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Adherence Quality criteria for MBT-programs (Bales, Hutsebaut & Bateman: 2nd version, June 2017)

The table below offers a list of 20 criteria for assessing the quality of MBT-programs. The criteria can be used as a target for improving quality within the MBT quality system and as an instrument for auditing MBT-programs. Criteria include organizational, team and therapist factors. They can be scored on a 5-point scale:

1: very poor
2: poor
3: adequate
4: good
5: very good

Nr.	Criterion	Level	Score (1-5)	Motivation / Strengths and/or weaknesses / Points of attention
1.	The organization (board) is fully committed to implement the MBT-program as intended, including having basic knowledge about the program, providing financial support, creating support within the whole organization and creating a learning environment	Organization		
2.	The management of the MBT-department fully supports and facilitates the MBT-program, including a (pro)active policy to create a healthy working environment, rapid response to potential problems, understanding burden of work and collaborating closely with program supervisors and MBT experts/consultants.	Organization		
3.	The MBT-program has established a committed and reliable collaboration with relevant stakeholders, including establishing a clear pathway to local crisis services, collaboration with addiction services, and collaboration with major referral centers.	Organization		
4.	The MBT-program has an organized referral process, providing assigned patients efficient inflow and rapid access to treatment.	Organization		
5.	The MBT department has established a routine monitoring system to inform about quality of treatment, including outcome monitoring, monitoring of parameters of quality, and treatment integrity.	Organization		

Anna Freud
National Centre for
Children and Families

6.	All MBT- programs at the unit are clearly structured and provide a phased treatment trajectory. This involves defined maximum treatment duration of the program and structuring of program according to the initial, middle and end phase requirements.	Organization		
7.	Team functioning should be oriented at continuously improving team consistency and continuity within a coherent MBT framework; the organization facilitates this by embedding sufficient time for treatment plan review, supervision and intervision	Organization/ team		
8.	Team members are recruited based upon their proven affinity with the targeted population and upon their skills, competencies and characteristics necessary to treat PD patients from an MBT model. Team members demonstrate willingness to improve their skills and understanding through training and supervision	Organization/ team		
9.	Management/team supervisor and team are responsible for creating and maintaining a well balanced and mentalizing team, characterized by openness and a genuine reflective stance	Organization/ Team		
10.	Individual roles and responsibilities are clearly defined and met within the multidisciplinary team. There is clear and accepted leadership in the team.	Organization/ Team		
11.	Each team has a Program Supervisor, who monitors and supervises clinical processes and enhances a mentalizing environment in the team.	Team		
12.	A clear, coherent MBT framework is present, noticeable by a consistent approach within the therapist and in the team.	Team		
13.	Each patient has an appointed primary clinician, who is responsible for assessment, treatment planning and treatment coordination.	Team		
14.	Medication review and somatic screening are provided by a psychiatrist integrated within the unit (one –team model)	Team		
15.	Treatment should be goal-focused and guided by a treatment plan, including a dynamic formulation of problems and individualized and collaboratively discussed treatment goals.	Team		
16.	Treatment should be process-oriented, monitored and revised when necessary in regular treatment review meetings with team and patient.	Team		

17.	The team works with a clear crisis management protocol, based on MBT treatment principles, including regular risk assessments, crisis plans and consistent and active crisis management	Team		
18.	The team has an active and outreaching approach to enhance commitment of patients to treatment, including assessment of situational triggers and mental states leading to (possible) drop out, active assessment of actual risks and dealing with commitment problems in accordance with MBT protocols.	Team		
19.	The therapist's attitude reflects their continuous efforts to enhance patients' autonomy and thus own responsibility, including shared decision making, involvement in treatment review and stimulating responsibility taking in crisis	Therapist		
20.	All therapists take a mentalizing stance in contact with patients. They focus on enhancing mentalizing of self, others and relations and they use interventions according to the intervention spectrum.	Therapist		

Legend

1. This criterion refers to the full commitment of the organization/board to implement the MBT-programs as intended, which should be demonstrated by the following aspects:
    a. The board has basic knowledge about the program, the patient population it is intended for and the basic program requirements to organize the program
    b. The board has basic knowledge about the rationale and working of the MBT quality system and is fully supportive in this
    c. The board facilitates and supports the clear and undisputed embedding of the program within the whole organization
    d. The organization creates and enhances a learning environment, accepting the possibility of mistakes and providing learning opportunities
    e. The board understands and financially supports the need to invest sufficient time on activities that are not primarily patient-related such as training, supervision, treatment review, session reflection, etc.
2. This criterion refers to a responsive and proactive management that collaborates with supervisor and team members to provide a supporting and facilitating working environment. This should be demonstrated by:
    a. The MBT department management is (pro)actively involved in maintaining a professional and supportive working environment, enhancing job satisfaction and preventing staff turnover and/or absences
    b. The MBT department management is approachable for and responsive to team members and/or Program Supervisor and provides rapid response to potential interferences
    c. The MBT department management fully understands the specific risks of treating complex and high risk patients and the associated burden of work
    d. The MBT department management is committed to the MBT model; he/she understands MBT well enough to support procedures that enhance treatment integrity and collaborates with the Program Supervisor and/or team concerning important managerial decisions about the program or personnel
    e. The organization strives for continuity in managerial approach so that possible reorganizations or change of managers have a minimal impact on the working environment

3. This criterion refers to the managerial task of embedding the MBT-programs within the chain of health care providers and collaborating in order to provide integrated care. This should be demonstrated by:
    a. Active collaboration with major referral centers
    b. Bi-annually reviewed contract with local crisis services about the pathway to crisis admission, including agreement on roles and responsibilities
    c. Annually reviewed contract with specialized services for substance abuse, including agreement on roles and responsibilities
4. This criterion refers to the organization of a referral and intake procedure that assigns the right patients as efficiently as possible to the MBT-program, which should be demonstrated by:
    a. Established clear pathways for referrals outside and within the organization providing rapid access to the MBT services. Duration between referral and first orientation at MBT-department should not exceed four weeks.
    b. Clearly defined inclusion and exclusion criteria for each MBT-program; allowing a transparent assignment process and preventing mis-assignments
    c. Flexible and rapid flow-through from admission to MBT-department, providing adequate transfer of relevant patient information and prior risk assessments
    d. Reducing waiting list by providing rapid treatment, intermediate care or collaboratively designing a waiting list treatment in accordance with patient, general doctor and/or current therapist.
5. This criterion refers to providing instruments to monitor quality of treatment through outcome and through assessing processes that may affect outcome. This includes:
    a. Routine Outcome Monitoring (ROM) including assessment of specific MBT treatment outcomes (quarterly) or more frequently using Patient Outcome Database (POD) as part of the therapeutic collaborative process.
    b. Monitoring of parameters of quality (attendance, drop-out, crisis, incidents) (1-2 times a month)
    c. Monitoring of therapist adherence (2-4 times a year)
    d. Monitoring of program requirements (2-4 times a year)
    e. Audits (annually)
6. This criterion refers to the clearly defined structure of the MBT treatment including the phasing of the treatment into an initial, middle and end phase. The basic requirements of each phase are:
    a. Basic requirements for the initial phase include: assessment of the patients mentalizing capacities, psycho-education (MBT-I), stabilizing social and behavioral problems, crisis planning and case management to stabilize financial and social problems, collaboratively formulating a treatment plan and agreeing outcome monitoring.
    b. Basic requirements for the main phase include: goal-oriented treatment, main focus stimulating more robust mentalizing ability within attachment relationships, treatment monitoring and review, multidisciplinary coordination (one-team model).
    c. Basic requirements for the end phase include orientation towards termination of treatment and a tailored follow-up program focusing on further re-integration and relapse prevention (maintaining achieved gains).
    d. Treatment duration is clearly defined. The main phase of treatment should not exceed 18 months.
    e. Treatment (dis)continuation is guided by explicit criteria based upon outcome monitoring and treatment review by team and patient
7. This criterion refers to the importance of maintaining consistency and continuity within a coherent MBT framework. This should be the focus of team functioning and should be facilitated through the organization of team meetings. These include:
    a. The team meets once a week for treatment review
    b. The team meets at least twice a month for team supervision
    c. The team meets at least once a month for intervision
    d. The Program Supervisor attends these team meetings
    e. Team members are able to contact each other easily outside these team moments to discuss interventions (during working hours).

8. This criterion refers to the selection of competent personnel that have proven affinity to working with the target population and willingness to continuously improve their knowledge, skills and competencies in order to create a coherent MBT-team.
    a. Team leader has excellent communication and leadership skills and the competence to build teams and to maintain a healthy, professional working environment effectively. He/she must maintain a constructive alliance and sufficient political influence within higher levels of the organization.
    b. Therapists are active, responsive, flexible and effective team players. Therapists should be neither too anxious not too avoidant, more proactive than reactive, and should be able to maintain mentalizing when arousal is high (see quality manual for further criteria staff selection)
9. This criterion refers to the continuous efforts towards developing and maintaining a secure, open and cohesive team, creating and maintaining a mentalizing environment enhancing team functioning and multidisciplinary collaboration. This is demonstrated through the following requirements:
    a. The team also consists of therapists whom are not directly involved in the treatment of specific patients, for ex. by providing two treatment groups
    b. A team consists ideally of 5-9 therapists (range 4-12)
    c. The team should be well enough balanced to prevent the mentalizing process from getting stuck in a team. By selecting team member who react differently when losing their mentalizing abilities, signs of non-mentalizing among team members can be more easily detected by others
    d. The team signals loss of own mentalizing, help each other restore mentalizing and, if still insufficiently helpful, consult the supervisor to restore mentalizing and guide treatment decisions
    e. Each team is supervised by a Program Supervisor, whom is not directly involved in treatment of patients from that particular program. The program supervisor's focus is on monitoring clinical process and enhancing team mentalizing and reinstalling when lost (preventing destructive team processes).
    f. The team meets 1-2 times a month for intervision
10. This criterion refers to importance of creating a safe, predictable environment for therapists and patients;
    a. Individual roles and responsibilities are clearly defined within a multi-disciplinary team coordination. It should be clear for each team member what his/her responsibilities are and what the roles and responsibilities are of the other team members.
    b. Team members help each other and address each other when responsibilities are not met
    c. Team leadership: the team leader (program supervisor, coordinator or manager needs to be clearly defined) plays a crucial role in implementing and delivering a coherent and consistent MBT program and in managing the group of therapists.
11. This criterion implies that team functioning should be monitored and supervised by a Program Supervisor. The Program Supervisor:
    a. should not be involved in the treatment of patients of that particular program;
    b. works sufficient time for the department, to ensure his/her availability in team meetings (recommended is at least 16-24 hours/week);
    c. helps the team by supervising clinical processes and enhancing mentalizing within the team;
    d. collaborates closely with the manager (also see 2 d)
12. This criterion refers to the importance of a coherent framework; patients with PD are sensitive to inconsistencies, possibly leading to destabilization. A coherent framework with focused, clear, consistently applied interventions by all team members are believed to enhance treatment effectiveness. For therapists to be consistent, they all need to understand basis of MBT and integrate this understanding in their interventions. Requirements:
    a. All team members demonstrate willingness to work according to the MBT model
    b. All team members are Level A MBT therapists (Nl: MBT basistherapeut)
    c. A minimum of 1 therapist per treatment program is a level B practitioner level therapist (NL: MBT therapeut)
    d. The program supervisor is an MBT supervisor or at minimum a Level B- practitioner therapist
    e. The psychiatrist in the team has followed the MBT basic training course and had a minimum of 6 supervision sessions.

13. This criterion refers to the need for clear leadership in treatment coordination. Each patient should have an appointed primary clinician whom is responsible for assessment, treatment planning and treatment coordination. Additional requirements:
    a. The primary clinician is preferably a level B practitioner
    b. The primary clinician should work at least 24 hours for the department
    c. The case load of primary clinicians should not exceed 24 patients, including low-frequent follow-up patients (not more than 18 should be in an active treatment trajectory)
14. This criterion refers to the role of the psychiatrist as integrated part of the multidisciplinary team. This includes:
    a. The psychiatrist responsible for medication review is not in the same time a patient's primary clinician
    b. The psychiatrist is responsible for physical health screening at the beginning of treatment
    c. The psychiatrist is committed to the MBT model and will prescribe medication in consultation with the primary clinician in treatment review meeting
15. This criterion refers to the need for a goal-focused treatment approach. This approach should be demonstrated by the treatment plan. This includes:
    a. Each patient should have a signed (preliminary version of a) individualized treatment plan within six weeks after start of treatment
    b. The treatment plan should be collaboratively designed with patient and relatives
    c. The treatment plan should consist of a dynamic formulation of problems and individualized, collaboratively discussed goals
    d. All concerned team members should know and use each patient's treatment plan to focus their interventions
    e. Treatment plans are leading in monitoring treatment progress during treatment review meetings
    f. Treatment plans should be updated regularly
16. This criterion refers to importance of evaluating treatment progress and keeping a process-oriented focus throughout treatment. Such an approach includes the following aspects:
    a. Treatment progress should be reviewed at least every six weeks within active treatment team
    b. Treatment review occurs at least quarterly in the presence of patient, all concerned therapists (also from other facilities) and (in some instances) relatives
    c. Routine outcome data are integrated in treatment review at least twice a year to assess treatment progress and inform decisions on continuation or cessation of treatment
17. This criterion refers to the necessity of a clear crisis management protocol, based upon MBT principles. This requires:
    a. Assessment of (self-) destructive symptoms and formulation in treatment plan
    b. Availability of an individualized crisis plan for all patients with (self-)destructive behavior within four weeks after start of treatment (based on mentalizing functional analysis)
    c. Discussion and sharing of crisis plan with relevant parties and availability for all team members in cases of crisis management
    d. Active assessment of risks each treatment day, based upon risk factors of crisis, including individualized risk factors and mental states as formulated in crisis plan. When risk is heightened, primary clinician sets out active approach according to treatment plan and protocol.
    e. Crises during working hours should be dealt with by the team according to crisis protocols; out reaching work is done when necessary.
    f. Agreements about crisis management outside working hours are clear for patients, relatives and crisis intervention teams
18. This criterion refers to an (pro)active approach towards commitment issues. The team should demonstrate the following:
    a. Early assessment of situational triggers and mental states possibly leading to commitment problems. These are included in the treatment plan.
    b. Assessment of risk of drop out (at least weekly). When risk is heightened, primary clinician sets out active approach according to treatment plan and protocol.
    c. Handling commitment problems in accordance with MBT protocols
19. This criterion refers to a basic attitude of each therapist to stimulate autonomy and taking of responsibility by patients. MBT is by definition collaborative. This includes among others:
    a. Stimulating shared decision making regarding treatment program, treatment goals, crisis planning etc
    b. Active involvement of patients and relatives in treatment review
    c. Stimulating patients own responsibility before, during, and after crisis

20. This criterion refers to each therapist's focus on enhancing mentalizing, independent of the particular treatment modality (individual, group, verbal, art therapy). Therapists:
    a. Record individual and group sessions on a quarterly base
    b. Should demonstrate at least adequate adherence on the MBT Adherence Scale