Implementation: lessons learned the hard way

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MentEd Mentalisierungsbasierte Pädagogik

Erasmus+

Understanding Society

This is a story… about failure

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This is a story… about falling down

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This is a story… about scrambling up again

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This is a story… about idealism

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This is a story… about hope

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This is a story… about a phoenix rising from its ashes

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This is a story about Mentalization-Based Treatment

- Evidence-based treatment based upon attachment theory, originally developed by Anthony Bateman & Peter Fonagy
- Initially designed for the treatment of adults with severe Borderline PD
- Supported by several well controlled studies across Europe
- Included in all professional guidelines for the treatment of Borderline PDs

This is a story about success!

- MBT was introduced in the Netherlands in 2004
- Between 2008-2018, more than 30 units had been trained in the Netherlands
- Between 2008-2022, over 2000 professionals have been trained in MBT in the Netherlands

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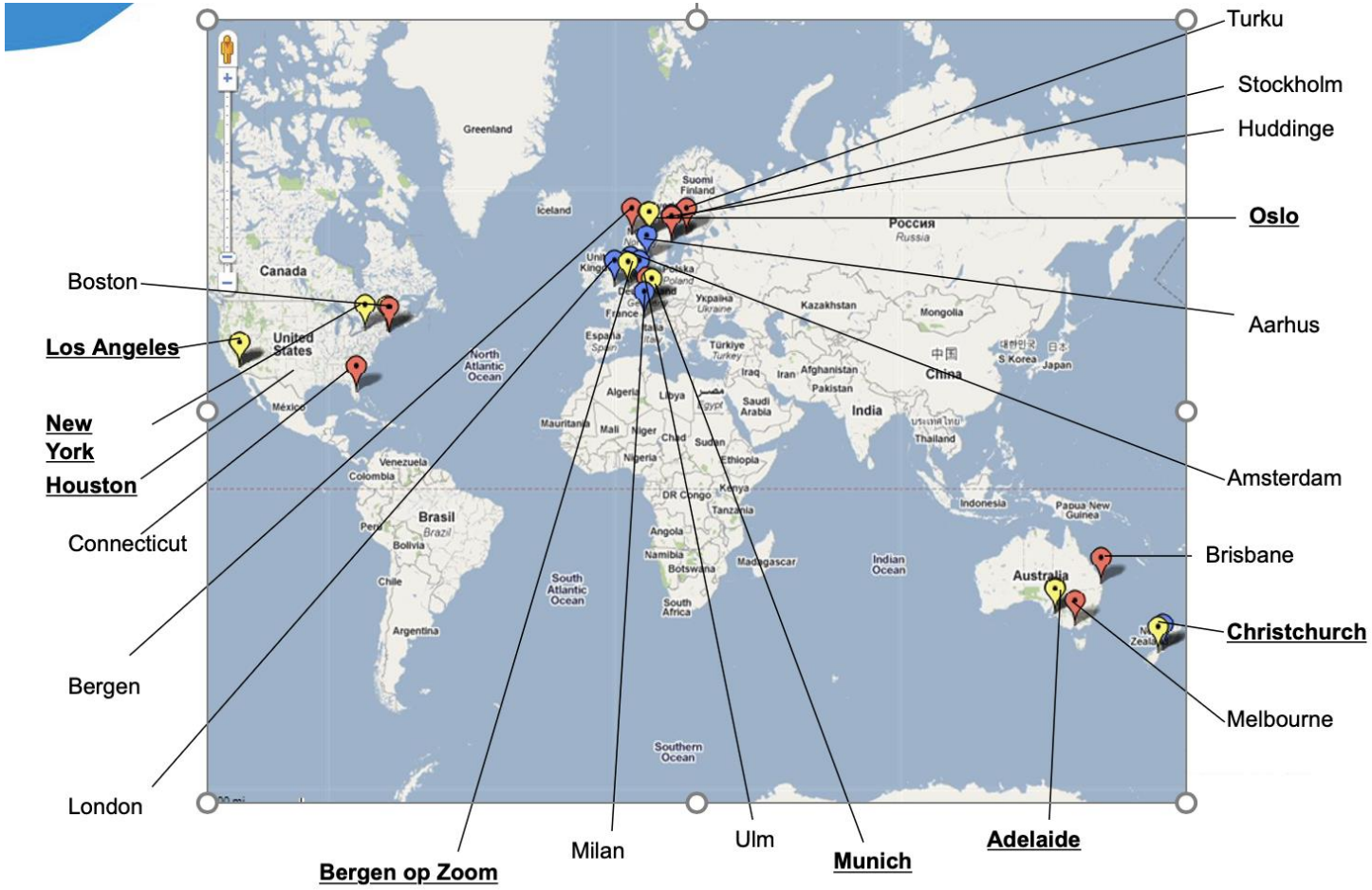
This is a story about worldwide success!



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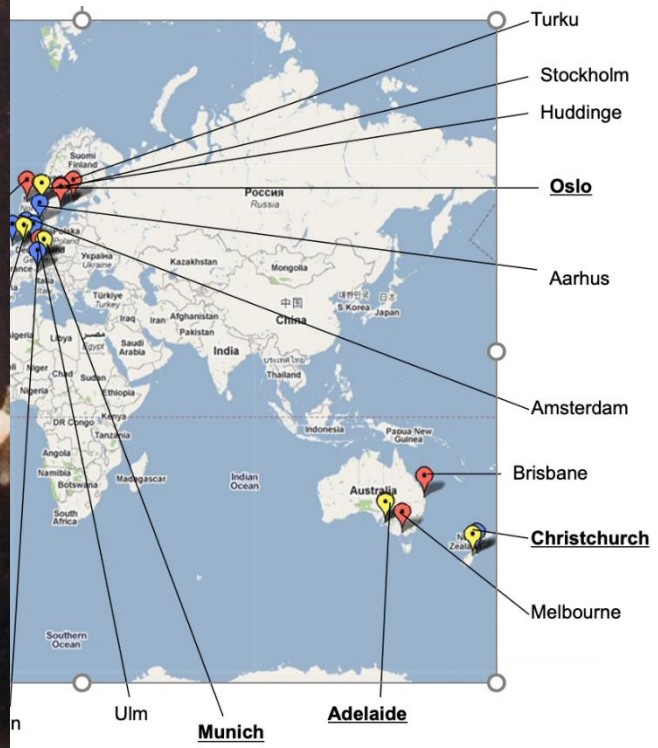
HOORAY



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And it’s a story about adolescents at high risk

- 2007: inpatient unit at de Viersprong
- Strong increase of very suicidal, self-harming young persons
- The existing therapeutic approach didn’t accomodate these young persons anymore
- Let’s implement MBT!!

Almost a career based on failure

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

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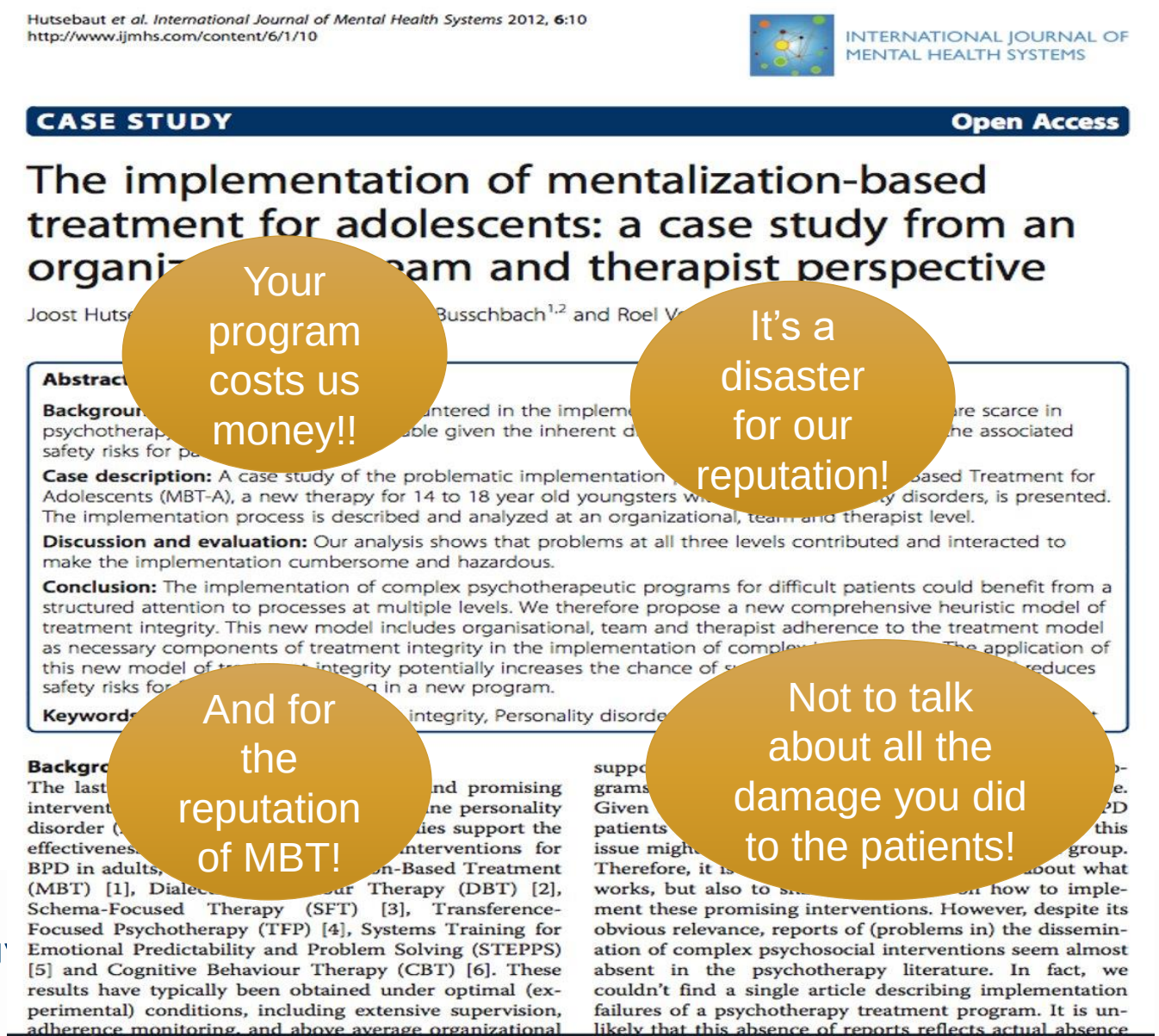
Almost a career based on failure



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Joost Huts… …Busschbach[1,2] and Roel V…

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Backgro…

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Your program costs us money!!

It's a disaster for our reputation!

And for the reputation of MBT!

Not to talk about all the damage you did to the patients!

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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

This is a story about… relief

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Barriers and facilitators to the implementation of mentalization-based treatment (MBT) for borderline personality disorder

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ABSTRACT

There are several evidence-based treatments for borderline personality disorder, but very little is known about the success or failure of implementation in daily practice. This study aims to investigate the success or failure of newly started mentalization-based treatment programs, and to explore the barriers and facilitators. The implementation trajectories of seven different mentalization-based treatment programs in six mental health clinics in the Netherlands were included in a multiple case study combining a qualitative and quantitative design. Semi-structured interview data were collected from several stakeholders of each program. Narrative reconstructions of each interview were assessed by 12 independent experts. Results showed that several programs struggled to implement their program successfully, leading to discontinuation in three programs. According to the experts,

8 cases of MBT implementations

Table 1: Summary of outcome and determinants of each case

Unit	Program	Outcome of implementation	Determinants
A	PH (2 groups)	Negative outcome: program stopped, high expenses, high burden for personnel, high turnover of personnel	• Organizational split between 'care' and 'cure' treatment programs • Lack of support within the organization • Upsetting discussions within the unit and overt fights concerning leadership • Lack of role differentiation • Nurses felt incompetent • Splits between management and team
B	Lower dosage PH (3 days, 1 group) and IOP (1 group)	Positive: for PH (lower dosage) and IOP: low drop-out rate, 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	PH (2 groups)	Negative outcome: program stopped, high absence through illness, high turnover, financial loss	• 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

8 cases of MBT implementations

D	PH (2 groups)	Negative: program has stopped at time of writing; high turnover of personnel, dissatisfaction of patients, financial loss	• Choice of new program by select group and top-down implementation • Split between management and team • Isolation of the team within the institution • Problems with insufficient patient inclusion • Recruitment personnel not based upon competences and interest/motivation • Split within team
E	PH (2 groups) and IOP (1 group)	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

8 cases of MBT implementations

Table 1: (continued)

Unit	Program	Outcome of implementation	Determinants
F	PH (2 groups)	Positive: quick expansion of the unit; mission to include 'difficult' patients was accomplished; few incidents and drop outs; good outcome results	• Strong support from higher management, 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	PH (2 groups) and IOP (2 groups)	Positive for IOP Mixed for PH: high burden among team members, high level of dropout, many crisis-like incidents, formal 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

PH, partial hospitalization; IOP, intensive outpatient.

What caused failure/success?

Table 2: Success and/or failure of implementation: (relative) contribution of organizational, team and therapist factors as judged by experts on a 0–5 Likert rating scale (average score and range)

	Case A	Case B	Case C	Case D	Case E	Case F	Case G	Average
Success or failure (phase 1)	Failure	Success	Failure	Failure	Mixed	Mixed	Success	
Success of implementation depends on a combination of factors at organization, team and therapist level	4.8 (4–5)	4.4 (4–5)	4.8 (4–5)	4.6 (3–5)	4.2 (3–5)	4.4 (3–5)	4.1 (3–5)	4.49
Organizational factors have contributed to success/failure	4.8 (4–5)	3.8 (3–5)	4.1 (3–5)	4.1 (3–5)	3.9 (3–5)	4.4 (3–5)	3.6 (2–5)	4.1
Team factors have contributed to success/failure	3.9 (3–5)	4.5 (4–5)	4.4 (3–5)	3.8 (3–5)	4.9 (4–5)	4.0 (3–5)	3.8 (3–5)	4.2
Therapist factors have contributed to success/failure	2.4 (1–4)	3.8 (3–4)	3.3 (3–4)	3.1 (2–4)	3.8 (3–4)	3.9 (3–4)	3.8 (3–4)	3.4

1: Strongly disagree; 2: Disagree; 3: Neither agree nor disagree; 4: Agree; 5: Strongly agree.

Determinants of success/failure

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

Not related to MBT, by the way

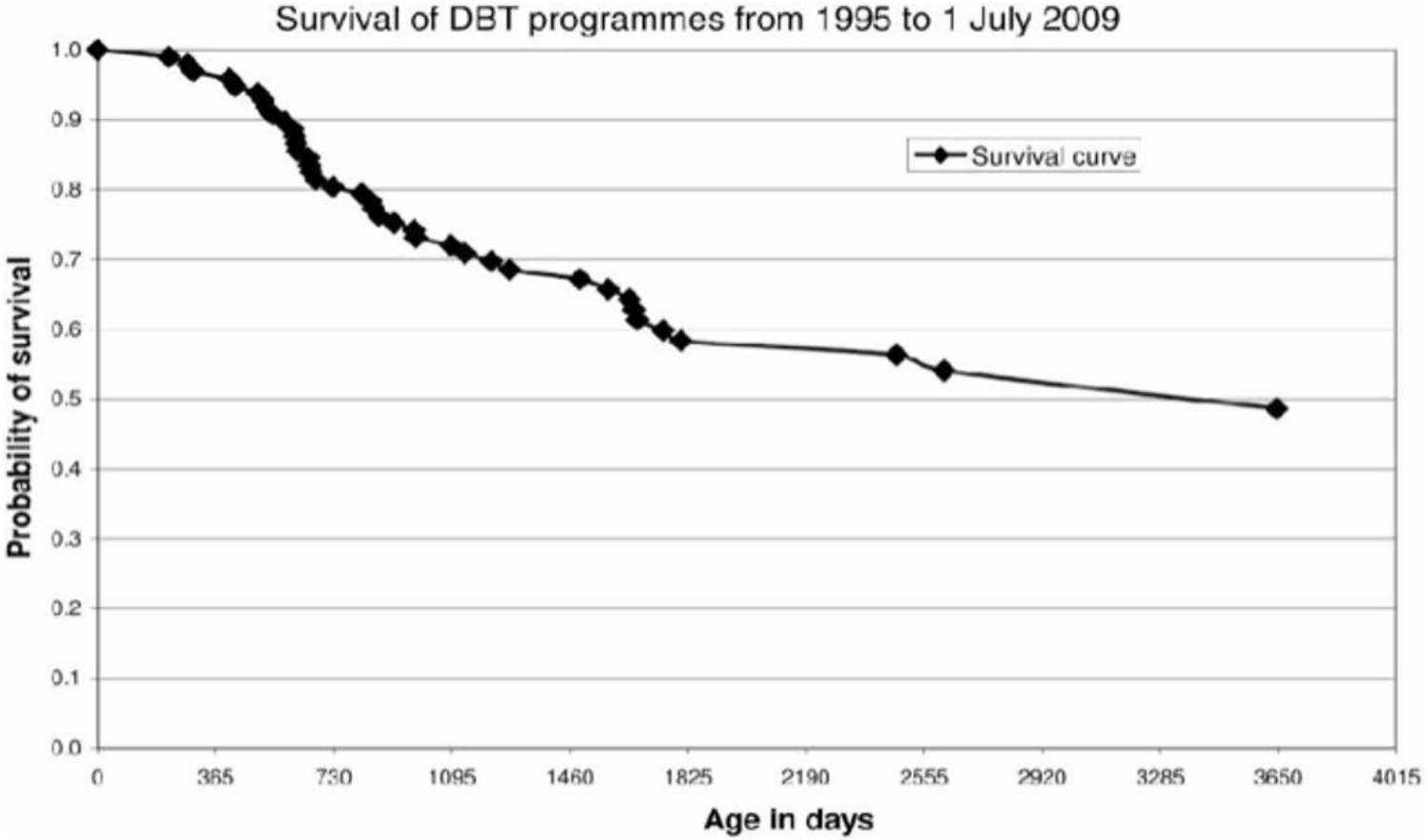

Figure 1. Survival curve.

But most importantly: it affects also outcome of our treatments

Personality and Mental Health

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Implementation of evidence-based treatments for borderline personality disorder: The impact of organizational changes on treatment outcome of mentalization-based treatment

DAWN L. BALES[1], REINIER TIMMAN[1,2], PATRICK LUYTEN[1], JAN BUSSCHBACH[1,2], ROEL VERHEUL[1] AND JOOST HUTSEBAUT[1], [1]Viersprong Institute for Studies on Personality Disorders (VISPD), Halsteren, the Netherlands; [2]Erasmus Medical Center Rotterdam, Section of Medical Psychology and Psychotherapy, Rotterdam, the Netherlands

ABSTRACT

The quality of implementation of evidence-based treatment programs for borderline personality disorder (BPD) in routine clinical care is a neglected issue. The first aim of this mixed-method naturalistic study was to explore the impact of organizational changes on treatment effectiveness of a day-hospital programme of mentalization-

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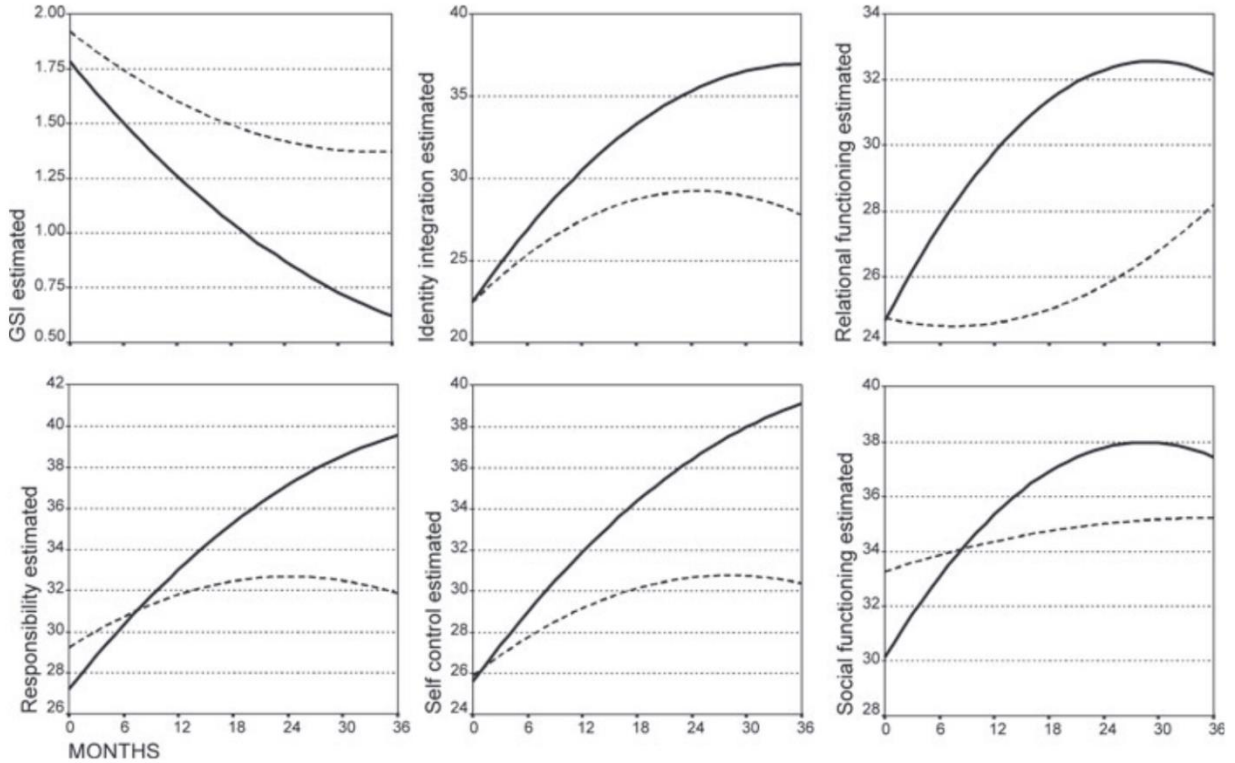
Treatment is 2 to 3 times less effective when implementation is cumbersome



Note: Solid lines = 'Pre-reorganization Cohort' (PRE-REORG); dotted lines = During reorganization Cohort' (REORG)

Figure 1: Estimated courses of outcome variables. Note: Solid lines, pre-reorganization cohort (PRE-REORG); dotted lines, during reorganization cohort (REORG)

How come?

Table 4: Consensus ratings on adherence of two cohorts at organizational, team and therapist level

	Cohort 1 (PRE-REORG)	Cohort 2 (REORG)
Organization		
Commitment and support within the organization to fully implement MBT	7	4
Availability of comprehensive implementation plan	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
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: programme structure, clear definition of roles and responsibilities	6	2
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.

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Summary

- To implement a new way of thinking and to change actual practice is a tough challenge
- Change can be initiated by individuals, but success in change is teamwork
- Broad support on all levels of an organisation in combination with leadership may be needed
- If people don’t feel comfortably (at the start) with this new way of thinking, don’t push them

How may this translate to introducing a mentalizing approach at schools?

I don’t know but here are some ideas…

- Change should be supported by principals, but not be demanded top-down (be aware of the specific team/school culture before initiating changes)
- Change should be introduced as a way to help and empower teachers in some regards, starting from daily struggles they recognize
- Change should enable teachers to remain sufficiently in their comfort zone (not to have to do something completely new)
- Change should be initiated by a small subteam, creating mutual support
- Benefits of change should be measurable, so people stay motivated