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Challenges for Providers Working in Assertive Community Treatment

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
2018

Abstract

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

This project explored the challenges confronting clinicians who work with the Assertive Community Treatment Program (ACT), a government-sponsored clinic-based program providing services for individuals with persistent and recurrent mental health challenges in a large metropolitan city in the southern United States. The project involved semistructured interviews with 15 health care clinicians to explore what they perceived as challenges and their recommendations for addressing them. Themes were organized around the 6 dimensions of the the relationship-based care model: leadership, teamwork, professional nursing, care delivery, resources, and outcomes. Identified patient challenges included transportation, lack of health insurance, housing, acceptance of certified peer specialists, the stigma of seeking help for mental health issues, problems with tracking patients, family interference, and fear of discharge from the program. Challenges related to the work environment were identified as poor pay for mental health staff, increasing paper work, professional boundaries, and balancing work demand and personal experiences. Recommendations to address challenges included open communication, interdisciplinary meetings to improve coordination of resources, increased support for family participation, and community support for mental health services. This project adds to the knowledge on ACT programs and will assist organizations planning or delivering ACT services in channeling resources to areas recommended by ACT clinicians. Recommended organizational changes will provide a positive social change to improve care of individuals with mental health challenges in the community.

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Dedication

This project is dedicated to my parents that taught me the essence of humility and treating everyone with love regardless of their circumstances. That love and teaching translates to patient advocacy and has helped m ould my passion for the vulnerable population such as individuals with mental health challenges

This work also is dedicated to my kids Michelle, Diana, Chidera and Nicole. Your help and support at different stages of this project helped me to be steadfast in completing this work. Thanks to you all.

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Finally great thanks to God Almighty for his grace towards my life. I could not accomplish any of these without his guide, grace and protection.

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Section 1: Nature of Project

Introduction

Exploring the challenges for clinicians who work with individuals with persistent and recurrent mental health illness in the community is vital to improving the quality of care provided by these clinicians**.** Individuals with mental illness are often stigmatized, isolated, and socially excluded (ACT Tool Kit, 2008).

Provision of a comprehensive set of community-based, recovery-oriented, and evidence-based services for people with mental and substance use disorders has been supported by current health care reforms and executed by both federal and state agencies via Assertive Community Treatment (ACT; Doherty et al., 2014). The essence of ACT is to provide comprehensive, client- centered, mental health care on an outpatient basis to individuals with severe and persistent mental illness, with frequent relapses and rehospitalizations (Molly, et al., 2015). Pope and Harris (2014) described ACT as a "team approach, based in the community and designed to provide comprehensive psychiatric care, rehabilitation, and support to people with severe and persistent mental illness" (p. 18). Emphasis on preventive care and care delivery to individuals where they reside has been supported by the Institute of Medicine in its Transforming Nursing Leadership (2011) report. The Institute recommended coordinated effort between physicians, nurses, social workers, physical and activity therapists, psychologists, and others for effective patient care (NAS, 2011). ACT employs the services of diverse professionals to deliver services to mental health consumers in the community where they reside. Services that are provided by ACT clinicians range from housing, social services, medication administration, and vocational readiness training, to peer support and diagnostic

assessment. A tool for measuring ACT fidelity is the Dartmouth Assertive Community Treatment (DACT) tool. This tool measures the effectiveness and efficiency of ACT in several areas including caseload, staff capacity, intake rate, time-unlimited services, and no dropout policy.

In this project, I used semi-structured interviews to explore the challenges faced by clinicians who work in an ACT program in a large urban healthcare system in the southeastern United States. The findings contribute to existing knowledge about ACT and may assist other organizations planning to set up ACT with channeling organizational resources to needed areas of improvement.

Problem Statement

Individuals with recurrent and persistent mental health problems often face challenges that make it difficult for them to function effectively in the community. The debilitating symptoms of their mental illness, coupled with a lack of a support system and other comorbid problems such as drug abuse, lack of access to programs within the community, and poverty, often make it hard for this population to obtain benefits and care that could help them live to their full potential in the community. ACT is an evidence-based program that employs the services of different professionals to deliver effective and efficient mental health services in the community 24 hours per day, 7 days a week, 365 days per year. The program provides comprehensive and efficient services to consumers who have needs that have not been well met by traditional approaches to service provision.

ACT employs the services of different professionals such as psychiatrists, registered nurses, licensed professional counselors, social workers, vocational specialists, mental health technicians, drug counselors, housing experts, peer specialists, and psychotherapists to deliver round the clock care to individuals in the program. These clinicians offer various services to mental health patients in the community. ACT interventions have shown to improve patient outcomes through targeted individualized treatment plans and use of peer support specialists to care for this population (Pope & Harris, 2014).The success of ACT programs using consumers as employees and trainers stems from shifting recovery and intervention perspectives from a symptom dominant view to one that regards recipients in holistic terms through the exploration of users strengths, talents, and social/emotional concerns (Salyers and Tsemberis, 2007).

Despite the noted successes of ACT programs, there has been little research exploring challenges that clinicians face when working with ACT patients. In existing reearch from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2008), some of the issues reported by service providers include a feeling of interference with individual autonomy, safety, stressors from paperwork, transportation, consumer's premorbid symptoms, medication compliance among users, and substance abuse and prostitution. Safety was recognized as one of the biggest issues that ACT clinicians face. Moser, Monroe, and Teague (2013) have noted problems releated to specialty intervention. Because each team member is expected to step in and provide most services at any time with an underlying complementary promotion of a generalist approach to service provision, ACT team specialists struggle to provide specialty-related

services with consistency (Moser et al., 2013). Increased burnout was associated with greater stress resulting from delivering clinical and behavioral interventions through a team-based approach (Harvey, Killaspy, Martino, & Johnson, 2012). In this project, I explored these problems from the perspectives of clinicians who work with an ACT program in an urban hospital and recommended steps to reduce the challenges.

Purpose

The purpose of this project was (a) to explore the challenges faced by ACT clinicians, and (b) to report recommendations to ACT administrations from these clinicians for improving delivery of ACT services. My goal with this project was to improve community care for individuals with persistent and recurrent mental health problems byaddressing challenges faced by clinicians who offer the services. The practice focused questions were: what are the challenges facing clinicians in providing care for clients through the ACT program? What recommendations for improving delivery of ACT services are offered by these clinicians?

Delivering efficient and effective care to patients in the communities where they reside will not only reduce chronic illnesses, but also encourage preventive care through primary care service. In 2013, the World Innovative Summit for Health implemented a strategy to strengthen care for individuals with mental health care needs that emphasized the provision of comprehensive, integrated, and responsive mental health and social services in communities where the consumers reside. The six policy actions implemented by the group included:

- Empowering people with mental health problems and their families.

- Building a diverse mental health workforce.
- Developing collaborative and multidisciplinary mental health teams.
- Using technology to increase access to mental health care identifying and treating mental health problems early.
- Reducing premature mortality in people with mental disorders. (Desilva, Samele, Saxena, Patel & Darzi, 2014, para.1).

Understanding the challenges of ACT clinicians will not only facilitate the above policies but will also improve the efficiency and effectiveness of care delivered to the mental health patients in the communities where they reside. The six policy actions found expressing in the 5-year strategy from the Qatar National Mental Health Strategy (Desilva et.al. 2014), which was developed as a strategy for comprehensive and integrated mental health care that offers choices on how and where mental health patients receive their care. A 2012 local television report showed how ACT services from my project organizaion facilitated recovery and rehabilitation of an individual with persistent and recurrent mental health problem in the community. The report showed a consistent, effective, and efficient intervention method by ACT clinicians that led to decreased emergency room visits, reduced run with the jail system, and improved quality of life.

Nature of the Doctoral Project

Evidence for this project came from interviews with clinicians who work on the three teams of the ACT program. Each team consisted of 12-15 different professionals who offer various services to mental health consumers in the community. These

clinicians include (a) psychiatrists, (b) advanced practice registered nurses/physician assistants, (c) registered nurses, (d) substance abuse counselors, (e) licensed clinical social workers, (f) peer specialists, (g) housing experts, (h) vocational specialists, and (i) licensed professional counselors. These clinicians provide services associated with housing, parenting, benefits, symptom and medication management, medical care, counseling, diagnostic assessment, substance abuse treatment, and job readiness (SAMSA, 2008). The project supported my role as a doctorally prepared nurse who serves as both a promoter of evidence-based practice and translator of research into practice.

The databases and search engines I used to gather research related to the practice problem included CINAHL Plus with full text, Medline with full text, SocIndex with full text, Center for Disease Control and Prevention, Georgia Department of Behavioral Health and Developmental Disability, and Georgia Collaborative Services Organization. Some of the key search terms were *assertive community treatment, mental health, community health,* and *ACT clinicians*. In the reviews, I concentrated on peer review articles, ACT organizations, and state behavioral health departments, and materials associated with my project site. The majority of the peer-reviewed articles were within the past 5 years, and the behavioral health sources that I explored were officially approved sites for the state, organizations, and the Centers for Disease Control and Prevention (CDC).

Significance

I conducted this project on the premise that exploring the challenges faced by ACT clinicians at a large urban health system could not only improve the quality of care delivered by ACT clinicians in the community, but also could assist organizational stakeholders in understanding the challenges that impact staff retention and burnout, which may contribute to meeting the goals and objectives of the program. State, community, and other clinicians could gain more insight on how ACT functions. The stakeholders may benefit from this project included the health system, the families, communities, and mental health consumers in the ACT program. Other beneficiaries of this project included clinicians who work on the ACT program.

Summary

This exploration of the challenges faced by clinicians who work on the ACT program may assist organizations that use ACT to improve team services and support overall improvement in the quality of care provided to the consumers, their families, and the communities. The project findings have the potential to guide agencies proposing the practice via recommend steps and strategies to minimize challenges to reduce staff burnout. In Section 2, I describe the theory underwriting the practice question, the study's relevance to nursing practice, my role as DNP student, and the historical background and context for the project.

Section 2: Background and Context

Introduction

The challenges posed by mental health diagnosis make it imperative that health care systems employ skilled clinicians who will help meet those challenges in a timely and efficient manner. In this project, I sought to explore the challenges described by clinicians who delivered ACT services to mental health consumers in the community. Themes identified from the interviews assisted in developing recommendations for improving ACT services.

Concepts, Models, and Theories

I used the relationship-based care (RBC) model to frame this project. This model includes six dimensions of care: (a) leadership, (b) teamwork, (c) professional nursing, (d) care delivery, (e) resources, and (f) outcomes (Glembocki, 2010). The model framed the interview questions for the project. The model highlights the importance of trust between patient and care provider in the formation of an interpersonal relationship. It can be used to explore the care providers relationship with patients and families, the her or himself, and with other members of the health care team (Fitzpatrick, 2014).

Relevance to Nursing Practice

Current ACT program outcomes included (a) demonstrating improvement in the quality of life, (b) reducing emergency room visits, and (c) reducing incarceration for mental health consumers. Research has shown that, when compared with other mental health treatments, ACT not only reduced psychiatric hospitalization and provided a higher level

of housing stability, but also has a better effect on consumer's quality of life, symptoms, and social functioning (ACT Tool Kit, 2008). Family members and consumers utilizing ACT services reported greater satisfaction and better outcomes.

Providing care for individuals with persistent and recurrent mental health challenges in the community where they reside brings primary and population care closer to the community. It offers the opportunity to meet these individuals needs and be the family and community support while working through recovery and rehabilitation. Consumers serviced by ACT over time develop a bond of trust, which is hard to break even when they leave the program. Molly et al. (2015) noted that part of the problems facing ACT clinicians is clients' resistance to transition, and relapse in the absence of ACT support. Chen and Herman (2012) noted that the relationship established between ACT clinicians and patients is a reason why ACT has worked and other modalities have failed. The authors explained that the time-unlimited nature of the ACT program allows clinicians and consumers to develop a healthy, long-term clinical relationship, which is considered the most important part of ACT services (Chen & Herman, 2012). Cases have been reported about the lack of preparedness of follow-up agencies after patients discharge from ACT services. Because of inadequate outpatient treatment time needed for a solid patient-doctor relationship and restrictions on reimbursement of overlapping services during transition, ACT clinicians are sometimes forced to provide voluntary services to ensure stability and successful transition of consumers during discharge (Chen & Herman, 2012). Coordinating mental health care with complex comorbid conditions presented by this population poses a peculiar challenge to clinicians as they have to

balance both cares consistently. This balance requires referrals for clinical conditions such as hypertension, diabetes, infection, pregnancy, and various skin problems (Randall, Wakefield, & Richards, 2012). Issues related to staffing shortages and turnover pose a challenge to efficient care delivery to individuals with mental health problems (Barry, Abraham, Weaver, & Bowersox, 2016). In a related study, some mental health professionals reported that administrative procedures were cumbersome and noted that the daily meetings could take more time than intended (Lexen & Svensson, 2016).

Local Background and Context

The community-based ACT program that served as my project site has served a large urban community for over 10 years. A report from a local news service (2012) showed the success of using ACT in the recovery and rehabilitation of an individual with persistent and recurrent mental health problem in the community. With this program, "Multiple contacts may be as frequent as two to three times per day, seven days per week, and are based on consumer need and a mutually agreed upon plan between the user and ACT staff" (Georgia Tool Kit, 2008). Many, if not all, staff share responsibility for addressing the needs of all users requiring frequent contact. The successes recorded by this ACT program has led the state government and the Department of Justice (DOJ) to signing an extension of the settlement agreement modifying the original terms of the 2010 American with Disabilities Act Settlement (DBHDD, 2013). The governor noted that the agreement is a significant accomplishment for the state and is possible through the dedication of team members and provision of high-quality care to individuals with behavioral health challenges and developmental disabilities. The governor also noted that

the extension agreement reflects quality health care services delivered in areas of transition from state hospitals to community settings, community-based supports, and services for people with developmental disabilities (DBHDD, 2016).

The expected total number of face-to-face contacts per consumer, per month, is a median of 12 contacts (DBHDD, 2011). ACT service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse, and vocational rehabilitation to deliver care to mental health patients in the community. Additionally, a certified peer specialist is an active member of the ACT Team, providing assistance with the development of natural supports, promoting socialization, and the strengthening of community living skills (DBHDD, 2011). By exploring the challenges faced by clinicians who work on this program, I sought to help strengthen this evidence-based practice and create a more favorable environment for delivering efficient and effective care to individuals with persistent and recurrent mental health problems in the community. Addressing specific specialty problems faced by clinicians will provide a sense of ownership and commitment to advance the program.

Definitions

Mental health problems: A"set of medical conditions that affect a person's thinking, feeling, mood, ability to relate to others, and daily functioning; These conditions include; depression, schizophrenia, psychosis, bipolar disorders, Attention-deficit hyperactive disorder, post-traumatic stress disorder, developmental and behavioral disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, and self-harm or suicide" (Desilva, Samele, Saxena, Patel, & Darzi, 2014).

Assertive community treatment (ACT): An evidence-based practice that is consumer-centered, recovery-oriented, and a highly intensive community-based service for individuals who have severe and persistent mental illness (DBHDD, 2011).

Role of the DNP Student

As an advanced practice registered nurse (APRN) who specializes in the care of mental health patients both on an outpatient clinic basis and in the ACT program, I anchored this project on my experiences gained by working with the mental health population for over 7 years. My role in this doctoral project was to use an established relationship with ACT clinicians to explore the challenges faced by professionals who work with mental health patients in the ACT program, document their recommendations for change, and share these recommendations with ACT administrators.

Summary

In Section 2, I discussed the RBC model framing this project and the evidence supporting the ACT programs. Results from this project serve to describe challenges faced by clinicians who work in ACT programs and may be used to assist organizations that wish to start ACT. In Section 3, I explore the project's plan, implementation, and analysis.

Section 3: Collection and Analysis of Evidence

Introduction

Despite the recorded successes of ACT programs, few researchers have explored the challenges that face clinicians who work with ACT patients. Through semi-structured interviews, I explored the challenges faced by clinicians and gathered their recommendations for addressing these challenges. In this section, I discuss the sources of evidence for this project, the project plan for implementation, and analysis.

Practice Focused Question

The practice focused questions for this project were: What are the challenges facing clinicians in providing care for clients with persistent and recurrent mental health problems in the Assertive Community Treatment (ACT) program? What recommendations for improving delivery of ACT services are offered by these clinicians? I invited all clinicians working for the ACT program that served as my partner organization to participate in semi-structured interviews. These interviews focused on their challenges in providing care for clients in the program and on their recommendations for improving these challenges. I interviewed 15 ACT clinicians working in a large urban health system in the southeastern United States to explore these challenges and recommendations.

The diverse professional background of clinicians working with the ACT program resulted in diverse experiences and assessments of their challenges while working with individuals with persistent and recurrent mental health problems in the community.

Reports from personal experiences of these clinicians highlighted their challenges and informed recommendations to address those challenges.

Sources of Evidence

Participants

Fifteen clinicians who worked on the two teams of the ACT program contributed evidence to address the practice-focused questions. ACT participants were full-time clinicians working with the ACT program for a minimum of 1 year. Clinicians included registered nurses, social workers, licensed professional counselors, housing specialists, vocational specialists, substance abuse counselors, peer specialists, licensed clinical social workers, and mental health practitioners.

Sampling Strategy

After receiving approval from the Walden Institutional Review Board (IRB) 05-10-17-0391358, IRB number was presented to project site to request approval for project interviews. A letter of support from project site was obtained for formal permission to conduct the interviews. The director of the ACT program introduced me at each team meeting to discuss the project. A follow-up email with my contact information was sent to the clinicians, inviting them to participate in the interviews. Interviews will be scheduled in a private room at a time convenient for the participant. All materials and information gathered during the interview was locked up in a secure cabinet located in my house. I was the only one with access to the materials. All data will be securely stored for 3 years and then destroyed. The semi-structured interviews were framed using the six dimensions from the RBC model: (a) leadership, (b) teamwork, (c) professional nursing,

(d) care delivery, (e) resources, and (f) outcomes (Glembocki, 2010). I recorded the interviews with each participant in a designated private setting within the ACT treatment center or in the community. I transcribed each interview to identify major themes.

Analysis and Synthesis

Upon completion of the interviews, I identified themes associated with the challenges and recommendations for change using the RBC framework.

Summary

In Section 3, I described the process I used to explore the challenges faced by clinicians who work in the ACT program. This information added to scholarly and clinical knowledge of ACT and assisted organizational stakeholders in understanding the challenges of various clinicians who care for individuals with persistent and recurrent mental health problems in the community. In Section 4, I present the findings and implications of this project.

Section 4: Findings and Recommendations

Introduction

The care for individuals with chronic and persistent mental health conditions requires coordinated and interrelated activities. The physical and mental capacity of care providers and their ability to use evidence-based practice in care delivery will improve the quality of outcome for individuals with persistent and recurrent mental health problems.

This project explored the challenges that face clinicians that work on the Assertive Community Treatment (ACT) program and seek recommendations to reduce such challenges. The goal of this project was to improve community care for individuals with persistent and recurrent mental health problems through addressing challenges faced by the clinicians that offer the services. In addition, the challenges for the clinicians and their recommendations for changes would be addressed. The practice focused questions were: what are the challenges facing clinicians in providing care for clients through the GHS ACT program? What recommendations for improving delivery of ACT services are identified by these clinicians? Interview questions were based on the six dimensions of the Relationship. Fifteen clinicians from different professional background were interviewed during the project. Identical questions were asked to all clinicians that participated in the study.

Table 1.

Clinicians Interviewed

Clinician Role	Number
Registered Nurse	1
Peer Specialist	2
Substance Abuse Counselor	2
Team Leaders with Social Work Background	2
Licensed Clinical Social Workers	2
Housing Specialist	1
Vocational Specialist	1
Licensed Professional Counselor	1
Social Worker	2
Mental Health Clinician	2

Table 2

RBC Model and Interview Questions

RBC Model Framework	Questions
Leadership	What are the leadership challenges encountered as a CLINICIAN working on the ACT program? What recommendations will reduce these challenges?
Teamwork	What are the challenges encountered in areas of teamwork by the CLINICIAN working on the ACT program? What are the recommendations for reducing this challenge?
Professional nursing/Other professions	What are the professional challenges encountered by the CLINICIAN working on the ACT program? What recommendations will reduce this challenge?
Care delivery	What challenges are encountered by the CLINICIAN in care delivery using the ACT program? What recommendations will enhance care delivery for a CLINICIAN on the ACT program?
Resources	What challenges are present in areas of resources for a CLINICIAN working in the ACT program? What recommendations will reduce this challenge for a CLINICIAN working on the ACT program?
Outcomes	What are the challenges that affect CLINICIAN outcome on the ACT program? What recommendations will reduce this challenge?

Recommendations

I transcribed all the interviews and identified challenges and recommendations. The identified challenges and recommendations were them grouped by themes using the dimension of the RBC model. Table 3 describes the challenges and recommendations based on each theme of the RBC model.

Table 3

Themes and Challenges of ACT Clinicians

Dimensions of relationship care-based model	Challenges	Recommendations
Leadership	Communication	❖ Use different forms of communication such as text messages, morning rounds, e mails, access to organizational phones
	Overlap of clinicians role	❖ Clear orientation of Clinicians role in patient recovery. ❖ Encourage interdependence yet independence of Clinicians to initiate actions necessary for patient recovery and care.
	Work load burn out and high turnover among `staff	❖ Increase staff, increase pay, reduce paperwork ❖ Maintain healthy balance between work, private life and personal experiences ❖ Open communication between management and staff
	Time management-coordinating all activities of ACT clinicians	❖ Encourage participation in interdisciplinary team meetings and use approved communication gadgets for company to access information in a timely manner
	Self-care	❖ Organize programs outside work for team building and take breaks as necessary

Teamwork	Interchangeability of roles Clash of clinicians interventions models	❖ Setting appropriate boundaries on Clinicians role. ❖ Coordination of care ❖ Removing personal emotions ❖ Refer to ACT policies, protocols and manuals ❖ Interdisciplinary team meetings, group text, group e mails
Professional nursing/other professions	Patient acceptance of Peer Specialist role as a clinician Clash of Clinicians role High turnover of staff. challenge of job requirement, documentation, paperwork	❖ Education and training and increased awareness of mental health. ❖ Programs to reduce stigma attached to mental health by patients and community at large ❖ Being mindful of professional boundaries while staying interconnected in ACT program. ACT is a wrap-around service ❖ Care for staff needs. ❖ employing individuals with experience on Act and mental health. ❖ Scheduling to accommodate enough time for patient interventions and documentations
Care delivery	Lots of calls from patients No health insurance. ACT expected to provide patient medications and care even without patient having insurance	❖ A substance abuse counselor quoted; “sometimes, I have a client call me by one, two o'clock in the mornings, saying "I can't sleep", I said well, "Try doing what I do, listen to some music," go take a shower, clean your room, do some things that will help you, activities, that will help you relax. ❖ ACT is a 247 service. Start discharge plans for patients from Day 1. Connect patients to community resources ❖ Coordinate with Medicaid services to get approval for patients health insurance. ❖ Apply for patient assistance programs from pharmaceutical companies ❖ Government should reduce bureaucracy in getting social benefits for ACT patients.

	Homelessness	❖ Work with available resources to get affordable home for them or place them in shelters until we get them placed
	No Identification card for patients	❖ Coordinate with state vital statistics department to get patients birth certificate and information to help obtain proper identification cards from state. ❖ Coordinate with proper government agencies to obtain identification cards for patients Coordinate with country embassies to get vital documents for immigrants that has lost their documents
	Tracking patients	❖ Providing easy access to patients through phone, family contacts and education for patients to contact ACT during hospital admissions, change of address, travel and another visit
	Safety of clinicians - especially during psychotic episodes for patients	❖ Trust your instincts, follow safety guidelines established by your organization, pair up with other clinicians ❖ Apply professional training – de-escalation, redirecting, encouragement, empathy, rescheduling
	eing on disability interferes with them seeking job opportunities	❖ Provide options where patient could have a job and still qualify for disability ❖ Adequate knowledge of community resources.
	Coordinating and getting resources for patients	❖ Planning ahead for patients need with different clinicians. For example, getting housing for patients in hospitals before discharge to ACT program ❖ Patience and follow up with agencies for patient care. Checking with hospitals and jail

		systems and family members when patient is missing ❖ Visiting patients in hospitals to coordinate care and facilitate discharge to community ❖ Educating hospital emergency room staff to call ACT when ACT patients are admitted to the hospital. ❖ Educate ACT patents to notify hospitals that they are with ACT upon admission
	Patients in denial of having mental illness	❖ learning requirements of other agencies that could play a role in patient care delivery such as immigration services
	Patients on ACT that was discovered to have developmental disabilities but was never documented	❖ Educate and use resources such as Cognitive Behavioral therapy to break that barrier. Inform clinical staff for proper evaluation and management
	Not getting information on time about patients medical condition for adequate and necessary intervention due to patients comfort with particular ACT clinician	❖ Clinicians communication of patients medical need to medical team such as registered nurse and psychiatrist
	Medication adherence. Not picking up their refills from pharmacy	❖ Medication education. ❖ Use bubble pack pill system to enhance compliance ❖ Coordinate with pharmacy for patient medication refills and pick up or use pharmacy delivery services to patients home. Family education.
	Family participation in patient recovery and treatment Some patients think ACT assertive nature is too much visit and	❖ Work with patients on level of care change/educate them on the benefit of ACT

	interference in their private life	
Resources	Housing	❖ Familiar with government housing options. ❖ Government should set aside adequate housing for individuals with mental health challenges ❖ Coordinate with government resources for subsidized housing for patients ❖ Political advocacy from ACT clinicians for improved awareness and resources for mental health.
	Transportation: lack of transportation especially in rural areas for patients	❖ Government expansion and provision of transportation to rural areas. ❖ Provision of transportation for organization to move patient to needed programs
	Transportation of patients with history of abuse by opposite sex clinicians	❖ Request for same sex clinicians to transport patients with sexual/abuse history
	Transportation and movement for Clinicians using personal vehicle for ACT program.	❖ Mileage reimbursement from company and provision of company vehicles or partnering with transportation companies
	Driving long hours on the road daily for patient intervention	❖ Administrative scheduling ahead for staff helps reduce movement and coordinate effective care
	Limited resources in the community for mental health patients.	❖ Work on patient assistance programs for needed programs such as medications, , subsidized housing and food stamps.
	Lack of adequate skill training centers for individuals with mental health challenges.	❖ Government should provide more skill training centers for individuals with mental health challenges to train and equip their transition into real life work environments
	Finance for organization	

		❖ Explore resources and grants for ACT programs
	Lack of education, social skills and job experiences	❖ Meet the patient where they are and progress from there
Outcomes	Tension during discharge	❖ Reduce gap in intervention during discharge. Stepping patients to a commensurate less intensive care management ❖ Start discharge process from first day of admission to ACT program. ❖ Affiliate patients to community resources during ACT program- shelter, clothing stores, AA meetings, food banks etc.
	Attachment to ACT program by patients	❖ Celebrate patient discharge with an award and educate patients that discharge signifies recovery from illness and provide community resources to emergency for patients
	Symptoms of mental illness/comorbid issues some ACT patients will never qualify to work due to debilitating mental illness	❖ Knowledge of mental illness and appropriate care protocols. ❖ Working to realize patient individual set goals. ❖ Explore patient hobbies
	Poor job retention due to illness and time in hospital	❖ ACT is work in progress. Patient education on symptoms recognition, medication compliance and staying in touch with ACT clinicians
	Family influence - discouraging patients from maintaining a job for fear of losing their social security benefits	❖ Education and options offered to patients
	Cheque dependency	❖ Educate on the benefits of earning more income from job and many opportunities for a better quality of life than depending on social security cheque.

	Long hours getting ready and attending job interviews Relapse during ACT program and after discharge form ACT	❖ Devote time to patient care ❖ Educate them about harm reduction and encourage personal safety. ❖ Get patient equipped with adequate resources before discharge such as food stamp, housing, medication management, family support (where available)

On the first question of leadership challenges faced by ACT clinicians while delivering ACT services, while all the clinicians noted communication as a major challenge, the team leaders noted poor remuneration, paperwork, and maintaining healthy work-life balance, and personal experiences as major challenges. The team leaders recommend increased pay, reduced paperwork, and open communication between staff and management as a solution to the challenges. The challenges of communication among clinicians were reduced with the use of different forms of communication such as text messages, morning rounds, e-mail, and access to organizational phones to improve communication while delivering ACT services.

When asked about teamwork, all the clinicians I interviewed identified the intertwinning of ACT clinicians' roles as a major challenge. Teamwork was seen as a major advantage of the ACT program because all the clinicians work as a team to deliver effective care to the patient in the community. The cohesion could sometimes result in clinicians stepping into another clinicians' role for patient care. The team leader noted that the challenge is guided by the policies and procedures for ACT program.

When asked about professionalism and professional role, the registered nurse noted that a major challenge in the ACT program is patients' noncompliance with medications. A recommendation for this challenge was educating patients on the consequences of not taking their medications and relapse.

One of the major challenges noted by the peer specialists related to care delivery was patients' acceptance of peer specialists' role as clinicians. The peer specialists noted that some patients do not want a recovered mental health patient handling their chart. A recommenmdation to ease this fear was better education for the patients. Clash of clinicians' role was also noted as a challenge in care delivery by all clinicians interviewed. Another challenge noted in care delivery was many calls from patients at odd hours to staff who are not on call. This is partly due to the relationship and rapport that has been established working with the patients. Educating patients to use on-call line during non office hours was recommended to reduce this challenge. Lack of health insurance and homelessness was noted as a challenge in delivery of ACT services. High turnover on the clinicians' part was also noted as a challenge by most clinicians interviewed. Increased pay, more staff employment, and increased communication between management and staff was recommended to reduce this challenge. Security for clinicians delivering services to mental health patients who may have relapsed is another challenge noted by all clinicians. Clinicians have to pair up during visits to patients who have tendencies for violence or have relapsed. Family intervention was noted as a challenge by the vocational specialists. The specialists cited family intervention in areas of discouraging patients to seek jobs in order not to lose social security benefits.

Recommendation to change this trend is education to patients and family on the importance of being self reliant, having a job and fulfilling patients potentials rather than depending on social security benefit.

Participants identified several challenges in answers to the question on resources. These challenges included housing for patients, health insurance, transportation for both patients and staff, lack of resources in the community for patients, and challenges of mental health. For the housing challenge, one of the clinicians suggested provision of more subsidized housing for mental health patents. She also suggested participation in advocacy for more housing options for individuals with mental health challenges. Regarding transportation, the clinicians suggested expansion of public transportation to rural areas to decrease the urge for patients to move to the cities where they could go missing and be hard to track for care delivery. More resources and easy access to social security benefits and health insurance to mental health patients will reduce the problem of lack of resources.

For the final area of exploration, outcomes, clinician challenges involved tension during discharge, family influence, limited resources, poor job retention for patients, attachment to ACT program, cheque dependency, and relapse. Recommendations for these challenges included initiating discharge plans from day one of admission, education of patient and family, and provision of job readiness programs for patients.

Strengths and Limitations of the Project

Strengths

A major strength of the project was the interview from clinicians with lived experiences of an ACT program. Interview from clinicians who are directly involved in ACT program provided detailed accounts of first hand knowledge and experience. The number of years for most of the participants added strength to their experiences. Another strength of the project was my unbiased and effective report, given my over 5 years of experience working on an ACT program.

Limitations

A major limitation for this project was that the interviews were carried out in only one ACT program. Although there were 15 different professionals represented, there were only one or two from each profession on the two teams that participated in the project.

Section 5: Dissemination Plan

In this project, I explored the lived experiences of a variety of health care professionals who provide community-based services to patients with persistent mental health issues. The project was part of a quality improvement initiative for the center that served as my project site. I will share results and recommendations from the interviews with ACT administrator and the project participants.

Analysis of Self

Practitioner

This project deepened my commitment to improving healthcare and quality of service provided to the community as a nurse practitioner. Provision of effective and efficient healthcare service to every individual is a task that a doctorally prepared nurse practitioner should be ready to engage in at any point of healthcare delivery. As an independent nurse practitioner, this project inspired me to the idea of establishing an ACT program as an addition to the current behavioral health programs that were approved for my center by the state, namely the Partial Hospitalization Program (PHP), the Intensive Outpatient Program (IOP), the Drug Abuse Treatment and Education Program (DATEP), and the Ambulatory Detox Center with Extended Services. My knowledge as a practitioner who has devoted many years caring for individuals with persistent and recurrent mental health problems has been enhanced by this project and the different interventions I have learned during the course of this project for better outcome for this population.

Scholar

The promotion of evidence-based practice in nursing as a scholar is not only important to improve the quality of healthcare delivery, but also gives the doctorally prepared nurse the tool and power to choose and recommend best practices in different care settings, especially in mental health. This project planning, design, analysis, and synthesis coupled with evaluation helped me grow as a nurse scholar through the process of initiating and completing a capstone project. The dissemination of the project outcome to project administrators and staff of the project site will increase their knowledge of ACT and help managers direct appropriate resources to needed areas of the program. Publication of project will assist nursing students, mental health institutions, and families of individuals with mental health challenges gain better knowledge of ACT services.

Project Manager

The hurdles that I encountered in the course of this project tested my temperament as a doctorally prepared nurse who should exhibit the highest form of decorum, patience, and understanding when dealing with other individuals with diverse opinions on a particular issue or topic. I encountered several challenges during this project, including issues associated with the project site change and IRB compliance. Overall, I complied with the available standards and protocols set by Walden University and its IRB.

Summary

This project demonstrated the commitment of professionals who support an evidence-based mental health program in their community. The ACT staff, through their lived experiences, verbalized their commitment and concern for improving the lives of

the patients, their families, and their co-workers. As an employee of ACT program, I will continue to advocate for addressing the concerns of the professionals working in the program in order to continue to maximize our commitment to quality patient care.

References

Barry, C., Abraham, M., Weaver, R., & Bowersox, W. (2016). Innovating team-based outpatient mental health care in the Veterans Health Administration: Staff-perceived benefits and challenges to pilot implementation of the Behavioral Health Interdisciplinary Program (BHIP*). Psychological Services, 13*(2), 148-55. doi:10.1037/ser0000072Chen, F. & Herman, D. (2011). Discharge Pactices in a Time-Unlimited Intervention: The perspectives of practitioners in assertive community treatment. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(3), 170-179. doi: 10.1007/s10488-011-0344-1

Desilva, M., Samele, C., Saxena, S., Patel, V., and Darzi, A. (2014). Policy actions to integrated community-based mental health services. *Health Affairs*, *33*(9), 1595-1602. Retrieved 10/08/2018 from; https://www.healthaffairs.org

Dougherty, H., Lyman, R., George, P., Ghose, S., Daniel, A., & Delphin, M. (2014). Assessing the evidence base for behavioral health services: introduction to the series. *Psychiatric Services, 65(1):* 11-15Fitzpatrick, J. (2014). Relationship based care and the psychiatric mental health nurse, *Archives 28*(4), 223. doi:10.1016/j.apnu.2014.05.006

Georgia Department of Behavioral Health & Developmental Disabilities (2012). *Dartmouth Assertive Community Treatment Scale Fidelity Review Report Region 3*. Retrieved from http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related

_files/site_page/Reg%203%20ACT%20Fidelity%20Review%20Report%20-%20Grady%20Team%202.pdf

Georgia Department of Behavioral Health and Developmental Disabilities, (2016). State negotiates an extension of settlement agreement with Department of Justice [press release]. Retrieved from http://dbhdd.georgia.gov/press-releases/2016-05-18/state-negotiates-extension-settlement-agreement-department-justice

Georgia Department of Behavioral Health and Developmental Disabilities (2011). *The provider manual for community behavioral health providers.* Retreived from https://gadbhdd.policystat.com/policy/242181/latest/

Georgia Department of Behavioral Health and Developmental Disabilities (2013). Georgia program tool kit for assertive community treatment (ACT) teams. Retrieved from https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Georgia%20Toolkit%20for%20ACT%20Teams.pdf

Glembocki, M., (2010). Building an organizational culture of caring: Caring perceptions enhanced with education. *Journal of Continuing Education in Nursing, 41*(12), 656-570. doi:10.3928/00220124-20100701-5

Harvey, C., Killaspy, H., Martino, S., Johnson, S., (2012). Implementation of assertive community treatment in Australia: Model Fidelity, patient characteristics and staff experiences. *Community Mental Health Journal, (48*): 652–661.

Hodges, B. & Videto, D. (2011). *Assessment and planning in health programs*. Sudbury, M.A: Jones and Barnett Learning.

Irving, S. (2013). *Interviewing as qualitative research (4th ed.). A Guide for Researchers in Education and the Social Sciences.* New York, NY: Teachers College Press

Kettner, P. M., Moroney, R. M., & Martin, L. L., (2008). *Designing and managing programs: An effectiveness-based approach (3rd ed.).* Thousand Oaks, CA: Sage.

Lexen, A., & Svensson, B. (2016). Mental health professional experiences of the flexible assertive community treatment model: A grounded theory study. *Journal Of Mental Health, (27):* 1-6.

Marshall, Max, Lockwood, Austin. Assertive community treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews 2011, Issue 4.* Art. No.: CD001089. DOI: 10.1002/14651858.CD001089.pub2

McEwin, M., & Wills, E.M. (2014). *Theoretical basis for nursing*. (4th. Ed.). Philadelphia, PA: Wolters Kluwer Health

Molly T. F., Jennifer I. M., Ana Z. T., Candice S., Fraser, H.L., Cecily, A. S., Reber, H.M., Reddy, A.D., & Miracle (2015). Clinicians' Perceptions of Challenges and Strategies of Transition from Assertive Community Treatment to Less Intensive Services. *Community Mental Health Journal; (51*): 85-95

Moser, L; Monroe-DeVita, M. & Teague, G. (2013). Evaluating Integrated Treatment Within Assertive Community Treatment Programs: A New Measure. *JOURNAL OF DUAL DIAGNOSIS, 9(2),* 187–194

National Academy of Sciences. (2011). *The future of nursing: Leading change, advancing health.* Retrieved from; https://download.nap.edu/catalog.php?record_id=12956.

Nelson, J; Tinker, A; & Smith, S., (2013). Relationship-based care as an intervention of caring for vulnerable adults in home care. *International Journal for Human Caring, 17(2),* 59-66

Polit, D. F., & Beck, C. T. (2014). Essentials of nursing research: Appraising evidence for nursing practice. Philadelphia: Wolters Kluwer Health /Lippincott

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins. p. 293-324, 523-552

Pope, and Harris, L (2014). Assertive community treatment (ACT) in a rural Canadian community: Client characteristics, client satisfaction, and service effectiveness. *Canadian Journal of Community Mental Health; 33 (3*): 17-27

Randall, G; Wakefield, P; and Richards, D. (2012). Fidelity to Assertive Community Treatment Program Standards*: Community Ment Health Journal, (48):*138–149

Ridenour, N., & Trautman, D. (2009). A primer for nurses on advancing health reform policy. *Journal of Professional Nursing, 25*(6), 358-362. Retrieved on 4/14/2016 from the Walden Library using the ScienceDirect database.

Salyers MP; Tsemberis S (20 ACT and Recovery: Integrating Evidence-Based Practice and Recovery Orientation on Assertive Community Treatment Teams. *Community Mental Health Journal (**COMMUNITY** MENT HEALTH J), 43 (6*): 619-41.

Seidman, I. (2013). *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences* (4th Ed.). New York: Teachers College Press

Stull, L., Mcgrew, J., & Salyers, M. (2012). Processes underlying treatment success and failure in assertive community treatment. *Journal of Mental Health, 21(1)*: 49-56

Substance Abuse and Mental Health Services Administration (SAMHSA) (2008). *Assertive Community Treatment: Building Your Program.* DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Terry, A. J., (2015). *Clinical research for the doctor of nursing practice.* (2nd ed.). Burlington, MA: Jones & Bartlett Learning

Volpe, T., Boydell, K.M. and Pignatiello, A. (2014). Mental health services for Nunavut children and youth: evaluating a telepsychiatry pilot project. *Rural and Remote Health; 14 (2):* 1-14.

White, K., & Dudley-Brown, S. (2012*). Translation of Evidence Into Nursing and Health Care Practice*. New York: Springer Publishing Company