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Mental health professional experiences of the Flexible Assertive Community Treatment model: a grounded theory study

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Abstract

Background: Despite the lack of evidence for effectiveness of the Flexible Assertive Community Treatment (Flexible ACT), the model is considered feasible and is well received by mental health professionals. No current studies have adequately examined mental health professional experiences of working with Flexible ACT.

Aims: The aim of this study was to explore mental health professional experiences of working with the Flexible ACT model compared with standard care.

Method: The study was guided by grounded theory and based on interviews with 19 theoretically-chosen mental health professionals in Swedish urban areas primarily working with consumers with psychosis who had worked with the Flexible ACT model for at least 6 months.

Results: The analysis resulted in the core category: “Flexible ACT and the shared caseload create a common action space” and three main categories: (1) “Flexible ACT fills a need for a systematic approach to crisis intervention”; (2) “Flexible ACT has advantages in the psychosocial working environment”; and (3) “Flexible ACT increases the quality of care”.

Conclusions: Mental health professionals may benefit from working with the Flexible ACT model through decreased job-strain and stress, increased feeling of being in control over their work situation, and experiences of providing higher quality of care.

Keywords: Integrated services, severe mental illness, implementation, clinical experience

Introduction

Flexible Assertive Community Treatment (Flexible ACT) was originally developed in the Netherlands as a Dutch variant of Assertive Community Treatment (ACT) (van Veldhuizen, 2007), and the first FACT teams were set up in the Netherlands in 2003 (van Veldhuizen & Bähler, 2013). ACT focuses on outreach and providing persistent and intensive care and treatment for the approximately 20% of the most severely mentally ill persons in treatment who are difficult to engage and are at risk of hospitalization, homelessness or neglect (Mueser et al., 2013). Most of these persons have psychotic disorders and long-term psychiatric disability (van Veldhuizen, 2007). ACT is internationally recognized as an evidence-based practice and stabilizes housing in the community, reduces homelessness and hospitalization, and increases social functioning (Mueser et al., 2013). In contrast to ACT teams, Flexible ACT teams deliver services for the entire group of persons with severe mental illness in a region (van Veldhuizen, 2007). In Flexible ACT (Nugter et al., 2015), a multidisciplinary recovery-oriented team provides both “individual care” including case management and home visits for consumers who are mostly stable and “team-care” with a shared case-load for consumer in need for more intensive care. When a consumer is at risk of relapse, or in crisis, he or she is put on a digital Flexible ACT board. At that time, care switches from “individual care” to “team care,” with a shared caseload that functions according to ACT principles. As in an ACT team, there are daily meetings to plan treatment interventions for consumers who are registered on the Flexible ACT board. A case manager resumes provision of individual support when the consumer's condition has stabilized. In both models, the team has full responsibility for providing treatment services, and most contacts take place in the community. According to van Veldhuizen (2007) the flexibility of switching between the two service-delivery models, while remaining with the same team, enhances continuity of care and reduces dropout. The Flexible ACT principles are to: 1) assist the consumer wherever or

whenever needed for success, 2) support community participation, 3) find people with severe mental illness, link them to services, and provide continuity of care in the community and hospital, 4) provide ACT intensive care when needed, 5) provide evidence based treatments, and 6) support rehabilitation and recovery (van Veldhuizen & Bähler, 2013).

According to van Veldhuizen and Bähler (2013) an average Flexible ACT team can include 11-12 full time workers, and deliver services for about 200-220 consumers in a defined geographical area. The composition of the team is broadly multidisciplinary, and includes case managers, psychiatric nurses, psychiatrists, psychologists, social workers, addiction specialists, employment specialists, rehabilitation specialists, and a peer support worker. Each case manager is responsible for approximately 20 consumers with varying needs; twice as many as in a traditional ACT team. Compared to a traditional ACT team, the Flexible ACT model thus makes it possible to provide services to a larger number of consumers.

Little research has been done on the effectiveness of Flexible ACT (Nugter et al., 2015). Preliminary results indicate positive trends in quantitative medical outcomes, such as a higher probability of symptomatic remission for patients with severe mental illness than for controls receiving standard treatment, increased remission of psychotic symptoms (Drukker et al., 2008), higher levels of psychosocial functioning (Drukker et al., 2013), fewer hospital admissions and a 50% reduction of inpatient bed use (Firn et al., 2013), increased compliance with treatment, decrease in unmet needs, and improved quality of life (Nugter et al., 2015). In England, Flexible ACT has been shown more cost-effective compared to assertive outreach teams. This is the result of reductions in bed-use, face-to-face contacts, and changes in staffing (Firn et al., 2013). However, no randomized controlled trial (RCT) has been published to ensure that the model meets criteria for being an evidence-based practice, defined as the integration of sound research evidence based on systematic research, clinical

experience, consumer values, and contextual factors (Sandstrom et al., 2014). Currently, there are no available studies that highlight mental health professional experiences of working with the Flexible ACT model, and this underscores the relevance of the present study.

Despite the lack of systematic research on effectiveness of the Flexible ACT, the model is considered well-articulated and feasible, and is well received by mental health professionals (Bond & Drake, 2007). In the Netherlands, a large number of mental health care teams have implemented the model within a short time period, making it difficult to organize a randomized controlled trial because of the lack of a control group to provide 'treatment as usual' (van Veldhuizen et al., 2015). The same development is now seen in Sweden (CEPI, 2014). Accordingly, mental health professional experiences with the Flexible ACT model need to be explored in order to better understand the clinical experiences and why the model is so well received. This is especially interesting given that today, stress and burnout are significant problems in mental health services, and currently affect employees, their organizations, and quality of care (Morse et al., 2012; Rossler, 2012). We assume that the Flexible ACT can influence professionals working in the mental health care work situation, and this may explain why the model is so well received. The aim of this study was thus to explore mental health professional experiences of working with the Flexible ACT model compared with standard care.

Method

This grounded theory study was conducted during the spring of 2015 as part of an implementation study of the Flexible ACT model in Sweden (CEPI, 2014). Grounded theory was considered an appropriate method for approaching the study aim since it is explanatory in nature, and little is known about mental health professionals' point of view on the topic. Additionally, grounded theory is appropriate for explaining processes and actions in a

situation, as well as when a theoretical framework for further research is desired (Corbin & Strauss, 2007).

Eligibility and participants

Eligibility criteria included being a mental health professional: 1) in a Flexible ACT team in Sweden; 2) with experience of implementing the Flexible ACT model; 3) who had worked in accordance with Flexible ACT for at least six months; and 4) working in a team with a Flexible ACT fidelity score of at least 3.5 out of 5 on the Flexible ACT fidelity scale (Bähler et al., 2010). Participants were gradually included in the study, consistent with the concept of theoretical sampling (Corbin & Strauss, 2007); when the first interview had been analysed, the next participant was chosen on the basis of the emerging concepts (see data collection below). The process entails inclusion of mental health professionals of different ages and genders, from different Flexible ACT teams, with different professions, and who have varying lengths of experience (six months to two years) of working with the Flexible ACT model. First, the authors contacted the team leaders in all Flexible ACT teams in Sweden and introduced them to the study. All team leaders agreed to take part in the study, gave the authors permission to make contact with the team members, and provided a list of e-mail addresses of each team member. During theoretical sampling, the team leaders and previously interviewed team members provided information about suitable interviewees. Second, information about the study was given to a team member by one of the authors when an interview appointment was made. Each mental health professional that was asked to participate agreed to do so ($n=19$), and completed the interview. They were between 35 and 65 years old. Three were men and 16 were women. They had three to 40 years of experience of working in mental health care, and worked in ten different Flexible ACT teams in urban areas in Sweden. Team leaders, psychiatrists, case-managers, psychiatric nurses, social workers, psychologists, occupational therapists, and physiotherapists participated. The teams

primarily worked with consumers with psychosis, and had full responsibility for treatment services, including crisis intervention before and after the team started to work in accordance with Flexible ACT. There were no crisis resolution teams in the areas covered by the teams.

Ethics statement

The study was conducted in compliance with the established ethical guidelines of the Declaration of Helsinki. Verbal and written informed consents were obtained.

Data collection

The interviews lasted about 60 minutes each (range of 40 to 90 minutes), were conducted at the participant's work place, and were recorded digitally with consent from the participant. First, the participant was asked to share experiences (advantages and disadvantages) of working with the Flexible ACT model compared with standard care. Question areas included shared caseload, quality of care, crisis intervention, availability and flexibility of care delivery, and administrative procedures. The question areas were inspired by the Flexible ACT fidelity scale main-categories (Bähler et al., 2010) and the results of interviews with team leaders as part of the Flexible ACT implementation study (CEPI, 2014). If another topic of relevance was brought up during the interviews, participants were encouraged to share that as well, in accordance with Corbin & Strauss (2007). During the data collection process, the following question areas were added: work procedures, need of tools for handling consumer crises, complements to previous work procedures, team engagement (i.e., increased involvement and participation among the team members), views of the consumer, multidisciplinary input, social networking, supporting rehabilitation and recovery (i.e., focus on consumer wishes and goals), team spirit, cumbersome work procedures, improved documentation and emergency plans, preventing crises and hospital admissions, overview of consumers in crisis, reduced stress, being relieved, joint responsibility, not being alone, feelings of safety, and gaining control. The procedure of feeding initial results back into the

data collection process is seen as essential in grounded theory (Corbin & Strauss, 2007).

During the last three interviews, no additional question areas emerged that added to the emerging categories. This indicated theoretical saturation, and thus no further interviews were performed.

Data analysis

Throughout the analysis, the program Open Code 4.01 was used and memos were written to aid the analysis process after each interview and during data analysis, in order to describe ideas about codes and their relationships, emerging concepts, and categories. In grounded theory data collection, analysis and memoing are ongoing, and overlap (Corbin & Strauss, 2007). Both authors were involved in all parts of the data collection and analyses. The data were subjected to open and axial coding (Corbin & Strauss, 2007). In the first step, the interview transcripts were coded using *in vivo* codes by identifying concepts that represented the ideas contained in the data. In concurrence with open coding, crosscutting and comparing related concepts were performed (i.e. axial coding). During this process, one core category and three main categories were identified and illustrated in a conceptual process model.

Results

The analysis resulted in the core category, “*Flexible ACT and the shared caseload create a common action space*” and the three main categories: 1) “*Flexible ACT fills a need for a systematic approach to crisis intervention*”, 2) “*Flexible ACT has advantages in the psychosocial working environment*”, and 3) “*Flexible ACT increases the quality of care*”.

These are illustrated in the conceptual process model (Figure 1). The common action space was created when a consumer in crisis was put on the Flexible ACT board, which initiated intensive team care with a shared caseload according to ACT principles. This common action space was shared between different professionals in the team and could also access resources from other teams in the same psychiatric unit, inpatient care, municipal social services, and

the consumer's social network. The common action space was described as creating a common spirit, understanding regarding assessments, and increased involvement and participation when working closely together to help a consumer in crisis toward the common goal of reducing relapse and hospital admission.

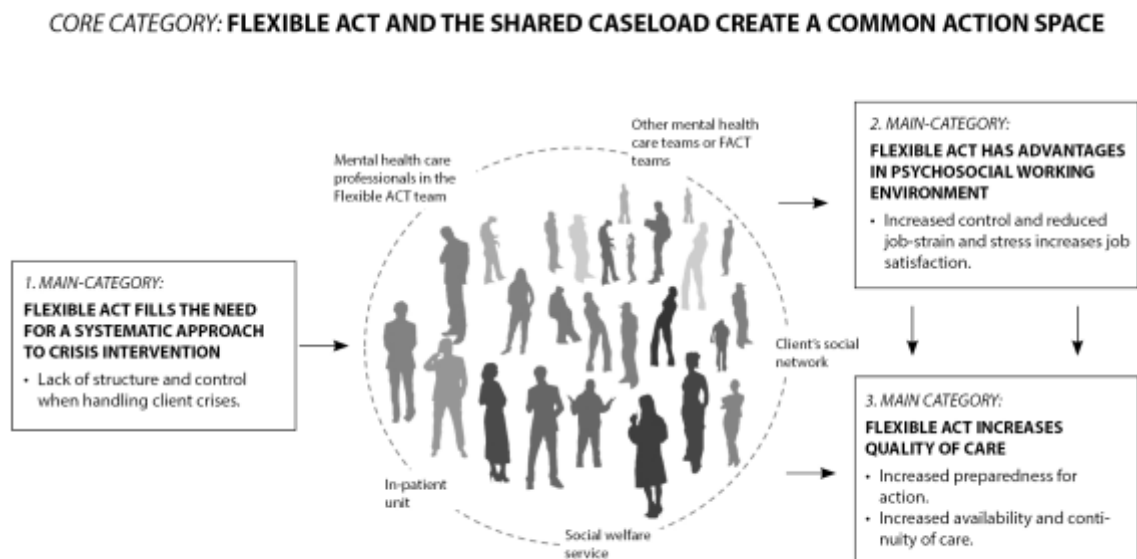


Figure 1. Conceptual model of mental health professional experiences of working with the Flexible ACT model.

1. Main category: Flexible ACT fills the need for a systematic approach to crisis intervention

The mental health professionals felt that the Flexible ACT model filled a need for consistent work procedures when handling consumers in crisis. The Flexible ACT model with the shared caseload provided a common rationale and routines for handling consumer crises.

Furthermore, the Flexible ACT board provided a good overview of the consumers in need of more intense support. In this way, the board made the professionals feel a higher degree of control of their work situation. One mental health professional expressed the following:

“I saw the Flexible ACT model as a new useful strategy to prevent relapse and hospital admissions - an area where I felt that our team needed to improve. When we decided to implement the model, I was therefore thinking mostly about the advantages of being able to provide flexible care, including crisis intervention and risk management according to consistent work procedures. In this way, we felt the need to develop into a more flexible, integrated, psychosis team.” (Interview 5)

2. Main category: Flexible ACT has advantages in the psychosocial working environment

Advantages of working with the Flexible ACT model in the psychosocial working environment were experienced by the mental health professionals. These were decreases in job strain and stress. The shared caseload made them feel less alone in handling a consumer in crisis, and reduced the workload and feelings of being stressed. This resulted in feelings of relief and less anxiety in their concern for their consumers. As a result of the shared caseload, they also got higher degrees of advice and support from their colleagues. Additionally, the digital Flexible ACT board gave a good overview of the consumers in need of more intense support. Together with regular meetings, the board increased preparedness for action, which in turn gave a feeling of being in control, and reduced stress. The professionals also felt that the shared caseload created and saved time, even though they spent more time actively helping their colleagues handle consumer crises. Another advantage was that the professionals were able to head home from work, take time off or be home with a sick child without feeling anxious and with a clear conscience, even if some of their consumers were in crisis and/or relapsing:

“The main strength of the Flexible ACT model is that my consumers in need of intense support are regularly monitored, even if I’m not available for some reason. It is written clearly on the digital Flexible ACT board what needs to be done day by day. Now I can leave work on time and head home without feeling anxious,

and without having the responsibility for the consumer hanging over me. Now I feel less alone and I don't need to carry everything alone anymore. Now we share the hard parts in the care for our consumers.” (Interview 8)

The team leaders also experienced a decrease in job strain and stress. The Flexible ACT board gave them a good overview of the team burdens, and the shared caseload resulted in a decrease in personnel matters because the personnel felt less stressed and the workloads were automatically distributed more evenly among the team members. One team leader said:

“I don't need to handle the team members' frustration over heavy workloads and stressful work situations to the same extent as before we started to work with Flexible ACT. The complaints have decreased, so it has become easier for me as a team leader.” (Interview 6)

However, some of the mental health professionals thought that the administrative procedures were cumbersome. The daily meetings could take more time than intended, and some of the professionals with fewer technical skills felt that it was difficult and time-consuming to handle the digital Flexible ACT board. One professional, who was frustrated with handling the board, said that: “...difficulties handling the digital Flexible ACT board put a damper on creativity when discussing consumers!” (Interview 9).

3. Main category: Flexible ACT increases the quality of care

The professionals thought that working with the Flexible ACT model resulted in improved documentation, more emergency plans, and increased preparedness for action to work with relapse prevention and avoidance of hospital admission. Additionally, the mental health professionals felt that working with this service delivery model resulted in an increased awareness of consumers in need of more intense support, increased consumer safety, reduced risk of relapse, and decrease in hospital days. One mental health professional shared the view:

“I think that we ensure quality of care. The Flexible ACT board gives an overview that makes all the consumers’ different needs clearly visible, and makes it easier to plan for necessary risk assessments and crisis interventions.” (Interview 1)

Furthermore, they also said that the recovery-oriented approach further increased shared decision-making with consumers, and enhanced the focus on the consumer’s wishes and goals. Together, this increased the quality of care. The professionals believed, that in the long turn, this might reduce the social consequences of severe mental illness. In contrary, some feared that the focus on crisis intervention might take the focus away from a consumer’s long-term rehabilitation goals:

“Flexible ACT is, at a first glance, focused on crisis management with the Flexible ACT board, the shared caseload, and the daily meetings to handle consumer crises. This might lead you to lose focus on the individual’s long-term goals”. (Interview 12)

Discussion

Our study provides a unique and enhanced understanding of mental health professional clinical experiences of working with the Flexible ACT model that has not been previously described. As reflected by the core category, mental health professionals experienced the Flexible ACT and shared caseload as creating a common action space. They thought that the Flexible ACT filled the need for a systematic approach to handling consumer crises, had advantages in the psychosocial working environment, and increased the quality of care.

The Flexible ACT model and the shared caseload (according to principles of ACT) provided important advantages in the psychosocial working environment of the mental health professionals through reduced job strain and stress. The Flexible ACT work procedures gave a feeling of being in control and less alone when handling consumer crises. Professional also

experienced a higher degree of support from their colleagues. This, in turn, increased their work satisfaction and sense of providing high quality care. These findings are consistent with the job demand-control-support model that describes that strategies to gain control over the work situation are important for management of work-related stress, and in maintaining wellbeing and job satisfaction (Van der Doef & Maes, 1999). Additionally, properly targeted social support has shown to moderate the negative effects of high job strain in maintaining wellbeing at work (Morse et al., 2012; Onyett, 2011; Van der Doef & Maes, 1999; Wood et al., 2011). Organizational level changes, rather than interventions directed towards the individual employee, have also been shown to be the most appropriate targets to reduce work-related stress and burnout among personnel (Morse et al., 2012; Rossler, 2012). The most recent systematic review by Morse and colleagues (2012) indicates that approximately 21-67% of mental health professionals may be experiencing high levels of burnout. Previous research also shows that mental health professionals are subject to increased risk for occupational stress (Lasalvia & Tansella, 2011; Morse et al., 2012). This may result in feelings of exhaustion and disengagement from work (Peterson et al., 2008). Little research has been conducted on interventions that aim to reduce burnout among mental health professionals (Morse et al., 2012). Further longitudinal, quantitative studies are needed to investigate the potential advantages in the psychosocial working environment of the Flexible ACT model regarding changes in job strain, stress, and job satisfaction over time.

In conclusion, the Flexible ACT model is valued by the clinical team because of advantages in work procedures, the psychosocial working environment, and quality of care. This may explain why the model is so well received by mental health professionals. These study results indicate that when it comes to Flexible ACT, clinical experience overrules scientific evidence and the other criteria that define an evidence-based practice. This may explain why the model is so easily implemented, despite the lack of evidence for the model's

effectiveness. In this respect, other evidence-based practice criteria need to be explored, in line with Sandström and colleagues (2014). For example, there is a need for a randomized controlled trial that compares Flexible ACT with treatment as usual, explorative qualitative research on consumer values in relation to the support provided in Flexible ACT, and research on contextual factors that might influence Flexible ACT service delivery.

Methodological considerations

In order to enhance study trustworthiness, guidelines to enhance rigor and quality in grounded theory research were used when designing and performing the study (Corbin & Strauss, 2007; Chiovitti & Piran, 2003). Theoretical sampling was used to increase study credibility; the mental health professionals were allowed to guide the inquiry process by feeding initial results back into data collection. To further increase credibility, memos were written continuously to aid the analysis process, *in vivo* codes were used, and the mental health professionals had the opportunity to comment on the preliminary findings. The professionals agreed with the authors' interpretations. Therefore, no additional changes were made.

Furthermore, each part of the analysis was discussed among the authors until consensus was reached. The authors had different backgrounds in nursing, occupational therapy, and mental health; differences that made it possible to challenge each other's interpretations.

Furthermore, a detailed method description was made to further enhance credibility. The restricted description of the mental health professional characteristics and the geographical setting may limit the possibility for other readers to assess the transferability to other settings. The reason for this limited description is to ensure study participant confidentiality. Another limitation is that this study reflects initial experiences of working with the Flexible ACT model, i.e. six months to two years after implementation. Accordingly, the experiences may reflect an initial enthusiasm for new work procedures. Further research is therefore needed on longer term and longitudinal mental health professional perspectives.

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