Community Mental Health Journal (2019) 55:448–453
https://doi.org/10.1007/s10597-018-0312-2

BRIEF REPORT

'It's Like You Do It Without Knowing That You're Doing It': Practitioner Experiences with ACT Implementation

Rebecca Lengnick-Hall[1] · **Karissa Fenwick**[1] · **Benjamin Henwood**[1]

Received: 2 September 2017 / Accepted: 28 July 2018 / Published online: 9 August 2018

Abstract

Using a case study approach, this study explores the experiences of providers at three organizations identified by county mental health executives as exemplar programs that have received continued and competitive funding to deliver assertive community treatment (ACT) in a large urban county in California. Interviews were conducted with 37 participants including program directors (n = 4), frontline staff (n = 31), and county mental health executives (n = 2). Frontline provider perspectives reveal that, in many ways, teams appear to be working within an ACT model in the absence of detailed explicit knowledge about ACT's core components, frequent or in-depth conversations about ACT, or awareness of fidelity monitoring. Integration of program director and county executive perspectives illustrates how inner and outer contextual information can explain these on-the-ground ACT implementation experiences. This study illustrates the nuanced ways that frontline staff might understand and define evidence-based practice (EBP) use and has implications for studying EBP implementation.

Keywords Evidence-based practice · Assertive community treatment · Community mental health

Introduction

Evidence-based practice (EBP) implementation, which ensures that clients receive up-to-date, high quality mental health services, is difficult to achieve (Beidas and Kendall 2014; Novins et al. 2013). Different levels of the organizational context influence how EBPs are supported and maintained over the course of active implementation (Aarons et al. 2011). The outer organizational context includes environmental characteristics such as client needs, external policies, and funding structures, while the inner context consists of intra-organizational features such as program leadership, training and supervision, and fidelity monitoring.

Factors in the outer context that have been identified as particularly important for supporting implementation include direct financing for the EBP and state-level support for the practice (Bond et al. 2009; Jones et al. 2014; Swain et al. 2010). Within the inner organizational context, key processes include ongoing EBP training, regular communications about the EBP, and balancing fidelity and adaptation (Hurlburt et al. 2014; Novins et al. 2013). High levels of staff turnover make continuous EBP training critical for mental health organizations (Swain et al. 2010; Woltmann et al. 2008). There is also a need for ongoing discussion and communication about an EBP with existing staff, typically in the form of supervision, coaching, or in-service presentations (e.g., during staff meetings) (Bearman et al. 2013; Swain et al. 2010; Willging et al. 2015). Additionally, balancing fidelity and adaptation can improve EBP use and effectiveness over time (Moore et al. 2013; Stirman et al. 2015), but requires regular measurement of fidelity and monitoring of adaptation to ensure that the EBP's integrity and effectiveness are preserved (Damschroder et al. 2009; Stirman et al. 2012).

Assertive community treatment (ACT) is an example of a well-established and widely used EBP for individuals with serious mental illness (Rollins et al. 2016). ACT's core components include a multidisciplinary team approach to service delivery, low client-staff ratios, contact made in community settings, a focus on daily living problems and medication management, rapid response to client emergencies, assertive outreach to hard-to-reach clients, and an individualized, holistic, time-unlimited service package (Bond and Drake 2015). In addition to objective measures of ACT fidelity, the

✉ Rebecca Lengnick-Hall
lengnick@usc.edu

[1] School of Social Work, University of Southern California, 669 W. 34th Street, MRF Building, Suite 214, Los Angeles, CA 90089, USA

attitudes of frontline providers, which represent the interface between an EBP and the clients for whom the EBP was designed, can also impact client outcomes during implementation (Henwood et al. 2011; Stanhope and Matejkowski 2010). Shifts in provider attitudes and the routinization of an EBP are less readily captured with quantitative measures and have been less emphasized in the research literature (Gupta et al. 2017; Proctor et al. 2011).

This study builds upon a body of qualitative work that uses practitioner perspectives and feedback to understand different aspects of ACT implementation (e.g. Finnerty et al. 2015; George et al. 2016; Meyer-Kalos et al. 2017). Using a case study approach (Padgett 2016; Stake 2005), this study explores how practitioners working within ACT programs at three organizations describe and understand their experiences with providing ACT in day-to-day service delivery. In addition, this study explores how the inner and outer organizational contexts may influence and explain staff perspectives (Aarons et al. 2011).

Methods

This study was conducted between June 2015 and February 2016 in a large urban county in California where the Mental Health Services Act (MHSA), passed in 2004, provides a high level of financial support for ACT implementation through programs known as full service partnerships (FSPs). The MHSA also encourages counties to tailor FSPs to fit local characteristics (Clark et al. 2013; Felton et al. 2010). To select sites for this study, we asked two county mental health executives to nominate organizations that are known exemplars for implementing high quality ACT programs and that have received continued and competitive county-level funding to deliver ACT services. Out of four nominated organizations, three agreed to participate in this study. The fourth site did not provide a reason for declining to participate. The two county mental health executives who nominated these programs also participated in one-on-one interviews to provide perspectives about the outer context related to ACT implementation.

At each study site, we first interviewed program directors to obtain relevant information about the organization and its experience with ACT implementation. Information obtained in these initial interviews provided background information that informed subsequent semi-structured interviews with members of ACT teams at each organization. Program directors provided lists of ACT team members who were interested in participating in individual interviews. We conducted individual interviews until we reached saturation, as determined by consensus that no new insights or issues relevant to the study purpose were arising from the data (Charmaz 2006). Team members were asked to define ACT and how they learned about ACT, when and how they talk about the ACT model, and how they know whether they are meeting ACT standards. At the request of a program director at one of the organization, a focus group was conducted as a way to introduce the study to the team and receive overall team input. Follow up interviews were conducted with four of the individuals who participated in this focus group and volunteered to provide more in-depth information about their experiences. All study participants gave informed consent prior to data collection. To protect confidentiality, interviews were conducted in quiet, private rooms and individual level data were not shared with program directors or anyone else at the organization. All interviews, including the two county mental health executives and the focus group were digitally recorded, transcribed verbatim, and uploaded into NVivo 10 software for analysis. Audio recordings and transcriptions were de-identified and stored on secure computers. Study participants received a $35 incentive and organizations received a $500 incentive for participation. Roles represented in the study sample are program director/administrator (n = 4), team manager/leader (n = 3), case manager (n = 14), specialist positions (n = 7), psychiatric nurse practitioner (n = 1), nurse (n = 1), licensed vocational nurse (n = 2), intern (n = 1), and administrative position (n = 2). Case 1 included 8 individuals, Case 2 included 13 individuals, and Case 3 included 14 individuals. In addition to these 35 individuals, two county mental health executives were interviewed bringing the total sample size to 37 participants.

Transcripts were coded using an inductive approach (Padgett 2016). To understand and synthesize perspectives about the inner and outer context, transcripts were analyzed in several stages. The county mental health executive and program director interviews were reviewed first to obtain a comprehensive understanding of past and current experiences with ACT implementation in the county (i.e. outer context). Next, ACT team member and program director transcripts for each organization were reviewed and coded to investigate the inner organizational context. Case summaries of each organization were created for within case analyses (Stake 2005) and a case summary matrix was used to organize provider perspectives across the three sites (Miles et al. 2014; Patton 2015). Finally, findings related to the outer context were triangulated to help understand the within- and cross-case analyses of the inner context (Padgett 2016; Patton 2015). Several strategies of rigor for conducting qualitative methods were used, including: (1) ongoing debriefing meetings during data collection and analysis, (2) co-coding of transcripts, and (3) memos to create an audit trail of decision-making (Charmaz 2006; Padgett 2016).

Study policies and procedures were reviewed and approved by the University of Southern California

University Park Institutional Review Board. There are no known conflicts of interest. All authors certify their responsibility for this manuscript.

Results

The sample of 37 study participants was 60% female (n = 22) and 40% male (n = 15), and job tenure among ACT team members ranged from 3 months to 21 years. Participant age and race-ethnicity data were not collected. Perspectives of frontline providers that were derived from cross-case analyses are described followed by the key features of the outer and inner contexts of ACT implementation.

Frontline Provider Perspectives

Below we: (1) characterize the different ways in which frontline staff described ACT; (2) explain how ACT is not discussed in an explicit manner among frontline staff; and (3) describe how frontline staff appear to be implementing ACT without a clear model definition or awareness of fidelity monitoring.

Describing ACT: "ACT is the Model of What We Do."

None of the frontline staff descriptions of ACT included the terms "evidence-based practice" or "core components." Some responses indicated partial understanding of ACT's core components. For example:

> The case managers have, not a low case load but they all have a case load together so that the clients can go to anybody and the case managers really encourage that. We meet together every day as a team. The clients can go to any one of us. I can't think of other things about the ACT model.

Rather than describing the model by its core components, some team members defined ACT in terms of the attributes of the service provider. For example, "The main features of ACT, I would say, is to be genuine. To understand this person's condition, really." ACT was also described as giving clients hope and being compassionate.

Furthermore, ACT was described as an ingrained, fundamental way that the organization provides services. Across programs, frontline staff used similar language to define ACT:

> …everything that we're doing is a part of ACT… It's like you do it without knowing that you're doing it. You learn it and just go… I think we pretty much, it's second nature at this point, it's like breathing.

Finally, and most surprisingly, a consistent theme across programs was that frontline staff expressed that they didn't know what the ACT model was at even a basic level:

> I don't know if I really understand what ACT is. Okay, I don't even know what the acronym stands for. What does it stand for?

Implicit Versus Explicit ACT

Responses illustrated that there was little to no explicit discussion about ACT. Sometimes ACT came up in a general way when discussing client cases. As one team member explained, "I think like in every morning meeting we don't say that oh what is ACT model and stuff like that, but when we talk about that treatment, that really relates to ACT model, I would say so."

Other team members mentioned that the ACT model was raised during training activities, county official visits, and supervisor conversations. However, even though ACT was mentioned on these occasions, there was no explicit discussion about core components or specific implementation processes. For example, when describing how ACT was discussed during training activities one participant stated, "The principles of it does but I don't think we necessarily identify it that way, if that makes sense, Now we're going to talk about ACT." Still others asserted that ACT wasn't discussed in even a peripheral, informal way.

Years After ACT Adoption…What is Being Implemented?

Responses across the cases suggested little to no frontline staff awareness of or participation in fidelity monitoring activities. For example, one team member noted, "I don't know if anybody has ever actually used and tested us with a fidelity scale, I don't know." Other frontline staff described general program activities but were not able to describe it in terms of ACT implementation. When one participant was asked how he knew he was following ACT, the response was simply, "Hmm. That is a good question…I don't." This represented many of the participant responses on this topic.

However, despite an apparent lack of knowledge about ACT, discussions about ACT implementation, or awareness of fidelity monitoring, responses indicated that in day-to-day service delivery, frontline staff were often implementing many of the core features of the practice. "Doing ACT" without being able to articulate the model was a persistent theme across the cases. Core components including time out in the field, the multidisciplinary team approach, low caseloads, morning meetings, 24/7 availability and client-driven goal setting came up numerous times when participants were asked to describe a typical work day.

> I start my day off with the team. We have a meeting, a brief meeting or whatever. Whatever we got to outline for the day. And we'll go out as a team and do outreach maybe three to four days a week. And what I do is outreach, engage, either refer, make or try to enroll… And we get over there and I knock on doors.

Participants across the cases also indicated positive attitudes towards adaptation and acceptance of adaptation at their organization. For example,

> Not only that, they give us the freedom, I mean, they're flexible. They allow us to create some things and come up with ideas and do things in our own way.

These responses suggested that, again, participants were often "doing ACT" and making changes without an explicit understanding of the EBP or the degree to which fidelity is being achieved.

Outer Context

County mental health executives and program directors discussed how the MHSA was a landmark piece of legislation that substantially modified the funding and framework for community-based mental health service delivery in California. These interviewees noted that California's county-based mental health system enabled each county to use MHSA resources to implement ACT models that fit local characteristics. They also indicated that ACT implementation was greatly influenced by a mandate to include diverse stakeholders in planning processes, and that some client advocates expressed concern that the assertive nature of ACT services could be coercive. Finally, the interviewees reflected that the rapid allocation of funding and expansion of services after the MHSA's passage created the potential for mission drift, but that the county established ACT fidelity criteria and delineated the ACT service array, staffing expectations, and required outcomes for reporting.

Inner Context

Across the cases, program directors indicated that ACT has become an embedded part of the organizational cultures. Additionally, program directors and ACT team members described a heavy reliance upon on-the-job training to deliver ACT services. Program directors described fidelity monitoring processes differently at each site. At one organization, ACT fidelity monitoring was described as an informal process, while another organization had an active quality improvement department that handled specific fidelity monitoring activities. The third organization described adherence to the "philosophies and principles" of ACT rather than formalized evaluation processes. None of the program directors mentioned organizational policies for actively involving or explicitly discussing fidelity-monitoring activities with frontline staff.

Discussion

Our findings suggest that frontline staff appear to be implementing components of ACT in the absence of detailed explicit knowledge about the model, frequent or in-depth conversations about the practice, or awareness of or participation in fidelity monitoring. Analyses of inner and outer contextual factors help account for this counter-intuitive finding. For example, the flexibility to tailor ACT programs to county characteristics provided by the MHSA may help to explain why frontline staff did not express clear and uniform ACT model definitions, training polices, or fidelity monitoring standards. Inner contextual information also describes ACT as an ingrained, fundamental way that the organization provides services, which can explain how frontline ACT team members might implicitly implement an EBP like ACT in the absence of explicit knowledge or discussions about the practice or fidelity (Aarons et al. 2011). Additionally, the reported reliance upon on-the-job training, which focuses on skills rather than concepts, could help explain why frontline staff were unable to list ACT's core components despite describing how they implement these components in their daily service delivery (e.g. team meetings, low client to staff ratios, interdisciplinary teams).

It is important to note that while the sites in this study were known for delivering high quality ACT, an independent fidelity assessment was not conducted as part of the study. In addition, the suggestion that a frontline staff member can unwittingly deliver an EBP with high quality seems more plausible with an intervention like ACT, given fidelity standards that are heavily based on the structure of service delivery rather than the process of service delivery (e.g. fidelity measures for cognitive behavioral therapy). Future studies can explore the implementation of other EBPs as well as ACT implementation in other locations that may have a different outer context. For example, if licensing was dependent on ACT fidelity as it is in some states, frontline staff would likely be more informed about the model and describe their experiences differently than this study's participants. Future studies may also examine how staff knowledge, descriptions, and experiences related to the use of ACT may change over time as the organization progresses from adoption to active implementation to sustainment.

The study's findings raise several important questions for understanding and studying EBP implementation. First, results point to the nuanced ways that frontline staff might understand and define EBP use. ACT may be so deeply ingrained in the day-to-day operations of the organization

that it became intertwined with provider roles and organizational culture, rather than existing as a stand-alone practice defined by discrete core components. Of course, it also may be true that providers' limited awareness of ACT undermines the organization's ability to provide effective care. Findings also have implications for how researchers and managers discuss EBP implementation. Although participants often described adhering to core ACT principles, they were not able to talk about it in the language used by researchers and policy makers (e.g. core components, fidelity, evidence-based). This may suggest a need to identify ways of discussing EBPs that are meaningful to and resonate with practitioners, which aligns with Cutbush et al. (2017) who acknowledge that research on practitioners' understanding and operationalization of fidelity is currently lacking and may vary from the established intervention guidelines.

Finally, this study raises interesting questions about the role of ongoing training and fidelity monitoring processes. Bond et al. (2009) examined strategies for improving fidelity in the national implementing evidence-based practice project and noted, "…the majority of sites never fully embraced the fidelity monitoring philosophy." Interestingly, the lack of fidelity monitoring and reporting did not necessarily preclude the attainment of high fidelity in that study. The relatively informal training procedures described in this study may suggest that training needs and behaviors change over the course of EBP implementation but also raises the questions about who is responsible for fidelity monitoring and what role frontline staff should play in these activities.

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