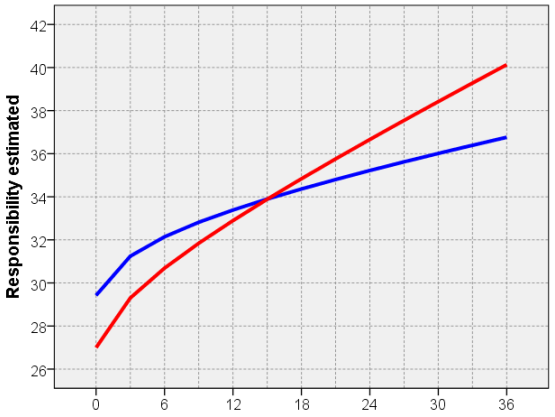
3 years: d = 0.92, p = 0.009



Relational functioning

d = 0.49, p = 0.076

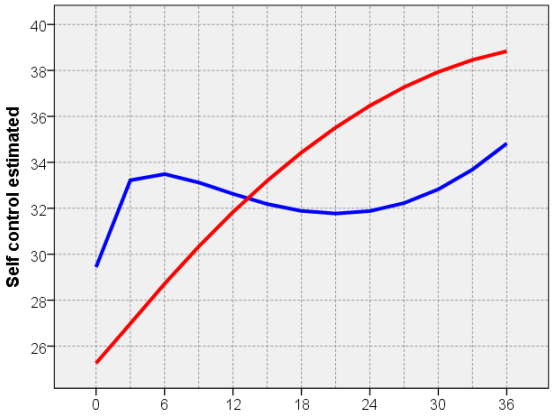
d = 0.34, p = 0.310



Responsibility

d = 0.45, p = 0.007

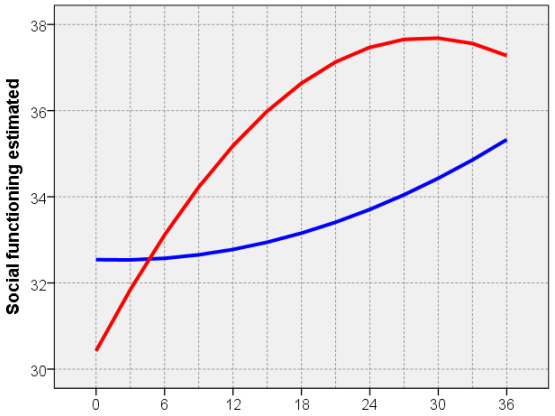
d = 0.92, p = 0.007



Self control

1½ years: d = 0.88, p = 0.001

3 year": d = 1.09, p < 0.001



Social concordance

d = 0.79, p < 0.001

d = 0.59, p = 0.028

MBT

OPT

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Effectiveness of (MBT) – a matched control study comparing MBT with other psychotherapies

Conclusion

- MBT and OPT patients improved over time in all outcome areas
- MBT patients report superior treatment outcomes than BPD patients receiving other psychotherapy.

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Mentalization-Based Treatment in a nutshell

- Evidence based treatment for adults with (severe) Borderline PD
- Originally developed by Anthony Bateman and Peter Fonagy (UK, 2004)
- Rooted in attachment theory and psychodynamic concepts
- Supported by four RCTs (Bateman & Fonagy, 1999; 2009; Jorgensen et al., 2012; Rossouw & Fonagy, 2012)
- Included in all guidelines / reviews on PDs (Cochrane, APA, NICE, Dutch MD Guidelines)
- Recent adaptations for families (MBT-F), adolescents (MBT-A), parents (MBT-P) among others

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Kwaliteitssysteem MBT, versie 1.0

- Manuals:
  - Organisatie-/Kwaliteitshandleiding met kwaliteitseisen (dec: Ndle versie)
  - Ondersteuningsaanbod met protocollen
- Supervisiestructuur
  - Implementatie supervisor en expert
  - Supervisie en consultatie (met start beschrijvingen rol, functie etc)
- Start monitoring/feedback cycli
  - Audit programma, auditverslag
  - Afvinklijsten
  - MBT Adherence & competence Scale afname
  - (Pilot Therapist Adherence Monitoring, klinisch gebruik)
  - (Pilotversie Team Adherence Monitoring, klinisch gebruik)
- Opleidingsstructuur
  - Opleiding/supervisies
  - Registratiesysteem

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Waarom een kwaliteitssysteem?

2. Omdat we onze eigen negatieve ervaringen met ‘maintenance’ hebben

- Study Bales et al., in preparation
- Drop effect size van 1.50 tot .50 door
  - *instabiliteit organisatie en unit* (te veel innovaties tegelijk, discontinuiteit in management, snelle uitbreiding unit, onduidelijke structuur en definitie van rollen, snelle groei team en te groot team)
  - *te weinig inhoudelijke expertise voor nieuwe situatie* (vele onervaren medewerkers, verminderde betrokkenheid supervisoren, verlies expertise, reflectie op teamprocessen verloren, minder holding, etc)

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Waarom een kwaliteitssysteem?

3. Omdat dit geen alleenstaand geval is in Nederland

- Hutsebaut, Bales et al. implementatiestudie in voorbereiding
- 8 implementatietrajecten MBT
  - 4 lopen nog
  - 4 zijn (tijdelijk) gestopt of ingrijpend gereorganisieerd omwille van ernstige implementatieproblemen

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Kwaliteitssysteem MBT

- Achterliggend model:
  - Op basis van implementatieliteratuur
  - Op basis van eigen implementatiestudie bij 8 programma's
  - Op basis van MST-model van kwaliteitsbewaking

- Basisstelling: Het succes van een implementatie en van het behoud van de effectiviteit van een programma in de 'dagelijkse klinische realiteit' wordt bepaald door de mate waarin 'kritische factoren' op drie niveaus kunnen worden geoptimaliseerd en geborgd:
  - Organisatie
  - Team
  - Therapeuten

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Research on MBT in the Netherlands

- Two randomized controlled trials are being run:
  - Dekker-trial in Amsterdam (Arkin)
  - MBT-dos, comparing different dosages of MBT (Viersprong, NPI, Lentis)

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Kwaliteitssysteem MBT

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  - Op basis van implementatieliteratuur
  - Op basis van eigen implementatiestudie bij 8 programma's
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  - Therapeuten

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Implementation of MBT in the Netherlands

- Introduced in 2004 at De Viersprong.
- Trained and supervised by Anthony Bateman.
- Replication of Partial Hospitalization and IOP program (Bateman & Fonagy, 1999).
- Expansion of the MBT-unit, 4 locations including:
  - 4 PH-groups, 10 IOP groups, 4 MBT-i groups, 1 mentalizing maintenance group
  - 4 MBT-A programs, MBT-P, MBT-early, MBT-F programs
- MBT-training:
  - In 2006: start of Dutch Viersprong courses in MBT
  - 2006-2014: about 1020 professionals have been trained by de Viersprong
  - 2007-2015: 23 institutions have followed in company trainings, including a long time supervision trajectory
- also other groups in de Netherlands teaching/training MBT

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MBT Research in the Netherlands

Two randomized controlled trials

- Dekker-trial in Amsterdam (Arkin)
- MBT-DOS (Viersprong, NPI, Lentis)

International published studies

- Bales, D., Beek, N. van, Smits, M., Willemsen, S., Busschbach, J.J.V., Verheul, R., & Andrea, H. (2012). Treatment outcome of 18-month, day hospital mentalization-based treatment (MBT) in patients with severe borderline personality in the Netherlands. Journal of Personality Disorders, 26(4), 568-582.
- Laurenssen, E.M.P., Hutsebaut, J., Feenstra, D.J., Bales, D.L., Noom, M. J., Busschbach, J.J.V., Luyten, P., & Verheul, R. (2014). Feasibility of Mentalization-based Treatment for adolescents with borderline symptoms: A pilot study. Psychotherapy.
- Bales, D., Timman, R., Andrea, H., v Busschbach, J., Verheul, R. (2014). Effectiveness of day hospital Mentalization-Based Treatment (MBT) for patients with severe Borderline Personality Disorder – a matched control study comparing MBT with other psychotherapies. Clin. Psychol. Psychother.
- Hutsebaut, J. , Bales, D.L., Busschbach, J.J., Verheul, R. (2012). The implementation of mentalization-based treatment for adolescents: a case study from an organizational, team and therapist perspective. Int. Jour. Of Mental Health Systems.

Studies submitted

- Bales, D., Hutsebaut, J., Timman, R., v. Busschbach, J., Verheul, R. (submitted). The impact of major organizational changes on treatment outcome of day hospital Mentalization-Based Treatment (MBT).
- Protocol artikel
- Long term (8 year) follow-up & predictors

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MBT in the Netherlands: a success?

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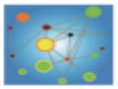
Hutsebaut *et al. International Journal of Mental Health Systems* 2012, **6**:10
http://www.ijmhs.com/content/6/1/10



INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS

CASE STUDY **Open Access**

The implementation of mentalization-based treatment for adolescents: a case study from an organizational, team and therapist perspective

Joost Hutsebaut[1,4*], Dawn L Bales[1], Jan JV Busschbach[1,2] and Roel Verheul[1,3]

Abstract

Background: Reports on problems encountered in the implementation of complex interventions are scarce in psychotherapy literature. This is remarkable given the inherent difficulties of such enterprises and the associated safety risks for patients involved.

Case description: A case study of the problematic implementation process of Mentalization- Based Treatment for Adolescents (MBT-A), a new therapy for 14 to 18 year old youngsters with severe personality disorders, is presented. The implementation process is described and analyzed at an organizational, team and therapist level.

Discussion and evaluation: Our analysis shows that problems at all three levels contributed and interacted to make the implementation cumbersome and hazardous.

Conclusion: The implementation of complex psychotherapeutic programs for difficult patients could benefit from a structured attention to processes at multiple levels. We therefore propose a new comprehensive heuristic model of treatment integrity. This new model includes organisational, team and therapist adherence to the treatment model as necessary components of treatment integrity in the implementation of complex interventions. The application of this new model of treatment integrity potentially increases the chance of successful implementations and reduces safety risks for first patients enrolling in a new program.

Keywords: Implementation, Treatment integrity, Personality disorders, Adolescents, Mentalization-Based Treatment

Background

The last two decades have yielded new and promising interventions for the treatment of borderline personality disorder (BPD). For example, several studies support the effectiveness of various psychosocial interventions for BPD in adults, including Mentalization-Based Treatment (MBT) [1], Dialectical Behaviour Therapy (DBT) [2], Schema-Focused Therapy (SFT) [3], Transference-Focused Psychotherapy (TFP) [4], Systems Training for Emotional Predictability and Problem Solving (STEPPS) [5] and Cognitive Behaviour Therapy (CBT) [6]. These results have typically been obtained under optimal (ex-

support. It is less clear how these evidence-based programs are actually implemented in regular practice. Given the many challenges associated with treating BPD patients and the complexity of these interventions, this issue might be particularly relevant to this patient group. Therefore, it is not only important to report about what works, but also to share experiences on how to implement these promising interventions. However, despite its obvious relevance, reports of (problems in) the dissemination of complex psychosocial interventions seem almost absent in the psychotherapy literature. In fact, we couldn't find a single article describing implementation

Unsuccesful implementation: lessons learned

- We understood the failed implementation of inpatient MBT-A as resulting from an interaction between three levels:
  - Organization:
    - Insufficient support for the new program within the whole institution
    - Organizational fences prevented an optimal use of available expertise
    - Incomplete implementation plan given the complexity of the innovation
  - Team:
    - Difficulties to change team culture
    - Lack of leadership
    - Issues of inconsistency, due to a lack of experience and a large team size
    - Lack of supervision ‘on the spot’ by a therapist experienced in the model
  - Therapists:
    - Lack of experience in the model creating doubts and uncertainty among professionals
    - No selection of personnel prior to starting

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The implications

- The MBT-A case raises important issues:
  - Do these findings reflect more universal issues in the implementation of MBT (or PD treatment programs in general) or do they simply reflect a very specific problem in a very specific context?
  - How are evidence based treatment programs transferred and disseminated in regular clinical practice?
  - What are the factors determining success of implementations?

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MBT-training in the Netherlands

- In 2006: start of Dutch Viersprong courses in MBT
- 2006-2013: about 830 professionals have been trained by de Viersprong
- 2007-2013: 15 institutions have followed in company trainings, including a long time supervision trajectory

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Results: outcome of implementation (as rated by interviewees)

Case	Success?	Outcome
Case 1	failure	Programme has been stopped, no research line, high turn over of personnel, financial losses high
Case 2	Rather succesful	Expansion of program, inclusion of more severe patients; high turn over of personnel; not really MBT
Case 3	Failure	Programme has been stopped; high turnover of personnel; financial losses
Case 4	Failure	Programme has been stopped, high financial losses; high turn over of personnel
Case 5	Rather successful	Programme still exists; but financial problems due to undercapacity; future insecure
Case 6	Succesful	Quick expansion of unit; some personnel turn over; good results
Case 7	Mixed	Intensive programma far less succesful than outpatient programme

Resultaten: bijdrage van verschillende niveaus

CASE	Organisatie	Team	Therapeut
1	4,8	3,9	2,4
2	3,8	4,5	3,8
3	4,1	4,4	3,3
4	4,1	3,8	3,1
5	3,9	4,9	3,8
6	4,4	4,0	3,9
7	3,6	3,8	3,8
Gemiddelde	4,1	4,2	3,4

Gemiddelde meting per niveau

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Hutsebaut, Bales (2015, submitted: **determinants of success and failure in disseminating MBT**

Results: support for 3-level hypothesis?

	1	2	3	4	5	6	7	8	9	10	Av
Case 1	4	5	5	5	5	5	5	5	4	5	4,8
Case 2	5	4	5	5	5	4	4	4	4	4	4,4
Case 3	5	5	5	5	4	5	5	5	4	5	4,8
Case 4	5	5	5	5	3	5	5	4	4	5	4,6
Case 5	5	4	3	5	4	4	4	4	4	5	4,2
Case 6	5	3	5	5	5	3	5	4	4	5	4,4
Case 7	4	4	5	5	3	3	5	4	4	4	4,1

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Results

- Based upon an inspection of the ratings
  - ‘In depth’ inspection of the implementation process reveals that no implementation was ‘spotless’
    - In 4 cases the program has been stopped or discontinued for a longer period of time
    - In 1 case, there are still doubts about continuation (due to reasons external to the implementation process)
    - In 2 cases, implementation was successful, but still with problematic episodes
  - Problems in the implementation process are highly correlated with:
    - The targeted patient population (less severe = less problems)
    - The dosage of treatment (higher dosage = more problems)
  - Problematic cases all show a highly similar pattern of interactions between all three levels

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