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OLMSTEAD MANDATED STATEWIDE IMPLEMENTATION OF ASSERTIVE
COMMUNITY TREATMENT: PRECIPITATING FACTORS AND PARTICIPANT
EXPERIENCES

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Social Work
at the University of Kentucky

By
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Lexington, Kentucky

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Lexington, Kentucky

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ABSTRACT OF DISSERTATION

OLMSTEAD MANDATED STATEWIDE IMPLEMENTATION OF ASSERTIVE COMMUNITY TREATMENT: PRECIPITATING FACTORS AND PARTICIPANT EXPERIENCES

Evidence-based practices for individuals with serious mental illness have not been widely implemented in United States public mental health systems. Mental health advocates have used the Supreme Court's Olmstead decision to force states with underfunded community mental health services to develop more robust treatment systems. Using a case study, this article-based dissertation examines the process of mandated widespread implementation of Assertive Community Treatment (ACT) in Kentucky through the experiences of individuals involved in ACT creation and documents related to implementation and the state mental health system. Study 1 identifies precipitating factors to the Kentucky Olmstead settlement agreement that contributed to a lack of research-informed practices for individuals with serious mental illness. Study 2 examines how ACT knowledge was communicated by exploring the learning experiences of individuals involved in implementation. Study 3 investigates the impact of requiring program creation through a settlement agreement on individuals responsible for building these new practices. All 3 studies used qualitative methods determine findings. Study 1 used a content analysis of publicly available documents related to the Kentucky mental health system while Studies 2 and 3 relied on the thematic analysis of semi-structured interviews with individuals involved in ACT formation. Findings highlight the importance of governments prioritizing evidence-based practice for individuals with serious mental illness. The use of settlement agreements to force service provision may accomplish an important goal of providing needed services to a vulnerable population. However, rushed or poorly planned program creation strains systems of care and is detrimental to the wellbeing of individuals involved. By engaging in a thorough assessment of barriers prior to program creation, entities using settlement agreements can facilitate more effective implementation of evidence-based practice for individuals with serious mental illness.

KEYWORDS: Evidence-Based Practices, Assertive Community Treatment, Serious Mental Illness, Olmstead Mandated Implementation

Elizabeth Owens Nelson-Cooke

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04/13/2020

Date

OLMSTEAD MANDATED STATEWIDE IMPLEMENTATION OF ASSERTIVE
COMMUNITY TREATMENT: PRECIPITATING FACTORS AND PARTICIPANT
EXPERIENCES

By
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Director of Dissertation
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04/13/2020

Date

Dedication

This dissertation is dedicated to my father. He spent years begging me to go back for a doctorate and had dreams of his daughter dazzling the academic community with her brilliance. I wish he could have made it with me to the Ph.D. finish line.

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Chapter 1: Introduction

The de-institutionalization of psychiatric facilities in the United States, a process starting in the 1950s that lasted for several decades, resulted in individuals with serious mental illness (SMI) receiving mental health services in the community rather than a psychiatric hospital. SMI includes one or more diagnoses of a DSM V mental disorder combined with a significant impairment in functioning (Interdepartmental Serious Mental Illness Coordinating Committee [ISMICC], 2017). Psychotic disorders and mood disorders are the most common SMI diagnoses, but other disorders may meet criteria if an individual's ability to function is severely impaired. Prevalence of SMI is higher among sexual minorities, people of color, and females with one in 25 adults diagnosed with SMI within a given year (ISMICC, 2017). After deinstitutionalization, community services were poorly funded which resulted in unmet needs in the areas of housing, employment, and substance use treatment (Gold et al., 2006; Substance Abuse and Mental Health Services Association [SAMHSA], 2015). Successfully integrating SMI individuals in community settings necessitates a holistic, wrap-around treatment approach beyond basic medication management, an approach that requires a level of funding and resources often lacked by public mental health systems.

In 1998, mental health stakeholders selected five evidence-based practices (EBPs) to recommend for nationwide implementation in public social services settings: Assertive Community Treatment (ACT), Supported Employment, Integrated Dual Disorder Treatment, Illness Management and Recovery, and Family Psychoeducation (Lehman et al., 1998). Evidence-based practices facilitate SMI recovery by giving service providers

effective, reliable tools to help clients manage symptoms and achieve their recovery goals (Carpinello et al., 2002). In 2003, President George Bush's New Freedom Commission evaluated the public mental health system and urged the creation of an integrated, consumer-centered, and recovery oriented mental health system driven by EBPs to address the complex needs of individuals with SMI (New Freedom Commission on Mental Health, 2003).

Community mental health centers (CMHCs) are the largest providers of mental health services in the United States, providing low-cost or free services to anyone in need of treatment (SAMHSA, 2013). Many of these agencies have been slow to change their services when research identifies a more effective treatment method. Reluctance about feasibility, cost, and acceptability of new services can deter a CMHC from trying a new EBP (Isett et al., 2007). Agencies have been particularly resistant to changing services to accommodate more effective EBPs for individuals diagnosed with SMI (Gioia & Dziadosz, 2008). If CMHCs are going to continue to provide the bulk of SMI treatment services, it is critical that these agencies offer the most up-to-date and effective services. One of the most widely implemented SMI EBP is ACT which has been implemented statewide in 21 states and all but seven states report the presence of at least one team (National Association of State Mental Health Program Directors [NASMHPD], 2015).

Assertive Community Treatment

The ACT model was created to treat individuals diagnosed with SMI who experience severe and persistent functional challenges as a result of their illness (Drake, 1998). Without intensive services they typically experience recurring crisis episodes that

result in psychiatric hospitalizations, housing instability, and involvement with the criminal justice system. ACT is most effective for individuals with the highest support needs – those with symptoms that do not fully respond to treatment and cause serious challenges to living independently in the community (SAMHSA, 2008). Traditional mental health services have been unable to fully meet the needs of these individuals. Major differences between traditional CMHC services and ACT services exist in the areas of values, combinations of services, methods by which services are provided, and overall professional practice (Gold et al., 2003).

ACT services are provided by an interdisciplinary team in an individual's home or other community location. Traditional SMI treatment typically involves multiple referrals to other providers for non-psychiatric services such as case management, vocational services, and substance use treatment. Often times these referrals are mishandled, or the clients do not follow-through with a referral which results in the individual not receiving the necessary support services to remain independent in the community (Gold et al., 2003). ACT centralizes these services and provides them by the team. A basic ACT team employs a team leader, nurse, psychiatrist, and case manager while a full team has a combination of therapists, vocational specialists, substance use specialists, housing case managers, and peer supports (SAMHSA, 2008).

The present study examines ACT teams in KY and given that 70 percent of the state is considered rural (Davis, 2009), it is important to talk about ACT teams in remote or low-populated areas. Teams operating in rural areas face a unique set of challenges; they often lack the resources of more densely populated areas such as public

transportation, housing options, and food banks. Low client density, lack of staff, and the necessity of traveling long distances between clients (which limits the ability to make frequent face-to-face contact) present barriers for rural teams (Bond & Drake, 2007; Isett et al., 2007). One of the biggest challenges for rural teams is high staff turnover and the difficulty of finding qualified staff (Bjorklund et al., 2009; Freuh et al., 2009).

Implementation of Assertive Community Treatment

ACT implementation is a complex process necessitating cooperation from every level of the public mental health system. It is important that each level adjusts to the needs of the ACT model. ACT services are costly in terms of money, time, and organizational resources, therefore the failure to provide high-quality services wastes both human and financial resources. Training and leadership are two key components of building an effective team.

Training is a crucial aspect in the introduction of any new practice to an organization, but it is particularly vital for the successful implementation of ACT. However, a definitive model of how to most effectively train staff to provide ACT services has yet to be created. In the absence of a definitive training approach, ACT implementation research places heavy emphasis on the role of the trainers and consultants in creating and supporting high-quality teams. Trainers should have a solid understanding of the EBP as well as the ability to apply theoretical knowledge to the practice of real-world cases in order to guide agencies and clinicians (Torrey et al., 2005). Education for EBP providers typically includes practice-based training, learning collaboratives, and the use of technical assistance centers (TACs) (Gioia & Dziadosz, 2008; Monroe-DeVita et

al., 2012). Technical assistance centers address the need for effective training and consultation by providing support and guidance to agencies in the mental health system necessary for implementation (Mancini et al., 2009; Salyers et al., 2007).

The ACT team leader (TL) is critical in determining the success or failure of a team (Carlson et al., 2012; Gioia & Dziadosz, 2008). To manage a team of three to nine interdisciplinary staff, the TL must have basic knowledge of a variety of disciplines. The TLs are one of the most important facilitators of knowledge translation during implementation through their communication with their team. They provide training and orientation to the ACT model for new staff and monitor existing staff to verify quality services are being provided to clients. As the main locus of responsibility, however, TLs are subject to stress and burnout. Developing teams experience higher rates of turnover. This frequent turnover impedes ACT implementation as it interrupts the transmission of knowledge from supervisor to direct-care staff (Moser et al., 2004)

Despite the availability of EBPs, many mental health systems have been slow to introduce them for their SMI populations. Bjorklund et al. (2009) assert that most state mental health authorities have not provided the necessary resources for widespread high-fidelity ACT implementation. The implementation of EBPs, particularly ACT, can be costly and necessitate significant changes to the status quo of SMI treatment systems (Gold et al., 2006). Some states that have been slow to provide EBPs to SMI populations have been forced into providing them by mental health advocates through the use of the nondiscrimination clause of the Americans with Disabilities Act (NASMHPD, 2015).

Kentucky, one of those states, was forced into the provision of statewide SMI EBPs after Protection and Advocacy (P&A), a mental health advocacy group, threatened to sue the state for violating the 1999 Supreme Court Olmstead decision. The Olmstead ruling determined states had a responsibility to provide services to help individuals with disabilities live in integrated settings (*Olmstead v. L.C.*, 1999). Protection and Advocacy successfully argued the chronic underfunding of services to help individuals with SMI live outside of institutional settings violated Olmstead. As a result, starting in 2013, KY funded the implementation of ACT teams across the state. Funders were also provided with monies for other recommended EBPs such as supported employment, crisis services, and peer services but the bulk of funds were devoted to the ACT teams. The ACT model was new to most CMHCs in the state and teams were formed quickly in order to meet the requirements of the settlement agreement. The KY public mental health system had little experience or workforce knowledge to support team development and mental health workers were responsible for learning an innovative, nontraditional treatment approach in a short amount of time. Exploring how the ACT model was communicated to CMHC staff during these early years of implementation, and how the requirements of the settlement agreement impacted the implementation process is important because understanding leads to improved processes that speed the provision of research-informed services for individuals with psychiatric disabilities.

Conceptual Framework

Successful implementation of an EBP into a health system results in substantial changes in several areas: adult professional behavior, organizational structures and

culture, and relationships between consumers, stakeholders, and systems (Fixen et al., 2005). The field of implementation science developed as researchers searched for a faster way to translate researcher knowledge about effective practices to those looking to provide evidence-based services. Implementation science has the potential to decrease the gap between EBPs and their availability in public mental health systems (Proctor et al., 2009). Full understanding of EBP implementation requires the consideration of multiple components involved in system-wide change. One framework for understanding the implementation process is the Consolidated Framework for Implementation Research (CFIR).

Consolidated Framework for Implementation Research

The CFIR is a tool derived from 19 theories about the promotion of implementation in health services research across multiple contexts (Damschroder et al., 2009). It identifies five major domains of implementation with each domain consisting of multiple constructs that influence, positively or negatively, the implementation of an EBP. It is the framework most applicable to this study because it addresses the communication of ACT knowledge across multiple levels of the mental healthcare system while also considering how those levels interact with each other to promote or impede information transmission. The framework has been used to guide data collection, coding, analysis, and reporting in implementation research (Kirk et al., 2016). CFIR has also been used to study statewide Supported Employment, a SMI EBP, implementation (Ruffolo & Capobianco, 2012).

The CFIR domains most relevant to this dissertation are the intervention characteristics, outer settings, inner settings, and process of implementation. Intervention characteristics are specific to each EBP and involve program aspects that impact adoption, such as program adaptability. In the outer setting, the constructs of external policies and incentives relate to the government mandated aspect of ACT implementation in Kentucky. Another important domain, the inner setting, speaks to the construct of culture that impacts implementation through its effects on organizations and individual employees responsible for providing an innovative service. The final domain relevant to this study is the process of implementation, specifically the engaging construct which involves the education and training necessary to communicate information about a new EBP to those responsible for implementation.

Theories of Implementation

In addition to ideas from CFIR, EBP implementation is also heavily influenced by concepts and ideas from theories about how new practices spread across systems (Damschroder et al., 2009; Procter et al., 2009). One theory often referenced by those researching EBPs is Roger's diffusion of innovations theory (Brooks et al., 2011; Leathers et al., 2016; Shen & Snowden, 2014). Roger defines diffusion as "the process by which (1) an *innovation* (2) is *communicated* through certain channels (3) *over time* (4) among the members of a *social system*" (2003, p. 11, emphasis in original). Rogers identifies five stages a decision-making unit goes through when choosing a new innovation. These stages range from learning about the existence of a new practice to eventual full implementation. The decision-making unit is categorized into five adopter

categories based on when the decision to change is made relative to the introduction of an innovation to a system: innovators, early adopters, early majority, late majority, or laggards. Diffusions of innovation theory has been used to analyze a diabetes prevention program for SMI (Schneider et al., 2011) as well as innovations in the British healthcare system (Brooks et al., 2011). It has also been combined with other theories of dissemination, transportability, and implementation to create a conceptual model of mental health EBP implementation (Proctor et al., 2009).

In terms of statewide adoption, the state of KY falls in the early majority adopter category because, at the time ACT was implemented in the entire state, less than half of the United States currently offer statewide ACT services (NASMHPD Research Institute, 2015; Rogers, 2003). Early majority adopters represent over one-third of adopters and these groups may ponder an innovation for a long time before adoption (Rogers, 2003). However, if KY is categorized in terms of when the ACT model was first implemented in the state, it would rank in the last quarter of states among the late majority. Rogers (2003) identified five variables that determine the rate of adoption of an innovation: perceived attributes of innovation, type of innovation-decision, communication channels, nature of the social system, and extent of change agents' promotion efforts. The decision to adopt an innovation is based, in part, on the amount of risk perceived to be involved (Panzano & Roth, 2006). There are benefits to delaying the decision to implement as later adopters have the opportunity to learn from early adopters' research on clinical efficacy, cost-effectiveness, and policy (Shen & Snowden, 2014).

Kentucky is an unusual case in that ACT implementation was the result of government mandate, not a natural diffusion process. The diffusion of ACT services would have probably looked different in the absence of the legal requirement to provide these services. Though KY did not follow the typical diffusion process for deciding whether or not to adopt ACT, other aspects of implementation can be examined using the core concepts of the theory. Diffusion of innovation theory provides a lens in the present study to understand the process of how knowledge of the ACT model was communicated to CMHCs in KY's public mental health system over time. Emphasis on perceived attributes of an innovation, communication channels, and the nature of a social system all speak to the process of dissemination of ACT knowledge to CMHC administrators and clinical staff, as well as the willingness of staff to absorb and utilize that knowledge in the provision of services.

In addition to diffusions of innovation theory, organizational theory, also presents a lens through which to look at EBP implementation for individuals with SMI. Organizational theory is not one, overarching theory but a multitude of theories and perspectives drawn from a collection of disciplines that include economics, social psychology, cultural studies, and political science, among others. According to the theory, an organization consists of six inter-related concepts: physical structure, technology, social structure, culture, and the environment in which the first four concepts exist (Hatch & Cunliffe, 2006). A final concept, power, is infused into each of the other five concepts. Organizational change is the result of numerous factors at multiple levels of an organizations such as individual, leadership, financial, cultural, and political. (Buchanan et al., 2005).

An organization's climate is created by its members' shared perceptions of the psychological impact of their work environment on their own wellness and functioning. Organizational climate has been associated with a number of issues that impact functioning such as staff turnover in CMHCs and clinician attitudes toward EBPs (Aarons & Sawitzky, 2006; Glisson & Williams, 2015). Staff turnover negatively impacts EBP implementation as the need to hire and train new employees consumes a large amount of resources. Frequent changes in staff contribute to poor morale, weaker teams, and inconsistent client services. Turnover in public mental health agencies is a serious problem with attrition being linked to high stress environment, low pay, and lack of support for staff (Aarons & Sawitzky, 2006).

Understanding the impact of a CMHC's climate on the facilitation or impediment of EBP implementation is important when exploring the diffusion of ACT knowledge across the state. Organizational climate impacts how receptive an organization, and its staff, will be to innovation. These concepts are particularly important when the decision to start ACT services was not one that arose organically from identified local treatment needs, but one that was forced on CMHC by their funders, regardless of a CMHC's preparedness or capacity to provide ACT. Concepts from implementation science, diffusion of innovation theory, and organizational theory were used as sensitizing concepts (Charmaz, 2016) throughout the design, data collection, and data analysis of this dissertation.

Research Purposes and Dissertation Overview

Given the importance of providing easily accessible SMI EBPs and the challenges mental health systems face in creating research-informed systems of care, this dissertation focuses on the mandated statewide implementation of ACT in KY. In a short amount of time, CMHCs in the state were introduced to and expected to create ACT services. The KY Olmstead settlement agreement, formally known as the Interim Settlement Agreement (ISA), resulted in a radical overhaul of SMI services. This dissertation aims to understand the factors that led to the forced creation of ACT teams, the communication of the ACT model to the CMHC administrators and program supervisors who were tasked with delivering this new service, and the impact of mandating program creation on implementation.

The dissertation encompasses three manuscripts that explore the development of the KY public mental health systems and SMI services post-deinstitutionalization as well as the experiences of individuals involved in mandated ACT program creation. The first paper (Chapter 2), *Social and Political Factors Underlying the Need for Mandated Evidence-Based Practices for Serious Mental Illness in Kentucky*, describes the historical, social, and political factors in KY that led to accusations of Olmstead violations and a settlement agreement to fund widespread EBPs for individuals with SMI. Using publicly available documents to examine the evolution of community-based SMI treatment services, five main issues were identified that contributed to the need for the ISA: 1) the de-institutionalization of psychiatric facilities, 2) underfunding of community services, 3) cycling through institutions, 4) high-profile events directing attention to the public mental

health system, and 5) contemporary understanding of recovery from SMI. These factors contributed to the threat of a lawsuit from mental health advocacy groups ultimately leading to a settlement agreement to provide statewide SMI EBPs. Findings from this paper highlight the need for governments to consider the ramifications of chronic underfunding of EBPs for individuals with disabilities as the Olmstead decision has been, and continues to be, used to force administrations to fund evidence-based services.

Using the experiences of individuals involved in implementation, the second paper (Chapter 3), *Experiences with Assertive Community Treatment Knowledge Communication during Statewide Program Implementation*, explores the communication of the ACT model during early program creation. Individual interviews, ACT training materials, and reports on implementation progress were used to identify themes related to how the ACT model was understood by those responsible for program creation. Individuals involved in statewide ACT implementation sought program information outside of formal training opportunities offered by the state and desired experiential learning opportunities. Data revealed that ACT supervisors wanted more training and support in managing the administrative needs of the team as well as adapting the model to best fit local population needs. Findings from this paper could inform the work of agencies looking to create ACT teams. Specifically, data suggests the benefit of providing new teams the opportunity to observe established programs and ensuring high levels of support in both understanding team dynamics and adjusting the program for agency clients.

Chapter 4, *Challenges with Mandatory Statewide Assertive Community Treatment in Response to an Olmstead Settlement Agreement*, delves into the impact of mandating program creation on those responsible for ACT formation. Interviews with people involved in implementation were used to discover commonalities in the effect of the settlement agreement on program development. Findings from this study revealed that the ISA required changes at each level of the public mental health system yet left little time to create the supportive infrastructure needed for effective ACT teams. Teams were expected to be functional despite lacking support structures important for success. The pressure and rapid implementation timeline specified in the ISA created a mistrust and resulted in poor mental health among those responsible for ACT creation. Study results make evident the need for governments and advocacy groups involved in creating settlement agreements to allot sufficient time for planning and addressing systemic barriers to successful ACT services prior to the creation of those services in order to facilitate implementation.

Lastly, the final section, Chapter 5, presents a summary of main findings from the three manuscripts and recommendations for future ACT implementation research. Future ACT research implementation should further refine the training curriculum for ACT staff. Continued research on the impact of mandating program creation on the implementation process will be important as states grapple with Olmstead-related settlement agreements.

Subjectivity Statement

The researcher subjectivity statement outlines who the researcher is in relation to whom and what they are studying, particularly the research participants (Preissle, 2008). Qualitative researchers use reflexivity in their research to increase the dependability and credibility of their findings (Finlay, 2002; Tracy, 2010). Being upfront about one's positionality helps the reader to make their own decision about the trustworthiness of the findings. Ideally, researcher reflexivity threads its way through the entire research process as the researcher must reflect upon their own experiences and biases during each phase of the project - from design to writing up findings (Finlay, 2002).

I approach this research as an insider (Preissle, 2008) in that I am a member of the main population that I studied. After working on an ACT team in New Orleans as an addiction counselor, I returned to KY in 2014 to be the leader of a new ACT team. I struggled with what I saw among my colleagues as a lack of understanding of the model and underlying principles of ACT. The CMHC I worked for did not seem to understand the unique needs of an ACT team which resulted in a lack of administrative support as well as tangible resources needed for the team to function effectively. Ultimately, the stress of feeling unsupported and overworked led to my resignation from the agency. Burnt-out and unsure if I wanted to work directly with clients again, I made a drastic career change and returned to school for my doctorate.

My experiences on the ACT team remained at the forefront of my mind as I progressed through my doctoral program. I experienced guilt for leaving my clients and questioned my inability to continue as the ACT team leader. Was it just me? Why

couldn't I make it work? I knew there had been a lot of turnover on the KY ACT teams and began to wonder if some of my experiences and frustrations were common among those who were starting up ACT teams. I missed some of the early ACT trainings and implementation discussions because my CMHC region was the last one to hire a team leader. In particular, I wondered about the training process that CMHC staff had undergone prior to team creation. I received very little training on the ACT model itself, though this may be because it was assumed I did not need to those trainings. I am curious what it was like for administrators and team leaders who were being introduced to the model for the first time and then expected to build a program from nothing.

My insider status gave me knowledge of KY's ACT implementation and the ISA that someone not involved in the process would likely possess. This added sensitivity and authenticity to my interactions with participants. It provided me with easier access to potential participants as well as instant credibility and connection. Some participants even remembered me from my time as a team leader.

Insider status can be a double-edged sword, however. I have personal knowledge and experiences of my research topic. I am a passionate advocate for ACT teams and am proud to have provided services to vulnerable and challenging clients during my time on them. I've seen ACT teams be involved with seemingly miraculous recoveries from SMI. That being said, my experiences with some aspects of KY ACT implementation were negative. In my research I tried to be careful not to assume my own negative experiences were universal among ACT team leaders and others involved with ACT and ISA. Practically, this meant keeping my interview questions neutral and letting the conversation emerge naturally. I was also mindful about my bias during data analysis to

ensure I did not pass over participants' positive experiences in favor of experiences that more closely match my own.

Many of my challenges with early ACT implementation were shared by study participants. However, not all experiences were negative. Although not the subject of this dissertation, many of the clinicians I interviewed were proud of their time working with ACT. Several participants who had moved to different jobs stated they missed their time with the teams and the clients. There was a feeling that we had all been involved in something important. Implementation had been frustrating, confusing, and overwhelming but the goal of helping individuals with SMI integrate into the community was worth the stress. None of the participants regretted their time working with the teams. I agree. ACT was chaotic, maddening, exhausting, and some of the most important work I have done in my social work career.

Key Terms

Assertive Community Treatment (ACT): An evidence-based practice to treat individuals with serious mental illness recommended by SAMHSA to be offered in all public mental health systems (Lehman et al., 1998).

ACT Team Leader (TL): Clinical lead and supervisor of an interdisciplinary team of professionals from backgrounds such as social work, addiction treatment, rehabilitative services, vocational services, counseling, peer support, and nursing. Also responsible for monitoring and coordinating psychiatric services for up to 100 individuals with serious

mental illness. Functions as the main transmitter of program knowledge to team members through education, supervision, and monitoring quality of services (Carlson et al., 2012).

Community Mental Health Center (CMHC): A government funded organization that provides mental health and substance abuse services to a community. A system of community mental health centers was founded to facilitate the deinstitutionalization of individuals with serious mental illness from psychiatric facilities that started in the 1950s (Gold et al., 2006).

Diffusion of Innovation Theory: A theory about how an innovation is communicated over time between members of a social system. Evidence-based practices are considered innovations and typically follow expected patterns of diffusion when they spread throughout a mental health system (Rogers, 2003).

Evidence-Based Practice (EBP): A program or treatment approach that empirical research has demonstrated to be effective at treating a specific population or issue. Despite the potential to help individuals, these research findings have been historically been slow to translate into real-life services (New Freedom Commission on Mental Health, 2003).

Experiential Learning: The process of learning through reflecting on one's experience or actions.

Fidelity: A measure of how closely a team replicates the core components of an evidence-based program with the belief that close replication results in improved client outcomes. Typically uses a standardized scale. Most teams are evaluated annually though

new teams may be assessed more frequently as they are building services (Monroe-DeVita et al., 2012).

Implementation: The creation and use of a new program or innovation in a specific setting (Damschroder et al., 2009).

Implementation Monitor: An individual involved in the statewide implementation of ACT in Kentucky as a consultant or monitor of ACT development.

Implementation Science: A relatively new field of knowledge that examines how evidence-based practices are translated to health systems and seeks to improve and accelerate the transmission process (Procter et al., 2009).

Interim Settlement Agreement (ISA): A 2013 settlement agreement between the Kentucky Cabinet for Health and Family Services and Kentucky Protection and Advocacy that mandated the funding and creation of a statewide system of evidence-based practices for individuals with serious mental illness (Brewer, 2014a).

Olmstead vs. L.C.: 1999 US Supreme Court case that determined states were responsible for providing adequate services to support individuals with disabilities with living in the most integrated setting appropriate for their needs (*Olmstead v. L.C.*, 1999).

Organizational Climate: The environment created by an organization's members shared perceptions of the psychological impact of their work environment on their own wellbeing and functioning (Glisson & Williams, 2015).

Personal Care Home (PCH): A long-term care facility, typically serving individuals with disabilities, that provides care for individuals in need of assistance beyond room and board. Typically provides meals, beds, bathrooms, personal care assistance, and assistance with medications. Does not provide rehabilitative services. (Carder et al., 2015).

Protection & Advocacy (P&A): An agency funded by the state of Kentucky that functions as an advocate for individuals with disabilities. This organization was prepared to pursue an Olmstead violation with the Department of Justice when the Kentucky Cabinet for Health and Family Services agreed to the terms of the Interim Settlement Agreement (P&A, 2012a).

Serious Mental Illness: A Diagnostic and Statistical Manual V diagnosis, most commonly psychotic disorders and mood disorders, that is accompanied by functional deficits that have persisted over a period of time (ISMICC, 2017).

Technical Assistance Center (TAC): An organization that provides expertise, training, consultation, and implementation assistance for evidence-based practices (Salyers et al., 2007).

Chapter 2: Social and Political Factors Underlying the Need for Mandated Evidence-based Practices for Serious Mental Illness in Kentucky¹

Abstract

The implementation of evidence-based practices in community mental health can be costly and require significant changes to service systems. Some states have been forced to provide evidence-based services to individuals with disabilities through the Supreme Court's Olmstead mandate. It is important to understand what leads to accusations of discrimination through Olmstead violations so that administrations can proactively address issues in their own systems of care to avoid similar legal action. This qualitative case study, focusing on Kentucky's public mental health system and personal care homes for individuals diagnosed with serious mental illness, examines precipitating factors of an Olmstead settlement agreement via content analysis on publicly available documents. Five main factors were identified: deinstitutionalization of psychiatric facilities, underfunding of community services, cycling between institutions, high-profile events and reports, and a modern understanding of serious mental illness. Findings suggest that policy makers should examine systems of mental health care and modify practices that result in the segregation of individuals with serious mental illness from their community.

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Introduction

For much of recent history, individuals diagnosed with serious mental illness (SMI) were kept away from their communities and forced to live in institutions such as asylums or jails. These illnesses were poorly understood and treatment primarily consisted of isolating the individual with the intent that removal from society was the only way to ensure their safety. Approximately one in 25 adults has a SMI with prevalence higher among sexual minorities, people of color, and females (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). The creation of effective antipsychotics in the 1950s provided relief from severe mental health symptoms and allowed individuals with SMI to be released from institutional settings. Unfortunately, community services were poorly funded, resulting in unmet needs in the areas of housing, employment, and substance use (Gold et al., 2006; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Supporting the integration of SMI individuals into community settings necessitates a holistic, wrap-around treatment approach that requires sufficient funding and resources often lacking in public mental health systems.

As individuals with SMI were discharged from institutions, a greater understanding of SMI treatment needs prompted the development evidence-based services to support this population. Evidence-based practices (EBPs) promote recovery by giving treatment providers tools to help individuals with SMI cope with disabling symptoms so they can function in daily life (Carpinello et al., 2002). A 2002 national evaluation urged the creation of an integrated, recovery-oriented mental health system guided by EBPs (New Freedom Commission on Mental Health, 2003).

Community mental health centers (CMHCs) are the largest providers of mental health services in the United States, providing low-cost or free services to anyone in need of mental health treatment (SAMHSA, 2013). Many CMHCs have been slow to change their services and have resisted modifying service models to accommodate more effective SMI EBPs (Gioia & Dziadoza, 2008). Hesitancy about feasibility, cost, and acceptability of new services can deter a CMHC from trying a new EBP (Isett et al., 2007). The implementation of some EBPs can be costly and necessitate significant changes to the status quo of SMI treatment systems (Gold et al., 2006). In their model of mental health innovation implementation, Brooks et al. (2011) posit that paternalism in the mental health system as well as concerns about potential harm caused mental health services to become risk averse. In that context, new EBPs can be viewed as a systemic threat to policies and procedures developed to minimize risk. Some states that have been reluctant to offer EBPs to SMI populations have been forced to develop them through the nondiscrimination clause of the Americans with Disabilities Act (ADA) (National Association of State Mental Health Program Directors [NASMHPD], 2015). Kentucky (KY) is one of those states.

Kentucky was forced into the provision of statewide EBPs after a client advocacy group threatened to sue the state due to the lack of services to help individuals with SMI live outside of institutional settings. The threat of lawsuit was enough pressure for KY to fund the implementation of multiple EBPs across the state starting in late 2013. This qualitative case study aims to identify and describe the factors that led to the need for these EBPs to be mandated.

Literature Review

In order to understand how treatment services in KY became so inadequate as to require legal intervention to bring them to an acceptable level, it is first necessary to understand the history of community-based mental health services and development of research-informed practices for the SMI population. As individuals diagnosed with psychiatric disabilities were discharged from facilities, the lack of support services contributed to homelessness and housing instability (SAMHSA, 2015). Individuals with SMI discharged without stable housing face poorer treatment outcomes and are more likely to experience re-hospitalization (SAMHSA, 2015). Individuals who lacked housing or necessary community supports were often held in psychiatric facilities.

The ADA (1990) determined that individuals with disabilities have the right to reasonable accommodations that will allow them to fully engage in the same activities and opportunities as individuals without disabilities. The Supreme Court's *Olmstead* decision stated individuals could not be held in institutions against their will due to a lack of housing as it amounted to discrimination based on their psychiatric disability. Furthermore, the court determined states must provide support services to allow individuals to live in the most integrated setting for their needs (*Olmstead v. L.C.*, 1999).

Though legally mandating the provision of community-based support services for individuals with SMI was a step in the right direction, it was left up to individual states to determine the best way to support SMI populations. Some states provided little funding for public mental health services and SMI treatment professionals had few choices when trying to find housing or other crucial services. Individuals with SMI who lacked traditional housing or had higher support needs were often housed in institution-like

settings instead of being provided with evidence-based services to support them in the community. Institutional housing is isolated from society and restricts resident choice in roommate, food, and opportunities to pursue community activities (NASMHPD, 2014)

In response, the United States Department of Justice (DOJ) and SMI advocacy organizations have sued states for Olmstead violations based on the chronic underfunding of public mental health services which contributed to individuals with SMI being segregated in institutional settings. The DOJ has been involved with SMI Olmstead violations in New Hampshire, New York, Connecticut, Delaware, and North Carolina because these states failed to provide appropriate supportive services to enable residents to live in integrated settings (NASMHPD, 2014). Other states, like KY, have agreed to settlement agreements with advocacy groups in the hope of avoiding DOJ involvement and have mandated the widespread implementation of EBPs to support individuals diagnosed with SMI.

Public Mental Health Funding

States with large rural areas typically struggle for money during times of economic downturn as smaller populations produce less tax revenue for public services. Out of all 50 states, KY ranked 45th in mental health expenditure per capita (SAMHSA, 2013). Poor funding of mental health services in KY contributed to a lack of evidence-based services for individuals with SMI outside of inpatient psychiatric settings. Kentucky residents with high support needs were often placed in personal care homes (PCHs) when services that would enable them to live independently were unavailable. A PCH is a long-term care facility licensed by the state that offers services such as staff supervision, personal care services, and recreational activities (Carder et al., 2015). Low-

income individuals in these facilities receive a state supplement to pay for full room and care. As most individuals with SMI are also considered low-income, the term PCH will be used to refer to those PCHs that lodge low-income clients and rely heavily on state supplemental funds for operation.

Department of Justice guidelines warn that a public entity may violate the ADA's integration through funding decisions, service system design, or programing choice that results in the segregations of individuals with disabilities (NASMHPD, 2015). In 2013, Kentucky's Protection and Advocacy agency (P&A) prepared to file a lawsuit on behalf of individuals with psychiatric disabilities for violating the ADA non-discrimination mandate. They argued KY's decades-long practice of housing individuals with SMI in PCHs disregarded the Olmstead ruling because once placed in a PCH, there were no services to assist individuals with transition to the community. To avoid a lawsuit, the state signed the Interim Settlement Agreement (ISA) to create services to help individuals diagnosed with SMI live in the most integrated setting appropriate for their needs. This study will explore the factors and conditions present in KY that led to the creation of the ISA. It is important to understand these factors so that policy makers can be proactive in modifying SMI services to avoid ADA violations.

Methods

This study used documentary data to identify and understand the historical development of KY's public mental health system and the elements present in the state that led to the signing of the ISA in 2013. According to Coffey (2014), "if we wish to understand how organizations and social settings operate and how people work with/in

them, then it makes sense to consider social actors' various activities as authors and audience of documents" (p. 368). The use of publicly available documents allowed me to explore more than the factual evidence contained within the documents, it also allowed me to examine the motivation of the authors and how they intended their documents to be used. Most of the documents used in this study were official reports from a variety of government entities, each with its own agenda and desire to shape the opinion of their audience.

Sample Selection

In qualitative research, samples are chosen to serve an investigative purpose rather than to be statistically representative of a population (Carter & Little, 2007). Purposive sampling was used to identify publicly available documents related to PCHs, the development of the ISA, and mental health services in Kentucky prior to the start of the ISA in 2013. Data sources included reports on PCHs, reports from an independent reviewer of the ISA, newspaper articles, a community advocacy blog, information from government agencies, and the settlement agreement. A full list of documents and sources is provided in Table 2.1. Documents were excluded if they were written about the mental health system *after* the signing of the ISA or if they were not relevant to service aspects of PCHs such as building regulations. Some documents were written after the signing of the ISA but were included because they contained information about the KY mental health system prior to the settlement agreement.

Table 2.1 Documentary Sources of Factors Leading to ISA in Study One

Document	Source
Advocates for Community Options (ACO) About Us	Advocates for Community Options
ACO Blog Post February 25, 2013	Advocates for Community Options
ACO Case Statement - July 2012	Advocates for Community Options
ACO Letter to KY Cabinet for Health and Family Services - July 18, 2012	Advocates for Community Options
ACO Letter to KY Senate and House of Representatives - March 5, 2012	Advocates for Community Options
Independent Review Report 1 – March 30, 2014	ISA Independent Reviewer
Independent Reviewer Report 2 – June 30, 2014	ISA Independent Reviewer
Independent Reviewer Report 3 – October 14, 2014	ISA Independent Reviewer
Independent Reviewer Report 4 – January 20, 2015	ISA Independent Reviewer
Interim Settlement Agreement	KY Cabinet for Health and Family Services
Kentucky Revised Statutes Rights of residents – Duties of facilities – Actions	KY General Assembly
921 Kentucky Administrative Regulations 2:015 Supplemental programs for persons who are aged, blind, or have a disability	KY Cabinet for Health and Family Services
P&A Press Release August 16, 2013	KY Protection & Advocacy
Personal Care Home: An Investigative Report of Breckinridge Manor	KY Protection & Advocacy
Personal Care Home: An Investigative Report of Gainsville Manor	KY Protection & Advocacy
Personal Care Home: An Investigative Report of Golden Years Rest Home	KY Protection & Advocacy
Messner’s: What is it?	KY Protection & Advocacy
Personal Care Homes in Kentucky: Home or Institution?	KY Protection & Advocacy
Personal Care Homes In Kentucky: Research Report No. 438	KY Legislative Research Commission
State shuts down troubled personal care home in Letcher	Lexington Herald Leader
Former Letcher personal care home director sentence in circuit court	Lexington Herald Leader

Most documents chosen for this study were produced by entities of the state of KY. A state-funded advocacy organization, P&A published reports based on their interactions with residents, staff, and administrators of PCHs between the years of 2009

and 2014. These reports included interviews with PCH residents, discussions with staff and administrators, inspections of facilities, and photographs of the conditions. Another state-produced document was a 2012 KY Legislative Research Commission report on PCHs (Knowles et al., 2012). This document explored the origins and evolution of the PCH system since its inception during deinstitutionalization. Its contents are an unflinching look at the state-funded factors that created and maintained the PCH system. The final source state-funded documents were produced by an independent reviewer hired to evaluate ISA progress. These reports were generated after the signing of the ISA but describe historical factors and barriers to EBP implementation.

In addition to reports from state entities, the sample included material from a blog maintained by a mental health advocacy group composed of organizations involved in the KY mental health system. This blog contained information about developments in the state mental health system as well as copies of correspondence with the state general assembly advocating for community options for SMI treatment. Also included in the sample were newspaper articles, press releases, and relevant KY licensing and policy regulations related to PCHs.

Documents as data have long been used in social science research (Coffey, 2014). Documents are more objective sources of data compared to interview transcripts or observation field notes and can be used to understand and make sense of social and organizational systems (Coffey, 2014; Merriam & Tisdale, 2016). Naturally occurring documents are important sources of context and history that help researchers better understand the complexities of a given topic (Ravitch & Carl, 2016). Most documents exist as naturally occurring objects, not created for the purpose of research but to speak to

the social world of the people who created them (Mogalakwe, 2009). In this study, documents were used to understand the formal and informal systems that developed across the state of KY that led to the need for a statewide mandate of EBPs through the ISA.

Data Collection

Publicly available documents were collected from online sources. Data were identified by searching state government websites and search engines. As search engines use unique algorithms to prioritize search results and these tools have the potential for bias (Merriam & Tisdale, 2016), multiple search engines were used to minimize the chance of relevant information being filtered out by algorithm. Searches were performed between June and July 2019 and search terms used included “personal care home,” “Kentucky mental health,” “community mental health Kentucky,” and “Interim settlement agreement.”

Data Analysis

Content analysis of documents produces data in the forms of excerpts, quotations, or passages that are organized by the researcher into major themes, categories, and case examples (Bowen, 2009). Qualitative content analysis is a highly systematic method that allows the researcher to mediate the risk of looking at the data only through the researcher’s own lens (Schreier, 2014). Hsieh and Shannon’s (2005) process of content analysis was used to guide the examination of the documents in this study. First, I read all data repeatedly to become familiar with the data as a whole. Next, I read data word by word to derive initial codes. Simultaneously, memoing was used to record first

impressions, initial analysis, and concepts. Initial codes were sorted into categories based on how they were related which were then used to group codes into relevant clusters. Next, I defined each category, including identifying exemplars of each code and category included from the data. These categories and definitions were used to present the factors present in the state of KY that necessitated the ISA.

Documents were downloaded from the internet and printed. I used open coding in the margins of each document. Microsoft Word was used to record codes and group them into clusters and categories. Writing and reporting are part of the analytic process in qualitative research (Carter & Little, 2007). My thoughts and interpretations about the factors preceding the ISA were further consolidated by memoing as well as the writing process itself.

Results

The factors in KY that led to the need for mandated statewide SMI EBPs have been present for decades. Not surprisingly, *de-institutionalization of psychiatric hospitals* in the middle of the 20th century caused a massive reorganization of KY's mental health system. Legislators made difficult choices about public treatment and supportive services for individuals with SMI transitioning out of psychiatric institutions. KY's legislators did not fully fund community mental health services and financing that could have gone to CMHCs to develop EBPs was instead directed to PCHs. As a result of *underfunding community services*, individuals with SMI in KY *moved from institution to institution*, sometimes experiencing incarceration or homelessness between institutional stays. Starting in the late 2000s, a series of *high-profile events and reports* called public and

legislative attention to the institution-like conditions and potential danger of the PCH system of care for individuals with disabilities. Pressure from advocates in the community as well as a *modern understanding of SMI* rehabilitative services led the state to acknowledge their neglected duty to provide comprehensive, accessible, community-based support services for individuals with SMI. By signing the ISA, the state of KY committed to building a strong system of SMI care.

Choices during KY De-institutionalization

Document analysis revealed that the earliest factor that led KY to mandate the implementation of statewide EBPs for SMI was the *de-institutionalization of individuals from psychiatric institutions* in the 1950s and 1960s, which changed the landscape of mental health care. In the 1960s the PCH level of care was officially established by the state with the intent of providing standardized, quality institutional care for vulnerable people such as the aged, chronically ill or infirm (Knowles et al., 2012). The PCH level of care, combined with the Supplemental Security Income (SSI) program for low-income individuals with disabilities, facilitated the discharge of thousands of residents who no longer needed care at the psychiatric hospital level but had nowhere to live (Brewer, 2014a).

Personal care homes provided housing, meals, assistance with medication self-administration, and support with basic activities of daily living. These services were paid for with a resident's SSI income plus a supplement from the state. Individuals with disabilities could also receive state supplemental payment to use for in-home caretaking, however these services were subsidized at lower rates which created an incentive for PCH placement. A March 2012 letter to the KY General Assembly from the Advocates

for Community Options (ACO) explains, “currently, public funding has a bias toward congregate living with few supports, severely limited individual choices and creating barriers to integrated living in the community” (para. 3). Kentucky subsidized supports for individuals with disabilities in PCHs at six times the rate of someone living in their own home.

The financial resources set aside to support individuals with SMI were directed to facilities that replicated the institutional conditions that de-institutionalization intended to address. PCHs mimicked aspects of institutional life with regimented schedules, crowded conditions, lack of choice in daily activities, isolation from the community, lack of privacy, and, for some, unsafe conditions (Kentucky Protection and Advocacy [KY P&A], 2012a). Concerns about the use of PCHs to provide care to individuals with psychiatric disabilities were expressed as early as a 1977 KY Legislative Research report that stated PCHs were not required to provide “psychiatric services, habilitation plans, or that other restorative treatment regimen be instituted” and amounted to “little more than a custodial arrangement” (as cited in Knowles et al., 2012, p. 80). A policy created with the intention of protecting individuals with SMI came to be seen as preventing them from recovering from their illness. According to the KY Independent Reviewer, PCHs reflect “an antiquated, discriminatory system for persons with serious mental illness who have not had options available to them for integrated housing and support services” (Brewer, 2014b, p.3). PCHs did not provide skills training or recovery support that would allow someone accustomed to an institutional environment to transition to a more independent setting (Brewer, 2014a; Knowles et al., 2012; KY P&A, 2012a,)

Underfunding Community Services

A second factor present in KY that contributed to the need for the ISA was the *underfunding of community SMI services*. Funding to support SMI individuals was directed to PCHs instead of CMHCs or other community-based services. Because of inadequate treatment and support, SMI individuals in KY experienced increased rates of crisis, homelessness, and involvement with the criminal justice system. As a result of chronic underfunding, KY CMHCs were unable to develop robust systems of care for individuals with SMI (ACO, 2012b). Even though it is less expensive to provide an individual with intense community-based supports than to pay for that person to stay in an institution (North Carolina Department of Health and Human Services, 2007), recommended SMI EBPs such as supported housing, assertive community treatment, and peer services were not available to the majority of individuals.

In addition to insufficient general funds being provided to CMHCs to develop SMI EBPs, KY lacked alternate payer sources for the implementation of evidence-based services. While Medicaid in some states covered community support services for individuals with SMI, historically KY Medicaid did not reimburse for these services. In a letter to the KY Cabinet for Health and Family Services, the ACO identified “a failure to cover proven community-based interventions for people with psychiatric disabilities in its Medicaid State Plan” (2012b, p. 2) as one of the ways the KY mental health system segregates individuals with psychiatric disabilities in institutional settings. Prior to the ISA, the 2012 KY General Assembly appropriated funds to Medicaid for the purposes of creating a more comprehensive system of care. However, this plan intended to serve 400

individuals, leaving thousands of citizens with SMI without access to adequate support services (ACO, 2012b).

The absence of a continuum of care placed additional strain on individuals living in rural areas, which sometimes lacked basic psychiatric services. At times rural residents were unable to access a psychiatrist for medication management as CMHCs experienced provider turnover and funding decreases (Knowles et al, 2012). Often the only in-home support service available to individuals with SMI was targeted case management, which was inadequate in providing the range of supports needed for individuals to be successful in the community (Brewer, 2015)

In addition to limited treatment options, individuals with SMI lacked access to affordable housing. Access to safe, affordable housing is integral to SMI recovery. Many individuals with SMI receive SSI, less than \$800 per month, as their sole source of income. Not surprisingly, this is often insufficient to meet basic food, housing, and transportation needs. Kentucky waitlists for housing assistance are long and without a rental subsidy, individuals with SMI cannot afford to live independently. Affordable housing barriers are exacerbated in rural areas which have fewer housing vouchers and landlords willing to accept vouchers. Even if an individual with SMI obtained a voucher and a willing landlord, without support services that individual was unlikely to maintain housing long-term.

The chronic underfunding of community-based treatment and support services created impediments to independent functioning and perpetuated the PCH system of care. For decades, PCHs were the only widespread housing option that offered any basic support services to individuals with SMI. However, PCHs did little to improve the

functioning of their residents. The lack of available evidence-based services resulted in many residents experiencing frequent crisis episodes leading to hospitalization, incarceration, or homelessness.

“Bouncing” Around PCHs

In addition to choices made statewide during de-institutionalization and underfunding of community services, analysis revealed the third factor precipitating the need for the ISA was the individuals *bouncing between institutional settings*. In the absence of mental health crises and support services, many SMI individuals fell into a cycle in which they traversed between psychiatric facilities, jails, homelessness, and personal care homes (KY P&A, 2012a). Individuals without community support services experienced crisis episodes that led to psychiatric hospitalizations. Once hospitalized, individuals were at risk of losing their housing from events that occurred during crisis or because they missed rent payments while institutionalized. To further complicate matters, after the Olmstead ruling in 1999, hospitals could not prevent discharge based solely on a lack of appropriate housing. According to the Legislative Research Commission report “in the current system of care... the only alternative for many supplement PCH residents is homelessness, interrupted from time to time by involuntary hospitalization, or time in jail.” (Knowles et al., 2012, p. 11).

Though psychiatric facilities understood the importance of stable housing to an individual’s recovery, few resources were devoted solely to the task of locating new housing for patients. Hospital discharge planners lacked options for post-hospital placement. Once an individual no longer met criteria for hospitalization, they legally had to be discharged. Patients were typically offered the choice between discharge to a

homeless shelter or a PCH. Understandably, when offered the choice between a shelter and a facility that promised to provide housing, medication, and food, many individuals opted for PCHs.

There was no standardized assessment used to determine which individuals were appropriate for PCH placement. PCH licensing requirements instructed PCHs to accept those individuals whose needs they could meet, without specifying what needs were appropriate to be met with a PCH level of care. Some PCHs accepted individuals with higher care needs than they could realistically provide (Knowles et al., 2012).

Employment requirements gave little guidance on appropriate levels of staffing, and only one awake staff was required for each floor of a PCH. One PCH reported having 60 residents in a one-story building, meaning that the PCH could provide only one staff for the entire PCH and be within licensing guidelines (Knowles et al., 2012).

Once an individual had been placed at a PCH, the PCH was responsible for finding alternative arrangements if they could no longer meet a resident's needs. However, there were few alternative housing arrangements available to PCHs unless a resident met requirements for a nursing home. The simplest way for a PCH to discharge an individual who they could not take care of was to wait for the individual to experience a crisis that led to a psychiatric hospitalization. Documents revealed PCH administrators admitting to taking advantage of hospitalizations to discharge residents who were too high need (Knowles et al., 2012). Once discharged from their PCH during a hospitalization, individuals were again faced with the choice between homelessness or a different PCH. Some jails also arranged for incarcerated individuals with SMI to live in

PCHs once they were released, again giving individuals the impossible choice between homelessness and a PCH.

Sometimes a PCH was proposed as a temporary solution where an individual could continue to regain stability following a crisis episode before transitioning to the community. However, the PCH system was not set up to facilitate this transition. Individuals with SMI benefit from rehabilitation services to develop skills necessary to function in the community, yet these opportunities were lacking at PCHs. PCHs were not, by regulation, required to assist residents with increasing daily living skills. In fact, one PCH feared allowing residents to engage in practicing daily living skills would undermine the PCH's funding or go against regulation (Knowles et al., 2012). Some PCHs went so far as prohibiting residents from doing their own cooking, laundry, and cleaning of their rooms (KY P&A, 2012a). The rural location of PCHs further complicated attempts to leave because a lack of transportation prevented residents from accessing the community to explore housing options.

Also preventing discharge was the financial situation of low-income residents. When an individual entered a PCH they paid almost all their monthly income to the PCH. Residents were left \$60 in spending money each month for personal needs. Residents used this money for over-the-counter medications, clothing, transportation, and other personal expenses. Most residents ran out of money before the end of the month (Knowles et al., 2012). Even if a resident saved all of their monthly allowance, it would take years to save enough for start-up expenses on an apartment. This created a financial barrier to SMI individuals wanting to transition out of PCHs.

Another element that made it challenging for individuals to leave PCHs was the

state system of public and private guardians. Almost half of PCH residents did not have the legal right to decide what living situation was best for them (KY P&A, 2012a). When their wards were discharged from psychiatric hospitals or other institutions, many guardians chose PCHs as a safer housing situation than homelessness. Guardians were unwilling to risk permitting individuals to live in the community without appropriate support services. Some guardians were so fearful of their wards being in the community they authorized restrictions preventing their residents from leaving the premises. One state guardian approved the use of ankle monitors to track wards while another instructed PCH staff to confiscate the shoes of the wards to prevent them from leaving the facility. These guardians expressed the sincere belief that they were acting in the best interest of their wards by keeping them in a facility where they could be monitored (KY P&A, 2013).

The PCH system of care in KY created instability and impeded the recovery of individuals with SMI for decades. PCH residents lacked treatment and services to help them improve or maintain their functioning. Individuals jumped from institution to institution, never staying in one facility long enough to make substantial gains in their ability to care for themselves. Neither the hospitals, jails, shelters, nor PCHs were equipped to provide the rehabilitative services needed to promote long-term recovery. Once an individual entered a PCH, a system of financial and service barriers made system difficult. Starting in 2007, several events brought these flaws in the PCH system to the notice of the public and legislators.

High Profile Events

Another factor that contributed to the ISA was a *series of high-profile events and reports* across Kentucky highlighting concerns with the PCH system of care. In 2007 and 2011, PCH residents died after wandering away from their facility. The death of the resident in a 2011 led to the passing of “Larry’s Law” which mandated individuals be assessed by a qualified mental health professional prior to admission to a PCH. The resident who inspired the law was diagnosed with a brain injury in addition to a SMI and was likely in need of a higher level of care. Larry’s Law was intended to ensure that PCHs did not admit residents whose needs they were unable to meet (Lowery, 2012).

In 2011, the state shut down a PCH after, over the course of many years, numerous citations and deficiencies were found, yet left unaddressed. Between 2007 and 2010 the PCH was cited for not administering insulin correctly, having an expired food supply, failing to ensure residents were protected from potential abuse, and failing to ensure enough staff were present to provide supervision to residents (KY P&A, 2012b). Residents also made multiple allegations to state agencies of abuse, rights violations, and financial exploitation (KY P&A, 2012b). The PCH owner was convicted of felony theft, exploitation, and theft of Social Security funds after using a resident’s funds to purchase multiple vehicles and pay personal mortgages (Spears, 2012a). The owner turned over administration of the PCH to his grandson, who was later convicted of multiple felonies after bribing a witness, tampering with a witness, and theft. Ultimately, the state’s Attorney General requested a restraining order against the PCH administrators, and a receiver was appointed to care for the PCH (KY P&A, 2013).

Starting in 2012, P&A released a series of in-depth reports on KY's PCHs that highlighted crowded environments, insufficient oversight, isolation of individuals with psychiatric disabilities, lack of basic personal rights, and warehousing of individual with SMI in institution-like conditions (KY P&A, 2012a; KY P&A, 2012b; KY P&A, 2013a; KY P&A, 2013b). The P&A reports documented the regimented, institutional nature of the PCH system of care as well as the general underfunding of the mental healthcare system. The majority of PCHs were located in rural areas of the state without access to community resources that could have assisted residents with their recovery.

Many PCHs were repurposed buildings that had previously been used as motels or medical facilities. PCHs contained used furniture and materials what were institutional-looking and the overall appearance of the facilities made it clear it the purpose was purely function, and not home (KY P&A, 2012a). The P&A reports included photographs of facilities that were old, in disrepair, and sometimes unhygienic. The reports highlighted the revolving door between psychiatric hospitals and PCHs as well as the barriers that prevented an individual from leaving the PCH system. They emphasized the desire of some residents to leave the PCH but felt there was nowhere else for them to go.

As the P&A reports were being released, an advocacy group composed of mental health stakeholders across the state, including P&A, sent a series of letters and case statements to administrators and committees in the state government. These letters detailed problems with the state's public mental health system and were warnings to the administration that they were in violation of Olmstead (ACO, 2012a; ACO, 2012b). Around the same time, a state-sponsored report on PCHs was presented to the Program Review and Investigations Committee in the state government. Though this report was

more conservative in its financial recommendations for system-wide changes, it supported the development of a broader spectrum of community-based SMI support services. This report highlighted pilot programs across the state providing small-scale support services that were effective in preventing institutionalization. It was clear that individuals throughout the mental health system recognized system-wide change was long-overdue and it was time to act.

Modern Understanding of SMI

The understanding of SMI treatment and recovery evolved in the decades after the establishment of the PCH system of care, and document analysis indicates this was the final factor contributing to the need for the ISA to mandate EBP implementation. Effective medications decreased the burden of symptoms experienced by individuals with SMI. As symptom burden decreased, individuals were able to focus more energy on developing the skills to function as a part of their community. With treatment professionals no longer concentrated exclusively on symptom reduction, evidence-based treatments were created to provide individuals with the supports needed to be successful outside of regimented, institutional settings (Knowles, et al., 2012). As explained in the July 2012 Case Statement sent to the KY General Assembly by the ACO:

Over the past four decades, the concept of ‘recovery’ has replaced notions that mental illness is chronic, life-long, and debilitating. Extensive research, declining numbers of adult hospital beds, and abundant personal experiences have more recently shown that people with mental illnesses can and do recovery to live, work, learn, and fully participate in our communities” (ACO, 2012b).

Though KY lacked widespread EBP implementation for individuals with SMI, providers were aware of recommended evidence-based services. Prior to the ISA, pilot programs were developed across the state to provide these services on a small-scale (ACO, 2012b). Several nonprofit agencies, primarily located in larger cities, provided supported housing (Knowles et al., 2012). KY was a recipient of SAMHSA funds to implement SMI supported employment programs as part of a research grant from Dartmouth. Some CMHCs recognized the importance of taking mental health treatment out of the office by forming community-based treatment teams modeled after Assertive Community Treatment teams. Many of these pilot programs were successful in helping individuals with SMI integrate into the community, but without greater changes within the mental health system, it was not possible to scale up programs to meet the needs of the SMI population (ACO, 2012b).

As attitudes and beliefs about recovery from SMI evolved, so did expectations of basic rights of individuals with psychiatric disabilities. Kentucky was one of several states pressured into developing a continuum of support services to allow individuals with psychiatric disabilities to function in the community (Brewer, 2014a). The letters from ACO as well as the reports from P&A were warnings to the state that it had violated Olmstead by financially creating and perpetuating the PCH system of care. Ultimately, KY chose a settlement agreement over a potential DOJ consent decree, which would be costly and allow the state less influence on the process. In August 2013, KY signed the ISA to fund a system of mental health services that would support individuals with SMI who had been in PCHs to transition into the community.

Discussion

The purpose of this study was to learn more about the factors present in KY that led to accusations of Olmstead violations which resulted in a settlement agreement requiring the provision of SMI EBPs. Five factors were identified through an analysis of publicly available documents related to the KY mental health system and PCHs used to house individuals with SMI: 1) de-institutionalization of psychiatric hospitals, 2) underfunding of community mental health services, 3) cycling through multiple institutions, 4) high-profile events and reports, and 5) modern understanding of SMI.

The first factor contributing to the need for the ISA is the de-institutionalization of psychiatric facilities that began in the 1950's. To facilitate the transition of individuals from psychiatric facilities, KY shifted monies from in-patient funds to develop a system of personal care homes to house individuals with SMI. In providing state supplements for low-income individuals in PCHs, the state incentivized the use of PCHs. The DOJ warns states that they may violate the ADA's integration mandate through funding choices and service designs that segregate individuals with SMI (NASMHPD, 2015). In providing financial support for PCHs, the state violated the ADA. A funding decision that, in its inception during the 1970s, intended to provide care for individuals with psychiatric disabilities came to be a violation of their basic rights.

The second issue related to ISA was the chronic underfunding of community health services. Unfortunately, after de-institutionalization, community services were poorly funded, leaving individuals with SMI with unmet needs in the areas of housing, employment, and substance abuse (Gold, et al., 2006; Lee et al., 2016; SAMHSA, 2015). Like many other states, KY did not fully fund its public mental health system and ranked

45th out of all 50 states in mental health expenditures per capita (SAMHSA, 2013). Hesitation about feasibility, cost, and acceptability of new services can deter a CMHC from trying a new EBP (Isett et al., 2007). Kentucky CMHCs were unwilling to attempt large-scale EBP implementation due to insufficient resources and lack of supportive infrastructure within the mental health system.

A third element present in the KY mental health system was the cycling of individuals with SMI between institutional settings such as psychiatric hospitals, PCHs, and jails. Without adequate funding, CMHCs are ill-equipped to handle the intense needs of the population (Gold et al., 2003). Individuals with SMI who are discharged without stable housing face poorer treatment outcomes and are more likely to experience re-hospitalization within a short time (SAMHSA, 2015). The only widespread SMI housing option in KY was PCHs, but they were unprepared to support the population and were not stable housing for most residents. Furthermore, the KY public mental health system had developed to be risk averse, like many other mental health systems in the country (Brooks et al., 2011). This was reflected in state guardian hesitancy to allow individuals to leave PCHs, even for brief amounts of time. The KY CMHCs were unable to create a robust system of services to prevent individuals with SMI from experiencing frequent crisis leading to psychiatric hospitals, homeless shelters, or correctional facilities.

Another component that impacted the creation of the settlement agreement was a string of events and public reports that brought public and government attention to the PCH system of care. Institutional housing is isolated from the larger community and affords residents little choice over their daily activities such as food, meals, or community activities (NASMHPD, 2014). These were the type of conditions documented

in the public reports issued by P&A and the KY Legislative Research Commission. State legislators were also warned of Olmstead violations by a mental health advocacy group which brought further scrutiny to the use of PCHs to house low-income individuals with disabilities.

A final factor that led to the need to mandate SMI EBPs was a modern understanding of SMI recovery. Research-informed practices developed to help individuals with SMI obtain independent housing, gain competitive employment, and improve quality of life (Torrey et al., 2005). They have the same rights and deserve the same opportunities as individuals without SMI (ADA, 1990). Recovery, once thought impossible, is now a normal part of living with an SMI. As understanding of the illness evolved, mental health practitioners realized it was no longer necessary to segregate or infantilize individuals with SMI. The paternalistic approach to mental health treatment had become outdated in the decades since de-institutionalization. The use of PCHs in KY to segregate this population reflected an outdated understanding of SMI and mental health advocates were right to challenge the PCH system.

Study Limitations

As with all research, findings should be considered in the context of study limitations. While the use of historical documents was appropriate given the purpose of identifying and understanding the factors leading to the signing of the ISA in 2013, these data lack first-hand experience from individuals who lived in PCHs or were otherwise involved in KY's public mental health system. Though some of the perspectives of individuals in PCHs were represented in the P&A and Independent Reviewer reports, they are second-hand accounts and do not allow for asking follow-up questions to obtain

specific details. Another limitation is that documents utilized in this study were not unbiased. Each document was written with the intent of persuading the reader to some purpose. For example, the P&A reports were written to highlight the worst of the PCH system to convince their reader that the system should be eliminated. While this does not alter the contents of these reports, the bias inherent in the documents used for this research should be acknowledged. Despite limitations, this study remains important because policy decisions made half a century ago impact our current system of mental health care. In exploring those policy choices and system development, it becomes possible for future administrations to avoid the mistakes of the past that led to the exclusion of individuals with SMI.

Conclusion

Kentucky's history of routing funding for individuals with SMI to institution-like facilities instead of community-based, research-informed treatment programs is a cautionary tale to governments considering skimping on funding for public mental health. Not only are those actions harmful to individuals with psychiatric disabilities, it is also illegal to deny them the opportunity to function as fully integrated members of their community (*Olmstead v. LC.*, 1999). In addition to the harm that is done on an individual level, those making funding decisions should be aware that if they do not willingly choose to fund effective services, the choice will likely be made for them. Now that mental health advocacy organizations have been successful in forcing the provision of appropriate services, more organizations will see the justice system as a viable way to obtain sufficient mental health funding (NASMHPD, 2014). Governments will be given no choice but to fund evidence-based services for individuals with disabilities. Ideally,

every government would recognize the importance and benefit of fully funding a robust system of mental health care. Until that day, mental health advocates can continue to use the legal system to force reluctant governments into providing services to vulnerable individuals.

Chapter 3: Experiences with Assertive Community Treatment Knowledge
Communication during Statewide Program Implementation²

Abstract

Assertive Community Treatment (ACT) is an evidence-based practice for individuals with serious mental illness recommended for implementation in public mental health systems. For systems starting ACT programs, it is important to understand how the program model is communicated to mental health practitioners. A qualitative case study was conducted on the statewide implementation of ACT in Kentucky. Semi-structured interviews with implementation participants and documents related to implementation were analyzed to explore participant experiences learning the ACT model. As a result of an accelerated implementation timeline and an ACT-naïve mental health system, team leaders took responsibility for learning the ACT model and valued experiential learning opportunities. Team leaders desired support in learning the administrative needs of team formation as well as adapting the model for local needs. Those looking to implement ACT should focus on providing opportunities to shadow established teams and provide additional training on team dynamics and model adaptation.

²To be submitted to *Community Mental Health Journal*

Introduction

Serious mental illness (SMI) impacts approximately one in 25 adults in any given year in the United States (Interdepartmental Serious Mental Illness Coordinating Committee, 2017). Though the definition of SMI varies slightly by state, the most common diagnoses are psychotic disorders and mood disorders. Individuals are considered to have an SMI when they have a qualifying diagnosis that has persisted over time along with functional deficits from that diagnosis. Individuals with SMI experiences higher rates of negative social outcomes such as homelessness, unemployment, and substance use (Substance Abuse and Mental Health Administration [SAMHSA], 2015). For much of history, individuals with SMI have been separated from their community in institutions such as jails or hospitals. However, recovery from SMI is possible and with adequate support services, individuals with SMI can live as integrated members of society.

Community-based treatment and support services developed for individuals with SMI following the de-institutionalization of psychiatric hospitals in the 1950s. Public mental health systems are recommended to provide a variety of SMI evidence-based practices (EBPs) to support individuals with living outside of institutional settings (President's New Freedom Commission on Mental Health, 2003). One of the most widely used SMI EBPs is Assertive Community Treatment (ACT), which uses an interdisciplinary team of professionals to provide intensive community-based treatment for individuals who have experienced repeated crisis episodes resulting in psychiatric hospitalizations, homelessness, and/or involvement with the criminal justice system

(Drake, 1998). For those in need of an intensive level of care, ACT has been shown to decrease hospitalizations and increase housing stability (SAMHSA, 2008).

ACT is a non-traditional approach to SMI treatment and the implementation of ACT in a public mental health system requires change at each level of the system: state, community mental health center (CMHC), and clinical staff (Bjorklund et al., 2009). Creating a new ACT team requires a retraining of existing clinical staff, or hiring of new staff, to instruct them on ACT techniques, which do not adhere to the traditional SMI treatment approach. As the expected ACT expert, the ACT team leader (TL) is the individual with greatest responsibility for training and monitoring the team (Carlson et al., 2012). It is important to understand the learning experiences of TLs so that training approaches can be improved to facilitate smoother implementation of ACT, ultimately resulting in faster provision of quality services to SMI populations.

This paper will explore the EBP educational experiences of individuals responsible for implementing ACT teams in an ACT-naive public mental health system. Given the important role of TLs in the communication of the ACT model to their team, the focus will be on the training experiences of TLs during initial implementation and their perception of training efficacy in preparing them for their role. After detailing the literature on SMI EBPs and ACT implementation challenges, this paper will describe a case study of mandated creation of ACT teams across the state of Kentucky using participant interviews and documents related to implementation with a focus on the communication of ACT knowledge to TLs.

Literature Review

In order to understand how the public mental health system in Kentucky became underfunded to the point of requiring legal intervention to mandate provision of ACT for individuals with SMI, it is first necessary to understand the history of community-based mental health services and development of research-informed practices for the SMI population. This review will examine how the deinstitutionalization of psychiatric facilities prompted the need for effective public mental health treatment which led to the diffusion of ACT services across the United States. This literature review will also explore the science of EBP implementation and learning that inform the adoption of any new practice in the mental health system.

Ongoing Institutionalization for Individuals with SMI

As individuals diagnosed with psychiatric disabilities were discharged from facilities in the 1950s, many experienced homelessness and housing instability due to a lack of support outside of institutional settings (SAMHSA, 2015). Individuals with SMI who are discharged without stable housing face poorer treatment outcomes and are more likely to experience re-hospitalization within a short time (SAMHSA, 2015). The Supreme Court's *Olmstead* decision in 1999 declared individuals could not be held against their will in the hospital because of a lack of housing. The Court also determined states were required to provide sufficient levels of services to support individuals with psychiatric disabilities in the most integrated setting for their needs (*Olmstead v. L.C.*, 1999). Following this decision, housing individuals with SMI in institutional facilities became a violation of the Americans with Disabilities Act (ADA), which prohibits discrimination based on disability.

Though this legislation was a step in the right direction in terms of legally mandating the provision of community-based support services, it was left up to individual states to determine how to support their SMI population. Some states provided little funding for public mental health leaving treatment professionals few choices when locating housing or obtaining other crucial support services. Individuals with SMI who lacked traditional housing or had higher support needs were often placed in institution-like settings instead of being provided with evidence-based services that could support them in a more independent setting (National Association of State Mental Health Program Directors [NASMHPD], 2014).

Following the Olmstead decision, the United States Department of Justice (DOJ) and SMI advocacy organizations began to sue states for ADA violations based on the chronic underfunding of public mental health services which led to individuals with SMI being segregated in institution-like settings instead of integrated into the community. At least ten states, including KY, have been sued or threatened with a lawsuit based on lack of appropriate supportive services to enable individuals with SMI to live in community settings (NASMHPD, 2014). As a result, some states opted to mandate the implementation of EBPs to support individuals with SMI.

Widespread implementation of SMI EBPs helps individuals obtain independent housing, gain competitive employment, and improve quality of life while also decreasing homelessness, hospitalizations, intrusive symptoms, and substance use (Torrey et al., 2005). Yet, there continues to be a gap between researcher knowledge of effective SMI EBPs and real-world implementation of that knowledge (Brekke et al., 2007). For example, ACT emerged as an evidence-based treatment model in the 1970s (Drake,

1998). Over 40 years later, less than half of states report statewide ACT availability (NASMHPD Research Institute, 2015). Despite the availability of EBPs, they have not been effectively implemented in the public mental health system (Freuh et al., 2009). Implementation is constrained by high turnover of clinical staff, lack of alignment of administrative rules with the needs of EBPs, general lack of resources, misaligned funding structures, and insufficient financial incentives to support implementation (Parks, 2008; Torrey et al., 2001).

Some states have chosen to implement EBPs across the entire state at one time, which presents a unique set of challenges (Bjorklund et al., 2009; Gold et al., 2003; Ruffolo & Capobianco, 2012). State mental health agencies are central to widespread EBP implementation (Isett et al., 2008). Their influence can manifest through formal policies as well as strategic efforts such as leadership and education (Becker et al., 2008; Isett et al., 2008). For instance, following the statewide implementation of trauma services for SMI, researchers identified the main challenges to implementation as: limited resources and commitment; knowledge deficits, biases and attitudes; and limited practice accountability at provider, facility, and systems levels. (Freuh et al., 2009). For effective implementation they recommended a comprehensive effort targeting each level of the public mental health system.

Assertive Community Treatment

The focus of the present study is the statewide implementation of ACT in KY. The ACT model developed directly as a result of the deinstitutionalization of psychiatric hospitals during the 1950s and 1960s. Envisioned as a community-based alternative to the hospital, the ACT intervention centers on a multidisciplinary team providing services

24-hours per day in locations chosen by clients. Clients are seen multiple times per week, even daily, based on need. Staff are cross-trained so the team can be responsive and flexible in accommodating a wide range of client needs.

ACT is shown to be efficacious in decreasing hospital use and increasing the length of time individuals diagnosed with SMI maintain independence in the community (Bond & Drake, 2015; SAMHSA, 2008). Some research, though not all, indicates ACT services result in symptom improvement, increased housing stability, and improved quality of life (Bond & Drake, 2015). ACT has also been found to decrease hospitalizations for Asian and African minorities, as well as immigrant populations (Yang et al., 2005). ACT is effective with SMI populations experiencing homelessness and has been adapted for implementation in other countries (Salyers & Bond, 2009; SAMHSA, 2008).

Between 1990 and 2003, twelve states disseminated ACT on a large scale (Gold et al., 2003). Other states implemented a scaled down version to reduce costs – however evidence suggests this should be done with caution as eliminating too many elements can result in a breakdown in teamwork and comprehensiveness of services (Gold et al., 2003). Whether as a full ACT model or an adapted one, the popularity of ACT continues to grow. By 2009, 21 states had implemented ACT services statewide and only 7 states reported not implementing ACT at all (NASMHPD Research Institute, 2015).

ACT Implementation Challenges

ACT implementation is a complex process necessitating cooperation from every level of the public mental health system. ACT services are costly in terms of money,

time, and organizational resources, therefore the failure to provide high-quality ACT services wastes large amounts of financial and human resources. Because the teams in the present study are located in a state considered rural, it is important to talk about ACT in rural areas (Davis, 2009). ACT teams in rural regions face a unique set of challenges. Remote areas often lack the resources of more densely populated areas such as public transportation, housing options, and food banks. Low client density, lack of staff, and the necessity of traveling long distances between clients (which limit the ability to make frequent face-to-face contact) present barriers for rural teams (Bond & Drake, 2015; Isett et al., 2007). One of the biggest challenges for rural teams is high turnover in staff and the difficulty of finding qualified staff (Bjorklund et al., 2009; Freuh et al., 2009).

New teams must learn to balance the core concepts of ACT with local conditions that impact services, something that developing teams struggle with (Monroe-DeVita et al., 2012; Salyers et al., 2003). The Consolidated Framework for Implementation Research (CFIR) identifies adaptability as a key aspect of EBP intervention characteristics that impact implementation (Damschroder et al., 2009). High quality training promotes high-fidelity teams as knowledgeable staff will provide services faithful to the original model (Mancini et al., 2009; Monroe-DeVita et al., 2012). A CMHC with a high-fidelity team indicates quality, effective communication flowing from trainer to team leader to staff providing ACT services. Poor staff morale and frequent staff changes are barriers to fidelity as unengaged staff have little incentive to meet fidelity standards and new staff must be taught how to provide high-fidelity services.

Another important aspect of implementation in the implementation process is the training and education of staff (Damschroder et al., 2009). Knowledge communication is

a crucial aspect of introducing any innovation to an organization, but it is particularly important for ACT implementation. ACT implementation research places heavy emphasis on the role of trainers and consultants in creating and supporting high-quality teams. Trainers must have a solid understanding of the EBP as well as the ability to apply theoretical knowledge of the practice to real-world cases in order to best guide agencies and clinicians (Torrey et al., 2005). Comprehensive EBP education for providers includes practice-based training, learning collaboratives, and the use of technical assistance centers (TACs) for expertise (Gioia & Dziadosz, 2008; Monroe-DeVita et al., 2012; Salyers et al., 2007).

The ACT TL is critical in determining the success or failure of a team (Carlson et al., 2012; Gioia & Dziadosz, 2008). The TL facilitates daily meetings to ensure client needs are met, provides guidance to staff as the clinical lead of the team, and maintains a working knowledge of each client at all times. Assertive Community Treatment TLs are one of the most important facilitators of knowledge translation during implementation through their communication with the team. They provide training and orientation to the ACT model for new staff and monitor existing staff to verify services accurately reflect the core principles of the model. ACT teams, particularly developing teams, experience high rates of turnover. This high turnover is an impediment to ACT implementation as it interrupts the transmission of knowledge from supervisor to direct-care staff (Moser et al., 2004).

Proper training and orientation of a new TL to the ACT model is necessary for the success of a new team. An important leadership task during the development of a new program is to monitor the use and outcomes of EBPs among staff to promote

implementation (Carlson et al., 2012). Without a solid understanding of the core principles of the ACT model, a TL is unable to communicate those principles to their staff and ensure high-quality services. Knowledge development should occur in a way that promotes self-efficacy and confidence in the ability to build a successful team. In addition, team leader stage of change toward model adoption influences overall implementation success (Damschroder et al., 2009). Mental health clinicians who report positive self-efficacy in the development of new EBP skills facilitate EBP adoption (Damschroder et al., 2009; Gioia & Dziadosz, 2008). Therefore, it is important to understand the experiences of TLs with learning the ACT model in order to determine the most effective method of communicating clinical and practical knowledge of ACT services.

Methods

The adoption of a new EBP requires intensive training, support, and monitoring (Mancini et al. 2009; Swain et al., 2010). The present study examined how the core principles of ACT were communicated to individuals responsible for team creation at each KY CMHC. Qualitative research was the most appropriate method for this study because qualitative research aims to understanding processes in society through the exploration of people's experiences, perceptions, and beliefs (Givens, 2016). The case study design is well suited to research where it is impossible to separate a phenomenon from its context. In the present study it is impossible to isolate the process of ACT knowledge transmission from the wider context of how it was implemented statewide. Case studies allow a researcher to explore deeper causes behind a problem and its consequences (Flyvbjerg, 2011).

A qualitative case study is most appropriate for this study because the research goal was to explore ACT implementation in a bounded system in a real-life setting. In this study, the unit of analysis is the KY public mental health system, using the individuals involved in statewide ACT implementation from the dates of the Interim Settlement Agreement (ISA), 2013 to 2016. For decades, the main source of housing for individuals with SMI was a system of personal care homes (PCHs) across the state that provided basic residential services to individuals with disabilities. Protection and Advocacy (P&A), a disability advocacy group, successfully argued that PCHs were institution-like facilities that segregated individuals with SMI, thus violating Olmstead. To avoid a lawsuit, the state of KY agreed to provide additional funds to the mental health system to move individuals with SMI out of PCHs. Focusing on implementation experiences across Kentucky will result in data with more depth and richness than focusing on a single CMHC's experiences. The case study method has been used frequently in implementation research to examine EBP implementation statewide due to the complexity of the implementation process (Brooks et al., 2011; Isett et al., 2007; Moser et al., 2004; Ruffolo & Capobianco, 2012).

The CMHCs in KY were chosen for their convenience and feasibility as a case study – practicalities that are not unimportant when selecting a research site (Ravitch & Carl, 2016). Mandated statewide ACT implementation is not a frequent occurrence so there are limited opportunities to study the phenomenon. To date only 21 states report implementing ACT statewide and not all of those experienced statewide implementation as a sudden push from the state government. It is important to acknowledge that I was involved in early KY ACT implementation as a TL and currently work in an agency

providing services to individuals with SMI. No doubt my professional work history facilitated this present study of KY ACT implementation in that I had instant credibility and connection with my participants. At best statewide ACT creation only happens every few years. Prior to KY's implementation, the previous statewide implementation effort was in North Carolina in 2012 after the DOJ and the state agreed to their own version of the ISA. The most recent example comes from a 2018 agreement between the state of Louisiana and the DOJ to expand community-based SMI services (DOJ, 2018).

Participants

Study participants included those involved with the KY public mental health system during the creation of ACT teams statewide. More specifically, they participated in the training and monitoring of ACT implementation that occurred between 2013 and 2016. This timeframe also corresponds with the period that a TAC was employed by the state to support the creation of ACT teams. The TAC provided formal ACT trainings, consultations, fidelity reviews, and general support to the CMHCs. Participants were involved in implementation at various levels of the KY public mental health system and had unique perspectives on the training provided to the CMHCs to facilitate statewide implementation. Eleven participants were recruited for this study and included state employees, CMHC program supervisors, monitors, consultants, and ACT team leaders. For confidentiality reasons, state employees, monitors, and consultants will all be referred to as implementation monitors as the small population of individuals involved in these roles during implementation makes identification by job title likely. Team leaders and CMHC supervisors will be given more specific descriptors because of the greater number

of individuals in those positions during the years of the ISA. Pseudonyms were assigned for all participants to protect participant anonymity.

Four team leaders, two CMHC supervisors, and five implementation monitors were interviewed. Participants primarily identified as female ($n = 7$) and all but one were Caucasian. All participants had obtained bachelor degrees and most held master degrees in their fields which included social work, psychology, counseling, and vocational rehabilitation. To supplement interview transcripts, additional data was gleaned from artifacts and documents related to the initial ACT training process. These documents included training slides, training information publicly available on the TAC's website, and quarterly ISA reports which contained information about implementation progress.

Data Collection

Interviews are used in qualitative research when it is not possible to observe behavior, feelings, or how a person interprets the world around them (Merriam & Tisdale, 2016). They allow the researcher to develop “holistic descriptions of perspectives, realities, experiences, and phenomena” (Ravitch & Carl, 2016, p. 147). The three-year period of interest has passed, making hearing from individuals who experienced implementation firsthand the only way to understand how information about ACT was communicated to those involved. Semi-structured interviews were used to gain understanding of the experiences of participants involved in KY ACT implementation and training. Multiple interview guides were used as the roles of participants in implementation varied. Each interview covered similar topics pertinent to ACT knowledge translation and training experiences but allowed for flexibility for the

interviewer to pursue unexpected subjects as they emerged. See Table 3.1 for sample questions for each type of participant.

Table 3.1 Sample Interview Questions from ACT Knowledge Transmission Interviews

Participant Type	Sample Interview Question
State Employees	What were some of the main training challenges you encountered when trying to support the start of multiple ACT teams at the same time?
Outside Monitor	As you were conducting your monitoring visits, what aspects of the ACT model did you feel would benefit from additional training or support?
CMHC Staff	How were you able to take your formal training knowledge, learning from your agency, the state, or the technical assistance center, and translate it into actually serving ACT clients?

Participants were recruited using the researcher’s personal connections, a list of ACT team leaders obtained from the state of Kentucky, and social media. Data were collected between August 2019 and January 2020. Participants were interviewed in-person and on the phone. Interviews were digitally recorded, and the interview length ranged from 40 to 100 minutes, with the average interview lasting 62 minutes. Interviews were transcribed using a professional transcription service, but the researcher checked completed transcripts for accuracy.

Documents relevant to ACT training were obtained from online sources as well as from participants. Quarterly ISA progress reports were found online, and ACT training materials were acquired from the technical assistance center’s website. In addition, participants provided copies of trainings received during the start of ACT implementation as well as materials participants created on their own for training purposes. Approval was

obtained from the University of Kentucky Institutional Review Board prior to commencement of research activities.

Data Analysis

Thematic analysis was used to analyze interview data which allowed the researcher to identify common ideas and topics across the interviews (Vaismoradi et al., 2013). Transcripts and documents were downloaded into Microsoft Word which was used to manage the data as well as facilitate manual coding and engagement with the data. Analyzing interview text involved several steps, the first of which was discovering themes and subthemes through the use of open coding (Ryan & Bernard, 2003). Open coding involved a close reading while documenting comments and thoughts in the margins of the transcripts. Supplemental materials (i.e. documents) were also coded. Categories and subcategories were created, and transcripts were coded a second time using these categories to clarify and expand on topics found in the data. Categories were then grouped to identify common themes in the experiences of participants with ACT implementation. Throughout the process, memos were generated to support the researcher's synthesis and understanding of the data.

Results

The present study examined the experiences of individuals responsible for developing teams with learning the core principles of ACT. While some CMHCs had experience with providing ACT-like services, most CMHCs had little to no experience supporting individuals with SMI in need of intensive services. The bulk of individuals from PCHs were expected to be supported by ACT teams, though the ISA mandated the

provision of other SMI EBPs. Due to the rushed nature of ACT implementation, expected transition timelines, and an overall lack of ACT workforce knowledge across the state, TLs had to *take responsibility for much of their own training*. They quickly determined that *seeing and doing* was the best way to understand such an innovative approach to SMI services. As their teams developed, TLs realized they needed preparation not only the clinical, but *administrative needs* of a new team. After learnings the basics of the ACT model, TLs desired support in being able to adapt that model to their *local context*. See Table 3.2 for a list of themes and corresponding quotes.

Table 3.2 Themes from Participant Experiences with ACT Knowledge Transmission

Theme	Exemplar Quote
Taking Responsibility for Learning	I had to reach out to somebody early on trying to find out if there was information available on that. There really wasn't, so that's why I had to just research it myself and put something in place for us to use. (Ally, Team Leader)
Seeing and Doing is Understanding	Coming to ACT services, it was different. So I just needed to see what it looked like. And once we had that model, like ok, what can we take from what we've seen to make this the best fit for us? (Emma, CMHC Supervisor)
Determining Administrative Needs of Successful Teams	We found out she had relapsed and that was the week she was supposed to start. It was difficult to keep that position filled, which I found out is the case for peer supports in general. It's just a difficult position. (Grace, Team Leader)
Adapting the ACT Model	It was difficult in a fairly small often rural state to implement it all over the state ...there weren't that many ACT clients in some of the more rural regions. So an ACT team of six clients isn't really an ACT team. (Ben, Implementation Monitor)

Taking Responsibility for Learning

Kentucky ACT implementation occurred on an accelerated timeframe that allowed little time for the mapping out of implementation strategy or establishing a workforce training program. The TAC hired by the state for implementation assistance

and training was unable to spend intensive time with each of the 15 new teams to guide individual team development. Individuals employed by the state to be liaisons with teams during implementation lacked expertise or practical experience with ACT, particularly during the first year of the ISA. ACT was a new program for most CMHCs and few administrators or program supervisors were equipped with resources or knowledge to support a new team.

Due to the lack of supervisors with ACT knowledge and only periodic contact with the TAC or the state for training, TLs had no choice but to take responsibility for acquisition of detailed knowledge about the ACT model. Incorporating their self-taught knowledge, they built skills and competencies via trial and error as their teams learned to provide effective ACT services. Though participants felt trainings arranged by the state or the TAC were helpful, they were seen as occurring too late or being insufficient to meet their needs.

Ally, a female team leader of a rural ACT team, spoke about her initial introduction to the ACT model as consisting of a stack of material from her supervisor, “I just felt like we were thrown into it... she gave me a big three ringed binder of information that she had gathered... It was like, ‘Ok, here it is – go do this.’” Ally and others supplemented this printed material with ACT training they found online. Dave, the TL of a rural team, expressed regret that he had done his own research online because it gave him an unrealistic idea of what ACT was supposed to be. Dave reported if he could start over, “I would not do what I did back then... I was reading how they did things in Cleveland, in Chicago, Cincinnati.” Dave felt the way ACT was described in those urban settings did not translate to rural ACT services. Hannah, an implementation monitor

concurred that obtaining knowledge online did not prepare someone to provide ACT services, “you could go online with SAMHSA, read all that, and meet a client the next day and not have a clue what to do with them.”

Team leaders took responsibility for training their team in a variety of ways. Ally created handouts with an overview of ACT and engagement strategies to guide her staff in learning to work with SMI clients. Emma, a CMHC supervisor, described the method their team created to facilitate cross-training among the different disciplines, “we tried to get each team member to present something that they were passionate about or interested in... We really had to develop a lot of our own training and education.”

Participants consistently expressed a desire for additional ACT introductory training or instruction on how to provide intense community-based services with the SMI population. There was also a feeling that the guidance provided by the state was based on theory and teams needed help translating theory into real-life. Emma, a CMHC supervisor, wanted “anything that was more structured, more formal, and based on experience and actual services.” Dave, a TL, felt unprepared to support clients accustomed to institutional life. He stated, “I think a lot of it was just textbook ideas training.... I don’t think we were misled.... I don’t think the training we had back then would go today... It’s like a newborn baby. You got to teach them.”

TLs did not feel they could fully rely on the state or the TAC to teach them what they needed to know about day-to-day practicalities of working with ACT clients. By embracing responsibility for their own learning, TLs demonstrated dedication to enhancing the skills of their growing teams. They assessed staff educational needs and customized training and supervision to address knowledge deficits among their teams.

Nevertheless, even as they acquired their own knowledge about the model, TLs were particularly interested in seeing ACT in person in order to fully understand the core ACT approach.

Seeing and Doing Is Understanding

ACT was a new EBP for the state of KY and as such there were few individuals with practical experience providing services. The unique features of the ACT model can be challenging for newcomers to conceptualize. Applying theoretical knowledge of the model to real-life client situations is facilitated by observing ACT services in person. TLs were desperate to see ACT in action and sought out opportunities for experiential learning as best they could. However, not all CMHCs were able to fulfil their team's desire to shadow a more established team. This led to some teams learning about ACT using a "trial by fire" approach.

Intensive community-based SMI treatment services were new for most ACT TLs and the transition to in-home services was challenging for some. Many participants spoke about the unpredictable nature and the lack of a "standard" type of ACT client. This made theoretical knowledge difficult to generalize to individual client interactions. Hannah, an implementation monitor, described this challenge as:

Every time you encounter a different client it's like, "Ok, now how does it work with this person or this situation, with this going on?" And you really had no one to ask...your old policies and procedures and approaches, they're not going to work.

Grace, a TL, spoke about the types of unexpected situations she encountered while providing services to such a high need population. She reported frequently facing client situations that no amount or type of training could have prepared her to handle:

There are things that you will experience on an ACT team that no one ever told you was a part of it... at 3 am in the morning talking to a drunk client who is yelling how attractive the fireman who came and rescued her out of her apartment are. Nothing prepares you for that. But it's part of the job and it's a pretty common occurrence.

Natalie, an implementation monitor, described the challenges TLs faced in trying to extrapolate ACT services from trainings, saying there was “a lot of frustration at the team lead level with, like how is this supposed to look? Because it's almost like quicksilver, you can't really describe how it's supposed to look.”

At least one CMHC made arrangements for ACT TLs and supervisors to observe an established team operating in another state. Another team made arrangements to shadow a fellow KY team. For these teams, the opportunity to see the mechanics of ACT in person was beneficial to their understanding of the model and the development of their team. One participant described her interactions with more experienced teams as “golden nuggets” that allowed her to learn about the formal protocols and practices her team lacked. In the absence of opportunities to shadow established teams, TLs had little choice but to give ACT their best effort and adapt as they learned from their mistakes. Ally describes this process of building services as, “[we did] a lot of trial and error just trying things out... we've had to make a lot of adjustments, figuring out what works for us.”

The experiences of individuals involved in statewide KY ACT implementation highlight the desire for teams and their leaders to observe the day-to-day operation of a successful ACT program to understand how to build their own team. The distinctiveness of both the ACT client and the model require teams to learn experientially to translate theoretical knowledge to real-world services. Kentucky ACT teams attempted to obtain this knowledge through shadowing and communicating with other teams both within and outside the state.

Determining Administrative Needs of Successful Teams

A third theme related to the communication of ACT knowledge is the desire for additional guidance understanding the administrative needs of a team. The interdisciplinary nature of the team is a core component that contributes to the creativity and flexibility necessary to work with high-need clients. However, the building and supervising of that team can prove challenging as styles and personalities of team members may clash. While participants acknowledged that some of the TAC training and consultation touched on the administrative needs of the team, TLs felt that administration did not get sufficient emphasis and they would have liked to have been better prepared to address challenges with team dynamics.

Dave, a TL who experienced a lot of turnover with his first team, talked at length about the challenges he encountered finding the right team members. Here is how he spoke about hiring staff:

I didn't realize how important a team concept versus actual skills. When I got my first team together, I just went for skills, their experience and everything, instead

of personality meshing. I don't know if anybody would, at the beginning, would pick up on that.

Participants frequently discussed the importance of getting team members who were a good match for ACT. Julia, a CMHC supervisor, felt the community-based aspect of the model was a deterrent to individuals with higher levels of education, stating "you're going to be hard pressed to find a therapist to go out with you at 2:00 am." Samantha, a TL, spoke about the difficulty of hiring staff who could adapt to the team, program, and clients. She explained:

It was just not ultimately a good fit because you have to be able to say "Ok, put some clothes on and let's go" versus "Oh my God." So you just kind of have to take some things in stride.

ACT was such a new program that human resource departments and TLs did not know what to look for in potential staff. KY teams experienced a high amount of staff turnover during the first three years of implementation in part because agencies did not know how to select the most appropriate staff for the needs of the team. Some personnel were a poor fit for the team approach, some were too inexperienced to handle the intensity of client needs, and others realized they could do other jobs in the CMHC for the same amount of pay but with fewer demands on their personal lives, such as long hours or providing on-call services.

Team leaders desired more guidance on putting together a collaborative multidisciplinary team that would work synergistically to care for a population with intense needs. Team leaders encountered challenges hiring experienced staff who

embraced the ACT model of service provision. Staff were prone to burnout and quickly moved on to different jobs. The lack of workforce knowledge about ACT contributed to individuals being hired who were poor fits for the job requirements which contributed to staff turnover and decreased team stability.

Adapting the ACT Model

The final theme in the learning experiences of individuals involved in implementation was a desire to customize the ACT model. The rushed nature of KY ACT implementation left little time to obtain buy-in from the individuals responsible for building the programs, which resulted in a lack of appreciation for the core tenets of the program. Many TLs felt it was necessary to make substantial alterations to the model in order to provide services that were congruent with their area needs. Rural teams particularly struggled to create services in-line with the model due to the unique challenges of providing rural mental health services.

Teams made alterations to the model while trying to retain the core components that made ACT an effective SMI EBP. Barry expressed the desire for training tailored to the needs of his team, and wished rural and urban teams had received different training. Grace, the TL of an urban team, agreed that the TAC and the state “could have given us some more specific training to our regions and areas and population needs.” Some participants wondered if the ISA could have been more flexible in what types of EBPs could have been offered in rural areas while still meeting SMI treatment needs. Ben, an implementation monitor, suggested creating ACT teams in the more populated areas and using intensive case management programs in the rural areas because “the model fit for some of the regions wasn’t great.”

Participants felt that the TAC provided high quality training and support but was limited in the ability to spend time customizing the ACT model to fit each area. Emma, a CMHC supervisor, expressed understanding about the limitations of the TAC, saying “I don’t think [they] had a locus of control around being more helpful.... they really attempted to, and did, bring a high level of education and support to us when they could.” Team leaders wanted more time with TAC staff for consultation about the individual needs of their teams. Samantha, a TL, reported the TAC staff encouraged her to reach out with problems but she would have preferred personalized feedback based on her team’s performance.

Rural ACT looks different from ACT in more populated areas and the training needs of rural and urban teams are different. TLs wanted more support in adapting the model to fit the needs of their area. Each CMHC was responsible for multiple counties (one of the larger CMHCs had one ACT team to serve up to 17 counties) and clients could be hours apart. These geographical realities made implementing statewide ACT a particular challenge as the needs of the teams varied and teams had limited assistance altering the ACT model to fit their area.

Discussion

The purpose of this study was to examine how TLs responsible for program creation during statewide implementation acquired knowledge about ACT. It is important to understand how TLs learn the model in order to develop improved ACT education and training. Analysis of interviews with individuals involved in KY statewide ACT creation, as well as documents related to ACT training, revealed four themes in knowledge

transmission: taking responsibility for their own learning, seeking experiential opportunities, needing more support understanding team administrative needs, and wanting assistance adapting the program to local needs.

Participants in this study demonstrated a willingness to learn ACT independently of formal trainings and information provided by the state of KY. Evidence-based practice adoption is facilitated by practitioner feelings of positive self-efficacy (Gioia & Dziadosz, 2008). In addition, supervisors who approach organizational learning in a purposeful and self-aware manner support sustained innovation in mental health services (Brooks et al., 2011). Kentucky TLs may have initially sought additional training opportunities out of anxiety about their role in creating a novel program. However, in facilitating knowledge development, TLs showed confidence in their ability to learn the ACT model.

A second theme in participant experiences with ACT knowledge translation was the importance of experiential learning. Most EBP education approaches rely on practice-based learning, group learning opportunities, and TACs to provide guidance and expertise (Gioia & Dziadosz, 2008; Monroe-DeVita et al., 2012). Though KY TLs generally praised the level of expertise and training provided by the TAC, they felt opportunities to see and do ACT were more beneficial to their understanding of the model. According to Bandura's (1997) self-efficacy theory, one's sense of self-efficacy is influenced by seeing the successes of others perceived to be similar. Observing more experienced ACT teams gave some KY TLs confidence in their ability to successfully provide their own ACT intervention. Shadowing more experienced teams is a recommended activity that can build on a more formal approach to ACT education

(Salyers et al., 2007). Unfortunately, the closest established team was outside of KY and budget constraints prevented most teams from visiting.

Another common experience in ACT model communication was the desire for more training on the unique administrative needs of leading an ACT team. New programs often struggle with collaborating as an interdisciplinary team and at least one TAC has used an organizational psychologist to help teams build better relationships (Salyers et al., 2007). Poor management of internal team dynamics and internal conflict among staff are barriers to ACT implementation (Mancini et al., 2009). The team issues identified by participants were consistent with the literature. Participants struggled with finding, and retaining, staff who were a good fit for the team.

A final theme in participant experiences in learning ACT model was the struggle to adapt the model to fit local needs. A key task in developing new teams is balancing the core concepts of ACT with local conditions that impact services (Salyers et al., 2003). The ease of program adaptability is an important EBP intervention characteristic that can facilitate or impede implementation (Damschroder et al., 2009). Kentucky TLs, particularly rural TLs, felt the ACT model required significant modification to be effective in their area. Consistent with a few participants in this study, like Ben, some researchers believe ACT is not a good fit for rural areas (Bond & Drake, 2015). Rural teams encounter barriers such as low client density, staffing challenges, and long distances between clients (Bjorklund et al., 2009; Bond & Drake, 2015; Isett et al., 2007). The KY teams faced these same challenges and felt it was necessary to change the program to overcome these obstacles.

Study Limitations

This study was limited by its sample size and the amount of time between ACT implementation and participant interviews. It is not possible to infer causation between specific training approaches and subsequent outcomes for TLs due to the qualitative nature of this study. The high amount of turnover among ACT TLs since the beginning of ACT implementation in late 2013, made it challenging to locate TLs from 2013-2016. Almost 75 percent of the teams experienced TL turnover since the start of ACT with some teams experiencing turnover of multiple TLs in that time. Obviously, there are differences between the TLs who were still employed on the team and the TLs who left for a different job. The TLs who no longer work with ACT represent an important perspective and the findings would have reflected a wider variety of experiences had more of these individuals participated. In addition, asking about experiences from up to six years prior may have resulted in memories and reactions that were different from how participants experienced ACT implementation at the time. Time and perspective may have changed perspectives of events during initial implementation. Future research would benefit from focusing on TLs who had turned over during implementation to learn what experiences led to their decision to leave and if different training could have impacted their decision. Future research would also benefit from examining the development of ACT training in an area over time. How does the way a mental health system communicates knowledge about the ACT model change as implementation progresses and is sustained?

Conclusion

The interdisciplinary nature, team approach, unexpected client challenges, and need for creativity in problem-solving make it important to understand the process of learning ACT in order to best support mental health providers in providing effective evidence-based services. Practitioners benefit from learning approaches that emphasize practice and application of ACT principles versus textbook learning of theory.

Particularly when looking to start ACT in a mental health system that is unfamiliar with the model and lacks strong existing infrastructure or workforce knowledge that might otherwise facilitate the uptake of a novel program, the opportunity to experience ACT firsthand is one of the most important aspects of ACT knowledge transmission.

Chapter 4: Challenges with Mandatory Statewide Assertive Community Treatment in
Response to a Kentucky Olmstead Settlement Agreement³

Abstract

The Supreme Court's Olmstead decision has been used by the Department of Justice and mental health advocates to force the provision of evidence-based practice for individuals diagnosed with serious mental illness. While the provision of these services is a valuable addition to public mental health systems, the impact of large-scale mandated service provision on community mental health staff is unclear. It is important to understand the challenges of individuals involved with the creation of required programs as these are the individuals with the greatest impact on implementation success or failure. A case study was conducted on the statewide implementation of Assertive Community Treatment (ACT) in Kentucky. Semi-structured interviews and documents relevant to program creation were analyzed to explore the challenges faced by community mental health providers in statewide, court-mandated EBP implementation. Mandated ACT implementation required coordination and change at each level of the public mental health system. Participants felt teams were expected to be functional before the infrastructure was in place to support positive outcomes. The pressure of required program creation resulted in a lack of trust among those involved and was detrimental to the mental health of workers responsible for providing services. Administrations wanting to mandate the creation of ACT for individuals with psychiatric disabilities should ensure that legal agreements anticipate barriers to systemic change and build supportive infrastructure prior to the provision of services in order to facilitate implementation.

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Introduction

Evidence-based practices (EBPs) for individuals with serious mental illness (SMI) have existed for decades but the US public mental health system has been slow to adopt widespread provision of these services (Freuh et al., 2009). This may be due to the time and money necessary to create these programs as well as the complexity of aligning systems of care to create infrastructure that promotes program success (Parks, 2007; Torrey et al., 2001). The lack of access to EBPs to treat SMI results in many individuals with psychiatric disabilities going without critical services. As a result, individuals diagnosed with SMI experience higher rates of housing instability, unemployment, substance use, trauma, and involvement with the criminal justice system (Gold et al., 2006; Substance Abuse and Mental Health Administration [SAMHSA], 2015).

There is a well-documented gap between research knowledge of effective treatment and real-world provision of those services (Brekke et al., 2007). For example, Assertive Community Treatment (ACT), a SMI EBP, started as a model in the 1970s and is recommended for implementation by SAMHSA as one of the core EBPs that should be offered in all public mental health treatment systems (Drake, 1998; SAMHSA, 2008). However, access to ACT services varies greatly based on geography and program capabilities of local community mental health centers (CMHCs) (Bond & Drake, 2015). To address this disparity, mental illness disability advocates turned to the judicial system to force local governments to offer SMI EBPs. Across the United States, states have entered into agreements with the Department of Justice (DOJ) or advocacy organizations to increase funding for SMI EBP creation. These agreements require more than funding

increases, but also mandate the implementation of specific EBPs within a particular timeframe.

Innovative practices typically spread as organizations learn about and initiate new approaches that may fit an unmet organizational need (Rogers, 2003). According to Roger's (2003) Diffusion of Innovation theory, Kentucky (KY) would be considered an early majority adopter of statewide ACT implementation, but a late majority adopter of initial ACT services. However, KY did not experience a standard diffusion process, instead a complex system was changed based on a legal mandate. It is unknown how agreement-mandated EBP implementation varies from non-mandated EBP implementation. Forcing program creation is likely a different implementation process than the regular diffusion of EBPs across a health system. An accelerated, forced implementation process does not allow for a natural progression through the stages of organizational change or create an environment favorable to forming new services. To inform mental health program implementation and service delivery, it is important to study the effect of forced implementation on those tasked with the practicalities of daily program management. In 2013, Kentucky entered into an agreement mandating the statewide development of ACT teams and rapidly developed 15 new teams. Understanding the experiences of providers involved in this required implementation will inform how best to support mental health workers with forced EBP provision in the future.

Literature Review

Individuals discharged from psychiatric facilities in the 1950s and 1960s experienced high rates of homelessness and housing instability due to a lack of community-based support (SAMHSA, 2015). Individuals with SMI discharged without stable housing face poorer treatment outcomes and are more likely to experience crisis leading to re-hospitalization (SAMHSA, 2015). To avoid these negative outcomes, individuals were sometimes held in psychiatric facilities when community support was unavailable. However, in *Olmstead v L.C.*, the Supreme Court determined that holding someone against their will due to a lack of community support violated the Americans with Disabilities Act (1990) because it was discrimination based on psychiatric disability (*Olmstead v. L.C.*, 1999). The *Olmstead* decision also mandated that states provide support services to individuals with disabilities to prevent unnecessary institutionalization.

Though the *Olmstead* ruling instructed states to provide community-based support, it allowed each state to decide for itself the best way to support its SMI population. States without robust funding for public mental health services had few outpatient SMI treatment options. Mental health professionals looking for housing or support services lacked resources for their clients. Individuals with SMI who had significant support needs were placed in institution-like settings instead of being provided with EBPs that could support them in living in the community. These institution-like settings were typically isolated from the larger community and restricted client choice over their daily lives (National Association of State Mental Health Program Directors [NASMHPD], 2014).

The DOJ and disability advocacy organizations sued states for Olmstead violations based on long-term underfunding of community-based mental health support services. To date, at least ten states have been involved with the DOJ based on failure to provide supportive services to individuals with SMI (NASMHPD, 2014). These lawsuits have resulted in settlement agreements mandating services to transition SMI individuals out of congregate settings. In 2011, North Carolina agreed to start transitioning SMI individuals to the community by the spring of 2013. The process of building up community-based services and transitioning individuals out of care homes was so slow that in 2016 the DOJ asked a federal judge to compel the state to meet the terms of the agreement (Craver, 2016). Some states, like KY, have taken steps to avoid an official lawsuit when threatened by local advocacy groups by agreeing to settlement agreements mandating the provision of SMI EBPs without the involvement of the federal government.

Evidence-Based Practice for SMI

As individuals with SMI transitioned from institutions to community living, it became clear to mental health providers that it would take more than medication to support these individuals. Many individuals encountered difficulties such as a lack of daily living skills from living in institutional settings, cognitive deficits from their mental illness, and disruptive symptoms that did not respond to treatment (Freeman, 2001). These challenges led to higher rates of homelessness, involvement with the criminal justice system, substance use, poverty, and victimization (Lee et al., 2016; SAMHSA 2015). Community mental health centers, which were created for the purpose of caring

for SMI individuals, were often poorly funded and not prepared to meet the intense needs of this population (Gold et al., 2003).

Though EBPs for the SMI population have existed for decades, there is a gap between researcher knowledge and real-world translation of that information. For example, ACT emerged as an evidence-based SMI treatment model in the 1970's (Drake, 1998) but over 40 years later, less than half of states report statewide ACT availability (NASMHPD Research Institute, 2015). Evidence-based practices are often not implemented effectively in the public mental health system and even when EBPs are provided, the number of individuals actually receiving the services are limited (Bruns et al., 2016; Freuh et al., 2009). Implementation can be impeded by high turnover of clinical staff, lack of resources, lack of systems alignment with the needs of the EBP, and few financial incentives to support program creation and maintenance (Parks, 2007; Torrey et al., 2001).

To facilitate successful EBP implementation, it is necessary to educate and train each level of a public mental health system – from state agencies, to CMHC leaders, to CMHC human resources manager, down to program office support staff. New staff must be hired and existing staff retrained, agency structures should be adjusted to better fit the needs of the EBP, and administrators must understand the unique needs of the new practice (Becker et al., 2008; Moser et al., 2004; Ruffolo & Capobianco, 2012). Implementing EBPs across an entire state at one time presents additional challenges (Bjorklund et al., 2009; Gold et al. 2003). State mental health agencies play a strong role in implementation through formal policies as well as leadership and education (Becker et al., 2008; Isett et al., 2008). Following statewide implementation of trauma services for

SMI, researchers identified some of the main implementation challenges as: limited resources and commitment; knowledge deficits; and limited accountability at various levels of the mental health system (Bjorklund et al., 2009).

Evidence-based practices take between two to four years to fully implement at the CMHC provider level (Bertram et al., 2011). According to the National Implementation Research Network, there are stages of EBP implementation that impact success or failure. These stages are exploration, installation, initial implementation, and full implementation. The first stage, exploration, is arguably the most important stage. Missteps in the phase will reverberate throughout the implementation process. Key tasks in the exploration stage are to assess need, examine the proposed innovation, identify implementation challenges and evaluate EBP fit. Emphasizing proactive changes during the exploration stage facilitates future implementation. However, not fully considering the potential barriers and challenges of adopting a new EBP will magnify future problems as change attempts are made (Bertram et al., 2011). It is recommended that time and resources be devoted to the exploration and installation stages before participants are exposed to the new practice in the initial implementation stage. Skipping or rushing early implementation stages impedes implementation success through unsuccessful initiatives and crises that divert important resources and time (Bertram et al., 2011)

Assertive Community Treatment

Assertive Community Treatment is one of the most widely adopted SMI EBPs (NASMHPD Research Institute, 2015). Sometimes called the “Cadillac” of mental health services for its bundling of multiple high intensity service offerings into one team, it was envisioned as a community-based alternative to the hospital. An interdisciplinary team

provides services 24-hours a day in locations determined by clients. Clients are seen as needed, sometimes multiple times per day, and staff are cross-trained so each staff can provide any service at any time. The program has been shown to decrease hospital use and increase the amount of time individuals with SMI remain in the community (Bond & Drake, 2015; SAMSHA 2008). As of 2015, only 7 states reported not implementing ACT in any form (NASMHPD Research Institute, 2015) and it has been used effectively in other countries (Bjorklund et al., 2009; Salyers & Bond, 2009).

Assertive Community Treatment is costly in terms of money, time, and organizational resources but programs in rural areas face a unique set of implementation challenges. Rural areas lack resources such as transportation, housing variety, and assistance with basic needs such as food banks. Teams in remote regions experience barriers such as low client density, difficulty finding staff, and long distances between clients which limit the ability to make the frequent face-to-face contact required by the ACT model (Bond & Drake, 2015; Isett et al., 2007). High turnover in staff and the difficulty of finding qualified staff present some of the biggest challenges for ACT in rural areas (Bjorklund et al., 2009; Freuh et al., 2009).

To implement ACT, new teams must balance the core components of the model with local conditions that impact services (Salyers et al., 2003). Adaptation to increase regional acceptability of the program may reduce overall program impact (Bertram et al., 2011). Alternately, an over-emphasis on fidelity may ignore the needs of local context and culture. In these cases, fidelity improvement may not automatically result in improved client outcomes if the program model is not a good fit (Walker & Bigelow, 2011). While it is important to retain central aspects of EBPs, high or low fidelity in itself

does not guarantee good or bad client outcomes. Remaining faithful to essential principles and operations is a challenge for many teams and less than one-third of new ACT teams are able provide services closely aligned with the model (Monroe-DeVita et al., 2012). High quality training promotes high-fidelity teams and factors such as financing, organizational culture, agency leadership, and staffing can act as both facilitators and barriers to high-fidelity teams (Mancini et al., 2009).

The ACT team leader (TL) is a crucial piece of the success or failure of a new team (Carlson et al., 2012; Gioia & Dziadosz, 2008). The TL supervises a team of up to 9 professionals from a variety of disciplines including: nursing, social work, vocational rehabilitation, addiction counseling, peer support, and others. The TL leads daily meetings on client needs, acts as the clinical head of the team, assesses crises, and maintains a working knowledge of up to 100 clients at a time. Team leaders act as facilitators of ACT knowledge during implementation through their communication with the team. As the main locus of responsibility on the team, TLs are subject to high turnover which can impede implementation as it disrupts the flow of ACT knowledge from supervisor to direct-care team members (Moser et al., 2004).

Study Setting

In fiscal year 2009, Kentucky spent less than half (\$55.06) per capita of the national average (\$122.38) on mental health services and ranked 45th in mental health expenditure per capita in a ranking of all 50 states (SAMHSA, 2013). Poor funding of mental health services in Kentucky contributed to a lack of evidence-based services for individuals with SMI. Individuals with high support needs were placed in personal care home (PCHs) when support services were unavailable to help them live independently.

A PCH is a facility with resident beds. Services provided include “continuous supervision, basic health and health-related services, personal care services, residential care services, and social and recreational activities” (Carder et al., 2015, p. 2). These facilities are licensed by the state and designed as long-term care facilities. Low-income individuals in these facilities receive a state supplement to pay full room and care. They are primarily located in rural areas of the state and have minimal licensing requirements.

In 2013, Kentucky’s Protection and Advocacy agency (P&A) announced they were prepared to sue the state for ADA violations related to the widespread use of PCHs as segregated housing for individuals with SMI and a lack of community supports to help individuals with psychiatric disabilities maintain independence in the community. To avoid a lawsuit and potential DOJ involvement, state officials agreed to the Interim Settlement Agreement (ISA) in which they agreed to provide each CMHC with additional funding to create EBPs for individuals with SMI. These CMHCs were tasked with moving individuals out of PCHs and helping them maintain wellness. A major aspect of the ISA was the creation of 15 ACT teams, one for each CMHC region, that would provide services for individuals who had moved out of PCHs. Prior to the ISA, KY had only one fully-functioning ACT team in the largest city in the state, though some CMHCs had experimented with ACT-like programs. The ISA specified the agreement was to go into effect immediately. In a short amount of time CMHC were introduced to and expected to implement the ACT model in a mental health system that was not aligned with the needs of the new EBP.

Given that this study looks at ACT teams in KY and most of the state is considered rural, it is important to acknowledge rural cultural considerations in the

mandated implementation of services (Davis, 2009). People living in rural areas sometimes have a distrust of outsiders and can be wary of take charge, “big city” attitudes (Downing, 2014). Providers looking to introduce new services are recommended to approach rural areas with flexibility and a willingness to go slowly and learn the unwritten rules of each culture (Downing, 2014). Unfortunately, these attitudes are at odds with the accelerated implementation timeline expected by the ISA.

As the legal system is used with greater regularity to force the provision of community-based EBPs for individuals with disabilities, it is increasingly important to understand the impact of agreement-mandated implementation (Craver, 2016; DOJ, 2018). How does the rapid, forced alteration of a public mental health system impact those responsible for creating that change? Human factors such as buy-in, attitude, and EBP knowledge are known to influence implementation success (Rieckmann et al., 2011). Poor implementation results in the development of low quality EBPs which in turn impedes access to supports that enable individuals with disabilities to maintain wellness. Therefore, it is crucial to understand the difficulties faced by individuals tasked with developing and providing mandated services.

Methods

The purpose of this article is to understand the struggles of those responsible for creating new mandated programs in public mental health settings. Qualitative research is the most appropriate method to investigate this question because it aims to understand processes in society through the exploration of peoples’ experiences, perceptions, and beliefs (Givens, 2016). The goal of qualitative research is to understand how individuals

make sense of their lives and what process is undertaken as they engage in that sense making (Ravitch & Carl, 2016). The results of qualitative inquiry are expected to convey what a researcher has learned about a phenomenon not with numbers but with words that create an in-depth picture of individuals' collective experiences (Merriam & Tisdale, 2016).

The qualitative case study focuses on depth rather than breadth of a phenomenon, in this case, the challenges of those involved in KY mandated ACT creation. The case study method provides the best approach to describing and analyzing a bounded system in a real-life setting (Merriam & Tisdale, 2016), in this instance, the public mental health system in the state of Kentucky. Focusing on implementation experiences across the state resulted in richer and more in-depth data than focusing on a single CMHCs. The creation of ACT necessitates coordination between multiple systems of care and impacts each level of the public mental health system which makes ACT implementation research challenging (Gold et al., 2006). The case study method is commonly used to explore EBP implementation due to the complexity of the process (Brooks et al., 2011; Isett et al., 2007; Ruffolo & Capobianco, 2012).

To date, only 21 states report implementing ACT statewide and not all of those experienced implementation as a sudden push from the state government. Prior to KY's implementation, the previous statewide ACT mandate occurred in North Carolina in 2012 after an agreement with the DOJ to implement SMI EBPs to move individuals out of care homes. Kentucky is a good case setting to study the effects of forced program creation on community mental health staff because it is neither the first nor the last state to experience this phenomenon and represents a typical case. The KY mental health system

was also chosen for its convenience and feasibility, characteristics that are important when selecting a research site (Ravitch & Carl, 2016). Neither statewide ACT implementation nor settlement agreement-mandated EBP creation are common occurrences so there are limited opportunities to study these phenomena.

Study Participants

Study participants were involved with the KY public mental health system during the implementation of ACT during the Interim Settlement Agreement (ISA) from 2013 to 2016. This timeframe corresponds with the period that an outside technical assistance center (TAC) was hired by the state to support and monitor the creation of ACT teams. Participants were employed at multiple levels of the mental healthcare system and had unique perspectives on forced EBP implementation. Eleven participants were recruited for this study and the sample included ACT team leaders, CMHC program supervisors, outside monitors and consultants, as well as state employees. The small number of individuals involved in implementation make individual identification by job title a possibility. For confidentiality purposes, all state employees, monitors, and consultants will be referred to as implementation monitors as each acted as a monitor in some capacity.

Five implementation monitors, four team leaders, and two CMHC supervisors were interviewed. Participants primarily identified as female (7) and all but one were Caucasian. All participants had obtained bachelor degrees and most held master degrees in their fields which included social work, psychology, counseling, and vocational rehabilitation. Many held independent licensure in their field, indicating they had a high level of expertise and knowledge. To supplement interview transcripts, additional data

were obtained from documents related to the first three years of ACT implementation. These documents consisted of information from the TAC website about organizational readiness as well as quarterly ISA progress reports completed by an independent reviewer employed by the state to monitor and assess EBP implementation progress.

Data Collection

Participant interviews are used in qualitative research to create comprehensive descriptions of perspectives and phenomena when it is not possible to observe an individual's feelings or interpretation of their world (Merriam & Tisdale, 2016; Ravitch & Carl, 2016). The period of interest, 2013 to 2016, has passed which makes hearing from those who participated in creating ACT teams the only way to understand the experience of mandated EBP implementation. Semi-structured interviews were used and multiple interview guides were developed to best elicit each individual's experiences according to their role in the implementation process. Each interview guide covered similar topics pertinent to the implementation process as well as the preparedness of KY teams to provide services. Semi-structured interviews have a series of themes and questions but also allow for flexibility in type and sequence of questions to best produce an individual's stories and experiences (Brinkman & Kvale, 2015). A sample list of participant questions can be found in Table 4.1.

Table 4.1 Sample Interview Questions from Mandated ACT Implementation Interviews

Participant Type	Sample Interview Question
State Employees	What kinds of challenges did you encounter in working directly with the KY teams?
Outside Consultant	Is there anything you would have liked to have been able to do differently in regard to working with the KY teams?
CMHC Staff	Thinking back, how prepared did you feel to deal with client challenges?

Qualitative researchers use reflexivity in their research to increase the dependability and credibility of their findings (Finlay, 2002; Tracey, 2010). Being upfront about one’s positionality allows the reader to make their own decision about the worthiness of research findings. As such, it is important to note that I was involved in KY ACT implementation as a TL from 2014 to 2015. Participants were recruited through personal connections, a list of ACT team leaders, and social media. Data were collected between August 2019 and January 2020 and participants were interviewed in-person and on the phone. Interviews were digitally recorded and interview length ranged from 40 to 100 minutes, with the average interview lasting 62 minutes. Interviews were transcribed using a professional transcription service and transcripts were checked by me for accuracy. Documents related to ACT implementation were obtained from online sources. Quarterly ISA progress reports were obtained online and implementation readiness information was obtained from the TAC’s website. Ethics approval was obtained from the University of Kentucky Institutional Review Board.

Data Analysis

Qualitative thematic analysis was used to analyze participant transcripts. Thematic analysis allows for the identification of common ideas and topics across interview transcripts (Vaismoradi et al., 2013). Transcripts and documents were downloaded into Microsoft Word which was used to manage, manually code, and engage with the data. Interview text analysis involved several steps. The first step was to discover initial themes and subthemes through open coding (Ryan & Bernard, 2003). Open coding was done via the comments function; initial reactions and observations were marked in the margins. Supplemental materials were also coded. A document of researcher reaction was maintained to record my initial response and thoughts about the data. From open coding, categories and subcategories were created and then interview transcripts were coded a second time using these categories in order to clarify and expand on potential themes in the data. Categories were grouped to identify common themes in the experiences of participants with mandated ACT implementation. Throughout the process, memos were generated to support my synthesis and evaluation of the data.

Results

The purpose of this article is to understand the challenges experienced by individuals responsible for the Olmstead settlement-required creation of ACT teams. Kentucky ACT implementation necessitated *turning the proverbial ship* of public mental health infrastructure through coordination at each level of the system. The ISA requirements left little time to create a system of ACT teams to transition individuals with SMI out of PCHs. Teams were *building the boat while sailing it* by attempting to provide

services before the mental health infrastructure was knowledgeable about how to support ACT programs. The pressure and rapid implementation timeline resulted in participants *not trusting the motivations of others* and contributed to teams *experiencing mental health challenges*. A list of themes and exemplar quotes can be found in Table 4.2.

Table 4.2 Themes from Participant Experiences with Mandated ACT Implementation

Theme	Subcategory	Exemplar Quote
Turning the Proverbial Ship	Anticipating System Interactions	“That’s what makes a big project like this complicated. It’s one thing if it’s my agency. Doing it myself, I’ve got more control over it. But when you’ve got it statewide, and you’ve got feds, and you’ve got state, and you’ve got these regional providers, it gets complicated.” (Ben, Implementation Monitor)
	Obtaining Buy-In from Stakeholders	“You cannot support what we’re trying to do because the upper level management...has not bought into this. I don’t care what CMHC it is. Things have to be led from the top down and it’s not being led from the top down.” (Julia, CMHC Supervisor)
Building the Boat While Sailing It	Feeling Pressure from All Sides	“I understand where the state’s coming from. I mean, people going to lose their jobs. The state’s going to get sued if they don’t do whatever is in the [settlement agreement]” (Barry, TL)
	Having Unrealistic Expectations of ACT	“There was this whole complete misunderstanding of what ACT did and it wasn’t really explained” (Oliver, Implementation Monitor)
Not Trusting Motivations of Others		“Kentucky is about 10 to 15 years behind the curve.... I don't know if that comes out of some state issue or where it's coming from. But... God, people it is not rocket science.” (Julia, CMHC Supervisor)
Experiencing Mental Health Challenges		“It pains me to no end when community mental health providers don’t provide good behavioral health for their own people... you can’t have a job with that level of intensity and not have your team engaging in good behavioral health.” (Grace, TL)

Turning the Proverbial Ship

The first theme related to the challenges of agreement-mandated EBP implementation was that participants described *turning the proverbial ship*. This idea highlights the complexity involved in overhauling the state-wide system of public mental health care. Shifting SMI services from institution-based to community-based was a massive undertaking, the difficulty of which was not fully anticipated by those who agreed to the terms of the ISA. The lack of time and resources allotted to prepare for changing the system of SMI care impeded ACT implementation. The terms of the ISA specified the agreement was to go into effect immediately and CMHCs had approximately three months to create new programs, hire, and train staff to transition individuals out of PCHs. This rapid timeline resulted in early implementation mistakes such as not anticipating the difficulty of getting systems of care to collaborate and not getting buy-in from those responsible for implementation. After the first few years, red flags signaled that implementation was going poorly despite hard work from those involved. In fact, the new SMI EBP system was not functional. So many difficulties were encountered that the ISA was ended early in order to create a different settlement agreement with target numbers that were more realistic for the state.

Anticipating System Interactions

In order to turn the focus of the proverbial mental health care ship to community-based services, it is necessary to re-align multiple systems of care. Changing the status quo in a public mental health system is a complex and time-consuming task. The fifth ISA progress report described progress on this task:

The Cabinet has described the changing of Kentucky's behavioral healthcare system in terms of turning around the proverbial large ship. Significant moves by the Cabinet to shift dollars from institutions to community services are relatively new, and that shift of dollars now requires a cultural shift of all stakeholders statewide. (Brewer, 2015, p.1)

Participants spoke about the challenges of aligning the entities involved in the SMI system of care, particularly in the beginning before everyone was on board with the changes. Clair, an implementation monitor, felt the process needed a central leader who could make the state agencies work together because "each of those agencies have their own priorities. They have their own fish to fry, they have their own things that are on fire." Other participants commented on the complicated position in which the ISA placed the state. Kentucky was in no position to withhold funds from poorly performing teams because it had already agreed to fund multiple ACT teams. Hannah, an implementation monitor explained the awkward system as:

Sure the state could take away money but the state was also being forced to provide these services so it's not like the state can be like "your ACT team's really bad, we're going to give the contract to somebody over here."

Participants expressed frustration that the mental health system was not prepared to support ACT teams and teams were unable to produce the positive outcomes anticipated by those who championed ACT implementation. Hannah, an implementation monitor, expressed disappointment that "there was not one... difference, from how many people were discharged from the hospital to a personal care home before this started and when I ended, there was no difference." When later asked if she thought the timeframes

and number of transitions expected from the ISA were realistic, Hannah explained “the numbers could have been realistic if you’d had that infrastructure...the funding and the infrastructure.” Oliver, an implementation monitor, lamented the state’s lack of planning or understanding of on-the-ground issues:

We didn’t really have a good plan to begin with. And there’s a reason why so many of these ACT teams are not functioning... the [state] would say “well, why aren’t they functioning?” Well, I could tell you 10 reasons why they’re not functioning, but you don’t want to hear them.

Participant data demonstrate that overhauling the public SMI treatment system and shifting the locus of care to CMHCs required greater planning and coordination than was anticipated. As a result of trying to form ACT teams before the supporting infrastructure was created, teams struggled to provide services and the process of building high-functioning teams was prolonged.

Obtaining Buy-In from Stakeholders

Another crucial aspect of turning the proverbial ship is obtaining buy-in from the organizations and individuals responsible for ACT team creation. The rushed nature of ACT implementation and the timelines required to transfer individuals out of PCHs did not allow for sufficient time for providers to prepare for substantial organizational change. Although CMHCs responsible for creating teams were given extra money in their state contracts and instructed to provide specific SMI EBPs with the additional funds, more time was needed to obtain endorsement from those providing services. Some CMHCs were eager to form teams and saw the potential to fill a gap in SMI services, but

other CMHCs created out of compulsion, doing only what was required to fulfil their contract obligations.

Obtaining support from those responsible for ACT implementation prior to team creation is even more important when working with rural providers. The mandating of EBPs and accelerated implementation timelines prohibited flexibility and time to test services, instead forcing a rapid change to the status quo. This was an ill-advised approach for a state with mostly rural mental health providers. Hannah, an implementation monitor, explained the negative reaction of some CMHCs by saying “the agencies resented it. They weren’t part of the creation of the settlement agreement... They were told to do something. That never goes over well.” Ben, also an implementation monitor, described the challenges encountered by TLs when they were not supported by their agencies:

Here’s this team leader trying to put something together, and they’ve got kind of nobody above them that really has any kind of interest or investment. And it’s really hard because there are times a team leader really needs somebody higher up to help them get what they need. And I saw a lot of team leaders that were like “yeah, I can’t get that. Nobody’s listening.”

Data suggests that the lack of buy-in was a barrier to ACT in KY. Agencies desiring to implement ACT must make significant policy, procedure, and cultural changes to be successful. Agencies with leaders who either do not understand ACT or do not support program creation will not make the necessary adjustments for success. The provision of ACT services in KY was impeded by the lack of time allotted for aligning systems of care and the lack of investment from CMHCs tasked with program creation.

Building the Boat While Sailing It

A second theme found among individual's experiences with mandated ACT creation was feeling that teams had to *build the boat while sailing it* -they were expected to provide services without having a strong system of infrastructure to support success. The rapid implementation timeline and expectations of PCH transitions led to the creation of teams without infrastructure or workforce knowledge at the CMHC or state level to support them. Pressure combined with a lack of forethought about the practicalities of transitioning individuals from an institutional level of care resulted in teams dealing with unrealistic expectations of ACT services. Multiple participants talked about "building the boat while sailing" when describing the system that was unprepared to support ACT. Building teams was primarily viewed as a process of trial and error.

Feeling Pressure from All Sides

A subcategory of building the boat while sailing it was the feeling from participants that there was pressure to be functional before the mental health care system knew how to provide ACT services. Participants all spoke about a feeling of strain created by the expectations of the settlement agreement. Clair, an implementation monitor, felt the state should have negotiated different terms in the settlement agreement, a sentiment that was shared by other participants Natalie and Julia. Clair explained, "Honestly, I feel like at the time that P&A had certain entities over a barrel and they weren't actually going to say no to them, but they probably could have and should have." Samantha, a team leader, spoke about the stress felt at the state level due to the lack of time to prepare for implementation:

They were pressured, under the gun, again going back to the settlement... it starts when we sign but then it takes, understandably, some time to mobilize and understanding it and figure it out, what does this mean? So, I felt like the state people were kind of frazzled.

Julia, a CMHC supervisor, felt unsupported while trying to transition individuals out of PCHs, saying the team “did not get leadership from our own agency, nor did we get leadership from the state. We had people who would descend on you and say ‘you need to step it up. You’ve got this quota to move out.’” While participants tried to provide good care, they often felt underprepared with the skills to provide high-fidelity services. Grace, a team leader, spoke about feeling the state’s expectations were unrealistic:

They wanted us to have these things in place and to be offering these services and to be able to do this with a spirit of excellence. Which is what we attempted to do. But, we also needed some more support and assistance in being able to do that. And they weren’t able to provide that but still held us to that expectation.

Instead of viewing fidelity assessments as a way to measure progress and guide team development, at least one participant viewed the fidelity review as a punitive. Emma, a CMHC supervisor, wished low fidelity had instead been taken as “a sign we should increase support, training, and rally up around these community mental health centers to meet fidelity and have strong ACT teams.”

Though all participants referenced the pressure the state was under, they also expressed understanding of the situation. Dave, an ACT TL, stated “I’m not blaming nobody, I think the effort got a 9 or a 10. Everybody wanted us to be successful... A – it

was brand new to the state. B – you’ve got this lawsuit hanging on everybody’s head.” In describing a conversation she had with a liaison from the state, Hanna said “she [the liaison] was learning as she went. Everybody was. There wasn’t anybody who was an ACT expert, had any experience. It was just a brand new process to the whole state.”

Participant experiences with mandated implementation reflect a high level of pressure to produce a system of functioning ACT teams. Pressure to meet ISA requirements trickled down from the top, starting with workers at the state government pressured by the settlement agreement and moving to the CMHCs. Some of the standard mechanisms for measuring and guiding implementation progress, such as fidelity reviews, were seen as applying unhelpful additional burden in an already strained environment.

Having Unrealistic Expectations of ACT

Another aspect of building the boat while sailing was the unrealistic expectations of ACT held by those not in direct service. Participants felt those who agreed to use ACT teams to transition individuals out of PCHs had a poor understanding of the SMI population and ACT. The ISA implied all PCH residents would receive ACT services upon transitioning to the community. However, ACT has diagnostic and functional criteria for its clients and the model is intended to serve a subset of individuals with SMI who have not benefited from less intensive services. Some PCH residents did not need intensive care while others were assessed as needing a higher level of support than ACT could reasonably offer. Participants struggled with the disconnect between the expectations of the state and guidelines of the ACT model. Julia, a CMHC supervisor explained it this way:

The settlement was a whole other screwy story of “Oh, if you’re a settlement client, you get ACT.” It’s like, no, not necessarily. There’s criteria for ACT... there was a mismatch there. A three year sort of miscommunication about all the slots are for somebody who came out of a personal care home.

Participants also felt that those in charge of the settlement agreement had a poor understanding of the ACT model and their expectations for recovery were unrealistic. Samantha, an ACT TL explained, “I’ve felt like the state, P&A, whoever has always had this, ‘ACT is the end-all, be-all, and it’s going to solve everyone’s problems and nobody’s going to go back to the hospital ever again.’” She later elaborated with, “they’re [the state] not on the ground, and they don’t see what we’re seeing, and they’re dealing with a theoretical person.” Likewise, Julia, a CMHC supervisor said, “there is an idealized view of what someone with a serious mental illness looks like to someone that doesn’t work with seriously mentally ill people.”

The ACT model was not well understood by those in administration at the organizational and state levels. In addition, the KY mental health system was unaccustomed to serving higher-need SMI individuals outside of institutional settings and the unique needs of the population were unanticipated by the CMHCs. These unrealistic expectations exacerbated the stress felt by implementation participants as they felt pressed to generate outcomes they did not have the capacity to produce.

Not Trusting Motivations of Others

The environment of pressure in which statewide ACT implementation occurred gave rise to participants *not trusting the motivations of those around them*. Eighteen

months into the settlement agreement, the implementation progress reports expressed concerns that the state would not meet the provisions of the ISA yet increasing the pace of transitions was also not feasible (Brewer, 2015). Organizations and individuals looked for someone or something to blame for the lack of success. Participants referred to the “politics” of the ISA and expressed wariness about those involved in implementation.

Participants often referenced the “powers that be” or politics to convey a feeling of powerlessness in the process of ACT implementation. Oliver, an implementation monitor, spoke about the difficulty of getting individuals at the state to work together:

I went to a training once that was about forming implementation teams and they called certain people implementation killers. So we had several killers... we had this great plan, but nobody on the team liked each other and it just exploded and then the team would meet, nobody would take notes, and nothing would get done.

Another participant expressed frustration when state officials failed to negotiate a higher reimbursement rate, saying it was: “part of the why I went to [the next job] is I was so disillusioned with some of what the powers-that-be at behavioral health allowed to happen.” She later stated, “I’m not knocking myself anymore for doing the best I can at the time and then deciding, ‘oh, I can’t do any more of this.’ I’ve literally got so angry at the politics.” An implementation monitor, Natalie, described her decision to stop working with ACT as “the smartest thing I did, was get out of it all, because it’s just a big rat race. And the more... capable you are, the more it’s going to get to you.”

Participants who did not feel ACT was a good fit expressed a wariness of the decision to mandate implementation. A rural TL, Dave, felt overwhelmed after his first

team leader meeting and wondered “how much time or effort the state really put thought process into it, because KY is overall a rural state.” Oliver, was also suspicious of the effort put into EBP program creation: “the state did as little as they possibly could to get away with not having them [P&A] go to the Department of Justice and being sued like they should have been sued.” Other participants wondered if a lawsuit would have been better because it would have brought more money into the process. Natalie explained:

Everybody reacted to “Oh no, we’re going to be sued.” Big deal, I wish they would have sued. There would have been a lot more money poured into it... instead of reacting to that, they should have taken their time, taken a step back and said, “Who can help us implement this?” Because it’s going to be pretty damn big to implement.

There was also a feeling among participants that those higher in administration were more concerned with looking good than addressing barriers. Natalie expressed the futility in communicating to those above her of the challenges that teams were encountering:

I’d get asked “Well, how’s it going out there?” So I’d say how it was going. Then I’d get recriminated all the way back to my office. Did I have to tell them everything I knew? Well, I don’t know – I think you have to be honest, that there’s a frustration across the state with these jobs.

Similarly, Oliver’s feedback on implementation was not welcomed: “I had clearly lost favor. That was probably why they were like ‘no.’.... He needs to just go away, he has too many ideas.”

The ISA requirements and rapid creation of teams contributed to an environment of distrust among those involved in implementation. Individuals did not feel they could be honest about the barriers to implementation and those who were candid about ACT challenges felt their views were unwelcome. Participants felt powerless to effect change in such a large process. Those in positions of power seemed more interested in finding someone to blame for poor outcomes than doing the more difficult work of aligning the systems of care with the needs of ACT.

Experiencing Poor Mental Health

A final theme gleaned from interviews with service providers involved with establishing ACT in KY was that these participants *developed poor mental health* during the process of implementation. The environment of pressure and distrust impacted the psychological wellbeing of those who participated in ACT implementation and exacerbated the normal mental health challenges faced by a team providing high-intensity services. The lack of supportive infrastructure across the state combined with ethical struggles felt by individuals tasked with transitioning individuals into their own apartments contributed to negative outcomes for the teams.

The responsibility of caring for up to 100 individuals diagnosed with SMI with high support needs is challenging. Under normal circumstances it can be a stressful job, but when trying to provide ACT services in a tense environment with poor structural support, the job can seem intolerable. State officials seemed unaware of on-the-ground difficulties of providing ACT, which Natalie speaks poignantly about here: “those people at the state didn’t know anything, I’m just telling you. They didn’t know... those teams felt like they were drowning.”

Several participants spoke about the need for mental health organizations to take better care of their own staff. Julia, a CMHC supervisor, stated “you can’t expect your staff, without support and the ability to decompress, to continue at this level...we’ve never taken care of our own. You know, unfortunately, we all have a kind of suck it up buttercup attitude.” Grace, an ACT TL, spoke at length about her efforts to promote good self-care among her team:

If somebody’s that driven and passionate, being able to take a step back and say “ok, you haven’t taken a vacation day. How are you going to take care of yourself? What do you do to relieve stress? Today was a really sucky day, what are you going to do when you get home to get this day off of you?”

Poor team mental health contributed to and was exacerbated by staff turnover. Emma, a CMHC supervisor, reported that every role on the team turned over at least once during her 3-year tenure. Dave, an ACT TL, spoke about having a high turnover rate in the beginning because staff did not understand the needs of the SMI population. High rates of turnover impacted the development of high-quality services. Oliver, an implementation monitor, referred to turnover as the “killer of all of these evidence-based practices.” Grace explained:

The lifespan of an ACT team member is not very long. Turnover is real and by the time you replace someone and train someone else, make sure the people that are there are the best fit for where they are, that cuts into how much of an impact that you have because people leave and take their training with them.

Certain aspects of ACT work, such as being unable to find adequate housing for clients, contributed to burn out and turnover among team members. Several participants spoke about experiencing stress from challenges in finding housing for clients. Grace described the use of a local slum lord to house clients who were unable to be approved for other apartments:

Every time [CMHC] issued that check I cringed because I'm like... there's not better housing for them to have. This is it... There were times when he worked well for us and we built a good relationship, but I never let it go. I always made sure he understood, "Look, you are a slum lord, buddy."

Julia, spoke about transitioning a client into his own apartment. She described her sadness with the types of housing available to some clients:

He was so desperate to get out – he's like, "I'll live here"...it smelled like urine. It had no light. And I cried, I did. I had to leave, to go. I'm like, "I can't leave you here. I cannot, in good conscience, leave you here."

Not surprisingly, experiences with stress during early ACT implementation often led to burn out and high rates of turnover. Limited supportive housing infrastructure created additional strain on teams as they grappled with the necessity of using subpar housing situations for clients with a history of eviction or involvement with the criminal justice system. Though many would agree it is better for someone to have a roof over their head than to sleep on the streets or in a shelter, the realities of being involved in obtaining and maintaining inadequate housing created strain on team members.

Discussion

The challenges experienced by those involved in the early years of mandatory EBP implementation are important because requiring EBP service provision for individuals with disabilities is likely to continue (NASMHPD, 2014). Louisiana recently agreed to a consent decree to provide a stronger system of mental healthcare to prevent the institutionalization of individuals with SMI in nursing homes (DOJ, 2018). Addressing administrative barriers is an important aspect of successful EBP dissemination (Drake, et al., 2006; Ganju, 2003). Individuals tasked with creating and maintaining EBPs should be given preparation time to change complex systems of care (Torrey et al., 2005). One state, New York, approached the implementation of SMI EBPs in three phases. The first phase, consensus building, involved the state soliciting support from mental health stakeholders and testing programs before attempting statewide changes (Carpinello et al., 2002). This method allowed the state to identify and rectify systemic barriers to implementation before scaling up services. Due to the rapid program creation timeline expected by the ISA, KY was unable to be proactive in addressing structural challenges that impeded implementation.

Those involved in the ISA creation may be concerned that providing additional time and resources for planning implementation would delay the important goal of offering evidence-based support and treatment. However, allotting time for planning and anticipating barriers will facilitate the provision of quality services (Bertram et al., 2011). Attempting system-level change without adequate preparation extends the change process as unanticipated issues arise and must be dealt with before implementation can proceed (Bertram et al, 2011). Data from this study highlight how rushing the implementation process can be detrimental to the development of quality EBP services and to the

wellbeing of individual staff involved in implementation as it creates an environment of distrust and pressure that impedes the creation of new programming.

Research on organizational readiness supports the dedication of time and resources to obtaining buy-in and understanding from those responsible for EBP provision (Frambach & Schillewaert, 2002; Leathers et al., 2016; Salyers et al., 2007). Additionally, resistance from agency supervisors is damaging to the implementation of innovative mental health practices (Brooks et al., 2011). Organizational change and program creation are challenging under any circumstance and having support and dedication from the individuals who must bear the stress of that change is crucial. Without buy-in, staff and organizations, are less dedicated to program fidelity and more likely to seek alternate jobs rather than cope with the chaos of developing a new program (Aarons et al., 2009; Gold et al., 2003). Mandating EBP implementation without preparation time is counterproductive as too much pressure impedes implementation and harms those involved.

The provision of widespread EBPs for individuals with disabilities is a worthy endeavor. To paraphrase a participant, forced ACT implementation is a sad way to have to drive change but if it drives change then so be it. New EBPs should be introduced into a system so not to overburden those responsible for those services. Stressed providers cannot deliver quality services and may do more harm than good if they attempt to provide services they are unprepared to deliver. Trust between community mental health workers is also important to program success and the breakdown of trust impedes implementation (Brooks et al., 2011). Additionally, the learning environment is enhanced when staff feel psychologically safe to try innovations and are a valued part of the change

process (Damschröder et al., 2009). Participants in KY implementation did not feel safe or valued during team creation. No matter how much effort individual staff and teams put into developing their ACT services, without the right support in the larger environment, the teams were fighting a losing battle to produce improved client outcomes (Freuh et al., 2009).

Study Limitations

As with any research, findings should be considered in light of study limitations. First, this study was conducted approximately 5 years after the start of the ISA. Participant feelings toward implementation and the way in which they recalled their experiences may have changed with time. Time likely affects the accuracy of memory and participants may have remembered their experiences differently than if they had been asked to recall experiences shortly after they occurred. Alternately however, time can provide perspective and enhance the ability of participants to view ACT implementation more holistically which may have led to greater insight. A second study limitation is the small number of participants. Both the amount of time since the start of implementation and the high rates of staff turnover were barriers to participant recruitments, particularly among CMHC providers. The nature of qualitative research does not allow for the determination of causes and effects of mandated implementation on individuals responsible for EBP program creation. A future line of inquiry could explore if self-care could impact the stress of forced ACT implementation. Additional research, perhaps using more quantitative methods could focus the point in time of mandated implementation rather than as a case study reviewing the implementation process post hoc.

Conclusion

Despite study limitations, this research is important because it contributes to the understanding of the impact of non-voluntary program creation on those responsible for building services. Policy makers and advocacy groups looking to require the creation of specific evidence-based services for individuals with disabilities should be mindful of the amount of time it takes to change a large healthcare system. Prior to specifying implementation timelines, a thorough assessment of the system is necessary to anticipate barriers to change. Implementation is aided when policymakers are proactive versus reactive when encountering these challenges. Anticipating and planning ways to overcome systemic barriers results in smoother and faster provision of quality services to individuals with SMI.

Chapter 5: Conclusion

Despite the existence of SMI EBPs for decades, they are not being effectively implemented in the public mental health system (Freuh et al., 2009). To combat the general lack of evidence-based practices (EBPs) for serious mental illness (SMI) in some areas of the United States, mental health advocates have used the Supreme Court's Olmstead decision to force governments to fund these services through settlement agreements (National Association of State Mental Health Program Directors [NASMHPD], 2015). It is important to understand how public mental health systems develop and adopt new practices. The purpose of this dissertation was to identify the factors that led to Kentucky's (KY) Olmstead settlement agreement and also to understand the experiences of individuals involved in implementing Assertive Community Treatment (ACT), one of the mandated EBPs. Specifically, this dissertation, using a qualitative case study design, aimed to answer three research questions: 1) What were the precipitating factors of the ISA?; 2) What were the experiences of individuals involved in implementation with ACT knowledge transmission?; and 3) What were the challenges in mandating program creation for individuals responsible for ACT implementation?

The first study identified five factors that contributed to the need for KY to seek legal intervention to force EBP implementation in the state. Analysis revealed the wide-scale release of individuals from psychiatric facilities in the 1950s impacted the development of community mental health services. Like many areas of the country, KY community mental health centers (CMHCs) were unable to provide recommended SMI EBPs which contributed to instability for individuals with SMI who, as a result, cycled

through various institutional settings. A series of high-profile events and reports critical of the personal care home (PCH) system, as well as a modern understanding of mental illness, combined to create pressure on the state government to change the mental health system. These findings are consistent with experiences of other states accused of Olmstead violations where communities with underdeveloped systems of evidence-based care engaged in practices that segregated individuals with SMI in care homes (NASMHPD, 2015). As individuals diagnosed with psychiatric disabilities were discharged from facilities, many experienced homelessness and housing instability due to a lack of appropriate support outside of institutional settings (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). Individuals with SMI in KY experienced housing instability which was one of the reasons for the creation of the PCH system.

The national average spent on state health administration is 140% of Kentucky's expenditures on mental health (SAMHSA, 2013). Insufficient resource allotment to community mental health results in unmet needs for individuals with SMI (Gold et al., 2006) which was reflected in the finding that KY individuals cycled from PCH to hospital to homeless shelter, never truly gaining stability. Olmstead will continue to be used to mandate EBP provision, as evidenced by the 2018 Department of Justice (DOJ) settlement agreement in Louisiana for segregating SMI individuals in nursing homes (DOJ, 2018). State governments that direct funds to institutional settings at the expense of community SMI services should quickly shift resource to community services. Those that do not make these adjustments of their own volition will have the choice made for them by the DOJ.

The second study examined the experiences of team leaders (TLs) with the communication of EBP information during statewide ACT implementation. Study results indicated TLs took initiative with learning the ACT model and sought their own training. Opportunities to learn by shadowing other experienced teams were limited, so TLs learned much of the ACT model through a trial and error process as teams built service capacity. Team leaders desired greater support in the areas of managing team dynamics and adapting the ACT model for local needs. These themes are consistent with research on ACT implementation. Practice-based and experiential learning methods are frequently used in EBP education (Gioia & Dziadosz, 2008; Monroe-DeVita et al., 2012). New ACT teams are advised to shadow a more experienced team to build on formal ACT education (Salyers et al., 2007). These recommended approaches were in line with what was desired by KY TLs, who strongly wanted interaction with more advanced teams. Team leaders believed seeing ACT in action facilitated the translation of formal knowledge into real-life practice. New ACT programs often find it challenging to work as an interdisciplinary team with a shared group of clients and internal conflicts among staff is a barrier to implementation (Mancini et al., 2009; Salyers et al., 2007). This was reflected in the team leaders' struggles with hiring staff who were a good fit with the program model and other staff.

Developing ACT teams must balance the central tenants of ACT with local population needs (Salyers et al., 2003). Kentucky teams experienced the same barriers to implementation as teams in other rural areas such as low client density, difficulty finding staff, and long distances between clients (Bjorklund et al., 2009, Bond & Drake, 2015; Isett et al., 2007). These conditions made TLs feel the ACT model needed significant

modification to serve local clients, however assistance making these adjustments was inadequate. When implementing the model in an ACT-naïve mental health system, trainers would benefit from a focus on experiential learning, team dynamics, and customizing the program for the agency.

The final study explored the impact of mandating implementation on individuals responsible for ACT team creation. Study findings showed the process of shifting the locus of SMI care from institutions to CMHCs was more complicated than anticipated. To meet the terms of the settlement agreement, teams were expected to provide ACT services before system infrastructure was created to support them. Individuals did not trust the motivations of those around them. The high-pressure environment resulted in poor mental health among those involved in implementation. The concerns expressed by participants about KY ACT are also reflected in research on EBP implementation. The Consolidated Framework for Implementation Research identifies planning as a crucial part of the implementation process (Damschroder et al., 2009).

Another important aspect of successful EBP implementation is addressing administrative barriers (Drake et al., 2006; Ganju, 2003). Individuals responsible for starting new EBPs should receive ample preparation time in order to align new programs and systems of care (Torrey et al., 2005). Adequate time was not devoted to preparing the KY public mental health system for the substantial changes needed to accommodate mandated EBPs and barriers were not identified or addressed proactively. Not allotting time to plan and address barriers impedes the provision of quality services (Bertram et al., 2011). The accelerated KY ACT creation timeline resulted in another misstep when support was not solicited from CMHCs. Research suggests that resistance from agency

supervisors hinders the implementation of new mental health programs (Brooks et al., 2011). The stress of working under ISA deadlines and the constant threat of a lawsuit created an unhealthy environment full of distrust and impacted the psychological well-being of participants. This was manifested in high staff turnover. Employees are more likely to leave during times of organizational change and high turnover impedes EBP implementation (Aarons & Sawitzky, 2006; Moser et al., 2004) and KY ACT turnover was impeded by frequent changes in team members. Additional research is needed on the impact of mandating EBPs through settlement agreements and whether self-care mediates the stress of working under a high-pressure agreement.

Implications

The themes and commonalities in individual experiences with statewide mandated ACT implementation found in this dissertation cannot be appropriately generalized beyond the present sample. Nevertheless, the studies highlight important considerations for policy makers as public mental health systems continue to shift away from institutionalization of individuals with SMI. Widespread SMI EBP implementation is crucial in unraveling this country's past mental health treatment mistakes of institutionalization and underfunding community mental health centers. However, merely mandating funding and service creation does not guarantee the development of effective or accessible services. While money and services are important components of changing public healthcare systems, systemic change is more complicated.

In researching the PCH system in KY, a comment was found on the Facebook page of a (now closed) PCH from 2011. Someone performing a facility inspection

“checked in” using Facebook and an acquaintance commented “dam who got tired of you and put you there lol.” This comment is emblematic of the way individuals with SMI have historically been treated. Whoever made this comment was obviously aware the facility housed people that society did not want to deal with. Changing the status quo in a large mental health system is complicated, chaotic, and stressful. The ISA was not written perfectly nor was it implemented in an ideal fashion. However, the goal of providing research-informed services was a noble one that resulted in important services to support KY citizens with SMI in living outside of institutions. With continued strengthening of the mental health system, hopefully we will reach a point where no one will be forgotten again.

Appendix

Interview Guide Topics for Participant Experiences with ACT Knowledge Transmission

Community Mental Health Center Staff Questions

- *General Training*
Sample Question: Fill in the blank: I would have liked additional training on _____ before I started with ACT.
- *State Involvement*
Sample Question: Can you tell me the role of the state in helping you learn the ACT model?
- *Community Mental Health Center Involvement*
Sample Question: Can you describe the process of training a new staff for the ACT team at your agency.
- *Technical Assistance Center*
Sample Question: What kind of training or support did you receive from the technical assistance center?
- *General Services*
Sample Question: How were you able to take your formal training knowledge, learned from your agency, the state, or the TAC, and translate it to actually serving ACT clients?

Implementation Monitor Questions

- *Implementation*
Sample Question: What challenges do you think KY faced while preparing ACT implementation?
- *System Function*
Sample Question: What was it like to interact with such a wide variety of entities (state workers, CMHCs, ACT staff, etc) concerning implementation? *Prompt: Communication*
- *Staff Training*
Sample Question: What, if any, additional trainings do you recommend for those supervising an ACT team?

- *Community Mental Health Center Role*
Sample Question: Can you describe any of the ACT training processes at individual CMHCs that you are aware of?
- *Kentucky-Specific*
Sample Question: Was there anything you felt was particularly good about the way the state went about implementing ACT?

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