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Barriers and facilitators to the implementation of a stepped care intervention for personality disorder in mental health services

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Abstract

Background: Individuals with personality disorders-particularly borderline personality disorder-are high users of mental health treatment services. Emergency service responses often focus on crisis management, and there are limited opportunities to provide appropriate longer term evidence-based treatment. Many individuals with personality disorders find themselves in a revolving cycle between emergency departments and waiting for community treatment. A stepped care approach may help to triage clients and allow access to interventions with minimal client, clinician and system burden. This study aims to understand the facilitators and barriers to real-world implementation of a stepped care approach to treating personality disorders. Methods: Managers and clinicians of health services engaged in implementation were interviewed to obtain accounts of experiences. Interviews were transcribed and thematically analysed to generate themes describing barriers and facilitators. Results: Participants identified personal attitudes, knowledge and skills as important for successful implementation. Existing positive attitudes and beliefs about treating people with a personality disorder contributed to the emergence of clinical champions. Training facilitated positive attitudes by justifying the psychological approach. Management support was found to bi-directionally effect implementation. Conclusions: This study suggests specific organizational and individual factors may increase timely and efficient implementation of interventions for people with personality disorders.

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Abstract

Background: Individuals with personality disorders – particularly borderline personality disorder (BPD) – are high users of mental health treatment services. Emergency service responses often focus on crisis management and there are limited opportunities to provide appropriate longer term evidence-based treatment. Many individuals with personality disorders find themselves in a revolving cycle between emergency departments and waiting for community treatment. A stepped care approach may help to triage clients and allow access to interventions with minimal client, clinician, and system burden. This study aims to understand the facilitators and barriers to real-world implementation of a stepped-care approach to treating personality disorders.

Methods: Managers and clinicians of health services engaged in implementation were interviewed to obtain accounts of experiences. Interviews were transcribed and thematically analysed to generate themes describing barriers and facilitators.

Results: Participants identified personal attitudes, knowledge and skills as important for successful implementation. Existing positive attitudes and beliefs about treating people with a personality disorder contributed to the emergence of clinical champions. Training facilitated positive attitudes by justifying the psychological approach. Management support was found to bi-directionally effect implementation.

Conclusions: This study suggests specific organisational and individual factors may increase timely and efficient implementation of interventions for people with personality disorders.

Keywords*:* implementation, personality disorders, evidence based practice, stepped care, borderline personality disorder

Personality disorders are of high prevalence in the general population (1, 2) and in mental health settings (3-6). Borderline personality disorder (BPD) is characterised by an instability of emotions, self-concept, and relationships (7). Individuals with personality disorders are high users of mental health treatment services (8, 9) and often present in crisis to emergency departments (6, 10). However, inpatient admissions may have iatrogenic effects (11) and have a high economic burden (12). An alternative treatment approach is needed for people with personality disorder presenting in crisis (13). Long-term outpatient treatment has the best evidence for recovery from personality disorder (14), however, in budget-, time-, and resource-constrained services, the opportunity to provide evidence-based treatments can be limited (15). The reality for many mental health services is individuals with personality disorder being involved in a revolving cycle between emergency departments in crisis, or sitting on long waiting lists for treatment and attempting to manage intense emotional experiences in the interim alone. Further, individuals experiencing BPD report they need interventions which support both symptomatic remission and functional abilities (16, 17). There is a need for interventions which focus on the individual need for the client and provide care in the space between crisis management and long-term treatment.

A possible solution to this revolving door cycle and differential needs of clients is a stepped care approach. Stepped care approaches are an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs (18, 19). Given the heterogeneity of personality disorder presentations and the high variability in outcomes, a model of stepped care within community health systems may be able to better account for clients who need minimal intervention for recovery (20). Our approach to stepped care involved a whole of service re-design so that staff working at all levels of acuity were implementing evidence based approaches, with an initial focus on care

planning within specific personality disorder stepped clinics, to support reducing suicide rates (21), emergency department presentations (22) and increase compliance with follow up (23).

We have evaluated this stepped care approach in a cluster randomised controlled trial in mental health settings for personality disorder presentations (24). The stepped-care model followed three processes; intake, brief intervention (25), and the option of psychological therapy in the community. The whole of service approach centred on a relational model, and was informed by relevant clinical practice guidelines (19, 26, 27). In the site where the stepped-care intervention was implemented, there was a 22% reduction in presentations to emergency departments over the eighteen month follow-up period and a significantly larger reduction in days spent in inpatient wards. While this work provides early indication of intervention success, it is also crucial to evaluate the process of implementation and modify as necessary.

A pressing issue in mental health care is the gap between empirically based treatment and treatments provided to clients in typical care settings (28). One strategy for successful implementation includes identifying barriers that may hinder implementation progress and strengths that increase effective implementation (29). The purpose of the current study is to explore the barriers and facilitators towards implementing a stepped-care intervention for personality disorder presentations in mental health settings. The experience of clinicians and managers implementing the approach were studied using qualitative methods to understand factors impacting implementation.

Method

The study reporting is informed by the Standards for Reporting Qualitative Research (30).

Design

In order to gain an in-depth understanding of experiences an interpretive phenomenological design (IPA) was adopted (31). Data was collected by individual semi-structured interview. The interview was developed by researchers and included open-ended questions reflecting topics related to implementation. Interviews were conducted by researchers who were independent of the clinical services provided in the health service sites.

Setting

The health care system in this study was a publically funded open access provider of health and medical services to the community in a large catchment area. Initially the area was divided equally into an implementation and a treatment as usual (control) area and matched based on size of the population and services provided. Once the treatment as usual area had been studied, it also implemented the model. Thus there were two study areas that formed the total implementation sample of study. Details of clinical outcomes have been previously published (24).

Participants

Purposeful sampling was used to identify key stakeholders involved in multiples aspects of implementation (32). Participants were mental health clinicians and managers actively involved in the intervention. Forty-six potential participants were contacted and 21 participants completed the interview, consisting of 13 clinicians, seven managers, and one individual who acted across both roles. In the final sample, 52.4% of participants were female (n = 11) with an average of 5.5 years (*SD* = 4.6, *range* = 1-15) of experience in their

current role. For seventeen participants who provided their age, mean age was 39.5 (SD = 9.7). Participant details were de-identified for confidentiality.

Procedure

Participants provided written informed consent following approval of the research protocol by the local Institutional Review Board. Interviews were audio recorded and transcribed verbatim. Interviews were conducted over 2011-12 when sites had been implementing the intervention for eighteen months. The interview included questions regarding overall success of implementation, in addition to perceived barriers and facilitators to the intervention.

Data Analysis

Interviews were recorded, transcribed verbatim and entered into NVivo 10 for analysis (33). IPA was used to understand individual experiences and transcriptions were thematically analysed (31, 34). Researchers became immersed in the data prior to coding, then initial codes were generated and codes were collated into common themes. Following this, metathemes and subthemes were defined and named. Three transcripts, representing over 10% of the data were coded by two independent raters and discrepancies were discussed until agreement was reached. Remaining transcripts were independently rated. The success of implementation was also rated categorically by researchers. The findings were then tested against a number of informants to validate the results with no further changes made.

Results

Demographic and clinical variables of the sample were collected during interviews and are presented in Table 1. Most clinicians interviewed were trained psychologists or practitioners actively involved in delivering the intervention.

Table 1

Demographic and Clinical Variables of Participants (N=21)

Experiences of Overall Success of Implementation

There were five groupings of clinicians across the study area. Following descriptions by clinicians and managers, two groups were rated 'moderate implementation' (some evidence of implementation with limited integration) and three rated 'good implementation' (evidence the intervention was accepted as a core practice and was routinely used). For convenience we have pooled these together and labelled them 'site 1' (moderate implementation) and 'site 2' (good implementation) in reporting. Table 2 displays typical descriptions of implementation success for each category.

Table 2

Statements from Participants on their Perception of Implementation Success

Thematic analysis

Six dominant themes emerged from the data in relation to barriers and facilitators of the intervention. These themes spanned across both individual and organisational factors.

Training

Training was used to increase knowledge and skills of mental health clinicians about personality disorders and their treatment specific to the stepped intervention. Participants' responses identified four subthemes impacting implementation.

Validation of psychotherapeutic approach

Participants reported training justified a psychotherapeutic treatment approach. One practitioner reported that "*by having that specialist training and by having that support*

from the – from the project, it's kind of like it's given us the justification to work like this… being the psychologists in a team" [14_C]

Engagement and attitudes towards working with the personality disorder population

Training increased awareness of effective therapies with the potential to reduce stigma. Participants also noted a barrier to implementation was lack of engagement by key medical staff. One participant described "*a little bit of a battle to I think, shift some of the thinking of some medical staff.... some of the difficulty you know [is] getting the medical staff engaged in the training and education"* [15_M].

Practical experience

Training alone was perceived as insufficient for practice, but a combination of training and hands-on experience was useful to build confidence. One participant stated "*that could perhaps be a good thing if it was - if everyone saw at least one person through it….they felt comfortable in it, they felt that they could relax… they could actually engage better with the person."* [03_C]

Timing of intervention training

The timing of training delivery in relation to implementation timeline was reported to be both a barrier and facilitator, depending on the area. Most participants commented on the need for ongoing training opportunities to continue facilitating the intervention implementation.

Clinical Champions

Clinical champions were reported as key facilitators of change and pivotal to implementation at both sites. A participant reported that the stepped intervention "*was well supported by clinicians who had good intent to make something happen."* [08_M]. However, at areas with

limited support from management, champions were restricted from working within the flexible treatment model of the intervention.

Management Support

Positive experiences of implementation were fostered by management support of clinician experience. As one participant remarked, "*…you know the managers were committed to making it work, they were just kind of leaving it up to us to, try and work out how to do it."* [14_C]. Conversely, a perceived lack of management support was a barrier. Lack of engagement of senior managers at site 1 resulted in a sense of isolation from clinicians and mangers actively implementing the intervention, where "*it had to get to the point where we just went and did it despite management, rather than with management."* [05_M].

Governance

Governance across both sites had an important impact on implementation. Three subthemes emerged describing relationship between governance and implementation.

Flexibility

Practitioners at site 2 consistently reported on how adapting the model to meet the needs of consumers and the service was vital in facilitating implementation; "*we took ownership of it very quickly. And we saw how it could work within our team, and within our sort of processes."* [16_M]. Conversely, at site 1 a lack of flexibility was a significant barrier to initially commencing implementation.

Perceptions of core business

Across both sites, conflicting opinions by staff about their role in working with people with personality disorders were evident. At site 1 this hampered implementation as the intervention was "*more seen as like an appendage rather than within the Health*

Service at times." [10_M]. At site 2 descriptions of success and sustainability were most positive, including "*the system works pretty well here, that it's a little bit more just integrated into normal work practice than I think it is at other areas."* [03_C]

<u>High sensitivity to risk of harm</u>

Governance within mental health services is focused on minimising risk of harm to clients. In implementing a crisis intervention, managers and clinicians were reluctant to diverge from this policy and staff members in acute teams were hesitant to increase their workload and take on additional risk. One manager reported "*clinicians would still refer to the clinic's acute care team. There was always… a barrier between the [stepped intervention] and the acute care team… Clinicians were frustrated by that and weren't happy to be holding risk like that"* [08_M].

Change Management

Participants' perception of change management was an important indicator of implementation. At site 1, the absence of a plan for change lead to confusion from staff and management about goals and logistics of the implementation. One clinician remarked "*there was just some kind of friction, misunderstanding, feelings of why… bring in trainers in from outside, when they could've used their own people*." [07_C]. The size of the area and the level of management support appeared to impact perceptions of change management. At smaller, isolated areas the lack of a structured process of change did not impede implementation in the context of strong management support. However, at larger areas the presence or absence of a plan for change was an important factor contributing successful implementation.

Feedback on outcomes

Most participants commented on the importance of demonstrating outcomes for the intervention. One participant stated *"I think the demonstration of outcomes has been the best thing. You know these people would just keep going around and around for a long time without any change... just seeing people – [they] have you know two, three sessions and you don't hear from them again. It's good*." [14_C]. Where outcomes were not communicated to the service providers, descriptions of implementation were poorer. For example, one manager commented "*I'm not saying I'm not positive towards the [stepped intervention], I just haven't seen any results. I've seen very few referrals, I've seen confusion, I've seen staff dwindle away*." [12_M]

Discussion

This study aimed to explore the experiences of clinicians and managers implementing a stepped-care intervention for personality disorders in mental health settings. Qualitative interviews were used to identify barriers and facilitators of change. Site 1 was rated by researchers as having 'moderate' success of implementation with some use of intervention model, and Site 2 was rated as having 'good' implementation where the intervention was integrated into core service practice. Results of thematic analysis elicited six themes in relation to barriers and facilitators, including training, clinical champions, management, governance, change management, and feedback on client outcomes. Themes can be understood in terms of individual and organisational factors.

Individual factors

Experiences of both clinicians and managers indicated individual factors – including attitudes and beliefs – influence implementation. Training increased knowledge of psychological therapies. Training was not perceived by participants as resulting in changing attitudes,

however it was seen as an adjunct to hands-on-experience to increase familiarity and confidence in clinical practice (35). For clinicians with compassionate attitudes towards personality disorder, training did validate their experience and skills and acted as an incentive to continue change.

The presence of clinical champions was vital to implementation. Mental health services tend to have limited psychologically trained staff members, which is linked to poor implementation of psychological therapies in public mental health (36). The effect of service wide training which validates a psychological model and gives psychologically trained staff 'permission' to use psychological therapies may be invaluable to future implementation programs.

Organisational factors

Organisational factors impacting on implementation were management support or leadership, governance, and organisational values and culture. At site 2 where clinicians experienced support from senior managers, they felt supported in their work and described more successful implementation outcomes. Effective leadership encouraged engagement and confidence to work with the population. A leadership style focused on understanding staff needs is useful for implementation of personality disorder interventions. This is consistent with findings that a transformational leadership approach promotes positive attitudes among staff (37, 38), and can predict more openness to innovation during implementation of evidence based treatments (39). At site 1 participants reported the perception that people with personality disorders should be treated by specialist treatment programs and not by services more generally within a stepped care approach. This culture resulted in a lack of engagement

with change, ineffective policy development, and ultimately poor implementation. Understanding the culture of the organisation is vital to appropriately facilitate change (40).

Clinical governance was perceived by some participants as a barrier due to conflicting opinions and organisational policies. Conversely, for other areas, formalised policy facilitated implementation by distilling referral pathways and clinician support structures. Flexibility in the application of clinical governance appeared to be the most important theme regarding governance.

Organisational experience in change management was reported as lacking at site 1. Implementation was perceived as chaotic and unplanned and managers reported feeling unskilled and unprepared for effecting change within the health setting. In this context, managers appeared to impede change by not committing adequate resources to the implementation which resulted in clinicians becoming over-burdened and limited success of implementation (41). Organisations should train managers and staff in implementation frameworks and relevant change theory, so they are better able to influence the implementation process (42).

Perceptions of the outcomes of implementing the change were important for engaging in and sustaining implementation. Feedback on intervention outcomes provided evidence for the change which prompted action towards change. The importance of transparent outcomes is consistent with models of change (40) and considering the positive experience of informal feedback, future implementation programs may benefit from incorporating overt evaluation and dissemination plans.

A number of limitations are relevant to this research. Firstly, the sample size of this study was small, limiting generalisability of the findings. Future studies could employ alternate statistical methods to capture a wider breadth of experiences. Secondly, the IPA method is limited as individual experiences are not necessarily an accurate representation of the experiences of a sample (43). Additionally, the sampling technique may have resulted in a selection of those with the most positive experiences of change. However as negative experiences were also reported, it is likely selection and positive reporter bias was minimal.

Conclusions

This study highlights a number of issues relevant to clinical practice. Most importantly, the study found mental health services have the capacity to implement stepped therapeutic interventions for personality disorders. Further, it provided an opportunity to improve understanding with regard to the key factors for success in implementing such strategies. Management support appeared to be the most important factor, but when not available, experience of training and the role of champions facilitated change in health settings. Demonstration of the impact of change was vital for continued engagement in implementation. Based on these findings implementation processes could be refined to focus on five key factors for success; (1) clear and accountable leadership commitment at the level of senior clinical staff and (2) establishing and supporting clinical governance outlining clinical pathways to specific treatment clinics and (3) clinician support structure. Further important aspects include (4) ensuring sufficient penetration of training to all staff, including ongoing training opportunities, and (5) training managers and senior clinical staff or clinical champions on how change occurs and factors associated with success or barriers and development of prospective plans for evaluating and disseminating outcomes of implementation. This study aids in understanding how to implement evidence-based practices

in real world settings for a challenging population. Further research is needed to continue closing the gap between research and practice, thus giving help-seeking individuals with BPD the best possible treatment for their individual level of need.

References

1. Tyrer P, Mulder R, Crawford M, Newton-Howes G, Simonsen E, Ndetei D, et al. Personality disorder: a new global perspective. *World Psychiatry*. 2010;9(1):56-60.

2. Jackson HJ, Burgess PM. Personality disorders in the community: A report from the Australian National Survey of Mental Health and Wellbeing. *Soc Psychiatry and Psychiatr Epidemiol*. 2000;35(12):531-8.

3. Korzekwa MI, Dell PF, Links PS, Thabane L, Webb SP. Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure. *Compr Psychiatry*. 2008;49(4):380-6.

4. Zimmerman M, Rothschild L, Chelminski I. The prevalence of DSM-IV personality disorders in psychiatric outpatients. *Am J Psychiatry*. 2005;162(10):1911-8.

5. Leontieva L, Gregory R. Characteristics of patients with borderline personality disorder in a state psychiatric hospital. *J Pers Disord*. 2013;27(2):222-32.

6. Lewis KL, Fanaian M, Kotze B, Grenyer BF. Mental health presentations to acute psychiatric services: 3-year study of prevalence and readmission risk for personality disorders compared with psychotic, affective, substance or other disorders. *BJPsych Open*. 2019;5(1).

7. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM-5)*. Washington, D.C: American Psychiatric Pub; 2013.

8. Sansone RA, Farukhi S, Wiederman MW. Utilization of primary care physicians in borderline personality. *Gen Hosp Psychiatry*. 2011;33(4):343-6.

9. Bender DS, Dolan RT, Skodol AE, Sanislow CA, Dyck IR, McGlashan TH, et al. Treatment utilization by patients with personality disorders. *Am J Psychiatry*. 2001;158(2):295-302.

10. Shaikh U, Qamar I, Jafry F, Hassan M, Shagufta S, Odhejo YI, et al. Patients with borderline personality disorder in emergency departments. *Front Psychiatry*. 2017;8:136.

11. Paris J. Is hospitalization useful for suicidal patients with borderline personality disorder? *J Pers Disord*. 2004;18(3):240-7.

12. Meuldijk D, McCarthy A, Bourke ME, Grenyer BF. The value of psychological treatment for borderline personality disorder: Systematic review and cost offset analysis of economic evaluations. *PloS One*. 2017;12(3):e0171592.

13. Fanaian M, Lewis KL, Grenyer BF. Improving services for people with personality disorders: Views of experienced clinicians. *Int J Ment Health Nurs*. 2013;22(5):465-71.

14. Cristea IA, Gentili C, Cotet CD, Palomba D, Barbui C, Cuijpers P. Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis. *Jama Psychiatry*. 2017;74(4):319-28.

15. Choi-Kain LW, Albert EB, Gunderson JG. Evidence-based treatments for borderline personality disorder: Implementation, integration, and stepped care. *Harv Rev Psychiatry*. 2016;24(5):342-56.

16. Ng FY, Bourke ME, Grenyer BFS. Recovery from borderline personality disorder: a systematic review of the perspectives of consumers, clinicians, family and carers. *PloS One*. 2016;11(8):e0160515.

17. Miller CE, Lewis KL, Huxley E, Townsend ML, Grenyer BFS. A 1-year follow-up study of capacity to love and work: What components of borderline personality disorder most impair interpersonal and vocational functioning? *Personal Mental Health*. 2018;12(4):334-44.

18. Paris J. Stepped care and rehabilitation for patients recovering from borderline personality disorder. *J Clin Psychol*. 2015;71(8):747-52.

19. Grenyer BFS. An integrative relational step-down model of care: The Project Air strategy for personality disorders. *The ACPARIAN*. 2014;9:8-13.

20. Paris J. Stepped care: An alternative to routine extended treatment for patients with borderline personality disorder. *Psychiatr Serv*. 2013;64(10):1035-7.

21. Fleischmann A, Bertolote JM, Wasserman D, De Leo D, Bolhari J, Botega NJ, et al. Effectiveness of brief intervention and contact for suicide attempters: A randomized controlled trial in five countries. *Bull World Health Org*. 2008;86:703-9.

22. Greenfield B, Larson C, Hechtman L, Rousseau C, Platt R. A rapid-response outpatient model for reducing hospitalization rates among suicidal adolescents. *Psychiatr Serv*. 2002;53(12):1574-9.

23. Rotheram-Borus MJ, Piacentini J, Cantwell C, Belin TR, Song J. The 18-month impact of an emergency room intervention for adolescent female suicide attempters. *J Consult Clin Psychol*. 2000;68(6):1081.

24. Grenyer BF, Lewis KL, Fanaian M, Kotze B. Treatment of personality disorder using a whole of service stepped care approach: A cluster randomized controlled trial. *PloS One* 13:e0206472, 2018

25. Project Air Strategy for Personality Disorders. *Brief intervention manual for personality disorders*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute, 2015

26. Grenyer BFS. Improved prognosis for borderline personality disorder. *Med J Aust*. 2013;198:464-5.

27. National Health and Medical Research Council. *Clinical practice guideline for the management of borderline personality disorder*. Melbourne: NHMRC; 2012.

28. Proctor EK, Landsverk J, Aarons G, Chambers D, Glisson C, Mittman B. Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Adm Policy Ment Health*. 2009;36(1):24-34.

29. Powell BJ, Waltz TJ, Chinman MJ, Damschroder LJ, Smith JL, Matthieu MM, et al. A refined compilation of implementation strategies: Results from the Expert Recommendations for Implementing Change (ERIC) project. *Implement Sci*. 2015;10(1):21.

30. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: A synthesis of recommendations. *Acad Med*. 2014;89(9):1245-51.

31. Smith JA, Osborn M. Interpretative phenomenological analysis. In: Breakwell GM, editor. Doing Social Psychology Research. Leicester, Englang: British Psychological Society, Blackwell Publishing; 2004. p. 229-54.

32. Patton MQ. *Qualitative research and evaluation methods*. California: Sage Publications; 2002.

33. Castleberry A. NVivo 10 [software program]. Version 10. QSR International; 2012. *American Journal of Pharmaceutical Education*. 2014;78(1).

34. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101.

35. Liebman RE, Burnette M. It's not you, it's me: An examination of clinician-and client-level influences on countertransference toward borderline personality disorder. *Am J Orthopsychiatry*. 2013;83(1):115.

36. Hulbert C, Thomas R. Public sector group treatment for severe personality disorder: A 12-month follow-up study. *Australas Psychiatry*. 2007;15(3):226-31.

37. Alimo-Metcalfe B, Alban-Metcalfe J. Leadership: Time for a new direction? *Leadership*. 2005;1(1):51-71.

38. Aarons GA. Transformational and transactional leadership: Association with attitudes toward evidence-based practice. *Psychiatr Serv*. 2006;57(8):1162-9.

39. Aarons GA, Sommerfeld DH. Leadership, innovation climate, and attitudes toward evidence-based practice during a statewide implementation. *J Am Acad Child Psychiatry*. 2012;51(4):423-31.

40. Kitson AL, Rycroft-Malone J, Harvey G, McCormack B, Seers K, Titchen A. Evaluating the successful implementation of evidence into practice using the PARiHS framework: Theoretical and practical challenges. *Implement Sci*. 2008;3(1):1.

41. O'Connor N, Kotze B, Vine R, Patton M, Newton R. The emperor's edicts stop at the village gate. *Australas Psychiatry*. 2012;20(1):28-34.

42. Graham ID, Logan J, Harrison MB, Straus SE, Tetroe J, Caswell W, et al. Lost in knowledge translation: Time for a map? *J Contin Educ Health Prof*. 2006;26(1):13-24.

43. Pringle J, Drummond J, McLafferty E, Hendry C. Interpretative phenomenological analysis: A discussion and critique. *Nurse Res*. 2011;18(3):20-5.

Tables

Table 1

Demographic and Clinical Variables of Participants (N=21)

Variable	N	%
Profession		
Psychologist	12	57.2
Nurse	3	14.2
Psychiatrist	1	4.8
Occupational Therapist	3	14.2
Social Worker	2	9.5
Current Role		
Clinician	13	61.9
Manager	7	33.3
Clinician and Manager	1	4.8
Attended implementation training		
Yes	20	100
No	0	0

Table 2

Statements from Participants on their Perception of Implementation Success

Rating	Site	N	Description
Moderate	1	10	*"The mental health service doesn't – hasn't really changed its policy around, seeing personality disorders as a serious mental illness".* [12_M] *"I don't believe the [intervention] is working. I don't think we are capturing enough people*." [12_M]
Good	2	11	*"...there [are] clear strategies and people are seeing that they are having a really good impact."* [14_C] *"...we're running five appointments a week... putting them through this different pathway, actually, frees up the access."* [16_M] *"It's increasingly becoming embedded in the culture, I think."* [21_C]

Note – M = Manager; C = Clinician