



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, particularly elements at the organizational level (i.e. organizational support) and team level (i.e. leadership) contributed to implementation outcome. These findings have important implications for the translation of guidelines and research findings in daily practice. Copyright © 2017 John Wiley & Sons, Ltd.

Introduction

According to several international guidelines and review studies, evidence-based psychotherapy programs, such as dialectical behavior therapy (DBT), mentalization-based treatment (MBT) or schema-focused therapy (SFT), are considered to be the treatment of choice for adults with borderline personality disorder (BPD).^[1–3] Randomized controlled trials (RCTs) generally yield large effect sizes for these treatments on several outcome parameters, including borderline and other psychiatric symptoms and social functioning (e.g.^[4–6]). However, RCTs are designed to maximize efficacy through, for

instance, extensive organizational support, involvement of developers of the program, monitoring of treatment fidelity and sufficient budget for training and supervision. As we have argued before, such conditions are rarely met in regular clinical practice.^[7] Programs are almost never implemented in exactly the same format or structure as in experimental studies, therapists are rarely selected for the specific program, and ongoing model supervision and fidelity checks are rarely provided beyond the initial training. Given these differences, the large effect sizes as obtained in RCTs cannot be readily generalized to the programs implemented in real-life practice. An important question is therefore under what

conditions these large effects can be obtained in daily practice.

A recent study suggests that organizational (in) stability has a profound impact on treatment outcome in a MBT program for BPD patients.^[8] We found that initially large treatment effect sizes diminished spectacularly in periods of major organizational changes for the same patient population in the same unit. Findings of this historical or retrospective cohort study are potentially interesting: whereas it demonstrates large effects under non-experimental conditions, it also demonstrates the difficulties in maintaining the quality and treatment outcomes in a changing organizational context. Outcomes dropped significantly in periods of expansion of the unit, organizational and managerial instability, and high personnel turnover.

Given the high prevalence of BPD in mental health care, and its high individual, societal and economic burden of disease,^[9,10] it is remarkable how little attention the field of BPD has devoted to the implementation of evidence-based psychotherapy in clinical practice. Our own interest in this topic was initially raised following the difficulties we met when implementing a new treatment program for adolescents with BPD.^[11] Due to many problems, the program was discontinued temporarily. The organization suffered from high financial losses and personnel turnover, and patient outcomes were less beneficial. In a reconstruction of the elements contributing to these problems, we concluded that only a complex interaction of elements at an organizational, team and therapist level could sufficiently account for the negative outcomes. We proposed a new model of treatment integrity, arguing that the concept of treatment integrity might usefully be extended to include aspects of organizational and team functioning as well.^[7]

Although interesting and challenging, the abovementioned findings are based on one single case study. Therefore, we cannot exclude the possibility of selection bias. The present study aims to explore the generalizability of our previous

findings to other institutions and contexts. More specifically, the research aim was twofold. First, we investigated success or failure of implementation of seven MBT programs in the Netherlands, including an exploration of important determinants influencing the (quality of) implementation and the course of the implementation trajectory (phase 1 of the study). Second, we explored the hypothesis that success or failure in the implementation of MBT involves multiple causes at organizational, team and therapist level, and we attempted to identify the crucial barriers and facilitators of implementation (phase 2 of the study).

Methods

Design

A multiple case study design using a combined qualitative and quantitative research design. A *sequential exploratory strategy* was chosen in which a qualitative study (phase 1) is followed by a (partial) quantitative study (phase 2). Both methods are integrated in the interpretation phase.^[12] In the qualitative study, phase 1, we started with an exploratory ('content-driven') approach, creating the possibility of generating new categories, and completed with a more confirmatory ('hypothesis-driven') approach.

Phase 1

Participants: Participants included were departments of mental health-care institutions in the Netherlands that intended to implement the full MBT Partial Hospitalization or Intensive Outpatient program in the same format as studied in the RCTs^[4,5,13,14] and that restricted these programs exclusively for BPD patients. Based upon these criteria, seven departments from six different mental health centres were requested to participate in the study. All centres agreed.

Procedure: The first author approached the management of the department, explained the research focus and design and asked for

participation. Subsequently, two employees from each participating department were interviewed, i.e. the manager formally responsible for the department, and the principal therapist of the MBT team. The research purposes were explained, and informed consent was asked from each respondent. Both respondents were interviewed separately in order to obtain relevant and reliable information from different perspectives ('top-down' and 'bottom-up'). All interviews were conducted by the first author, and the interview procedure was observed and checked by co-first author.

Instrument: A semi-structured in-depth interview format was developed for the purpose of this research with a double focus. The interview consistently started with open-ended exploratory questions. First, respondents were asked whether the implementation of MBT was successful or not. Second, respondents were asked to reflect upon the implementation phase—expanding over the first two years—and to identify important factors influencing outcome ('In your opinion, what elements contributed to the (positive and/or negative) outcomes of the implementation of the program at your unit?'). The topics the respondents raised were explored in more detail. After having explored the spontaneously produced information in detail, respondents were more specifically asked (from our hypothesis-driven approach) to comment upon organizational, team and therapist issues, which might have contributed to the outcome of the implementation (e.g. 'In your opinion, to what degree was there sufficient support for this program within your institution and can you comment upon that?' or 'In your opinion, to what degree were team members competent enough to apply the MBT model?'). The interview format can be requested from the authors.

Analyses: To develop a narrative reconstruction of the implementation trajectory, the transcripts were analysed systematically:

- (1) All interviews were audio-taped and transcribed.
- (2) Each transcript was coded to organize the (fragmented) texts.
- (3) The researchers analysed the implementation trajectory of each department (combining the coded texts of the two interviews per department) and developed a narrative reconstruction with an integrated understanding of the interaction between several contributing elements influencing the implementation trajectory.
- (4) A quality assurance procedure (member's check) was used. Reconstructions were returned to both respondents separately to check on the accuracy of our interpretation and integrated description of their implementation trajectory. Feedback and additional information were iteratively processed until a version was obtained that both respondents agreed on as reflecting a joint understanding of the implementation trajectory in their department. All respondents consented to the final versions for further study.

Phase 1 resulted in seven narrative reconstructions—one for each department—detailing the relevant determinants of the implementation trajectory in a narrative and interactional way.

Phase 2

Participants: Twenty expert reviewers, selected based on their extensive experience in two areas (i.e. the treatment of BPD patients and/or management of BPD treatment programs not restricted to MBT), were approached to participate in this study. Twelve of those expert reviewers agreed to participate and returned a completed review questionnaire.; *Procedure:* The seven narrative reconstructions (phase 1) were masked for review, the identity of the organizations being concealed to assure confidentiality of delicate 'organizational' information and to enhance objectivity of the

reviewers. The masked reconstructions were sent to the panel of 20 expert reviewers. They were asked to review the seven blind narrative reconstructions by filling in a questionnaire. This procedure took an average of 1.5 h to complete.; *Review questionnaire*, : A questionnaire was developed to review the reconstructions. In this questionnaire, participants were asked to (1) to assess whether the success or failure of the implementation of each MBT case involved multiple barriers and/or facilitators at organizational, team and therapist level; (2) to rate the relative significance of each level; (3) to identify returning determinants of success or failure; (4) to list the determinants according to their importance as judged by the rater; and (5) to add relevant determinants according to their own judgment of the cases and own experience.; *Analyses*, : Average scores were calculated.

Results

Phase 1

A summary of the outcomes and determinants of each case is reported in Table 1. Short summaries of each narrative reconstruction are included in Appendix 1. The full narrative reconstructions can be requested from the one of the first authors. Table 1 shows that implementation was clearly successful in two programs (29%), outcomes were mixed in the two programs (29%) and implementation failed in three programs (43%), resulting in discontinuation of those programs.

Phase 2

The second part of the research tested the hypothesis that success or failure in the implementation of MBT involves multiple causes at organizational, team and therapist level and explored the crucial barriers and facilitators of implementation.

1. Multiple causes at organizational, team and therapist level

Table 2 provides the average ratings of expert's judgment of the correctness of the statement 'Success of implementation depends on a combined action of factors at organization, team and therapist level', according to a 6-point likert scale, ranging from 0 (statement is clearly contradicted in this case) to 5 (statement is completely confirmed in this case). Results clearly suggest that experts support the statement as being applicable to all the cases, with scores—depending on the particular cases—ranging between 4.1 and 4.8.

2. Relative contribution of organizational, team and therapist factors

Table 2 provides ratings of experts of the relative contribution of organizational, team and therapist factors to the perceived implementation success or failure. Although all factors contributed, therapist factors were rated somewhat less important (3.4) as compared to organizational (4.1) and team factors (4.2).

3. Identification of crucial barriers and facilitators

Experts were asked to identify recurring patterns of critical barriers and facilitators of success/failure throughout the narrative reconstructions. In order of importance (as determined by the number of times each determinant was mentioned by an expert), experts referred to (1) support within the organization ($n = 8$); (2) leadership ($n = 7$); (3) selection of therapist ($n = 7$); (4) training ($n = 5$); (5) highly structured project-based implementation ($n = 5$); (6) availability of methodical expertise ($n = 3$); (7) budget ($n = 3$); and (8) team size ($n = 2$). All other determinants were mentioned only once.

4. Identification of additional barriers and facilitators

Finally, experts were asked to identify additional barriers and facilitators of success/failure. The following aspects were mentioned (none of them

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	PH (2 groups)	Negative: program has stopped at time of writing; high turnover of personnel, dissatisfaction of patients, financial loss	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

(Continues)

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.

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.

more than once): severity of patient population, phasing the implementation, changing an existing team vs. starting with a new team, extra incentives (like an RCT), charismatic leadership, ability to manage destructive team processes and ability to keep up team morale.

Discussion

Summary of results

This multiple case study is to our knowledge the first attempt to understand some of the determinants of success or failure in the implementation of

evidence-based treatment programs for BPD. Our results testify of the complex nature of implementing evidence-based psychotherapy programs in regular mental health centre institutions. In summary, our findings indicate that the implementation of evidence-based MBT programs in the Netherlands is associated with mixed outcomes at best. Implementation was clearly successful in two programs (29%), outcomes were mixed in the two programs (29%) and implementation failed in three programs (43%), resulting in discontinuation of those programs. Furthermore, our findings suggest that in all cases the course of implementation was influenced by multiple elements at organizational, team and therapist level. Although each implementation trajectory constitutes its own story, involving local issues and specific team cultures, our results yield suggestive evidence for some more generic barriers and facilitators across all implementation trajectories. Facilitators include the presence of organizational support, sound financial management, strong and consistent leadership, highly structured project-based implementation, managing (negative) team processes, therapist selection, sufficient expertise and training opportunities, whereas the absence of these elements is a barrier to implementation.

Strengths and limitations

The current study has various strengths and limitations worth mentioning. First, our study fits well in with a growing recognition of the critical role of implementation science in health services research.^[15,16] In mental health care, previous studies have generally focused on the dissemination of evidence-based treatments (i.e. key factors in spreading information so that organizations and clinicians can adopt them) and initial implementation factors such as training and supervision. During implementation, it is important to monitor progress for unanticipated influences (i.e. barriers and/or facilitators) and progress toward implementation goals.^[17] To the

best of our knowledge, this study is one of very few in the *mental* health field exploring potential barriers and facilitators *during* implementation at multiple levels. Further, we would like to point to the innovative study design, and the careful and rigorous strategy of data collection and exploration. However, various limitations might hamper the interpretation of results. First, as this study is limited to MBT, it is unknown to what degree our findings can be generalized to other evidence-based psychotherapy programs for BPD patients. This limitation is somewhat mitigated by the fact that several of our expert reviewers, who originated from various different theoretical backgrounds, explicitly mentioned that they recognized the described problems from their own practices. Second, narrative reconstructions were based upon interviews with two involved professionals of the program (manager and therapist), thereby excluding information obtained from each team member, patient experiences and outcome data. In theory, the apparent success or failure of an implementation might be evaluated differently through the eyes of the patients or other therapists. This limitation is somewhat mitigated by the fact that all three programs that were rated as clear failures were ultimately discontinued; these discontinuations can be considered indicators of external validity of the ratings. Third, we are aware that a qualitative approach bears the risk of confirming the researcher's hypotheses. We attempted to prevent this in three ways: (1) the interview schedule provided ample opportunities for respondents to come up with 'their own story' of the course of implementation (exploratory approach); (2) the integration of information of both respondents in a narrative reconstruction was double checked through both respondents to assure it was a reconstruction of their story; and (3) we asked independent experts to interpret the reconstructions and draw conclusions regarding confirmation or disconfirmation of our hypotheses. Finally, the partially hypothesis driven focus on the levels of organizational, team and therapist

factors possibly limited the more robust emergence of the fourth category, the higher-order level contextual factors. The awareness of and attention to this higher-order system level (e.g. federal, state and local policies, insurance companies policies, mental health-care infrastructure and funding system, national income and public sector expenditure) is becoming increasingly important, as outlined for instance in the Mental Health Systems Ecological model.^[18] As this study was conducted in the Netherlands only, which is generally considered a well-resourced country in the management of PD, we were not able to investigate potential determinants of implementation success and failure at the system level. We should, however, keep in mind that the relative importance of factors at the organizational, team and therapist level might be different in other contexts, for example in lower income countries with poor mental health-care infrastructure and funding.

Scope of implications

This study focused exclusively on the implementation of MBT programs in BPD patients. Some aspects might be applicable to other evidence-based psychotherapies for BPD as well, whereas other aspects might be unique to MBT. Similarly, some aspects might be unique to BPD, whereas other aspects are applicable for other mental disorders as well. Regarding the applicability to other psychotherapies for BPD, it is noteworthy that many experts explicitly recognized these implementation issues from their own experiences in different settings using different therapy methods. However, MBT originally was designed for very severe BPD patients. In all but one of our cases, the program intended to include the most severe BPD patients. In most of the participating treatment centres, these patients had been excluded from other psychotherapy programs before starting MBT. Working with these very severe BPD patients undoubtedly affected the burden for personnel,

the amount of crisis and the general level of arousal in teams providing treatment for these patients. Thus, other psychotherapies might seem easier to implement to the extent that they include a less severe BPD group. Furthermore, we observed that the partial hospitalization MBT programs were associated with more implementation problems than the intensive outpatient MBT programs. The partial hospitalization setting is characterized by a high treatment dosage in terms of contact frequency and intensity. Other evidence-based treatment programs, such as schema-focused therapy and DBT, have mostly been provided in lower dosages, comparable to the dosage of intensive outpatient MBT. Our experience is that a higher treatment dosage not only requires more organizational facilities but is also related to higher levels of arousal in team and patient groups. An interesting hypothesis for future studies would be that characteristics of the treatment format are more important than specific theoretical orientation to account for success vs. failure of implementation.

Regarding the applicability to other mental disorders, it is noteworthy that the treatment of BPD patients is widely considered to be especially challenging, given the emotional turbulence, high level of crisis and strong emotional appeal that characterizes patients with BPD. Due to the relatively challenging nature of BPD, (lack of) critical success factors in organizations, teams and therapists might have a greater impact upon treatment outcome than in other mental disorders. For example, Davidson and colleagues demonstrated that even within the same treatment program, competent therapists averted five times more suicide acts than less competent therapists.^[19] We believe that existing issues in organizational, team and therapist functioning might be magnified due to the nature of BPD characteristics. In other patient samples, similar problems might remain less visible. However, also in the field of conduct disorders, it has been demonstrated that efforts to replicate the effects of Multisystemic Therapy (MST)^[20] in

Canada^[21] and outside North America^[22] were regularly associated with reduced effectiveness. Such findings have inspired the developers to implement a quality system, including licensure and quality assurance oversight by MST Services.^[23] The overall aim of MST's quality assurance system is to provide treatment conditions similar to the research conditions of the RCT's that provided support for the intervention. A recent study comparing community agencies using the quality oversight by MST Services with agencies lacking such a quality monitoring provided evidence for reduced treatment results—in terms of the number of court charges—in the latter condition.^[24] Interestingly, MST's Quality System pays a lot of attention to the organizational context of the MST treatment program, much alike our own findings concerning the major role organizational issues play in success of implementation (this study) and treatment outcome.^[8] This example of MST strongly suggests that the scope of our findings is not limited to BPD but, instead, does also apply to the treatment of other complex mental disorders such as conduct disorders.

Recommendations

Our findings touch upon an important issue that has been relatively left unexplored in the field of PD, namely the translation of scientific evidence into daily practice. A recent study revealed that only 23% of Dutch borderline patients received first choice treatment as recommended by the Dutch clinical guideline.^[25] This finding is in line with Balas and Boren's^[26] conclusion that it takes an average of 17 years to turn 14% of original research findings into beneficial change in clinical practice. The development of the first evidence-based treatments for BPD dates back to the nineties with the landmark studies of Linehan *et al.*^[27] and Bateman and Fonagy.^[4] Approximately 20 years later, the time has come to take our field one step further and develop strategies to close the gap between scientific

findings and clinical practice. According to the current study, the critical issue is not so much 'what works for whom', but rather 'how to disseminate and implement science into practice?'

This study adds to growing awareness of and attention to key factors that should be taken into account when implementing psychological treatments for BPD. Based on an integration of our findings from this study and the implementation literature, the following factors can be considered important. At the organizational level, (1) highly structured project-based implementation; (2) full commitment of the board, including financial support; (3) proactive management collaborating with supervisor and team to provide a supportive working environment; (4) active collaboration with major referral centres to provide integrated disease management across echelons; (5) establishing clear pathways for referrals (including clearly defined inclusion and exclusion criteria) and rapid service access; (6) quality monitoring of treatment processes and outcomes; (7) clearly defined treatment program structure including treatment phasing; (8) facilitating sufficient time for treatment plan review, supervision and intervision; (9) recruiting professionals based on affinity with BPD and necessary skills and competencies; and (10) a team leader with the competencies to effectively build teams and to maintain a healthy and professional working environment. Important factors at the team/therapist level include (1) maintaining consistency and continuity within a coherent (MBT) framework enhancing focused, clear, consistently applied interventions by all team members; (2) willingness of team members to improve their skills and understanding through reflection, training and supervision; (3) optimal team size consisting of five to nine therapists with an absolute maximum of 12; (4) team consisting of active, responsive, flexible and effective team players; (5) clearly defined roles and responsibilities and a culture in which team members help each other and address when responsibilities are not being met; (6) a program supervisor who

monitors and supervises clinical process and team functioning; (7) unambiguous clinical leadership; each patient has an appointed primary clinician who is responsible for assessment, treatment planning and treatment coordination; (8) all therapists, including the psychiatrist, integrated in a one-team model; (9) a goal-focused and process-oriented treatment approach guided by a treatment plan and monitored and revised when necessary in treatment plan evaluations; and (10) crisis management protocol and a commitment protocol guiding consistent team intervention.

Conclusion

Despite its exploratory nature, this study provides strong evidence that implementation of evidence-based treatment programs for BPD can be cumbersome and depends on a whole range of factors. There are few reasons to believe that the problems described in six different mental health centres are limited to these specific centres or to the Netherlands alone. It is fair to state that underestimating the complexity of implementing treatment programs for BPD is not only costly from an economic perspective (given the waste of budgets for training and implementation) but also from a human perspective (given the high burden among patients and personnel). Our field is in high need for evidence-based models and strategies for dissemination, implementation and quality maintenance. We hope this study will inspire others to undertake relevant scientific and clinical work to that end.

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Appendix 1: Short summary's of Case A – Case G

Short summary of Case A

Unit 1 intended to develop two PH programs. Outcome of the implementation trajectory is negative according to both respondents: the program has been discontinued, the intended research never started, key team members have left the organization, there was a high absence through illness, the program was not profitable while running and the institution suffered huge financial losses (due to lost investment on implementation, training, supervision; due to excessive sick leave etc). At the time of starting up the program, the institution underwent a major reorganization which led to territorial fights concerning the allocation of the severe BPD patients between the 'cure' and 'care' part of the organization. There was a major split in the organization that could not be resolved by the board of management. The MBT program was directly involved in these fights as they included former 'care' patients in the 'cure' programs. The new program was perceived with jealousy as the 'favourite' of the management. As a consequence, the MBT program and all costs involved with training and supervision were not supported by all departments of the institution, leading to negative stereotyping and huge pressure on the new MBT program to develop more quickly and start with a new group readily. At the start of the second group, an additional conflict emerged between both principal therapists of the two groups, involving issues of leadership and definition of what 'real' MBT is. The conflict escalated into a split between both sub-teams, leading to fights, negative stereotyping and inability to work together within the same unit. Several team members suffered from the conflicts and especially nurses felt insufficiently supported to deal with the severe acting out of patients. They felt incapable and incompetent in dealing with the patients. The board of management was too distanced and not fully aware of the severity of

the ongoing conflicts. There were also hostility and negative stereotyping between management and team. The team lacked clear leadership due to all splits. All the conflicts consumed huge amounts of energy, resulting in a high absenteeism due to sick leave and staff turnover. This in turn led to a permanent cessation of the program.

Short summary of Case B

Unit 2 transformed an existing psychotherapy program into a PH program and started a new IOP program. Outcome was considered by both respondents to be positive for both programs in terms of realization of intended programs, small number of dropouts, increasing development of competences and inclusion of BPD patients. The program has only gradually included severe BPD patients, while first treating less severe personality disordered patients. During the first two years, some personnel had to be replaced as they were less suited for working with BPD patients. Adherence to the model was accomplished slowly. At the start there was broad support within the institution to implement MBT. The organization supported the innovation the program brought. Experts from all fields within the organization were consulted and supported the new program. Training was provided by an internal expert, who was closely involved in the MBT treatment groups. He was perceived as a strong leader, capable of dealing with crisis, enhancing team cohesion and keeping team focused on model. He was backed up by a strong co-therapist. In general, the team consisted of several strong personalities. Respondents perceived it as helpful that the program took sufficient time before including more severe BPD patients.

Short summary of Case C

Unit 3 intended to develop a PH program gradually. After one year, goals had been met with two groups running as planned. After two years, the whole unit was dismantled after several key therapists left the program due to extreme team

conflict. The institution suffered huge financial losses during the dismantling of the groups. The burden for personnel had been extremely high with a high turnover of personnel. The organization had decided to implement the program 'top-down': an existing program was transformed into a MBT program without participation of team members in the decision. Personnel were assigned by the management and conflicts existed between management and team at the start of the program, resulting in two forced resignations. Two newly recruited and highly motivated therapists were trained, assigned to the same treatment group and asked to engage the rest of the team (consisting of 'old' team members) into the new model. Both teams soon split up between an engaged team 'on model' and a skeptic team 'off model'. A critical and non-reflective team culture put a high burden upon many less experienced and less skilled team members. Within the teams, a split between skilled psychotherapists and 'less skilled' nurses existed. The model was experienced as complicated and not practical enough. Destructive team processes expressed themselves in gossiping and excluding team members from social activities. There was no leader with active support from all team members who could oversee and manage these team processes. These processes escalated further after an internal reorganization, putting the management even further at a distance. The newly recruited coordinator did not support the model, roles and responsibilities became unclear and the team became more suspicious and withdrew from the management. Team members became ill or left the team, and vacancies could not be filled in easily, leading to understaffing and termination of the program.

Short summary of Case D

Unit 4 intended to implement two PH groups. After two years, both groups are still running, although both respondents agree outcomes are mixed. The program has never been profitable, due to under capacity of both groups, making its

continued existence uncertain in times of budget cuts. Further on, there has been a high turnover of personnel, and the program had to be adapted several times to deal with vacancies, leading to dissatisfaction and formal complaints of patients. Respondents agree that treatment quality is poor. In this organization, the implementation of MBT was decided by a select group of 'experts' and implemented 'top-down'. The program rivaled with a DBT program in the same setting, leading to problems with inflow of patients into the program. Further on, many team members had small contracts, leading to high overhead costs, leading to non-profitability of the program. Support for the 'expensive' MBT program diminished within the organization, leading the program to become more isolated within the institution. The board of management was at a distance and was not trusted by the team, leading to a defensive withdrawal of the team. The team was tied together by feelings of hostility and distrust towards management and the rest of the institution. Respondents agree that the team might not be strong enough to survive this struggle. Team members were not recruited based upon competences or motivation to work with severe BPD patients. Several team members refused training and supervision, leading to a split in the team between the 'motivated' and 'passive' team members. However, these splits were covered up and not spoken about given the isolated position of the team within the institution. Team members were completely absorbed by destructive team processes, affecting quality of treatment. Finally, the team imploded when the main therapist left the team. At the time of writing, the program has stopped.

Short summary of Case E

Unit 5 intended to implement two PH groups and one IOP group. Both PH groups have been implemented, the IOP group not (yet). The main issue is the profitability of the program due to under capacity of both groups. The continuity of the program has always been subject of discussion in the institution, although the programs are still

running today. The team is highly motivated to keep the program running and to improve their expertise and adherence to the MBT model. Turnover has been high among nurses. The start of the MBT program was broadly supported within the institution, and there was sufficient budget for training and supervision. The unit management was actively involved and very supportive. The program fitted excellently within the institution's mission to enhance availability of psychotherapy for a broader range of (difficult) patients. A randomized trial was designed and gained support for continuing the program despite budget problems. A major issue was a sequence of reorganizations and changes at different managerial levels, making it necessary to discuss the need of a (non-profitable) program again and again. Goodwill was experienced as dependent upon the interest of the manager in charge. Part of the problems with profitability was due to a bad positioning of the program within the (huge) organization, creating problems with patient inflow. Therapists experienced a constant pressure to demonstrate its relevance. The strong co-leadership in the team buffered against this pressure. The team was led by two experienced psychotherapists with strong personalities, different enough to cover all different opinions among team members, but similar enough to bridge differences in opinion. Those leaders managed to create a safe learning environment, focused on developing expertise and improving model adherence. However, not all team members turned out to be suited for working with severe BPD patients. Pressure to assign 'internal candidates' has led to two drop outs among personnel. The lack of concreteness of the MBT manual was experienced as unhelpful to support less skilled team members.

Short summary of Case F

Unit 6 intended to implement one PH group. After two years, the program was expanded with another PH group, and plans for two IOP groups were being made. There was low personnel

turn-over, and the whole team is closely involved in the expansion of the unit. The MBT program was chosen by a large group of experts of all departments in the institution to accomplish the mission of the institution to include very severe patients in psychotherapy. The new program was supported by the whole board of management. Research was set up from the beginning. There was some skepticism in the rest of the institution, but the different location of the unit protected it from possible negative stereotyping. Changes in management did not affect support for the program. There was a large budget, and the innovation was considered important for the survival of the institution in the new century. Management was directly and closely involved. There was a strong co-leadership at the unit, by two experienced and strong personalities. The team itself was small and very cohesive, with personnel that was recruited specifically for the new program. There was a clear hierarchy within the team; roles and responsibilities were accepted by everyone. The start of a second PH group initially created some rivalry, but this was dealt with as the second therapist took on a learning attitude and hierarchy was respected. The team developed through learning and supervision.

Short summary of Case G

Unit 7 started with a PH and IOP program, each including two groups of nine patients. Implementation of the IOP program went much

more smoothly than the implementation of the PH program. The later was characterized by high levels of verbal aggression from patients, two formal complaints from patients, a high burden among team members, high drop-out rates and clinical impressions of mixed treatment results. The IOP program included the same patients but experienced much less problems. Respondents mentioned several elements impacting upon the implementation. Most noteworthy was the quick start with four patient groups, especially in the PH program, lacking time and a well-developed implementation plan to implement both programs and all four groups. Roles and responsibilities were not sufficiently cleared out, especially between trainers and management, leading to an uncertainty among team members, that most often lacked experience in the model and were rather young and inexperienced in treating BPD patients. The team lacked protocols to deal with severe aggression and suicidality. This mainly affected the PH program due to the intensity of the program, creating a spiral of escalating arousal, undermining the confidence of team members and creating temporary splits between management and trainers, with further role confusion. The team diverted more from the model and could not maintain a reflective stance well enough. These problems mainly affected the PH team, while the IOP team benefited from a slower start and less continuous arousal due to the lower intensity of the program.