The Roles and Contributions of Team Leaders to High Fidelity Assertive Community Treatment: A Collective Exemplary Case Study

By

Lynette M. Studer

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The dissertation is approved by the following members of the Final Oral Committee:

Tally Moses, Professor, Social Work
Elizabeth J. Kramer, Professor, Social Work
Stephanie A. Robert, Professor, Social Work
Maurice Gattis, Assistant Professor, Social Work
Gary R. Bond, Professor, Psychiatry

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“Acknowledging the good that you already have in your life is the foundation for all abundance.”

–Eckhart Tolle

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Table of Contents

List of Tables

Figures

List of Appendices

ABSTRACT

This exemplary collective case study of high fidelity Assertive Community Treatment (ACT) teams sought to better understand and describe the role and contributions of the team leaders in the context of successful ACT teams. Three questions were addressed: (1) describe the ACT team leaders; (2) understand their approach to leadership (i.e., what they do and how they do it); and, (3) understand what roles they play in promoting high fidelity to ACT. Two exemplary, high fidelity ACT teams, with high scores on ACT fidelity tools, were selected for participation: one from St. Paul/Minneapolis, Minnesota and the other from Lincoln, Nebraska. This case study used multiple methods of data collection including semi-structured interviews, focus groups, direct participant observations, and reviews of team documents. These captured the perspectives of the ACT team leaders, ACT team members, ACT psychiatrists, and agency supervisors. Data analysis was completed by identifying core categories and themes that address the three study questions within each individual case and then across cases. Data analysis revealed themes that the ACT team leaders had notable attributes and a personal job match with the roles and responsibilities of an ACT team leader. The team leaders performed many prominent functions, had a distinct communication style, paid deliberate attention to team members' wellbeing, and set a very intentional, positive work environment. Both team leaders demonstrated attributes and behaviors associated with high emotional intelligence and a mix of transactional and transformational approaches to leadership, with a heavy weight on the latter. Each team leader played a critical role in the promotion of high fidelity ACT services and used ACT fidelity as a guide for services. Cross case analysis revealed numerous similarities in descriptions of the team leaders as individuals and as shepherds of their respective teams, and very few differences between the two leaders. Contributions of this study include better

understanding the role of the ACT team leader and illuminating processes in the implementation of the evidence-based practice of ACT in effort to close the gap between EBPs and actual service delivery. Significant implications for social work practice, education, and mental health policy are outlined.

Chapter 1: Introduction

Background

Persons living with mental illness are among the most marginalized and most vulnerable individuals (Hughes & Bamford, 2011). These individuals often experience violations of their human rights, exclusion from social and economic activities, and are frequently denied opportunities for education and employment (WHO, 2010). Many individuals with mental illness either do not seek mental health treatment, have difficulty getting access to treatment, or are offered substandard treatment that lacks efficacy (Corrigan, 2004; Mechanic, 1991; Mueser, Bond, Drake, & Resnick, 1998). It has been estimated through data from the National Comorbidity Survey and the Epidemiologic Catchment Areas Study, that roughly only half of those individuals with serious mental illness receive some form of treatment in a given year (Kessler et al., 2005; Wang, Demler, & Kessler, 2002; Kessler et al., 1996; National Advisory Mental Health Council, 1993). While this estimate is disturbingly low, the effective treatment rate is even lower (Wang et al., 2002).

Among individuals with severe and persistent mental illness (SPMI)[1] living in the United States, fewer than 1 in every 6 receive treatment that could be considered, at best, minimally adequate (Wang et al., 2002). This translates into more than 8.5 million individuals with SPMI living in the United States who do not receive adequate and effective treatment for their illnesses (Wang et al., 2002). Other estimates indicate that it is closer to 95% of individuals with SPMI in the U.S. that receive either no care, inadequate care, or minimally adequate care for their mental illness (Drake & Essock, 2009; Lehman & Steinwachs, 1998a; New Freedom Commission on

[1] Different descriptors have been used throughout the literature to refer to individuals with severe and persistent mental illnesses (SPMI). These descriptors include: patient, client, or consumer. I have used these terms, as well as individuals or people with SPMI, interchangeably throughout this paper and have intended no disrespect by their use. When possible, I attempted to stay consistent with how individuals were described in the reviewed literature.

Mental Health, 2003; U.S. Department of Health and Human Services, 1999). The percentage of individuals receiving minimally adequate treatment is the lowest for the extremely vulnerable group of individuals with non-affective psychotic disorders such as schizophrenia, among whom fewer than 1 in 20 receive minimally adequate care (Wang et al., 2002).

The problem is not that we are unaware of what effectively works for individuals with SPMI. In fact, the opposite is true. Over the past decade, there has been a focus on identifying what effective treatments are for individuals with SPMI, and there are now agreed upon evidence-based best practices for the treatment of SPMI (Lehman & Steinwachs, 1998b; Mueser, Torrey, Lynde, Singer, & Drake, 2003; Drake & Goldman, 2003; Dixon et al., 2010). Evidence-based practices (EBPs) are defined, according to Drake and colleagues (2001), as "interventions for which there is consistent scientific evidence showing that they improve client outcomes" (p. 180). So, we have a good idea of what effective interventions are for individuals with SPMI, but the problem is that these EBPs are not being offered, or offered in a substandard way to consumers with SPMI (Wang et al., 2002; McHugo et al., 2007; APA/CAPP Task Force 2007; New Freedom Commission on Mental Health, 2003; Institute of Medicine, 2001).

Literature on EBPs suggests that there is a 15-20 year lag between the discovery of effective treatments and their wide use in routine patient care (New Freedom Commission on Mental Health, 2003; Gioia & Dziadosz, 2008; McHugo et al., 2007; APA/CAPP Task Force 2007; Institute of Medicine, 2001). This statistic supports that despite the extensive research evidence of, and agreement on effective mental health practices for individuals with SPMI, many mental health programs fall short of being effective (Drake et al., 2001; Frese, Stanley, Kress, & Vogel-Scibilia, 2001). These programs fall short because they either do not offer EBPs or implementation of services resembling EBPs often lack fidelity to evidence-based procedures

(Drake et al., 2001; Frese et al., 2001). Simply put, this gap between research and practice means people with SPMI are unable to benefit from effective treatments in a timely manner.

Research also shows that higher fidelity to evidence-based practices and procedures is consistently linked to better outcomes (Mueser et al.,1998; Bedell, Cohen, & Sullivan, 2000; Scott & Dixon, 1995; McHugo, Drake, Teague, & Xie, 1999; Mancini et al., 2009; Bond, Drake, Mueser, & Latimer, 2001). Such outcomes include those that directly relate to the lives of mental health consumers, such as spending fewer days in the hospital, living more independently, becoming competitively employed, and improving knowledge about the illness and learning coping mechanisms. If EBPs are not offered to individuals with SPMI, or are offered in a substandard way, mental health consumers are simply not afforded the best possible chance of recovery and living improved lives.

One prominent EBP for persons with SPMI is Assertive Community Treatment (ACT). ACT is a clinical treatment approach that provides comprehensive, integrated, community-based, psychiatric treatment, rehabilitation, and support services directly to people with SPMI (Stein & Test, 1980; Furlong, Leddy, Ferguson & Heart, 2009; Allness & Knoedler, 2003). The target population for ACT services includes individuals who have been diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorders (Allness & Knoedler, 2003). Additionally, these individuals often have had repeated and prolonged hospitalizations, high service needs in the community, and multi-faceted and complex problems (i.e., homelessness, criminal justice involvement, substance abuse) that the traditional mental health system has been unsuccessful in addressing (Mancini et al., 2009; Bond et al., 2001; Allness & Knoedler, 2003; Dixon et al., 2010).

Over 30 years of research indicates that ACT is effective among persons with SPMI at reducing psychiatric hospitalization rates (Stein & Test, 1980; Bond, Miller, Krumwied, & Ward, 1988; Burns & Santos, 1995; McGrew, Bond, Dietzen, McKasson, & Miller, 1995), increasing independent living (Dekker et al., 2002; Lafave, de Souza, & Gerber, 1996), and facilitating treatment retention (McHugo et al., 1999). At the same time ACT has less consistent effects on employment, criminal justice involvement, and quality of life outcomes (Salyers et al., 2010; Bond et al., 2001). Nevertheless, because of rigorous empirical support, ACT is considered an EBP for persons with SPMI, is currently recommended as a psychosocial treatment intervention for persons with schizophrenia (Phillips et al., 2001; Bond et al., 2001; Dixon et al., 2010), and is promoted as a service that should be available to all individuals who need it (NAMI, 2003).

Despite ACT's identification as an EBP for persons with SPMI, implementation of ACT has not been without challenges, and there is an identified gap between recommended and actual practices (Aarons, 2006; Rosenheck, 2001). Because of a lack of understanding regarding how ACT could be successfully integrated into existing mental health settings, over the past decade more public health funding and research attention has focused on dissemination efforts and better understanding the barriers and facilitators to the faithful implementation of ACT (Mancini et al., 2009; Bond, Drake, McHugo, Rapp, & Whitley, 2009; Carlson, Rapp, & Eichler, 2012; Rapp et al., 2008; McHugh & Barlow, 2010).

While many barriers and facilitators have now been identified for high fidelity ACT implementation, the role of the front line supervisor (i.e., the ACT team leader) has emerged as a particularly important factor (Mancini et al., 2009; Carlson et al., 2012; Marshall, Rapp, Becker, & Bond, 2008; Rapp et al., 2008; Moser, DeLuca, Bond, & Rollins, 2004). Leadership at the

agency and program levels were found to be the most common facilitating factor across all EBPs in the National Evidence-Based Practices Project and was deemed indispensable to the implementation and sustenance of EBPs, including ACT (Torrey, Bond, McHugo, & Swain, 2012; Bond et al., 2009; Brunette et al., 2008; Mancini et al., 2009; Rapp et al., 2008).

While the findings of recent studies suggest that multiple factors contribute to the successful implementation of high fidelity ACT services (Bond et al., 2009; Brunette et al., 2008; Mancini et al., 2009; Corrigan et al., 2001; Rapp et al., 2008), they also illuminate gaps in our knowledge about the role team leaders play in the dissemination and implementation of ACT in real practice settings. Within the ACT model, the vehicle for the delivery of all treatment, rehabilitation, and support services is the multi-disciplinary team, led by a team leader (Allness & Knoedler 2003; Boust, Kuhns, & Studer, 2005). However, despite over 30 years of research on ACT, there has yet to be any study to this writer's knowledge, that richly describes ACT team leaders on high fidelity ACT teams. Additionally, we understand very little about ACT team leaders' approaches to team leadership or how they promote leading high fidelity ACT teams.

All of these gaps suggest that more research about ACT team leaders is warranted and essential to our understanding of high fidelity ACT implementation and sustenance. Filling these gaps may lead to more knowledge and contribute to improving the selection and training of ACT team leaders and lead to higher quality of care for individuals with SPMI in ACT teams. This qualitative, collective exemplary case study proposes to address and fill these identified gaps.

Specific Aims

The purpose of this collective (multi-case) exemplary case study of high fidelity ACT teams is to understand and describe the role and contributions of the team leaders. Based off of my fifteen years of practice experience in the ACT field, conversations with practitioners,

administrators, and experts around the country, and evidence from ACT and leadership research, I believe that the team leaders play a central role in the success of high fidelity teams. What is less known is how this is accomplished. The primary objectives of this study of high fidelity ACT teams were to (1) describe the ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it); and, (3) understand what roles they may play in promoting high fidelity to ACT.

To explore these aims, this collective exemplary case study identified two high fidelity ACT teams and used in-depth interviews with the team leaders, team psychiatrists, and agency leadership; focus groups of ACT team members; direct observations of the team leaders, teams and physical environments; and, reviewed documents relevant to the ACT programs.

Expected Contributions

Findings from this study generate new insights related to team leaders on high fidelity ACT teams. By providing a rich description of who these ACT team leaders are, what they contribute to high fidelity teams, and how they approach leadership and overcome challenges, this study provides a deeper understanding and awareness of the role of the ACT team leader and identifies topics for future research. Further, by exploring what team leaders do and how they do it, social work researchers can better identify processes team leaders use that may influence implementing and sustaining high fidelity ACT teams. This project contributes to better identification of optimal leaders who may be more successful in leading high fidelity ACT teams.

There are also implications of this study for social work practice. Social workers play a major role in the delivery of mental health services, making up approximately 60-70% of the mental health work force and providing more mental health services in the community than any

other professional (Stanhope, Tuchman & Sinclair, 2011; U.S. Department of Health and Human Services, 2004). Social workers are typically the largest represented discipline employed on most ACT teams. In addition, a large proportion of ACT team leaders in the United States are social workers. Thus, extending our knowledge about ACT team leadership has implications for the field of social work, as social workers are at the forefront of ACT service provision and frequently occupy the ACT team leader role. This research may help social work leaders to better understand how to create, facilitate, and foster supportive teams to support positive outcomes for people with serious mental illness.

Finally, this study aligns with the overall mission of social work practice. According to the National Association of Social Workers Code of Ethics, the "primary mission of the social work profession is to enhance the human wellbeing and help meet the basic needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW Code of Ethics, 2008). Through a richer understanding of high fidelity ACT team leadership, and contributions to future research agendas on ACT implementation and sustenance, improved outcomes for individuals with SPMI may be realized. Many consumers may move towards personal recovery through participation in high fidelity ACT treatment services. As social work researchers, it is our obligation to improve the lives of vulnerable individuals living with SPMI, and working to implement and sustain high quality evidence-based practices, such as ACT, is one way to accomplish this.

Organization of the Dissertation

This dissertation is divided into five main chapters: introduction, critical review of literature and conceptual framework, research designs and methods, findings, and discussion.

In the critical review of literature and conceptual framework chapter, I review the literature connected to the study's purpose and questions, and the conceptual framework employed. Chapter 2 consists of 10 separate parts:

- A definition of SPMI and ACT's target population;
- A brief background, definition of, and summary of selected components of the ACT model;
- A review of ACT as an evidence-based practice (EBP);
- An examination of the importance of fidelity to the ACT model, including a brief description of tools used to measure ACT fidelity;
- A brief review of efforts to disseminate ACT;
- A overall review of the literature on implementation of EBPs, including the National EBP Project;
- A review of literature specific to the EBP of ACT;
- A review of the general leadership literature including an overview, specific examination of literature on leadership within community mental health teams (CMHT) or teams in other psychiatric settings, and summary of conclusions;
- A review of the use of conceptual/theoretical frameworks including the use of theory in case study research and this study's conceptual framework comprised of three components: Bass's Multifactor Model of Leadership, relevant concepts identified in the literature, and a priori ideas and knowledge;
- A brief conclusion of this chapter.

In the research methods and design chapter, I detail the research design, methods, and relevant personal information regarding my own background and influence on conducting this case study. The research methods and design chapter is divided into six separate parts:

- An overview of proposed qualitative research design including support for the research design, definition of a collective exemplary case study, and advantages and criticisms of case study design;
- A disclosure of my positionality as a researcher including my paradigm and statement of reflexivity that may influence my inquiry and implementation of this collective exemplary case study;
- A detailed description of my methods including my sampling strategies and recruitment procedures, including brief case descriptions of the two individual ACT teams ("cases") in this study;
- An outline of my data collection procedures including TMACT assessments, semi-structured interviews, focus groups, direct participant observations, and review of documents;
- A detailed description of the data analysis plan and Stage 1 (within case analysis) and Stage 2 (cross case analysis) procedures; and,
- The strategies used to increase trustworthiness and rigor of the study.

In the findings chapter, I outline the within-case findings for both ACT teams, providing a rich description of the cases, along with cross-case findings. This chapter is divided into two main parts:

- Detailed within-case findings for each case including an in-depth description of the case context, setting, and description of all participants. A presentation of core categories and themes discovered are organized by study aim.
- Cross-case study results between the two ACT teams, including similarities and differences between the two teams are presented.

In the fifth and final chapter I provide a discussion of findings, study contributions, implications of this research as well as study limitations and future research directions. There are six sections to this chapter including:

- A description of how the findings align with Bass' Multifactor Model of Leadership and highlight the applicability of this theory to the current study.
- A summary of how the findings align to prior research and literature on leadership.
- An acknowledgment of this study's limitations.
- A review of the unique contribution this study makes to the field.
- A brief description of implications for social work practice, social work education, and mental health policy.
- A suggested list for future research in the area of ACT team leadership is offered.

Chapter 2: Critical Review of the Literature and Conceptual Framework

Definition of Severe and Persistent Mental Illness & ACT Target Population

Two key concepts for this paper–severe and persistent mental illness, and the target population of individuals served by ACT–require further definition to better understand and interpret the literature presented.

Definition of severe and persistent mental illness (SPMI). Individuals with SPMI are an extremely heterogeneous group, which creates challenges for defining who actual members of this group are. For the purpose of this proposal, severe and persistent mental illness (SPMI) will be defined in terms of diagnosis, disability, and duration (Goldman, Gatozzi & Taube, 1981; Goldman, Rosenberg & Manderscheid, 1988). Typical diagnoses include schizophrenia, schizoaffective disorder, bipolar disorder, recurrent depression, or other disorders determined to be chronic. The resultant disability from these mental illnesses includes substantial functional impairments in adult roles in such areas as independent living, community integration, personal and social relationships, and vocational aptitude (Goldman et al., 1988; Schinnar, Rothbard, Kanter, & Jung, 1990). The duration of SPMI is considered lifelong and typically characterized by recurrent symptoms (Frey, 1993). While much progress has been made in recent years to help individuals with SPMI improve, there still is no cure or complete resolution of the illness. Together, these three conditions –diagnosis, disability, and duration–determine if an individual is labeled with SPMI.

ACT target population. Because individuals with SPMI comprise a heterogeneous population, individuals served by ACT teams can be considered a subset of this overall group. ACT consumers are typically individuals who experience the most intractable symptoms of SPMI, have the greatest level of functional impairments, and who have not been able to

effectively use or benefit from less intensive types of mental health services (Bond et al., 2001; Latimer, 1999; Phillips et al., 2001). These individuals typically also have the poorest quality of life (Phillips et al., 2001). The ACT model serves individuals with SPMI, who are considered "hard to serve" because of their severe psychiatric symptoms, histories of repeated or prolonged hospitalizations, and concurrent, complex, high service needs in the community (e.g., homelessness, substance use, criminal justice involvement; Kirsch & Cockburn, 2007; McGrew & Bond, 1995). Many times these individuals have been referred to as the most vulnerable group of individuals living with SPMI (Allness & Knoedler, 2003).

Background and Definition of ACT

The Assertive Community Treatment (ACT) model is perhaps one of the most widely known and studied community mental health service models for individuals with SPMI to date (Mueser et al., 1998; Allness & Knoedler, 2003). ACT is a clinical treatment approach that provides comprehensive, integrated, community-based, psychiatric treatment, rehabilitation, and support services, 24 hours a day, 365 days per year directly to people with SPMI (Stein & Test, 1980; Furlong et al., 2009; Bond, 1991; Mueser et al., 1998; Allness & Knoedler, 2003). ACT, originally called the Training in Community Living (TCL) model, was developed at Mendota Mental Health Institute in Madison, Wisconsin during the late 1970s (Stein & Test, 1980; Stein & Test, 1985; Allness & Knoedler, 2003).

The initial purpose of this innovative model was to address the "revolving door" psychiatric hospitalization phenomenon and to challenge the idea that some individuals were too sick and “un-dischargeable” (Dixon, 2000, p. 759). One identified factor influencing the revolving door of repeated hospitalizations was the lack of continuity of care in the community experienced by individuals with SPMI (Test, 1979). Individuals with SPMI, discharged from the

hospital, would experience extensive fragmentation of public mental health services, which ultimately contributed to psychiatric decompensation and subsequent re-hospitalization. The ACT model sought to help individuals with SPMI stay in their communities and achieve stable and meaningful lives of decent quality by intercepting patterns of repeat hospitalizations, ameliorating the system's fragmentation, and offering comprehensive, community-based treatment and rehabilitation services (Kirsh & Cockburn, 2007; Stein & Santos, 1998).

Stein and Santos (1998) supplied this definition of the ACT model:

> ACT is best conceptualized as a service delivery vehicle or system designed to furnish the latest, most effective and efficient treatments, rehabilitation, and support services conveniently as an integrated package. It serves as the fixed point of responsibility for providing services to a group of individuals with severe and persistent mental illness identified as needing ACT services to achieve any several desired outcomes (e.g., reduced use of 'revolving door' hospital services, increased quality and stability of community living, normalizing activities of daily living such as competitive employment). Services are not time-limited or sequenced. Service intensity varies with changes in desired outcomes. Services are provided for as long as needed, which is usually a matter of years and, for some clients, a lifetime (p. 2).

The ACT approach is characterized by a set of key principles including a multidisciplinary team who acts as a fixed point of responsibility for clients around the clock; a shared case load among all team members; a high frequency of client contacts most of which are conducted in the community; low client-to-staff ratio; assertive and optimistic approach; highly individualized treatment and rehabilitation services, and, a continuous long term service

availability (Allness & Knoedler, 2003; Bond 1991; Mueser et al., 1998). The philosophy of the ACT team is to provide whatever assistance is needed to help consumers continue to live in the community and reach a higher quality of life (Boust et al., 2005). Detailed descriptions and elements of ACT are provided in Appendix 1.

ACT has pushed the mental health field to re-conceptualize the type of services needed by persons with SPMI to live successfully in the community and impacted the way in which services are organized and delivered to this vulnerable population (Gold et al., 2003; Allness & Knoedler, 2003).

ACT as an Evidence-based Practice

The benefits of ACT have been well established in the empirical literature. The ACT model has been the subject of more than 25 randomized, controlled trials over the past three decades (Bond et al., 2001) and no other model is more widely researched and validated as a service available for the care of this group of individuals with mental illness (Santos et al., 1993).

ACT's most robust demonstrated outcome is in reducing psychiatric hospitalizations (Marx, Test, & Stein, 1973; Stein & Test, 1980; Bond et al., 1988; Burns & Santos, 1995; Hoult, Reynolds, Charbonneau-Powis, Weekes, & Briggs, 1983; McGrew et al., 1995; Mueser et al., 1998; Phillips et al., 2001; Rosenheck & Dennis, 2001). In comparison of outcomes between usual mental health treatment, traditional case management services, and ACT, a meta-analysis concluded that ACT is superior to traditional mental health services, and clinical case management in reducing hospitalization (Ziguras & Stuart, 2000). Within this meta-analysis, forty-four studies from between 1980 and 1998 were analyzed. Thirty-five studies compared ACT or clinical case management with usual treatment, and nine directly compared ACT with clinical case management. Overall results reported that the total number of hospital admissions

and the proportion of clients hospitalized were reduced in ACT compared to clinical case management and traditional mental health treatment (Ziguras & Stuart, 2000).

ACT has also demonstrated other positive outcomes including increased housing stability (Dekker et al., 2002; Lafave et al., 1996; Bond et al., 2001), moderately improving symptoms and subjective quality of life (Bond et al., 2001), improved retention in mental health services (Bond, McGrew, & Fekete, 1995), and ACT is more satisfactory to consumers and their families than standard care (Phillips et al., 2001). Further, from an economics perspective, ACT was found no more expensive than traditional mental health care (Weisbrod, Test, & Stein, 1980; Bond et al., 1988).

However, the ACT model is not without some criticism. One criticism is that the effectiveness of ACT found in previous U.S. studies has not been consistently replicated outside the United States, including Europe (Burns, Fioritti, Holloway, & Rössler, 2001; Killaspy et al., 2006; van Dijk, Mulder, Roosenschoon, Kroon, & Bond, 2007; Holloway & Carson, 1998). For example, the first randomized controlled trial (RCT) of ACT teams in the UK supported earlier studies of intensive case management models, and concluded that ACT had no benefit over 'usual' community mental health care for inpatient admissions and clinical or social outcomes (Harvey et al., 2011; Killaspy et al., 2006). Likewise, in a RCT of assertive community treatment in the Netherlands, ACT was significantly better in sustaining contact with patients, but not in reducing admission days (Sytema, Wunderink, Bloemers, Roorda, Wiersma, 2007). Furthermore, there were no differences found in housing stability, psychopathology, social functioning, or quality of life in this study (Sytema et al., 2007).

Explanations for this difference in outcomes have been offered and many highlight the variable of the changing context of mental health treatment over time. For example, one

explanation is that the standard care now offered and representing the control condition in these RCTs has been much improved in recent years (McHugo, Hargreaves, Drake et al. 1998; Burns, Fioretti, Halloway, Malm, & Rossler, 2001; Killaspy et al., 2006). Researchers have suggested that due to the popularity of ACT, certain values and interventions such as *in vivo* care and a more assertive attitude of case managers might have been integrated into typical standard mental health care now compared to the past (Essock et al., 2006; Sytema et al., 2007; McHugo et al., 1998). The development of improved standards of care for individuals with mental illness may explain why earlier trials of ACT evidenced more efficacy than later studies (Burns, 2008 Harvey et al., 2011).

A second explanation offered is the variability of the outcome variable, psychiatric hospitalization days (Sytema et al., 2007, p. 106; McHugo et al., 1998). The most robust outcome for assertive community treatment studies has been a reduction in psychiatric admission days (Bond et al., 1988; McGrew et al., 1995; Phillips et al., 2001; Sytema et al., 2007). However, in several countries, including the U.S., the number of overall psychiatric hospital beds available has been reduced over the years (Sytema et al., 2007). In such a context, it may be very difficult for ACT to further reduce the number of admission days to hospitals, rendering this outcome variable insensitive to ACT-related changes (Sytema et al., 2007). Researchers suggest that because the mental health context of today is so different from the context of the 1980s and 1990s when the earlier studies of ACT were conducted, that new trials studying the effectiveness of ACT in the United States is warranted (Sytema et al., 2007).

A final explanation offered for the difference in ACT outcomes is variations in model fidelity (Harvey et al., 2011; Teague, Bond, & Drake, 1998). The issue of ACT fidelity will be discussed in further detail below.

Despite these criticisms of ACT, ACT has still emerged as an evidence-based practice (EBP) for people with SPMI and is currently recommended as an essential mental health intervention for persons with schizophrenia (Phillips et al., 2001; Dixon et al., 2010; Lehman 1999; Lehman et al., 1998a, Lehman & Steinwachs, 1998b; U.S. Department of Health and Human Services, 1999).

Importance of Fidelity to the ACT Model

Program fidelity is defined as the extent to which a program adheres to the intended model, both including features that are deemed essential to achieving the aspired outcomes and excluding those that would interfere (Waltz, Addis, Koerner, & Jacobson, 1993; Monroe-DeVita, Teague, & Moser, 2011). According to Mowbray and colleagues (2003), measures of fidelity typically include a combination of qualitative and quantitative indicators that assess the key features of an intervention as implemented compared against the optimal or evidence-based model (Monroe-DeVita et al., 2011).

The evidence-based practice of ACT is a "packaged" intervention consisting of multiple clearly delineated components (Allness & Knoedler, 2003). The majority of research to date supports the practice of the entire ACT model, not the selective adoption of any of its particular elements, to achieve the best outcomes (McHugo et al., 1999; Boust et al, 2005; Latimer, 1999; Dixon et al., 2010; McGrew, Bond, Dietzen, & Salyers, 1994). However, more recently in a UK study, it was found that only some specific aspects (e.g., structure and organization) of the ACT model are associated with better client outcomes (Burns, Catty, Dash, Roberts, Lockwood, & Marshall, 2007). This research highlights the need for continued study to identify the critical components of the ACT model; however, in the absence of this definitive knowledge it is widely accepted that the “packaged” model produces the most robust results.

Some research supports the idea that ACT interventions with higher fidelity to the original ACT model have stronger outcomes (e.g., reduced hospital admissions) than those with lower fidelity that have adapted or modified key elements (Dixon et al., 2010; Latimer, 1999; McGrew, Bond, Dietzen, & Salyers, 1994; MuHugo, Drake, Teague, & Xie, 1999). In a 2004 study, Bond and Salyers found marginal significance for fidelity on reduction in hospitalization and more recently, a study found that ACT model fidelity was associated with better patient outcomes (less homeless days and improvements on level of functioning; van Vugt et al., 2011). The idea that fidelity to a model can produce better consumer outcomes is supported in other evidence-based practices (EBP) as well (Godfrey, 2010). For example, in the EBP of supported employment, it is estimated that 20 to 60% of the variance in program outcomes can be accounted for by program fidelity (Godfrey, 2010; Drake, Bond, & Rapp, 2006). Despite the supporting evidence to date that higher fidelity ACT leads to more positive consumer outcomes, there continues to be great variability in how ACT is interpreted, adopted, and implemented into actual practice (McHugo et al., 1999; Allness & Knoedler, 2003).

McHugo and colleagues (1999) offer one explanation for this variance to be the theoretical differences among ACT experts. On one side, ACT advocates have argued strongly for the faithful implementation of the model, with no modifications (Allness & Knoedler, 2003). On the other side, some insist that model programs such as ACT cannot be implemented at certain sites without local adaptation (Bachrach, 1998; McHugo et al., 1998). These advocates argue that because communities differ socially, politically, racially, and economically, the exact adoption of a model is not feasible (Bachrach, 1988; Berry & Davis, 1978; Rossi, 1978). However, with too much local adaptation, implementation of program models like ACT, are susceptible to "program drift" (Bond, 1991, p. 74) and move further away from high fidelity and

intended outcomes. Complicating the situation, current research does not clarify which elements of the model are essential to obtain the outcomes demonstrated by previous teams (Boust et al., 2005). The field continues to be guided by expert consensus of the critical ingredients (McGrew & Bond, 1995; Test, personal communication, March 15, 2007). Until empirical research emerges that determines if certain components over others of the ACT model are more essential to obtaining desired outcomes, the adoption of the entire "package" with as minimal adaptation as possible is the recommended best practice.

Tools for measuring ACT fidelity. In effort to better measure ACT, many investigators have called for the development of methods for empirically validating this program model (Teague, Mueser, & Rapp, 2012; McGrew et al., 1994; Brekke, 1988, Drake, Osher, & Wallach, 1991, Levine, Toro, & Perkins, 1993). To date, investigators have attempted to identify and operationalize the critical ingredients of ACT through continued expert consensus and the creation of fidelity tools, including the Index of Fidelity of Assertive Community Treatment (IFACT; McGrew et al., 1994), the Dartmouth Assertive Community Treatment Scale (DACTS; Teague, Bond, & Drake, 1998), and most recently, the Tool for the Measurement of Assertive Community Treatment (TMACT; Monroe-DeVita et al., 2011).

While an extensive review of each of these tools for measuring ACT fidelity is beyond the scope of this work, a brief history and overview of these measures is worth highlighting. McGrew and colleagues (1994) first examined the issue of using expert consensus for rating ACT fidelity. They interviewed 22 experts on ACT and then constructed a list of proposed critical ingredients of ACT from the literature, asked the experts to assign relative weightings of importance of individual ingredients to the ACT model, and then asked those same experts to include any other critical ingredients not on the list (McGrew et al., 1994). Interexpert agreement

on ratings of importance for many critical components were high (intraclass r=.94; McGrew et al., 1995). Examples of identified critical ingredients with high agreement among the experts included the use of in vivo contacts, the adoption of the treatment philosophy that the team assumes full responsibility for the client, and the overall treatment goal and foci on increasing consumer functioning (McGrew et al., 1994). However, there was less agreement concerning ideal model specifications, such as the size, makeup, and operation of an ideal team (McGrew et al., 1994).

This study of expert consensus provided the catalyst for the same investigators to examine the variation of these ingredients within a sample of programs based on the model and create and test the IFACT tool (McGrew et al., 1994). A 17-item subset of the expert-identified critical ingredients was used to construct a fidelity index with three subscales: staffing, organization, and service (McGrew et al., 1994). McGrew and colleagues (1994) demonstrated that programs with greater fidelity to the ACT model, as defined in terms of the subset of identified critical ingredients, were also more effective in reducing hospital use (as cited in Teague et al., 1998). However, the authors cautioned that the results should be interpreted only as preliminary as ratings for many of the variables on the fidelity measure were obtained retrospectively (McGrew et al., 1994). Additionally, the results were also limited to the prediction of reduction on psychiatric hospital days and not suggestive of other client outcomes (McGrew et al., 1994).

The next ACT fidelity tool to be created was the Dartmouth Assertive Community Treatment Scale (DACTS; Teague et al., 1998). Teague and colleagues (1998) drew from a combination of expert consensus, review of the literature, and previous research on critical elements (Bond, 1991; Test, 1992, Test & Stein, 1976; Boust et al., 2005). The DACTS

organized the critical elements of ACT into three categories: 1) human resources (both structure and composition; e.g., small caseloads; having a practicing team leader); 2) organizational boundaries (e.g., having explicit admission criteria; time unlimited services); and, 3) the nature of services (e.g., community based; frequency of contacts) (Teague et al., 1998; Boust et al., 2005). Each element has a potential score from 1 (low) to 5 (high; Teague et al., 1998). This 26-item scale was found to have good face and content validity, explicitly reflecting the features reported in the literature about the ACT model (Teague et al., 1998); however, the predictive validity of the tool was not studied. The authors stated that although the overall and scale scores on the DACTS were useful in discriminating among groups of substantially different programs (conventional services versus ACT), the sensitivity to differences between similar programs was lowered (Teague et al., 1998). This lack of sensitivity is problematic as it is harder to distinguish between two ACT programs with this tool (Teague et al., 1998). Despite the DACTS being created for a particular study, it has become the standard fidelity measure for ACT and is the most widely utilized tool in assessing ACT fidelity across the literature to date (Teague et al., 2012; McHugo et al., 2007). Because the tool was created prior to the publication of the first ACT manual, and had a clear and accessible format and protocol, it was frequently used as a guide for ACT implementation despite the authors' assertions that some key processes were not assessed (Teague et al., 2012). The DACTS emphasis on structural features and omission of some critical process risked weaker ACT implementation and research inferences, especially as the ACT model evolved over time (Teague et al., 2012).

Recently, a new tool, the Tool for Measurement of Assertive Community Treatment (TMACT; Monroe-Devita et al., 2011) has been created and validated for assessing ACT fidelity and addressing the problematic issues of the DACTS (see Appendix 2; Teague et al., 2012).

This tool has added enhancements to the DACTS, including standards and measures for the development of team members' role expectations, enhanced team functioning, and integration of other evidence-based practices (including supported employment; Bjorklund, Monroe-DeVita, Reed, Toulon, & Morse, 2009). The TMACT addresses some of the limitations of previous fidelity measurements by assessing organizational structures and clinical processes that experts agree reflect high ACT fidelity (Luchins, 2009).

Creating reliable and valid fidelity tools that capture the complexity of the ACT model implemented in the real world is a huge challenge. The process is iterative and must constantly adapt to the knowledge that we continue to gain. The challenge specific to the ACT model is how to create a fidelity tool that incorporates the changing philosophy of the recovery movement as well as the integration of other evidence-based practices identified as important for positive consumer outcomes (Bond, Salyers, Rollins, Rapp, & Zipple, 2004; Monroe-DeVita et al., 2011; Salyers & Tsemberis, 2007). The TMACT tool has incorporated the concept of recovery by including items appraising person-centered planning and practices, and is more sensitive than the DACTS in assessing the focus of treatment and interactions with consumers (Teague et al., 2012). To date, the TMACT is the most comprehensive tool that attempts to capture the complex "package" of ACT and integrate these important emerging core ideas and processes (Monroe-DeVita et al., 2011). One study has confirmed the TMACT as a more comprehensive and higher standard than the DACTS and more sensitive to program change (Teague et al., 2012; Monroe-DeVita et al., 2011). The TMACT is a highly detailed tool that "sets a higher bar for ACT program performance", better distinguishes among ACT programs at different levels of functioning and quality, and is becoming the standard for the measurement of ACT fidelity (Monroe-DeVita et al., 2011, p. 25).

However, the TMACT is not without criticisms. One such criticism is that, currently, many of the TMACT items have not yet been rigorously evaluated, but instead incorporated on a hypothetical basis (McGrew, 2011). The TMACT authors argue that this incorporation of hypothetical items is consistent with precedent set by the development of other fidelity measurements in general and claim that these item inclusions are needed at this point for the fidelity measurement of ACT (Teague, Moser, & Monroe-DeVita, 2011).

Similarly, another criticism is that many non data-based items also lead to potential confusion about the critical elements of the ACT intervention (McGrew, 2011). McGrew (2011) argues that when including new items on a fidelity scale (i.e., psychoeducation, supportive housing), the authors "are proposing that they are critical ingredients" (p. 32). He suggests, at minimum that all elements should have been studied and included in the studies establishing ACT as an evidence-based practice. The TMACT authors address this argument by stating if they were to exclude new elements until they have been rigorously empirically validated, the opportunity to expand knowledge about ACT would be lost (Teague et al., 2011). They go on to state that neither the technology of EBPs nor the vision of recovery were known and embraced in the early years of development and dissemination of ACT, but the model was defined in terms of providing the best possible practice of the day. They assert that the TMACT brings a contemporary update to the study of ACT. ACT teams can actually exceed the original foundation of the model by including concepts pertaining to the recovery orientation and incorporating what has been learned about effective rehabilitation practices (Teague et al., 2011).

A final criticism of the TMACT is that it takes a significantly large amount of time and resources to complete, which may inhibit its adoption and utility as a measure (Farchaus Stein, 2011). Most of the process relies on in-person, on-site review by two experienced fidelity

evaluators (Monroe-DeVita et al., 2011). However, given the high cost of ACT teams and of the potential value of accurate assessment and gains in performance, the authors feel that the fidelity investment is justified, particularly for new teams and at least periodically for more mature teams (Monroe-DeVita et al., 2011). Future plans do include exploration of distance technologies and methods to narrow the scope of the review for follow up with teams that have previously demonstrated good fidelity (Monroe-DeVita et al., 2011). Additionally, the TMACT authors call for assessment of the psychometric properties of the tool with a larger sample of programs as well as more formal tests of interrater reliability (Monroe-DeVita et al., 2011).

Despite the criticisms of this newly developed tool, it does appears that the changes incorporated in the TMACT have helped move toward evaluation that better discriminates among low-, medium-, and high-fidelity ACT teams. It has also provided more targeted feedback to teams to guide ongoing performance improvement efforts, and thus offers a basis for advancing knowledge about the critical ingredients of this service model (Monroe-DeVita et al., 2011).

Dissemination of ACT

Dissemination refers to the efforts to get knowledge and information about an EBP, such as ACT, distributed to individuals, agencies, and communities in effort to create system change (Godfrey, 2010; Backer, 1991; Rogers, 1995). Implementation is carrying out strategies through action to adopt this knowledge and integrate it into every day practice (Grimshaw et al., 2005; Godfrey, 2010). Research on dissemination and implementation seeks to highlight the processes that are critical to moving EBP from research to actual real world settings (Rosenheck, 2001). A major challenge for the public mental health system has been the dissemination and successful

implementation of evidence-based practices for individuals with SPMI (U.S. Department of Health and Human Services, 1999; New Freedom Commission on Mental Health, 2003).

Efforts to disseminate ACT began immediately after the groundbreaking research by Stein, Test, and Marx (Stein & Test, 1980) and continue through today. Initial disseminations of the model occurred in Michigan, Australia, Chicago, Illinois, and Indiana (Test, 1992) and continued spreading throughout the 1980s to Rhode Island, Delaware, Maryland, and Missouri (Boust et al., 2005). In the 1990s, 7 more states adopted and implemented ACT programs (Meisler, 1997). Research published emphasizing a significant decrease in costly psychiatric hospitalizations provided a catalyst for many mental health systems to adopt ACT in statewide mental health initiatives (Bond & Salyers, 2004; Godfrey, 2010).

In 1996, the National Alliance on Mental Illness (NAMI) began an assertive marketing campaign promoting the incorporation of ACT in both public and private managed care systems within all 50 U.S. states by 2002 (Godfrey, 2010; Flynn, 1998). While NAMI fell short of the goal of getting every state to implement ACT, they commissioned the writing of the first PACT manual, provided free to NAMI state offices, state departments of mental health, state Medicaid authorities, and key legislators (NAMI, 2003), and mobilized local advocates to push for inclusion of ACT services in all state plans (Boust et al., 2005). Additionally, NAMI established an ACT technical assistance center to assist organizations in their efforts to make the ACT model widely available and developed National ACT standards to define practices necessary for model fidelity (NAMI, 2003; Boust et al., 2005).

Another influence on dissemination efforts of ACT occurred in 1999 when President Clinton supported the wide-spread adoption of ACT by directing the Health Care Financing Administration to authorize ACT as a Medicaid-reimbursable services (Godfrey, 2010; News &

Notes, 1999). Dissemination and implementation of ACT was also supported in many other ways during the late 1990s, including in the Surgeon General's Report (U.S. Department of Health and Human Services, 1999), by expert consensus panels in the Schizophrenia Patient Outcomes Research Team (PORT) guidelines (Lehman & Steinwachs, 1998a), and by various federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH; Goldman et al., 2001; Godfrey, 2010).

Literature on Implementation of EBPs

National EBP project. One of the most systematic efforts to assess knowledge around effective treatment practices for people with SPMI, which led to the study of dissemination and implementation of EBPs, including ACT, was initiated in 1998. A national panel of experts was assembled at a conference sponsored by the Robert Wood Johnson Foundation in 1998 (Drake et al., 2001; Bond et al., 2009). The outcome of this panel meeting was the recommendation of six practices (five that were psychosocial practices[2], including ACT) that "should be offered in every community mental health center" (Bond et al., 2009, pg. 571). A final recommendation from the panel was that a more organized and efficient strategy was necessary for the dissemination and implementation of the EBPs (Bond et al., 2009).

Resultant of this meeting, the National EBP Project was initiated in 1999 to address the dissemination and implementation of EBPs, including ACT (Drake et al., 2001; Mueser et al., 2003; Torrey et al., 2001; Torrey, Finnerty, Evans, & Wyzik, 2003; Torrey, Lynde, & Gorman, 2005). This multi-phased project investigated the implementation of the five identified psychosocial practices in 53 mental health centers, across 8 different states over a 2 year period (McHugo et al., 2007; Brunette et al., 2008). An intervention model of practice dissemination,

[2] The five psychosocial practices included (1) supported employment, (2) ACT, (3) integrated dual disorders treatment, (4) illness management and recovery, and, (5) family psychoeducation.

comprised of a resource kit on the EBP, and a consultant-trainer, guided the overall implementation of this project funded by SAMSHA (McHugo et al., 2007; Mueser et al., 2003).

In Phase 1, resource kits, or "toolkits", were developed for each individual EBP (Drake et al., 2001; Mueser et al., 2003). Included within the toolkits were educational and training materials geared toward various stakeholders (researchers, program administrators, clinicians, consumers, family members) as well as implementation recommendations and fidelity scales to assist community mental health centers with the monitoring of the EBPs implementation (Godfrey, 2010; Drake et al., 2001; Mueser et al., 2003).

Phase 2 of this project conducted from 2002-2004, utilized the developed toolkits and a consultant-trainer who provided direct face-to-face training to new teams to study facilitators and barriers to implementation of EBPs in community mental health centers (Godfrey, 2010). There were several key findings from this phase of the study. First, more than half the sites (55%) showed high fidelity implementation of EBPs at the end of two years (McHugo et al., 2007). Second, a critical time period for implementation of the EBP was identified to be approximately 12 months, after which fewer advancements toward fidelity were made (McHugo et al., 2007). Three, no single factor accounted for high fidelity, but instead it was a multitude of intersecting factors that accounted for success or lack of success in achieving high fidelity to a program model (Bond et al., 2009; McHugo et al., 2007).

The conclusions from Phase 2 of the study included that in addition to the education and training tools, programs needed the following factors to maximize the successful implementation of EBPs: (1) ongoing consultation and technical assistance, (2) adequate funding mechanisms aligned with the goal of implementing the EBP, (3) on-site leadership that "bought in" to the

EBP, (4) routine feedback regarding fidelity, and (5) a dedicated, competent, and persistent workforce (Bond et al., 2009).

Looking specifically at leadership variables, several other conclusions were made from this National EBP project. One common theme in all the sites that successfully implemented an EBP was leadership committed to implementing the practice (Bond et al., 2009). Sites with committed leadership more often used feedback to make necessary changes to achieve higher fidelity, and effective leaders removed barriers to high fidelity by discontinuing services that were at odds with the EBP (Bond et al., 2009). However, to better interpret these results, it is important to delineate between two different types of leadership within EBP implementation – leadership from within the team (i.e., team leader) and leadership outside of the team (i.e., system leaders; Godfrey, 2010). Both levels of leadership can impact the outcome of high fidelity implementation (Godfrey, 2010).

System's leaders, outside the team, have been found influential in impacting high fidelity implementation. Successful system's leaders must be able to set and communicate goals for the system's practice implementation and develop other systems to support practice and provide feedback to programs on the process and outcomes of the initiative (Torrey, Finnerty, Evans, & Wyzik, 2003). Additionally, system level leaders must establish a flow of adequate funding, monitor the program's successes and outcomes, establish technical assistance to support the EBP, and require that the practice be offered as part of a contractual or certification process (Torrey et al., 2003). Lacking any of these factors may inhibit the implementation or sustenance of the EBP.

For example, in the National EBP Implementation Project, in most instances, the center director was instrumental in ensuring structural changes often by committing adequate resources

(Bond et al., 2009). Rapp and colleagues (2008), in a qualitative study identifying strategies used to implement the EBPs of Supported Employment (SE) and Integrated Dual Disorder Treatment (IDDT), found that positive actions by upper management (in conjunction with front line supervisors) tended to overcome hostilities to new expectations related to the EBP practice (Rapp et al.2008). One of five strategies that emerged from the study was the unique role of upper management (Rapp et al., 2008). Using the exact same data set, but instead looking at barriers to the EBPs of SE and IDDT, Rapp and colleagues (2010) found that in five of the six sites, the team had support or active championing by the upper management for the successful EBP implementation (Rapp et al., 2010).

In a follow-up study to the National EBP Implementation Project, Swain and colleagues (2010) returned to look at the number of sites from the original EBP Project that sustained practices two years after implementation (Swain, Whitley, McHugo, & Drake, 2010). They found that 80% of the sites sustained practices for two years post implementation. Reasons given for sustaining the practices included state support for the practice (including direct financing, technical assistance, and practice evaluations) and the support of agency leadership for the EBP (Swain et al., 2010). Agency leadership was tied (with skills of EBP practitioners) for the second highest factor affecting the sustainability of the EBP, (the number one factor was practitioner attitudes toward the EBP; Swain et al., 2010). These findings on system's leadership are supported by other literature where ongoing leadership has been identified as important for preventing the slide backwards into old patterns (and away from EBPs), and for promoting fidelity (Torrey et al., 2003).

While many studies of EBP implementation identify leadership outside the team as an important element, it is suggested that this system's leadership factor is necessary but insufficient

in alone explaining successful implementation (Rapp et al., 2010). Leadership from within the team has also been identified as an important factor for the success of the EBP implementation. Leadership within the team is typically considered a team leader, or emergent leadership from other team members, or possibly the psychiatrist.

In a study conducted by Aarons (2006), he specifically looked at mental health systems, and the association of team leadership with attitudes of staff towards adopting EBPs. He proposed that leaders were likely to influence mental health providers' attitudes toward the adoption of EBPs. The main finding was that more positive team leadership ratings were associated with more positive attitudes toward adopting EBPs. Additionally, he found the relationship between the team leader and team member dyad was a potentially important point of influence in affecting team members' attitudes towards EBPs. He concluded by stating that leadership of the direct supervisor actively promotes front line staffs' acceptance and adoption of innovation and change, which is critical to the success of implementing EBPs. Front line leaders can influence staff's work attitudes, perceptions, behavior, service quality, and client outcomes (Aarons, 2006).

Similarly, working with six sites in one state that participated in the National EBP Implementation Project, Rapp and colleagues (2010) reported in their qualitative study that one significant obstacle to implementing EBPs (e.g., SE and IDDT) emanated from the behaviors of supervisors. At each site, the front line supervisor of pilot teams was designated as the team leader (Rapp et al., 2010). In every instance, the supervisors were found seriously lacking and according to the researchers, were "probably the single greatest barrier to implementation" (Rapp et al., 2010, p. 114). This study identified common supervisory deficits, across all sites, including: (1) team leaders did not set expectations and allowed practitioners to develop their

own sense of how to do the job; (2) team leaders only provided consultation around service delivery when confronted with difficulties; (3) many team leaders went out of their way to avoid conflict with staff; (4) team leaders did not provide meaningful feedback on staff practice; (5) most team leaders had only superficial knowledge of how their workers practiced; (6) team leaders rarely set any consequences for poor performance; and, (7) team leaders did not run productive team meetings (e.g., dominated by one person, unfocused discussions, never arrived at resolution or next steps), and in most cases, the initial set of leaders never mastered the skills necessary for group supervision. At two sites, the team leader actively sabotaged the project by not following through on decisions emanating from leadership outside the team and by refusing to set EBP expectations or monitoring staff's implementation of the EBP (Rapp et al., 2010).

Even more recently, a study investigated the domains of implementation activities and correlated them to implementation success during the National EBP Implementation Project (Torrey, Bond, McHugo, & Swain, 2012). It was concluded that EBP implementation success was correlated with active leadership strategically committed to re-designing the flow of work and strengthening implementation through measurement and feedback (Torrey et al., 2012). Active, involved, visible leadership was found to strongly influence successful implementation (Torrey et al., 2012). While implementation barriers were a part of all sites, strong leaders actively took on and overcame these barriers (Torrey et al., 2012). The findings suggest that leaders should prioritize active strategies that focus on facilitating change that supports the EBP (e.g., reworking the documentation, policies, meeting structures, and support staff functions; Torrey et al., 2012). A limitation of interpreting this specific study is that the authors do not clearly define the construct of leadership, and so it is difficult to discern if this is leadership

within or outside of the team. However, findings from this study continue to emphasize the importance of both types of leadership in the implementation of EBPs.

Literature More Specific to the EBP of ACT

Specific to the EBP of ACT and as part of this National EBP project, training and consultation was provided to 13 newly implemented ACT teams in two states (Mancini et al., 2009). Findings from this part of the study on the facilitators and barriers of implementing ACT were categorized and reported by state and organizational levels. At the state level, the investigators found that the mental health authority administrators played a central role in addressing obstacles to implementing ACT (Mancini et al., 2009). Poor leadership from administrators created barriers for ACT implementation across teams in two states, including a failure to understand the ACT model, an excessive focus on productivity standards, poor selection and management of team leaders and ACT team members, and reluctance to dedicate the required resources (Mancini et al., 2009; Godfrey, 2010). Earlier research from 2004 found one of these states to have administrative policies regarding unreasonable productivity standards that were particularly significant in inhibiting the development of high fidelity ACT teams (Moser, DeLuca, Bond, & Rollins, 2004). The authors of that study concluded that actions taken by the state mental health authority leadership were the single most influential factor in determining the extent of successful ACT implementation (Moser et al., 2004; Godfrey, 2010). Strategies offered to overcome some obstacles of ACT implementation at the state level included having adequate Medicaid reimbursement frameworks, adequate start-up funding, licensing standards that did not inhibit practice, and technical assistance provided to the teams (Mancini et al., 2009).

At the same time, effective administrative leaders were found to promote effective adoption and implementation of ACT by having a clear understanding of the model, communicating this understanding to staff, hiring staff with appropriate credentials to meet program standards, allocating sufficient resources, and monitoring the team performance and fiscal viability (Mancini et al., 2009).

At the organizational (agency) level, Mancini and colleagues (2009) identified program leadership, that is leadership within the ACT team, as one key facilitator to ACT implementation. They reported that "effective leadership was essential to implementation and was largely reflected in allocation of sufficient resources, promotion of a change culture, and sound personnel practices" (Mancini et al., 2009, p. 193). They described effective ACT team leaders as having a thorough understanding of the ACT model, holding staff accountable, and promoting morale within the team (Mancini et al., 2009). Effective leaders were active in the service delivery to ACT consumers, empowered team members to make independent decisions, and were inspirational about the mission of the program (Mancini et al., 2009). Less effective ACT leaders empowered the team members less, were less organized with service delivery, tended to not address personnel problems or managed workloads equitably among staff (Mancini et al., 2009). Programs led by less effective ACT team leaders were in "organizational disarray", had lower staff morale, and evidenced deficits in ACT implementation (Mancini et al., 2009, p. 193).

Based on their research, Mancini and colleagues (2009) concluded that successful implementation of ACT requires committed leadership at various levels (e.g. state, agency, team), along with the allocation of adequate resources, and careful hiring procedures (Mancini et al., 2009). The factor of leadership was found to impact all the identified organizational

facilitators and barriers in this study of ACT implementation (Godfrey, 2010; Mancini et al., 2009).

Despite this more recent identification of committed leadership within the team being essential to the implementation of ACT, this appears to be a relatively unexplored aspect of the ACT model. Prior to 2000, team leaders or supervisors were rarely included in implementation theory and research (Carlson, Rapp, & Eichler, 2012). As noted thus far within this literature review, there are very few studies that focus specifically on ACT team leadership at the program level. One recent exception has been a publication that aimed to identify the critical behaviors of supervisors for the successful implementation of the EBPs of ACT, IDDT, and SE (Carlson, Rapp, & Eichler, 2012).

In this study, 45 experts who work with supervisors to support the EBPs were asked to identify the importance of some supervisory behaviors of direct program leaders to facilitate the EBP's implementation (Carlson et al., 2012). There was substantial agreement among the experts as to the importance of supervisory behaviors in the areas of facilitating team meetings, building and enhancing staff skills, monitoring and using outcomes, and continuous quality improvement activities (Carlson et al., 2012).

However, this study is somewhat representative of a problem within the literature on ACT team leaders. While this study provides important behaviors of supervisors, it only gives a few behaviors that were somewhat pre-determined by earlier research. Much of the published literature on ACT provides vague descriptors or highlights "bits and pieces" about the ACT team leader or what she does, but a complete description is largely absent. Because of this lack of deliberate focus on ACT team leaders, there is less of a clear picture of what holistically contributes to successful leadership within the ACT model. Specifically, rich descriptions of the

ACT team leader role, or a deep and comprehensive understanding of what an ACT team leader does, are lacking in the literature. This gap in our knowledge about the ACT team leader within the larger body of literature on ACT seems considerable when recent findings suggest that team leadership underlies a majority of other identified facilitators and barriers to the high fidelity implementation of ACT (Godfrey, 2010; Mancini et al., 2009).

In many ways, it makes intuitive sense that the team leader, the individual in charge of managing the entire program, would exert influence over factors that matter to the implementation of a new EBP (i.e., hiring and maintaining a well trained staff; Torrey et al., 2001; Mancini et al., 2009). Additionally, the experiences of ACT team leaders have the potential to offer valuable information and insight regarding implementation and sustenance of the ACT model with high fidelity. Because of recent findings on ACT implementation, ACT team leadership and its subsequent connection to implementing and sustaining high fidelity ACT warrants specific study.

Given the vagueness and lack of a comprehensive picture within the literature on ACT team leadership, it may prove useful to turn to other literature on leadership for extending our knowledge about the ACT team leader. Since the topic of leadership is extremely broad and crosses several disciplinary lines, the following section will narrow the leadership literature to that which may be the most useful for this study. First, a general overview including a brief definition of leadership will be offered, and then concludes with a table that presents the eras of mainstream leadership theory and research (Table 1).

Second, the literature on leadership within community mental health teams (CMHT) or teams in other psychiatric settings will be examined. This literature on community mental health teams (CMHT) and leadership may provide some insight as both the client population (e.g.

people with severe mental illness) and/or the teams' objectives are likely to align more closely to what an ACT team and team leader does. This section examines 16 articles identified via a comprehensive literature search and is sub-divided into studies conducted inside versus outside the U.S. Finally, a summary of what the CMHT and teams in other psychiatric settings literature may lend to this study of ACT team leadership is suggested.

General Leadership Literature

Overview. To most people, the importance of leadership is obvious no matter what the setting (Van Wart, 2003) and the concept of leadership has been studied for centuries. Despite this, many experts still do not agree on exactly what it is (Roussel & Ratcliffe, 2013). Many definitions of leadership have been offered, including that of Stogdill who defines it as a "the process of influencing the activities of an organized group in its efforts toward goal setting and goal achievement" (Bass, 1981). Bellows (1959) defines leadership as "the process of arranging a situation so that various members of a group, including the leader, can achieve common goals with a maximum of economy and a minimum of work" (as cited in Bass, 1990, pg. 15). This latter definition includes two themes that recur within the literature on leadership: the coordination of work, and attention to leader-team member relations (Garman & Corrigan, 1998). These two themes seem highly applicable to ACT team leaders, as a main job duty for ACT team leaders includes the coordination of all work activities, across a multidisciplinary team that operates 365 days a year, 24 hours a day in order to meet the needs of all ACT consumers (Garman & Corrigan, 1998). Arguably, both tasks and relationships are important to understand the construct of leadership.

Before moving further into this review of leadership literature, it is important to address several issues related to the concept of leadership. The first issue is how leadership is defined

within the literature. Terms like leader and team leader have a wide range of variability in meaning and definitions. The literature often lacks a clear and consistent definition in many studies. There appears to be a "shared perception" that the term does not always need definition. A prerequisite to a rigorous evaluation of any model is a clear and consistently used definition of terms; however, no such clarity or consistency exists for the term “leader” (Schofield & Amodeo, 1999). The failure to distinguish terms (e.g., leader, manager, clinical leader, unit chief) from one another and to use the terms interchangeably in articles adds difficulty to both the synthesis and comparison of leadership literature and research (Schofield & Amodeo, 1999). For this case study, my definition of the team leader was simply the individual employed within that specific role on the ACT team.

Second is the difference between the idea of "leadership" and "management". While a thorough analysis is beyond the scope of this study, acknowledging the general delineation between the two different, but overlapping concepts is important. Managers are seen principally as administrators, they seek order and stability (Kotter, 1990; Maccoby, 2000). Conversely, leaders get organizations and people to change (Maccoby, 2000). Leadership is a social transaction in which one person influences others (Roussel & Ratcliffe, 2013). Some literature states that management is a function that must be exercised by any business, and leadership is more about relationship between leader and followers that can energize an organization (Maccoby, 2000).

Bass (2008) indicates that there is a line of reasoning that draws a sharp distinction between leadership and management. It considers leadership to be the discretionary activities and processes that are beyond the manager's role requirements as mandated by rules, regulations, and procedures (Bass, 2008). For example, leadership is whatever discretionary actions are needed to

solve the problems a group faces that are embedded in the larger system (Osborn, Hunt, & Jauch, 1980). However, it is argued that the two concepts of leadership and management inevitably overlap because leaders often must be able to produce and manage periods of stability, often at the same time as planning future changes (Kotter, 1990; Firth-Cozens & Mowbray, 2001). As the reader can tell, discerning the difference between leadership and management is difficult and clearly no definitive consensus exists within the literature.

A third issue related to the concept of leadership is that studies in leadership must involve a consideration of the leader's characteristics, behaviors, and the situation simultaneously (Sashkin, 1989). Leadership seldom emerges in a vacuum (Bennis, 1998) and is more likely because of a complex interplay between variables including individuality, culture, context, values and beliefs, power, and gender issues to name but a few (McCallin, 2003). Leadership should be viewed as a dynamic, interactive process that involves the leader, the follower, and the situation; each influencing the other (Roussel & Radcliffe, 2013). For ACT, it is impossible to dissect the behavior of the leader in the absence of the environment, which includes the ACT team, the parent agency, and the state. So integrated are the leader, team, and environment, all must be discussed in order to give context to the "who is the ACT team leader?" question.

Despite the drawbacks of defining and studying the issue of leadership, it is still the subject of thousands of studies and an important phenomenon to investigate. The research on leadership is highly prevalent in the organizational, business, psychology, and military fields. Leadership research is wide ranging, covering the personality or behavior of the leader, the context in which leadership takes place, and the people who are led.

Organizational psychologists have examined personality traits that differentiate leaders from followers (Stogdill, 1974), behavioral characteristics of competent leaders (Hemphill &

Coons, 1957; Likert, 1967), task-oriented versus relationship-oriented leadership styles (Fiedler, 1964), and situationally defined models of leadership (Hersey & Blanchard, 1982; Corrigan, Garman, Canar, & Lam, 1999). Researchers have also looked at leaders and their influences on various targeted outcomes. In organizations, effective leadership provides higher-quality and more efficient goods and services, it provides a sense of cohesiveness, personal development, and higher levels of satisfaction among those performing the work; and it provides a vision and sense of direction, and a resource for stimulating the organizational culture (Van Wart, 2003).

While an extensive review of the theories and research of leadership would be beyond the purpose of this study, Van Wart (2003) provides a summary of eras of mainstream leadership theory and research which will provide a useful foundation for the reader on the topic of ACT leadership (Table 1).

Table 1: Eras of Mainstream Leadership Theory and Research

Era	**Major Time Frame**	**Major Characteristics/Examples of Proponents**
Great Man	Pre-1900; continues to be popular in biographies.	• Emphasis on emergence of a great figure such as a Napoleon, George Washington, or Martin Luther, who has substantial effect on society. • Era influenced by notions of rational social change by uniquely talented and insightful individuals.
Trait	1900-48; current resurgence of recognition of importance of natural talents	• Emphasis on the individual traits (physical, personal, motivational, aptitudes) and skills (communication and ability to influence) that leaders bring to all leadership tasks. • Era influenced by scientific methodologies in general (especially industrial measurement) and scientific management in particular (e.g., the definition of roles and assignment of competencies to those roles).
Contingency	1948-80s; continues as the basis of most rigorous models but with vastly expanded situational repertoire.	• Emphasis on the situational variables leaders must deal with, especially performance and follower variables. Shift from traits and skills to behaviors (e.g., energy levels and communication skills to role clarification and staff motivation). • Era influenced by the rise of human relations theory, behavioral science (in areas such as motivation theory), and the use of small group experimental designs in psychology.
Transformational	1978-present	• Emphasis on leaders who create change in deep structures, major processes, or overall culture. Leader mechanisms may be compelling vision, brilliant technical insight, and/or charismatic

		quality. • Era influenced by the loss of American dominance in business, finance, and science, and the need to re-energize various industries that had slipped into complacency.
Servant	1977-present	• Emphasis on the ethical responsibilities to followers, stakeholders, and society. Business theorists tend to emphasize service to followers; political theorists emphasize citizens; public administration analysts tend to emphasize legal compliance and/or citizens. • Era influenced by social sensitivities raised in the 1960s and 1970s.
Multifaceted	1990s-present	• Emphasis on integrating the major schools, especially the transactional schools (trait and behavior issues largely representing management interests) and transformational schools (visionary, entrepreneurial, and charismatic). • Era affected by a highly competitive global economy and the need to provide a more sophisticated and holistic approach to leadership.

Taken from Van Wart, 2003

As illustrated in Table 1, leadership theory and research has continually progressed and despite no agreed upon definition and framework for all studies of leadership, it continues to be an important topic for study.

Literature on leadership within community mental health teams (CMHT) or teams in other psychiatric settings.

Introduction. Despite the prolific research on the topic of leadership, by comparison, literature on mental health or interdisciplinary team leadership is meager. According to Corrigan and colleagues (1998), there are very few carefully controlled studies on leadership for mental health services. Further, little has been written about effective leadership of the mental health team (Corrigan et al., 1998).

Because of the dearth of literature that focuses specifically on mental health teams and because the type and quality of this research is so variable, the literature search for this paper cast a wide net. Several databases were searched, including PsycINFO, Academic Search, ProQuest,

and Google Scholar and included different combination of search terms such as "mental health teams," "leadership," "team leader," "social work," "leaders," "multidisciplinary teams," "team work," "assertive community treatment," "community mental health teams," "psychiatric," and "severe and persistent mental illness." From the results of the search, all article abstracts were reviewed, and 16 articles were chosen that had some relevance to the topic of ACT team leadership. In some cases, this relevance was an embedded reference to leadership since many studies focused on variables or outcomes other than leadership. Nonetheless, these studies were included in the effort to be comprehensive. Appendix 3 provides a summary of the 16 articles on leadership within a CMHT or teams in other psychiatric settings reviewed for this study.

The majority of information provided on team leaders in CMHT literature or teams in other psychiatric settings literature comes from looking at research on various team member outcomes (e.g., motivation, burnout). Rarely in the literature is the team leader the actual variable of interest, although there are a few exceptions. A limitation within this body of literature on leadership within CMHT or teams in other psychiatric settings, and a barrier to synthesizing conclusions, is that several articles do not describe *who* the team leader is; information such as gender, race, age, years in practice, or discipline is incomplete or missing. For example, in much of the multidisciplinary mental health team literature, team leaders may be identified as nurses, social workers, rehabilitation workers, or consulting psychiatrists. This variation in the discipline of the team leader could arguably matter as various disciplines are taught, conditioned, and see the world in different ways. Hence, without clear descriptions of who the team leader is, it is more challenging to interpret and compare findings across studies. When possible, within this review of the CMHT and teams in other psychiatric settings literature, I will denote how the study defined the leader to assist the reader with drawing comparisons.

Appendix 3 provides the reader with each article's definition of the team leader and other information that was provided descriptively.

Some of the most relevant studies for this dissertation are those that have examined whether leadership models developed in business and military settings are relevant for mental health and rehabilitation teams (Corrigan, Garman, Lam, & Leary, 1998; Corrigan, Garman, Canar, & Lam, 1999). Ten of the identified 16 studies specifically investigated mental health teams providing services to individuals with SPMI here in the U.S. (Corrigan et al., 1998; Corrigan & Garman, 1999; Corrigan, Diwan, Campion & Rashid, 2002; Corrigan et al., 1999; Corrigan, Lickey, Campion & Rashid, 2000; Garman & Corrigan, 1998; Liberman, Hilty, Drake, & Tsang, 2001; Toseland, Palmer-Ganeles, & Chapman, 1986; Wells, Jinnett, Alexander, Lichtenstein, Liu, & Zazzali, 2006; Yank & Barber, 1994). The remaining six studies were conducted outside of the U.S., primarily in the U.K. (Belling et al., 2011; Bowers, Nijman, Simpson, & Jones, 2011; Burns, 2004; Onyett, 2011; Rosen & Callaly, 2005; West, Borrill, Dawson, Brodbeck, Shapiro, & Haward, 2003).

Studies of mental health teams and leadership in the U.S. Of the ten studies that investigated mental health teams in the U.S., six studies were conducted by the same group of researchers led primarily by investigator Patrick Corrigan (Corrigan et al., 1998; Corrigan & Garman, 1999; Corrigan, Diwan, Campion & Rashid, 2002; Corrigan et al., 1999; Corrigan, Lickey, Campion & Rashid, 2000; Garman & Corrigan, 1998). Beginning with the earliest study, in 1998, results from the first phase of a 3 year mixed methods study were published (Corrigan et al., 1998). This study aimed to identify factors that mental health (MH) team members seek in their leaders and to assess the applicability of Bass's Multifactor Model of

Leadership[3] to mental health settings (Corrigan et al., 1998). The study included 389 staff members of MH teams who provided team-based clinical or rehabilitative services to persons with SPMI. These participants answered a survey about effective leaders. A second independent sample of 346 team members then completed a questionnaire on factors that were problematic within the team. Results included the identification of six leadership factors that were important including autocratic leadership, clear roles and goals, reluctant leadership, vision, diversity issues, and supervision[4]. The authors concluded that Bass's theoretical framework did have some relevancy for mental health team leaders as four of these six identified factors aligned with Bass's framework. The second phase of this study was creating a curriculum for developing effective mental health leaders (Garman & Corrigan, 1998).

Extending this work, in a descriptive article, Corrigan & Garman (1999) aimed to again illustrate the applicability of Bass's Multifactor Model of Leadership for leaders of mental health teams and continued the work of developing a curriculum specific to the needs of mental health team leaders. They confirmed the applicability of this model to mental health leaders and concluded that leaders who learn to incorporate transformational and transactional skills will produce better functioning teams (Corrigan & Garman, 1999). A limitation of this article was that it provided no clear definition of team leadership.

Similarly, Corrigan and colleagues (1999) then investigated whether Illinois rehabilitation staff members who worked in vocational rehabilitation departments reported the same factors in describing team leaders as mental health team members (Corrigan, Garman, Canar, & Lam, 1999). Findings included that the same four of six factors found in the mental health survey were replicated in the survey of rehabilitation team members (autocratic

[3] A thorough review of Bass's Multifactor Model of Leadership can be found beginning on Page 56 of this dissertation.
[4] Examples of these factors are described in Appendix 3 under the Corrigan et al., 1998 study.

leadership, clear roles and goals, reluctant leadership, and vision). Again, these four factors were the same ones that overlapped with Bass's multifactor model (Corrigan et al., 1999). The four factors suggested several things. First, team members had problems with leaders who communicated with them only when they made mistakes. Second, team members wanted their leaders to clearly define the goals of the team as well as the individual roles needed to accomplish these goals. Third, team members clearly wanted leaders who assumed responsibility and made appropriate decisions and reported dissatisfaction with leaders who could not make difficult decisions or control unruly colleagues. Fourth, team members wanted to understand the rationale for their work in terms of some higher order goal or vision provided by the leader (Corrigan et al., 1999). Within this study, leaders helped members exceed the normal limits of their job so they had a greater sense of accomplishment at work (Corrigan et al., 1999). A limitation of this study was that again no clear definition of leadership was provided.

In 2000, Corrigan and colleagues sought to determine the association between leadership styles of leaders of MH treatment teams and consumers rating of satisfaction with the program and quality of life (Corrigan, Lickey, Campion, & Rashid, 2000). Participants of this Midwest study included 143 leaders and 473 subordinates from 31 clinical teams, as well as 184 consumers served by these teams. Teams worked in state hospitals and community mental health programs and served adults with SPMI. Some teams were noted to provide SE, ACT, or drop in services. Most teams had more than one leader who commonly included a lead psychiatrist, charge nurse, or a clinical manager. Leaders and subordinates rated the leadership style of the identified leader, while the consumers rated their satisfaction with the treatment program and their quality of life (Corrigan et al., 2000).

This study had several important findings pointing to the impact of leadership on consumer outcomes. Consumers in programs led by leaders who rated themselves as "laissez-faire" (i.e., those who shirk their supervisory duties), or leaders inclined to use passive management by exception (i.e., intervenes only when performance is below expectations) reported lower satisfaction and diminished quality of life (Corrigan et al., 2000). On the other hand, results suggested that transformational leadership, where the leader elevates the follower morally about what is important and valued (Bass, 2008), was related to benefits for consumers. Some indirect effects of leadership on consumers were found as well; when staff/subordinates who viewed their leaders as charismatic, inspirational, and considerate of individuals, agency consumers reported relatively higher quality of life. Overall, leadership variables accounted for 40% of the variance in consumers' satisfaction and quality of life. The authors concluded by saying that leadership seemed to be an important variable for better understanding a team's impact on its consumers (Corrigan et al., 2000).

The final study from Corrigan and colleagues on this topic was published in 2002 (Corrigan, Diwan, Campion, & Rashid, 2002). In this correlational study, 54 U.S. mental health teams providing services to adults with SPMI in the Midwest participated (236 leaders and 620 subordinates). Teams worked in state hospitals and community mental health settings, and both team leaders and subordinates completed three measures that assessed perceptions of leadership style, organizational culture, and level of burnout (Corrigan et al., 2002). The aim of the study was to examine the relationship between leadership styles (transformational, transactional, and laissez-faire) and measures of organizational culture and staff burnout. Team leaders were defined within this study as individuals who had direct responsibility for supervising a group of staff members who provided clinical or rehabilitation services to persons with severe mental

illness (Corrigan et al., 2002). Results of the study showed that transformational leadership was positively associated with a cohesive organizational culture and negatively associated with burnout (Corrigan et al., 2002). Leaders and subordinates differed in their ratings of transformational leadership, with leaders viewing themselves more positively (both intellectually stimulating and individually considerate). Additionally, transformational leadership seemed to have an overall positive effect on team functioning. Transactional leadership failed to show any clear association with organizational culture or burnout (Corrigan et al., 2002).

Of the remaining four studies (out of the 10) investigating multidisciplinary MH team work and leadership in the U.S. (Liberman, Hilty, Drake, & Tsang, 2001; Toseland, Palmer-Ganeles, & Chapman, 1986; Wells, Jinnett, Alexander, Lichtenstein, Liu, & Zazzali, 2006; Yank & Barber, 1994), two were conceptual in nature (Yank & Barber, 1994; Liberman et al., 2001) and two were experimental studies (Toseland et al., 1986; Wells et al., 2006).

In a conceptual article, Yank and Barber (1994) described the mental health treatment and team from a systems model perspective. They offered several components of effective leadership from this perspective, including that team leaders must be mindful of many factors that affect the ability of other team members to provide honest feedback (i.e., desire to please the leader and how the leader responds to and reinforces the team member; Yank & Barber, 1994). Furthermore, they state that the ability of the team leader to promote team identity and "teamness" involves the utilization of the members' attitudes and feelings evoked by and about the leader (Yank & Barber, 1994). They define effective team leadership as the ability to delegate leadership functions to other persons and groups, and empower team members to set priorities, make decisions and take necessary actions as well as being aware of boundary issues that require balancing as they are, as team leaders, both inside and outside the team (Yank &

Barber, 1994). Unfortunately, Yank & Barber (1994) do not provide a definition of the leader within the article.

In the other conceptual article, Liberman and colleagues (2001) describe the properties and functions of the psychiatric rehabilitation multidisciplinary team and key attributes of effective teams (Liberman, Hilty, Drake, & Tsang, 2001). They purport that some of the important group dynamics of the team are cohesion, leadership, distribution of responsibilities and authority, participation in problem solving and decision making, and empowerment through participation in meetings and professional growth (Liberman et al., 2001). When the team's leadership encourages members' participation and shows respect for their expertise in goal setting, problem solving, task assignments, and decision making, members experience job satisfaction, challenge, control, and productivity, which the authors point out often corresponds with clinical excellence (Liberman et al., 2001). Specific to team leadership, leaders must possess leadership skills that include being able to organize and lead productive team meetings and maintain cohesion and morale among team members (Liberman et al., 2001). Likewise, leaders must help meet the personal and professional needs of team members, providing team members with mechanisms for discussing concerns and differences of opinions, solving problems and sharing expertise. Finally, leaders must be able to address system wide challenges to the delivery of comprehensive and coordinated services (Liberman et al., 2001). While no definitive definition of team leaders is provided in this article, some mention is made that psychiatrists typically function as the leaders of the team.

The final two studies conducted in the U.S. investigated teamwork and leadership in psychiatric settings versus CMHTs (Toseland et al., 1986; Wells et al., 2006). First, Toseland and colleagues (1986) employed a mixed methods, exploratory study that examined the

functioning of teams in psychiatric settings in order to identify factors that contribute to effective teamwork and to raise issues about team functioning. This study purposively sampled 15 of 18 teams from two state-run psychiatric facilities in two medium-sized cities in the same state. A total of 77 team members participated. Various disciplines were considered as team leaders. Results salient for team leadership included that team members who reported dissatisfaction with team function focused on the autocratic manner in which team leaders or unit chiefs made decisions without considering the opinions of team members who were expected to implement these decisions. Some team members also reported less team effectiveness was related to a lack of leadership and direction (Toseland et al., 1986).

Second, Wells and colleagues (2006) examined associations between team leader discipline and mutual respect among treatment team members and then mutual respect among team members and improvements in patient quality of life. In this study, the team leader was defined as the person who provided the strongest leadership on the team. Two separate models were run in this study. The first model consisted of 78 VA psychiatric treatment teams (51 inpatient; 27 outpatient) operating in units serving individuals with SPMI. Subjects for model 2 were 1638 individuals with SPMI in 44 U.S. psychiatric treatment settings. Findings indicated that mutual respect among team members was highest in social work led teams and lowest in physician led teams and that mutual respect among team members may improve some patient outcomes. Fostering mutual respect among team members falls within the relational dimension of team leadership and suggests that team leaders can affect team member dynamics in a number of ways such as by structuring rewards so that people benefit from collaboration rather than competition, by intervening when conflicts begin to develop, by teaching staff how to manage

conflicts proactively themselves, and through the norms they model in their own behavior (Wells et al., 2006).

Studies on mental health teams and leadership outside the U.S. The final six studies found in the literature search on community mental health teams or teams in psychiatric settings come from outside the U.S. (Belling et al., 2011; Bowers, Nijman, Simpson, & Jones, 2011; Burns, 2004; Onyett, 2011; Rosen & Callaly, 2005; West, Borrill, Dawson, Brodbeck, Shapiro, & Haward, 2003). Five of six studies were conducted in the UK, and the other one in Australia (Rosen & Callaly, 2005). A limitation of this body of literature includes the concern of how applicable it may be to the mental health setting in the U.S. due to potentially different service delivery systems and public mental health authority processes; however, I decided to include it to give the reader a comprehensive view of the literature. Additionally, much of this literature is recently published (three studies published in 2011) and this may help with understanding leadership in a more current context.

Beginning with the earliest study in this sub set of literature coming from outside the U.S., West and colleagues (2003) studied the relationships among leadership clarity (who is responsible for the team leadership), team processes, and innovation within health care teams in the UK. A sample of 3447 respondents from primary health care teams, community mental health teams, and breast cancer care teams were given questionnaires. In this study, leadership was defined on a team level (West et al., 2003). Major findings from this study included that team leadership predicted innovation with CMHTs, and that leadership clarity is associated with clear team objectives, high levels of participation, and commitment to excellence. Furthermore, the team leader had a key role in ensuring processes were in place to make sure team members could share information and ideas, and contribute to decision making. Team leaders emphasized

excellence so that team members could challenge and debate each other's ideas and provide the practical and social support to develop innovation (West et al., 2003).

Next, in a descriptive article, Burns (2004) describes community mental health teams in the UK. The clinical team leader is described most often as the consultant psychiatrist, but a "team manager" is also identified. This article supports much of the previous descriptive literature. That it is necessary to have clarity around leadership that the leader must have clinical oversight and authority, and team managers are responsible for management of the team and supervision of non-medical staff (Burns, 2004). Finally, it is suggested that the clinical team leader and team manager see "eye to eye" and work closely together. This final assertion has some applicability to ACT since the psychiatrist and team leader must also work collaboratively in meeting consumer outcomes and operating within the team.

In another descriptive article, Rosen & Callaly (2005) outline the constructs and applications of interdisciplinary teams in mental health services in Australia, specifically looking to determine the most effective types of teams and their leadership. Team manager is defined as the person held responsible for specified management functions, with delegated authority to ensure that the team applies operational policy and overviews the clinical work allocation (Rosen & Callaly, 2005). The authors contend that effective interdisciplinary teamwork in MH requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices (Rosen & Callaly, 2005). Effective team managers must be in tune with the state of team as well as externally aware of the demands on the team as whole (Rosen & Callaly, 2005). Team managers have an important role in containing difficult team emotions and in articulating and advocating consistently for the team

and service values and vision based on the needs and safety of the clients (Rosen & Callaly, 2005).

Of the remaining three studies in this sub-category of studies conducted outside the U.S., all were published in 2011. One is a literature review (Onyett, 2011) and two employ experimental designs (Belling et al., 2011; Bowers et al., 2011). In his review of the literature, Onyett (2011) aimed to update findings on burnout, job satisfaction, and sources of high and low morale in community mental health teams in the UK since a national survey of CMHTs in 1997. Community mental health teams varied in terms of the types of teams covered, and no further definition of CMHT or leadership was provided. The author reviewed the literature from 1997 through 2010. Onyett (2011) reported that the body of literature presented contradictory findings and used inconsistent methodologies. Regarding results pertinent to the construct of leadership, Onyett (2011) stated that effective team working, good leadership, management, support, and supervision appear to be protective factors from stress, dissatisfaction, and burnout. Lacking a supportive line manager was associated with higher emotional exhaustion among community mental health nurses (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2001) and more negative attitudes towards clients (Hannigan, Edwards, Coyle, Fothergill, & Burnard, 2000). Onyett (2011) reported that Decker (1997) found that the main predictors of job satisfaction for nurses were relationships with their managers and coworkers, along with opportunities to progress in their careers. A major limitation of Onyett's (2011) article is the difficulty of making comparisons across studies given no definitions of "effective" or "good" leadership is provided, likely due to the wide breadth of studies reviewed (Onyett, 2011).

Next, Belling and colleagues (2011) identified and explored facilitators and barriers perceived to influence continuity of care by health and social care professionals working in and

closely associated with CMHTs in London, England (Belling et al., 2011). They had a random sample of 113 health and social care professionals, including identified team leaders, although no definition of the team leader was provided (Belling et al., 2011). The largest group of professionals was nurses (46%) and social workers represented 20.3% of the total participants. The study employed a survey design utilizing a structured questionnaire followed by in-depth, semi-structured interviews with a random sample (Belling et al., 2011). The authors concluded that team leadership was a critical component with team leaders fulfilling pivotal roles in maintaining cohesive teams, reducing outside pressures, and creating supportive environments in which staff are able to operate and develop (Belling et al., 2011). Positive experiences of teamwork support, leadership and decision making were identified as facilitators to continuity of care (Belling et al., 2011).

In the final article identified in the review of literature on community mental health teams or teams in psychiatric settings outside the U.S., Bowers and colleagues (2011) studied the relationship among leadership, team working, structure, burnout and attitude to patients on acute psychiatric wards, and assessed how the relationships influenced rates of conflict and containment. The participants consisted of leaders (defined as managers at a higher level than ward staff) and teams on 136 acute psychiatric wards in England. In this multivariate cross sectional study, data was collected via 5 different questionnaires, and a total of 6,661 questionnaires were collected and analyzed. The authors concluded that leadership impacts team work, teamwork impacts structure, structure influences burnout, and burnout influences attitudes towards difficult patients. They also found that efficacy of the leadership did not show much direct relation to feelings of burnout and that poor leadership may retard the development of a well-functioning team (Bowers et al., 2011).

Conclusions from the literature on leadership within community mental health teams or teams in other psychiatric settings. Several conclusions can be drawn from the literature on leadership within CMHT or teams in other psychiatric settings. This body of literature indicates that ideas on leadership from other fields have relevancy to mental health teams and in particular, Bass's multifactor model of leadership framework seems, in part, applicable. We can conclude that styles of leadership influence both team variables (e.g., organizational culture, burnout, team functioning, acceptance of EBP adoption) as well as consumer variables (e.g., satisfaction with program, quality of life) and that leaders who incorporate transformational and transactional skills appear to produce better functioning teams (Corrigan & Garman, 1999).

This literature also suggests that attention to both task as well as relationships are important for understanding the influence of leaders and defining what effective leaders must consider. The majority of the reviewed literature looks at the team leader as an embedded construct within the team, and it appears the team leader may influence the team and team processes which may indirectly influence consumer outcomes. This makes sense as often times the team leader has little direct or systematic contact with ACT consumers compared to team members, but is still quite involved in many of the treatment decisions (via constant communication with team members) that may influence the consumer's life.

Looking critically, this body of literature presents difficulty in synthesis and cross comparison. There is wide variability in theoretical frameworks and the methods employed across studies, including how (and if) the construct of leadership is defined or operationalized. Much of the literature is descriptive in nature and lacks experimental scrutiny, which allows us to extrapolate only so far. Additionally, others issues of generalization come up. The studies that

look at teams in psychiatric in-patient settings may lack applicability to community-based teams given the very different parameters to consumer care and decision making outside of a locked facility. It could be assumed that team members must make more independent decisions "on the fly" in the community, which would impact how the leader operates. Further, over a third of the studies reviewed come from outside the U.S., which calls into question how the findings may apply to the current mental health context in the U.S.

Despite the challenges and limitations within the studies on mental health leadership, we can assert that studying leadership is still important and a worthy endeavor. The majority of the literature is clear that effective leadership appears to facilitate many positive outcomes while ineffective leadership appears to present less desirable outcomes, regardless of what outcome is being studied. Specifically looking at the ACT team leader, this literature has helped in illustrating that both task and relationship variables will be important to examine in trying to answer the study aims. Further, the literature suggests that many characteristics and behaviors of leaders appear to transcend disciplinary lines and are worthy of exploring within this case study of ACT team leaders of high fidelity ACT teams. While I can use some of this literature as a guide as to what I may find with ACT team leaders, I would also posit that the job of running a high fidelity ACT team is different in many ways compared to running a CMHT or an inpatient psychiatric mental health team. The literature clearly suggests environment and situations matter to understanding leadership. Because of this, the ACT environment (e.g., team, agency, and state variables) deserves inclusion and scrutiny as well.

Finally, this body of literature offers some guidance as to conceptual/theoretical frameworks that may have some applicability to the study of ACT team leaders. In the following

section, I review the use of conceptual/theoretical frameworks in case study research and provide an overview of the conceptual framework that was utilized for this case study.

Conceptual/Theoretical Framework

Use of theory in case studies. There is a lack of consensus on the extent to which theoretical frameworks should be utilized in case study methodology (Klenke, 2008). On one hand, some scholars argue that case researchers should approach the study without being influenced by any existing theory (Klenke, 2008). Scholars who take this position argue that the use of theory limits the researcher to focusing on concepts embedded within the theory and thwarts potential new lines of inquiry (Klenke, 2008). On the other hand, some scholars argue that very few of us can completely distance ourselves from existing theory (Klenke, 2008). It is suggested that case researchers, whether explicitly or implicitly, bring some type of conceptual framework to the research process, which acts as a filter for data collection and analysis (Cooper-Brathwaite, 2003; Yin, 2012; Klenke, 2008). According to Klenke (2008), it is unrealistic to suggest researchers enter the field without relevant concepts in their area of interest.

Many other case study researchers extend the debate further and advocate that reliance on theoretical concepts to guide design and data collection remains an important strategy for doing successful case studies (Yin, 2012). Theoretical concepts can be useful in conducting exploratory, descriptive, or explanatory case studies and for keeping the data collection within manageable proportions (Yin, 2012). The use of theory in case study gives researchers an opportunity to reveal (and minimize) substantive biases that may affect the design and conduct of a case study (Yin, 2012). By employing some conceptual/theoretical framework, the researcher can broaden the scope of inquiry to include other issues for examination beyond what he/she feels is important.

Several ways of using theory have been suggested within the case study methodology literature. Eisenhardt (1989) has identified three distinct uses of theory in case study research: (1) as an initial guide to design and collect data in an explanatory way; (2) as part of an iterative process of data collection and analysis (e.g., making sense of the findings); and (3) as the final product of the research. Within this study, I created a conceptual framework and used theory in the first two ways suggested by Eisenhardt (1989).

Conceptual framework for this case study. The conceptual framework for this study is drawn primarily from three sources –Bass's Multifactor Model of Leadership, relevant concepts identified in the literature, and a priori ideas and knowledge— in order to best inform the study aims. Appendix 4 outlines how these three sources were incorporated into the design of the questionnaires and subsequent data collection. While this conceptual framework was useful as a starting point, it was not my objective to use the framework solely in the study's design or analysis and interpretation of data. I did not wish to be "so focused on what I am looking for that I overlook the things I actually find" (Patchett, 2011, pg. 246). I remained open to discover other findings and did not try to fit all results into this one conceptual framework.

The first component to the study's conceptual framework is Bass's Multifactor Model of Leadership, also known commonly as Bass's Transformational Leadership theory.

Bass's multifactor model of leadership.

Background. Bass's (1985) Multifactor Model of Leadership stems from previous work conducted by Burns (1978) on transactional and transformational political leaders (Gellis, 2001). Burns' (1978) work described leadership behavior as falling within two broad categories of influence: transactional and transformational. The transactional leader influences followers by using rewards and punishment as a form of motivation (Burns, 1978; Bass, 2008). For example,

a transactional leader might reward a hard-working staff with an increase in time off. On the other hand, transformational leadership focuses on leaders motivating followers to do more than they originally thought possible (Avolio & Bass, 2004). This is accomplished through modeling and motivating followers, not because of an exchange of value, but for the love of their work (Dems, 2011). For example, a staff person may stay late and finish a task because it is for the good of the organization and client, without expectation of other tangible rewards.

Burns (1978) was the first to define leadership on a spectrum, with transactional leadership on one end, and transformational leadership on the other end (Conger, 1999). Bass conceptually extended the original work by Burns (1978), by proposing that the transactional and transformational dimensions were separate and suggested that a leader could embody both (Conger, 1999). Further, Bass (1985) set out to identify the actual behaviors that these leaders demonstrated along the two defined dimensions of transactional and transformational leadership (Conger, 1999). This idea that there are two distinct, but interrelated ideal types of leadership, transactional and transformational, resulted in a model called the Multifactor Model of Leadership (Bryman, 1992; Bass & Steidlmeier, 1999; Bass, 1985, 1990; Bass & Yammarion, 1991; Hater & Bass, 1988; Yammarino & Bass, 1990). Figure 1 illustrates Bass's (1985) Multifactor Model of Leadership.

Figure 1: Bass's (1985) Multifactor Model of Leadership

The Multifactor Model of Leadership was originally developed and disseminated in the business and military fields, but has been applied to many other settings including mental health and rehabilitation settings (Corrigan, Garman, Lam & Leary, 1998; Corrigan et al., 2002; Corrigan & Garman, 1999). Bass's Multifactor Model of Leadership (1985) has become more commonly known as the theory of Transformational Leadership and has been well researched over the past two decades. The following section will define the components of transactional and transformational leadership more thoroughly and include a description of the leaders' behaviors that contribute to each type of leadership. The components of Bass's Multifactor Model of Leadership are summarized in Table 2 below.

Components	Description of leadership style
Transactional	
Contingent Reward	Provides rewards for satisfactory performance by followers.
Management by Exception (active)	Attends to followers' mistakes and failures to meet standards.
Management by Exception (passive)	Waits until problems become severe before attending to them and intervening.
Transformational	

Idealized Influence (attribute)	Demonstrates qualities that motivate respect and pride from association with him or her.
Idealized Influence (behavior)	Communicates values, purpose, and importance of organization's mission.
Inspirational Motivation	Exhibits optimism and excitement about goals and future states.
Intellectual Stimulation	Examines new perspectives for solving problems and completing tasks.
Individualized Consideration	Focuses on development and mentoring of followers and attends to their individual needs.
	Adapted from the Multifactor Leadership Questionnaire--Form 5X

Table 2: Components and Descriptions of Transactional and Transformational Leadership Styles

Transactional leadership. The foundation of transactional leadership rests on the premise that there is a transaction or exchange process between leaders and followers (Gellis, 2001; Bass, 1985; Daft, 1999). Followers receive certain rewards (e.g. wages, prestige) for job performance while leaders benefit from the completion of tasks (Den Hartog, Van Muijen, & Koopman, 1997; Daft, 1999). Transactional leadership is based on a series of economic and social transactions to achieve specific goals (Daft, 1999). Leaders who practice transactional behaviors attend to the day-to-day tasks, which followers need to complete so the program can operate effectively (Corrigan & Garman, 1999). These leaders are focused on the here-and-now and excel at keeping an organization running smoothly and efficiently (Daft, 1999; Corrigan & Garman, 1999). Transactional leaders are good at traditional management functions such as planning and budgeting and generally focus on impersonal aspects of job performance (Daft, 1999). For this reason these leaders have often been described more as managers versus leaders (Bass, 2008). Transactional leadership is said to involve two components: contingent reinforcement and management-by-exception (see Figure 1; Bass & Steidlmeier, 1999).

Contingent reinforcement. Contingent reinforcement or reward is where the leader clarifies for the follower through direction or participation what the follower needs to do to be rewarded for the effort (Bass, 1999). The emphasis of contingent reinforcement is on the use of

rewards and penalties to motivate followers and achieve compliance with organizational goals and norms (A Dictionary of Business and Management, 2006). In addition to contingent rewards, transactional leaders are also said to "manage by exception"

Management by exception. Managing by exception refers to the idea that these leaders are less interested in changing or transforming the work environment, but seek to keep everything constant except where problems occur (Bass, 1999). These leaders take corrective action and intervene only when failures and deviations occur (Bass, 1990). This management-by-exception may be displayed in one of two ways: *active* or *passive*. Active management-by-exception is when leaders actively search and monitor the follower's performance to see if there are deviations or shortfalls and correct followers' mistakes (Bass, 1999; Bass & Steidlmeier, 1999; Bass, 1990). Passive management-by-exception is when the leader waits for followers' mistakes to be called to their attention before taking corrective action with negative feedback or reprimands (Bass, 1999; Bass & Steidlmeier, 1999). These leaders ask no more than what is essential to get the work done (Bass, 1990). This passive management-by-exception has been termed as a laissez-faire leadership style, described as the absence of leadership and the avoidance of intervention, and has been found in many studies to be an ineffective and counterproductive leadership style (Bass & Avolio, 1990; Skogstad, Einarsen, Torsheim, Aasland, & Hetland, 2007).

While transactional leaders can be effective, their commitment to "following the rules" and maintaining stability within the organization rather than promoting change may be detrimental to organizations needing to change and adopt new practices (Daft, 1999). While the transactional leader motivates followers to perform as expected, the transformational leader typically inspires followers to go beyond expectations (Den Hartog et al., 1997). It is for this

reason, that transformational leadership has been identified as important when an organization wishes to adopt change.

Transformational leadership. Transformational leadership is characterized by the ability to bring about change or transformation in followers to meet the needs of the organization (Daft, 1999). Within this type of leadership style, followers have an emotional and motivational attachment to the leader based on the leader's behavior (House, Woycke, & Fodor, 1988). Transformational leadership is based in the personal values, beliefs, and qualities of the leader and less on the transactional exchange process between leaders and followers (Daft, 1999). According to Hater & Bass (1988), "the dynamics of transformational leadership involve strong personal identification with the leader, joining in a shared vision of the future, or going beyond the self-interest exchange of rewards for compliance" (pg. 695).

Transformational leaders do not rely on tangible incentives to control specific transactions with followers, but instead focus on intangible qualities such as vision, shared values, and creative ideas in order to build relationships (Daft, 1999). Followers' perceptions of self-efficacy or confidence, as well as other aspects of their personal developmental potential, are enhanced through the transformational leadership process (Avolio & Bass, 2004). Bass (1985) identified three ways in which leaders transform followers: (1) increasing their awareness and acceptance about the purpose and value of the mission; (2) inspiring followers to transcend their self-interests for the good of the collective and its goals; and, (3) stimulating interest and activating followers' higher order needs (Yammarino & Bass, 1990; Burns, 1978, Den Hartog et al., 1997). By defining the need for change, creating and sustaining new visions, inspiring and mobilizing commitment of the group to these visions, transformational leaders can ultimately transform the organization (Tichy & Devanna, 1990).

There are four components that make up the dimensions of transformational leadership: (1) idealized influence or charisma; (2) inspirational motivation; (3) intellectual stimulation; and, (4) individualized consideration (Bass, 1985, 1998; Bass & Avolio, 1993; see Figure 1).

Idealized influence. Idealized influence can be thought of as charisma or the leader's ability to generate enthusiasm and draw people together around a common vision through self-confidence and emotional appeal (see Table 2; Bass & Avolio, 1997 as cited in Gellis, 2001; Fischer, 2005). Transformational leaders have followers who view them in an idealized way, and subsequently, these leaders hold power and influence over their followers (Avolio & Bass, 2004). The followers strive to identify with the leader and the mission of the organization, and invest trust and confidence in the leader's ability (Avolio & Bass, 2004). Idealized influence can be thought of along two dimensions, the *attributes* and *behaviors* of the leaders. Idealized attributes of leaders include, but are not limited to, being trustworthy, respectful, determined, and confident. Idealized behaviors of leaders include setting high standards of ethical performance, and being a role model (i.e., taking responsibility for actions, acting in a way that incites admiration in followers, being passionate about and personally invested in the organizational goals; Bass, 1985; Bass & Avolio, 1989; Packard, 2003; Fischer, 2005). Through idealized influence, transformational leaders arouse and inspire others that the vision or mission of the group can be accomplished through extra personal effort (Avolio & Bass, 2004).

Inspirational motivation. Similar to idealized influence, inspirational motivation occurs when leaders motivate followers to have high expectations and commit to the organization (Mary, 2005). Inspirational leaders articulate, in understandable ways, shared goals and mutual understanding of what is right and important (Avolio & Bass, 2004). These leaders not only provide the vision for what is possible, but assist followers in determining how to attain the

vision (Avolio & Bass, 2004). The premise of inspirational motivation is that followers are nurtured by watching others achieve goals. Inspirational motivation moves followers toward action, builds confidence, promotes positive expectations, and inspires belief in the cause (Gellis, 2001; Bass, 1988). Through the leader's vision, activities, and behavior, the followers get motivated and inspired.

Intellectual stimulation. Bass (1985) states that a leader demonstrates intellectual stimulation through creative and innovative problem solving with team members. An intellectually stimulating leader provides followers with challenging new ideas that stimulate thinking of old problems in new ways (Bass, 1985; Bass & Avolio, 1990). Followers are encouraged to question their own beliefs, assumptions, and values, and when appropriate, those of the leader, which may be outdated, or not applicable to a current problem (Avolio & Bass, 2004). As a result, followers develop the capacity to solve future problems, unforeseen by the leader and team (Avolio & Bass, 2004).

Followers learn to tackle and solve problems independent of the leader by being creative and innovative as the leader has previously encouraged them to contribute, learn, and be independent (Avolio & Bass, 2004). A key measure of a leader's effectiveness is how capable the followers are in the absence of the leader or without the leader's direct involvement (Avolio & Bass, 2004). Within this component of transformational leadership, the leader often becomes a teacher, helping followers question the status quo and explore new, creative methods of accomplishing the organization's mission (Bass, 1985).

Individual consideration. The fourth component of transformational leadership is individualized consideration. According to Avolio & Bass (2004), individual consideration means that the leader understands and shares in followers' concerns and developmental needs,

and treats each individual uniquely. Additionally, the leader will not only recognize and pay attention their followers' needs, but will work to develop and advance those needs in an effort to maximize individuals reaching their fullest potential (Avolio & Bass, 2004; Yammarino & Bass, 1990). This is one reason why transformational leaders set examples and assign tasks based on followers' individual strengths and needs (Avolio & Bass, 2004). The leaders view assignments as opportunities for growth (Bass, 1999).

Transformational leaders focus on one-to-one relationships with followers, which include mentoring, coaching, and clearly communicating information as a way of providing continuous follow up and feedback (Avolio & Bass, 2004). This individualized consideration is important, as it provides a link between the follower's individual needs and the organization's mission (Bass, 1985; Bass & Avolio, 1990; Avolio & Bass, 2004).

Most leadership experts suggest that the two leadership styles—transactional and transformational—should be integrated to maximize effective leadership and that transformational leadership augments the effects of transactional leadership (Bass, 1985; Dems, 2011). Many experts also agree any given leader will demonstrate a mix of these leadership approaches (Garman & Corrigan, 1998). However, research has convincingly demonstrated that highly effective leaders use transformational approaches more frequently than transactional approaches (Garman & Corrigan, 1998). Transformational leadership has been empirically tied to better outcomes across multiple disciplines, and is subsequently viewed as a more desirable leadership style (Bass, 2008; Wang et al., 2011; Judge & Piccolo, 2004; Conger, 1999).

Applicability of Bass's multifactor model of leadership framework to ACT team leadership. Bass's (1985) framework was a useful starting point for describing ACT team leaders and in identifying and understanding their approach to leadership. As noted in the

literature review, this theory has been shown to have applicability to studying leadership within mental health teams. Employing this framework assisted in answering "who are these ACT team leaders?" and in understanding their approaches to team leadership and what roles they play in promoting implementation and sustenance of high fidelity ACT.

Mancini and colleagues (2009) identified factors such as promoting team morale, managing team dynamics, holding staff accountable, empowering team members to make independent decisions, and inspiration for the program's mission as contributors to effective ACT team leadership. These findings are congruent with Bass's main principles of transformational leadership, such as idealized influence, inspirational motivation, and intellectual stimulation. A main strength of this theoretical framework is that it defines what effective leaders do and suggests how specific behaviors of leaders play a part in leadership effectiveness (Purvanova & Bono, 2009). The framework also takes into consideration that leadership is a complex process, made up of multiple factors. Applying this framework allowed for the exploration of multiple processes of ACT leadership.

However, this theory is too narrow for fully conceptualizing ACT team leaders and the roles they may play in promoting and sustaining high fidelity to ACT. While Bass's theoretical framework describes proximal leader behavior and interpersonal dynamics with direct team members, it does not address the other variables that the literature has identified as salient to implementing high fidelity ACT (described below). To more completely inform the study aims, an extension of this study's conceptual framework was necessary. Hence, the second component for this study's conceptual framework came from concepts identified in the EBP implementation literature as relevant factors to implementing and sustaining high fidelity ACT.

Relevant concepts from the EBP implementation literature. The reviewed literature highlighted many concepts that were important for understanding effective implementation of high fidelity ACT as well as factors that promote or constrain effective leadership. Many of these important concepts were less related to how the team leader functions or influences team members, and thus were not accounted for in Bass's framework. Factors such as state support for the EBP practice, financing, training, and utilization of outcome reporting (Swain et al., 2010) are identified as important, and so warrant inclusion in this study's conceptual framework.

Appendix 4 provides a thorough delineation of concepts from the literature that were included in this study's design and questionnaire development. To help the reader understand how the concepts were integrated into the study, I will describe, as an example, how the aspect of the state mental health authority was incorporated into the study's questionnaire design. I chose to highlight this aspect of a state mental health authority factor as it is one of the most robust examples of a salient element identified in the EBP implementation literature that would not be covered by Bass's theoretical framework.

Examples of state mental health authority factors that the literature identifies as important are the role of the state mental health authority, the setting of financial incentives, creating favorable Medicaid reimbursements, and regular and ongoing training (Bond et al., 2009; Insett et al., 2007; Isett et al., 2008; Swain et al., 2010; Moser et al., 2004; Rapp et al., 2008). The literature identifies that these factors can facilitate or inhibit the implementation of EBPs. In order to inform the specific study aim of understanding what roles the ACT team leaders may play in promoting high fidelity to ACT, I felt it was important to ask questions that had relevancy to the concept of state mental health authority factors. For example, Question 12 of the Questionnaire Guide for ACT Team Leaders asked what helped the team leader facilitate high

fidelity ACT services, and a probe under this question further asked how outside forces, including the state, helped with the leadership of the team. This question allowed the team leader to consider how the state MH authority did or did not play a role in her leadership of a high fidelity ACT team. Similarly, Questions 16 through 22 asked about items such as defined state standards, contingencies or incentives for following them, the role of any identified state leader, ongoing training or support that was offered, and the role of outcome monitoring in high fidelity ACT.

By incorporating these questions into the interview guides[5], the participants were prompted to describe if these factors, highlighted in the literature, were important or not to them. This allowed for exploration of how, if at all, these factors pertained to ACT team leadership of high fidelity teams. Again, several concepts from the literature were incorporated into the study's conceptual framework and are delineated in Appendix 4. The example of state mental health authority factors was offered simply as an illustration as to how these concepts from the literature were integrated into the study's conceptual framework.

A priori ideas and knowledge. The third and final component of the study's conceptual framework is a priori ideas or knowledge of ACT. This third component is very small by comparison to Bass's framework and salient concepts identified in the literature. Only four questions in the questionnaires were based on a priori knowledge; however, these ideas were important to acknowledge. As noted in my reflexivity statement (p. 77), I have previously been an ACT team leader, as well as an ACT consultant and program evaluator, as well as most recently a mental health state authority policy analyst. In some ways, this a priori knowledge has

[5] These questions were integrated into the Questionnaire Guides for the Team Psychiatrist and Agency Leader/Supervisor in addition to the ACT Team Leader.

shaped some of the design, data collection, and analysis of the study. Appendix 4 outlines the four questions that were incorporated based on my a priori knowledge.

For example, in the Questionnaire Guide for ACT Team Leaders, Question 5 asks “What do you do as an ACT team leader?” and probes further by asking for the types of clinical and administrative tasks the team leader may perform. This probe comes from knowledge that the team leader has a multi-faceted job that encompasses several domains, including but not limited to, both clinical and administrative tasks. This probe was created based on that prior knowledge and in an effort to help the team leader think widely about what she does.

Another example of a question and probe based on a priori knowledge is Question 8, of the Questionnaire Guide for ACT Team Leaders. The question asks, and then further probes "Tell me about your interactions with team members" and "What do your clinical supervision sessions look like?" In trying to more fully understand how the team leader interacts with team members, I know that the ACT model calls for individual supervision sessions with each team member, and that the TMACT evaluates the team leader on this dimension. I posit that if some individual consideration of staff is occurring, the clinical supervision sessions may be a logical place where this interaction happens. By asking questions regarding what the clinical supervision sessions look like, I am hoping to get another look at what the team leader does on a 1:1 level with team members.

Finally, an a priori idea I had was that the team leader and team psychiatrist relationship holds some importance. Both individuals can be considered leaders, and I believe it is worth exploring when asking about inhibitors and/or facilitators to the ACT team leader's work. This idea is also incorporated into a probe under Question 8 of the Questionnaire Guide for ACT Team Leaders. While incorporating these a priori ideas into the study's conceptual framework

was warranted to strengthen the study, I also made a conscious effort to be highly selective with how much "practice wisdom" was brought into the framework. I did not wish for my previous practice experience to bias the study's design, data collection, and analysis. I felt I accomplished this by only incorporating four a priori ideas into the conceptual framework.

In sum, these three components, –Bass's Multifactor Model of Leadership, relevant concepts from the literature, and a priori ideas and knowledge— collectively offered a promising conceptual framework for this study by providing a more comprehensive scope for informing the study aims.

Conclusion of Critical Review of Literature and Conceptual Framework

Despite a clear understanding of the most effective practices for treating individuals with SPMI, it is clear that the current public mental health system is inadequately meeting the objectives suggested by research literature (Bond et al., 2009; Institute of Medicine, 2006; Lehman & Steinwachs, 1998a; NAMI, 2006; New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 1999). The dissemination and implementation of evidence-based practices (EBPs) has been a focus of many researchers over the past decade, and we are getting closer to understanding the facilitators and barriers to the implementation of these EBPs, including ACT (Bond et al., 2009; Mancini et al., 2009). However, further understanding is still needed.

One factor noted to be important to the implementation of higher fidelity ACT teams is the program leader (Mancini et al., 2009). However, this leader position within ACT has been largely neglected in comprehensive research studies of ACT, and there remains a dearth of information regarding the roles and contributions of these leaders to high fidelity ACT teams. All current ACT literature falls short of providing a rich description of what these leaders are

like, what they do, or how they contribute specifically to high fidelity ACT teams. However, some conclusions from the literature on leadership in mental health teams can extend our insight into ACT team leaders.

While the place of a theoretical framework in case studies research is debated among scholars, this study employed a conceptual framework that contributed, in part, to the study's design, data collection, and analysis. This conceptual framework was drawn from three sources: Bass's Multifactor Model of Leadership, relevant concepts identified in the literature, and a priori ideas and knowledge. Utilizing this conceptual framework offered the best chance of thoroughly informing all of the study's aims.

Finally, this case study focusing primarily on the role of ACT team leaders should not suggest that the other factors to implementation of high fidelity ACT are less important. The purpose of this study was to take an in-depth look at the factor of ACT team leadership, which has been identified as one key variable in implementing high fidelity ACT, to better describe and understand the role of the ACT team leader. This study attempted to address gaps in the ACT literature by contributing a rich description of who these team leaders are, what they add to high fidelity ACT teams and how they approach leadership.

Chapter 3: Research Design & Methods

Study Design

Rationale for a qualitative case study approach. My decision to use a qualitative methodology depended largely on the overarching research questions and the goal of the study. Qualitative methods are appropriate when the research objective is to explore a topic about which little is known (Padgett, 1998), when a complex and detailed understanding of an issue is desired, or when researchers wish to understand the context or settings in which study participants address a topic (Creswell, 2007). Qualitative research allowed me to study elements in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people brought to them (Denzin & Lincoln, 1994).

Leadership is a topic that is suitable for qualitative inquiry (Creswell as cited in Klenke, 2008). Over the course of history of leadership research, research has relied heavily on traditional quantitative methodologies to help identify and understand leadership processes or problems (Klenke, 2008). However, these quantitative paradigms have been criticized as many researchers are dissatisfied with the type of information provided by quantitative techniques (Van Maanen, 1988; Weber, 2004). Quantitative methodologies can be poorly suited to help understand the meanings leaders and followers ascribe to significant events and the success or failure of their organizations (Klenke, 2008). Additionally, quantitatively generated leadership descriptors often fail to extend our knowledge or lead to deeper understanding of the constructs and processes of the phenomena we study, or to the adaptation of leadership to different contexts (Klenke, 2008; Buston, Parry-Jones, Livingston, Bogan, Wood, 1998; Padgett, 1998). In order to extend our knowledge, several authors assert that qualitative studies should play a more

central role in management and leadership research (Bryman, Stephens, & à Campo, 1996; Conger, 1998; Steiner, 2002).

Of the five qualitative traditions identified by Creswell (2007)–narrative research, phenomenology, ethnography, grounded study, and case study– I selected the case study approach. According to Yin (1994), case studies are the preferred approach when "how" and "why" questions are asked and when the focus is on a current phenomenon in a real-life context. Case study research involves the study of an issue explored through one or more cases within a bounded setting (i.e., a context or system; Creswell, 2007) and allows researchers to retain the holistic and meaningful characteristics of real life events (Yin, 2003).

Criticisms of case study methodology. However, there are some criticisms towards case study research design that should be addressed. Case study research has been criticized as lacking a guiding set of philosophical assumptions, failing to identify the researcher's paradigmatic position, failing to distinguish method and methodology, and/or failing to explicitly detail the approach to quality and rigor while omitting the researcher's analytic lens (Caelli, Ray, & Mill, 2003; Klenke, 2008). I minimized these limitations by applying quality criteria to the study (Creswell, 2007). Striving to produce a credible qualitative case study, I addressed three key areas (Klenke, 2008).

First, my theoretical position as the researcher is detailed. This position includes the identification of the paradigm and set of beliefs that shape my motives, assumptions about the phenomenon and informs the study's design, data collection, analysis, and write up (Creswell, 2007; Klenke, 2008). Second, this study has congruence between the methodology and the methods. Methodology reflects the beliefs about the knowledge that stem from the values of the researcher's framework; it represents a set of guidelines that dictates how the research should be

conducted (Klenke, 2008). Methods refer to the techniques used to collect and analyze the data, which must be congruent with the principles of the approach taken (Van Maanen, 1988). Third, there are outlined strategies for establishing the quality and trustworthiness of this study and I employed a rigorous approach to data collection, data analysis, and report writing (Creswell, 2007; Klenke, 2008). According to Creswell (2007), rigor is illustrated through the extensive collection of data in the field or through multiple levels of data. Rigor can be evidenced when the investigator validates the accuracy of the data using one or more of the procedures for validation, such as member checking, triangulating sources of data, or using peer or external auditors of accounts (Creswell, 2007).

Additional criticisms of the case study approach include utilizing small sample sizes and an overall lack of generalizability. Case studies can make no claims to be typical, and there are no ways of knowing empirically to what extent the multiple cases are similar or different from other cases (Hodkinson & Hodkinson, 2001). Rather a case study methodology was chosen to provide an in-depth look at an issue or event, and choosing too many cases would dilute the overall analysis and the depth of understanding (Creswell, 2007). While there is not a set number of cases a researcher can choose, it is a general guideline that no more than four or five cases should be chosen for a case study methodology (Creswell, 2007). In this study, two cases were chosen[6].

In response to the criticism regarding poor generalizability, Yin (2009) calls for a distinction between two types of generalizing: statistical generalization and analytic generalization. It is argued for case study research that analytic generalization is an appropriate

[6] Initially this dissertation study was designed using three cases. However, during the analysis and write up of results, it was determined to change and include only two teams in the data analysis and write up. The methods section was then changed accordingly, however the reader may find some incongruency with the informed consents or other appendices since the study, at the time of data collection, included three exemplary ACT teams and their leaders.

type (Yin, 2012). Qualitative research cannot statistically generalize to populations in the same way as quantitative research can and should make no claims to do so (Yin, 2012). However, a qualitative case study can be analytically generalized to broader theory and facilitates applying the same theoretical propositions to other situations outside the completed case study, where similar concepts and constructs might be relevant (Yin, 2012; Toma, 2006; Creswell, 1998; Creswell, 2009). In other words, analytic generalizations may provide more of a "working hypothesis" (Lincoln & Guba, 1985, p. 122-123; Crobach, 1975).

Despite criticisms of the case study method, the benefits of what this line of exploration provided in regards to the roles and contributions of the team leader on high fidelity ACT teams outweighed any limitations. Additionally, within this study in order to address some criticisms of a case study methodology, I employed the procedures of member checking, triangulation of data sources, and the use of a second coder and members of my dissertation committee in an effort to enhance the study's trustworthiness. This collective exemplary case study generated new knowledge related to team leaders on high fidelity ACT teams by providing a rich description of who these leaders are, what they contributed to high fidelity teams and how they approached leadership.

Case study method applied to the study of ACT leadership. ACT researchers have called for such case study, stating “the field is at a nascent level in which individual case studies are still useful in generating hypotheses and helping to understand barriers and facilitators of quality improvement [for evidence-based practices]” (Drake & Bond, 2007, pg. 82). This case study method provided an opportunity to gather information on the roles and contributions of ACT team leaders from multiple data sources (e.g., team leader, team members, agency leadership, direct observations, agency and program documents). Utilizing multiple methods

such as interviews, focus groups, and direct observation led to more valid, reliable, and diverse construction (Golafshani, 2003; Creswell, 2009) of ACT team leaders' roles and contributions to high fidelity teams.

This study was classified as a collective exemplary case study. A collective, or multiple, case study design was chosen to promote richness, depth, and complexity that is drawn from multiple events that help provide deeper understanding of the phenomenon of interest that is shared among the diverse cases (Stake, as cited in Denzin & Lincoln, 2005; Creswell, 2007; Lauckner, Paterson, & Krupa, 2012). Multiple cases allowed for a cross comparison and analyses organized by themes which contributed to the understanding of ACT team leaders on high fidelity ACT teams.

Further, this study's design also demonstrates characteristics of an exemplary case study approach. Yin (2009) defines an exemplary case study design as one in which all the cases chosen reflect strong, positive examples of the situation of interest. In this collective exemplary case study, I chose ACT teams and their leaders based on high (exemplary) fidelity to ACT, which is one of the main goals sought in the dissemination and implementation of evidence-based practices such as ACT. The intent of this sampling strategy was very deliberate in that I sought to better understand exceptional ACT team leaders and how they lead high fidelity ACT teams. While other research designs, such as comparing leaders on high and low fidelity ACT teams, may have informed some of the study aims, sampling ACT team leaders who are identified as running high fidelity teams seemed the best research design to comprehensively inform the study aims.

There were other advantages to the choice of this case study methodology of ACT team leaders on high fidelity teams. These advantages included having the flexibility to follow

unexpected ideas during the research and to explore processes more fully; having sensitivity to contextual factors that arose; and having increased opportunities to develop empirically supported new ideas, insights, and theories about ACT leadership that had relevancy and interest for practitioners and administrators (Ospina, 2004; Conger, 1998; Bryman, Bresnen, Beardsworth, & Keil, 1988).

Research positionality

Paradigm. In qualitative research, the researcher is the primary instrument in data collection (Creswell, 2009; Lincoln & Guba, 1985; Eisner, 1991). In addition, qualitative research is interpretative research (Creswell, 2009). Because of these two characteristics, a range of strategic, ethical, and personal issues are introduced into the research process (Creswell, 2009; Locke, Spirduso, & Silverman, 2007). According to Creswell (2007), credible qualitative research requires the investigator to make known the paradigms, worldviews, or beliefs guiding and influencing the inquiry. A paradigm or worldview is "a basic set of beliefs that guide action" (Guba, 1990, p. 17).

I designed and conducted my study from a social constructivism paradigm. Within the framework of the social constructivism paradigm, investigators seek understanding of the world in which they live and work (Creswell, 2007). I subscribe to this paradigm and believe humans develop subjective meanings of their experiences and are active agents in experiencing and defining their own individual realities (Creswell, 2007; Hovland-Scafe, 2010). Subjective meanings are formed through interaction with others (hence, social constructivism) and through other influences (e.g., historical, cultural; Creswell, 2007).

The goal of research within this framework is to rely as much as possible on the participants' views of the situation being studied (Creswell, 2009). In conducting the study,

questions were deliberately broad and general so that the participants could construct their own meaning (Creswell, 2007). I wanted to address the "processes" of interaction among individuals and was interested in making sense of the meanings others had about the roles and contributions of ACT team leaders in high fidelity ACT teams (Creswell, 2007). My intent within this study was to interpret the meanings others have about ACT team leaders while acknowledging that my own personal, professional, and cultural background influence my interpretations. Within the constructivism paradigm, the construction of meaning and "interpretation of the studied phenomenon is itself a construction" (Charmaz, 2006, p. 187).

Reflexivity statement. The articulation of potential researcher bias is a unique element in qualitative approaches (Noonan et al., 2004; Miles & Huberman, 1994; Morrow & Smith, 2000). As a researcher, I come from a social work perspective, having been a practicing clinical social worker providing services in the community to individuals with SPMI for 17 years. Within those 17 years of practice, I was an ACT team leader for 13 years, leading a well-established and nationally recognized ACT team. I found my job as a team leader to be gratifying and personally rewarding. I have served as a national ACT consultant and program evaluator, using the DACTS and TMACT to assist other mental health systems and individual teams in implementing and sustaining high fidelity ACT teams across the U.S. As an ACT consultant and program evaluator, I have evaluated each of the two teams within this study at least once over the past decade, and provided mentorship to one of the two team leaders (i.e., Lincoln) several years ago. Because of this previous relationship, both team leaders knew me when I approached them to participate in the study. I have been educated and mentored by well-respected ACT experts. During the data analysis stage of this dissertation following the finalization of findings from the Ramsey County ACT team and prior to the cross case analysis

of the two teams, I accepted a job with the State of Minnesota, Department of Human Services (DHS) Adult Mental Health Division as an Agency Policy Specialist. While my job duties do not include any direct involvement with the ACT team, it still added another dimension to my viewpoint. All of these personal and professional experiences influenced the design and/or implementation of this collective exemplary case study. It is my assertion that this "practice wisdom" (Burke, 2007) was both my best asset and largest challenge to conducting this study.

Banks (1998) points out that researchers are all members of cultural communities where the interpretation of our life experiences is mediated by the interaction of a complex set of status variables, such as gender, social class, age, political affiliation, religion and region. Positionality is determined by where one stands in relation to the "other", and these positions can shift throughout a study (Milner, 2007; Miller 2010). I have observed and participated for an extended time in many details of ACT team leadership, which makes me privy to a depth of knowledge few researchers could obtain through more limited study. In addition, my previous position as an ACT team leader and consultant facilitated my rapport with the ACT team leaders as I was viewed as an "insider" for the most part. My professional experience as a previous ACT team leader seemed to serve me well in building rapport with various stakeholders in my research. I believe that the administrators, team leaders, and team members recognized my enthusiasm for the study and commitment to this area of research.

Despite this status, I remained vigilant in recognizing how my previous experiences may have biased what I was seeing during data collection and analysis. I attempted to minimize these biases through various strategies for enhancing the study's rigor, including member checking, use of multiple coders (including one non-ACT individual), triangulation of the data, and leaving

a detailed audit trail[7] (Padgett, 1998; Miles & Huberman, 1994). Further, I participated in peer debriefing and consistently drew upon the input of others by seeking out members of my committee, my dissertation support group, and ACT experts within the field to discuss my research. While none of these activities completely eliminated my preconceptions or my biases, they allowed me to better identify the potential biases I brought to this study and work to correct them (Miller, 2010). My goal was to remain open, inquisitive and respectful to the ACT team leaders and team members by interpreting the roles and contributions of the ACT team leaders within these high fidelity teams and generating new knowledge based on the actual cases and not my past experiences.

Biases and assumptions. Considering my education and training as a clinical social worker and social science researcher, as well as a practicing ACT team leader for 13 years, it is important that I articulate my personal biases and assumptions. I hold several assumptions about the ACT model of care. One, it is my personal view that high fidelity ACT is a treatment model that can benefit people with SPMI by providing them an opportunity to recover from the devastating effects of mental illness and to live with dignity and self-determination. Two, I believe that within the ACT model of care, the team leader has influence over various processes of the team and through this influence, impacts the fidelity of the overall team. Three, I believe that all consumers who need ACT should be offered high quality services to improve chances of recovery. Four, I believe that every individual living with SPMI has rehabilitation and recovery potential. Five, I have biases on effective versus ineffective ACT leadership. For example, I believe an effective team leader understands team dynamics and manages the team to accomplish

[7] All of these strategies will be expanded upon in the Data Analysis Plan section of this chapter, when I detail my plan for ensuring analytic rigor.

the consumer's goals. Additionally, I see effective team leaders as those who are competent clinically and understand ACT fidelity.

However, I also recognized that the team leaders and ACT team members may hold different beliefs than my own. Other leaders will likely have different personal experiences with their own leadership and construct meaning of their leadership within their ACT team uniquely. Their approach to leadership may be very different based on their background and environment. Throughout the study and analysis, I was reflective and worked to consistently monitor and manage my personal biases. Towards this goal, I utilized several different strategies to assess and verify the quality of my work.

I used the model presented by Lincoln and Guba (1985) to enhance trustworthiness of my study. Lincoln and Guba's (1985) model describes trustworthiness as the study's transferability, dependability, confirmability, and credibility. The strategy for how I enhanced my study's trustworthiness through this model is detailed in the Data Analysis Plan section of this chapter. Adopting such a model to assure rigor within this case study was necessary for me in my position, given my past professional experience and subsequent assumptions about the study topic.

Methods

Sampling strategies. In a collective exemplary case study, the choice of cases to study is made to advance understanding of the issue of interest (Stake as cited in Denzin & Lincoln, 2005; Yin, 2012). As previously mentioned, the cases for this research design were chosen based on their exemplary example of the phenomenon of interest (Yin, 2012). This study included two teams and their leaders that represented high fidelity ACT teams, so that the role and contribution of the team leaders on these ACT teams could best be informed.

My rationale for investigating two ACT teams ("cases") was that I wanted to look at more than one case in an effort to deliberately observe whether findings might be replicated, which is a common strategy for case studies (Yin, 2012). By designing a collective (multi-site) exemplary case study, I wanted to look not just within each case for themes that informed my research questions, but also across two teams to highlight potential similarities and differences and to provide greater confidence in the findings (Yin, 2012). However, I was aware that in a collective case study design there is the risk of reducing complex cases to a few comparable factors, which results in the loss of the uniqueness of individual cases (Stoecker, 1991; Lauckner et al., 2012). In order to mitigate this risk, I chose to include only two exemplary ACT teams, to avoid diluting the richness of those descriptions and in-depth understanding of the cases, which may come from sampling too many teams (Yin, 2012; Creswell, 1998).

Recruitment procedures.

Identification of exemplary teams. There was deliberate intent to identify ACT teams from different states to diversity team leader experiences and presumably to highlight variability across state and agency norms.

My search procedures began by contacting, via email or telephone, well-known national ACT fidelity experts I knew and asking which teams were considered the best from an ACT fidelity perspective. These experts included respected state administrators, TMACT authors and evaluators, ACT consultants, and ACT practitioners in numerous states. Additionally, I had some firsthand information on high fidelity programs from my past experience as an ACT consultant and evaluator. When talking with the experts, I described the study's purpose and aims, as well as the criterion I was looking to meet in regards to defining a high fidelity ACT team (i.e., a TMACT score of 4.0 or higher).

This procedure generated a total of 5 teams for consideration (Lincoln, Nebraska; Swarthmore (Delaware Co.), Pennsylvania; St. Paul (Ramsey Co.), Minnesota; Monticello, Minnesota; and Bremerton, Washington). Several experts mentioned two teams as high fidelity (e.g. Lincoln, Nebraska and St. Paul, Minnesota). All five of these identified teams were sanctioned by top mental health authorities within their respective states as high fidelity ACT teams that produce positive outcomes (e.g., reduced hospitalization days) and all were considered training or shadow teams (e.g., other ACT programs are sent on site with these teams for training) within their state. Given the desire to include teams from different states, the Monticello, Minnesota team was excluded first, leaving four teams, from four different states to recruit. My strategy was to recruit two teams (Lincoln, Nebraska and St. Paul, Minnesota) as there was some consensus among the experts as to the superior quality of these teams.

Recruitment of individual ACT teams. Prior to recruitment, ethical approval was obtained from the University of Wisconsin-Madison, Institutional Review Board in September 2012 (See Appendix 5).

The study's inclusion criteria were:

- The team's most recent TMACT evaluation summary score must be at or over 4.0 (out of a possible 5.0) to indicate the team is practicing as a high fidelity ACT team, and have occurred within the past 12 months of data collection;
- The team leader must be in the team leader role with the team under study for no less than two years, and be the leader who was evaluated under the last TMACT evaluation;
- In addition to the team leader, there must be at least 75% of the staff, including the team psychiatrist and agency supervisor who agree to participate in the study.

ACT team leaders were contacted via email and/or telephone where the purpose of the study was explained and an assessment of interest in study participation was confirmed. I first contacted the Lincoln, Nebraska team and the St. Paul, (Ramsey Co.) Minnesota team second. Both team leaders had been in their roles for two or more years. Additionally, the team leaders were able to verbally supply me with the date and score of their last TMACT evaluation for study consideration.

TMACT assessment. Next, I requested the most recent Summary of TMACT Items and Ratings for each ACT team (see Appendix 2). This allowed me to confirm that the date the TMACT evaluation was performed within 12 months of my data collection, as well as the composite score falls on or above the score determined to represent a high fidelity ACT team (i.e., 4.0 to 5.0). This was necessary to assure the cases I chose accurately represented current high fidelity ACT teams and their leaders. The TMACT has its own protocol for data collection, which was followed to assure validity in the resulting score (see Appendix 2).

For the purpose of this study, I defined a *recent* TMACT fidelity score as a TMACT evaluation that had occurred within the past 12 months and was the most current TMACT score available for the team. The 12-month cut off was chosen to mitigate the concern that a fidelity score older may not represent the team's current practice. While ideally a TMACT evaluation would occur within weeks of the data collection, the reality is that this is not always possible given the work flow of an ACT team and the labor intensity of the TMACT evaluation. One team (Lincoln ACT team) in this study did have TMACT evaluations within 6 weeks of the on-site data collection.

The TMACT includes 47 items organized via six subscales: Operations and Structure, Core Team, Specialist Team, Core Practices, Evidence-Based practices, and Person-Centered

Planning and Practices (Monroe-DeVita et al., 2011). Each item is scored on a 5-point behaviorally-anchored scale. Based on the average scores for each subscale, an overall TMACT score is compiled, which will range from 1 to 5. Non-PACT teams will likely rate closer to 1.00 (L. Moser, personal communication, May 17, 2012). Teams that score a 4.0 or above reflect substantial adherence to the components of the ACT model (Monroe-DeVita et al., 2011).

To recall, the TMACT is a newly developed tool and has yet to be rigorously tested, nor have empirical norms been established. Because of this, I sought out the opinion of the tool's authors to best assess the current idea of what will define a high fidelity ACT team. Given the most current information, the authors of the tool asserted that they would define a high fidelity ACT team as one who has an overall score of 3.8 to 5.0 (G. Teague, M. Monroe-DeVita, & L. Moser, personal communication, May 17, 2012). For this study, I set the threshold of a high fidelity ACT team as obtaining an overall team TMACT score of 4.0 or higher. Further, to add confidence that the teams chosen represented high fidelity ACT teams, I calculated a concurrent DACTS score for each team. The TMACT protocol allows for a "walk over" of data in which a DACTS score can be computed without a separate data collection. It is my opinion that the TMACT is a better overall measure of a team's ACT fidelity and more holistically captures the processes of an ACT team; however, given the absence of empirical norms for the TMACT at present, calculating a DACTS score for each team should add to the credibility these teams are considered high fidelity. This DACTS to TMACT comparison is listed in Table 3.

A second issue with using the TMACT is to consider who is collecting and evaluating the TMACT data. In all cases, the TMACT evaluations were done by either authors of the TMACT tool, or individuals who had been through extensive training conducted by the TMACT authors. Ideally, both TMACT evaluations for this study would have been performed by a consistent team

to improve inter-rater reliability, but this was not possible. More on this issue of TMACT evaluation will be discussed in the limitations section of this paper.

During recruitment, it was found that the Lincoln ACT team had not had a recent TMACT evaluation (last evaluation was in 2009). However, the team leader and agency expressed interest in having a recent evaluation performed. I contacted and coordinated with the State of Nebraska's Deputy Director of the Behavioral Health Division, Sheri Dawson, to conduct a TMACT evaluation of the Lincoln ACT team with me. This TMACT evaluation occurred on 10/15/12 and 10/16/12 and the team's overall score was 4.22, which resulted in the team being able to participate in the study.

The Ramsey Co. ACT team had a TMACT evaluation approximately 11 months prior to the on-site data collection, in January 2012. The evaluation was conducted by two of the authors of the TMACT tool (Moser and Monroe-DeVita); however, I did participate in the on-site data collection as part of a larger team that Ramsey County, Minnesota had for an evaluation project of their six ACT teams county-wide. The final score for the Ramsey Co. ACT team was 4.10. While it would have been ideal to have a more recent TMACT evaluation, it was unrealistic to ask the team leader to go through another evaluation when she had done so less than one year ago. The team leader indicated she would be less willing to do so given the burden it would place on her and the team. Because of this, the TMACT score from 1/2012 was used.

Agency and team agreement. Each team leader approached agreed to participate, but needed to seek the approval of their respective agency leadership. I offered to send a letter (See Appendix 6) to the agency administrator/director identified by the team leader, explaining the study and the procedures. All team leaders preferred to discuss the study directly with the agency leader/supervisor themselves. I sent the introductory letter to the team leaders to use as a

framework for that discussion. Each team leader notified me when they had gained agency approval to participate. I agreed to create a release of information form for a consumer to sign in the event I attended a treatment planning meeting while on site; See Appendix 7).

My next step was to confirm interest across all the team members including the team psychiatrist and team leader's direct supervisor. While I offered to participate in a conference call or Skype interview, all team leaders again preferred to discuss the study and participation with individuals themselves. To help the team leaders prepare for the discussion, I again suggested they use the agency letter as a guide, and I emailed all informed consents to the team leader to share with team members. I also remained available to any participant who may have had questions. Initially, I was concerned that the team leaders were wanting to do all of the explaining of the study themselves, as I felt there was some risk involved in this as they were less familiar with procedures and may not be able to answer questions individuals may have, or that team members may feel a pressure to participate. However, a major benefit to having the team leader discuss the study with others was that the leader has relationships with team members and agency personnel and may be able to actually reassure staff members and build enthusiasm for the study. I attempted to diminish the potential risks of coercion by emphasizing to the ACT team leader that team members should not feel pressured to participate and that even if they give this preliminary consent to participate, at any time prior to or during on-site data collection, their consent to participate could be revoked without any retribution. While I am unable to determine with certainty if participants felt some degree of pressure to participate, the fact that some team members chose not to participate once on site provides reassurance that they felt comfortable making that decision to opt out.

After the team leaders' discussion with the respective teams and agency supervisors, both team leaders indicated that there were at least 75% of team members who agreed to participate. Both team leaders shared that the majority of team members expressed excitement and enthusiasm by being identified as an exemplary ACT team nationally and were more than willing to participate. My offer to hold a Skype/conference call with all stakeholders prior to the study in order for participants to meet me and gain clarity on what the study would involve was declined at each of the sites as the team leader did not feel that it was necessary. At each of the two sites, the agency supervisor, ACT team psychiatrist, ACT team leader, and over 75% of team members agreed to participate and were considered a full "case". All study participants were compensated for their participation, as was the agency for allowing me to access their ACT teams.

Case description[8]. Table 3 below summarizes each case's location, preferred name, program start date, leader name and start date (as leader), the most recent TMACT score, converted TMACT to DACTS score, number of team members, number of consumers served at time of data collection, and dates of on-site data collection for this study.

Case #1 team description. The ACT team in Ramsey County, Minnesota was the second team in this case study ("Ramsey County ACT Team"). The team is located in St. Paul, Minnesota and began in January of 2005. The Ramsey Co. ACT team is comprised of 15 multidisciplinary staff, including a team leader, program assistant, two psychiatrist prescribers (one psychiatrist and one nurse prescriber) along with a social work intern and psychiatric resident. The team leader has been with the ACT team since December 2007. This team is considered an urban team and served 85 consumers at the time of data collection. The Ramsey County ACT team has been recognized as a model ACT team, and they have served as an

[8] A more thorough and detailed description of each ACT team is located in Chapter 4: Findings.

example for other ACT teams within and outside of the state. In their most recent TMACT evaluation, conducted in January 2012, this team received an overall TMACT composite score of 4.1 out of 5.0.

Case #2 team description. The first team included in the study was the Lincoln, Nebraska, PIER (Partners in Empowerment and Recovery) team ("Lincoln ACT Team"). This team began in July of 2005, and is currently comprised of 13 multidisciplinary staff[9], including the team leader, program assistant, and two psychiatric care providers (one psychiatrist and one nurse prescriber). At the time of data collection, the team was serving 69 consumers and is considered by the state of Nebraska as an urban team. The team leader has been with the team since its inception as a clinician and became the team leader in May 2006. The Lincoln ACT team is considered by the state of Nebraska and national experts to be an exemplary, high fidelity ACT team. In their most recent TMACT evaluation, conducted in October 2012, the Lincoln ACT team received an overall TMACT composite score of 4.22 out of 5.0.

Table 3: Brief Summary of Team/Case Details

	Case 1	Case 2
Location	St. Paul (Ramsey Co.), Minnesota	Lincoln, Nebraska
Preferred Program Name	Ramsey Co. ACT Team	Lincoln ACT Team
ACT Program Start Date	1/2005	7/2005
Team Leader Name & Date Assumed Leadership	Alyssa Shoemaker, LICSW 12/2007	Catherine Fletcher, LCSW 5/2006
Most recent TMACT score & date	4.10 in 1/2012	4.22 in 10/2012
Converted TMACT to DACTS Score	4.52	4.35
# of multidisciplinary team members	15	13

[9] Staff was calculated by including all employed ACT personnel, both indirect and direct staff. This is different from the calculation of staff that is included in the TMACT evaluation.

# of consumers served by team at time of data collection	85	69
Dates of On-site Data Collection	12/4/2012–12/6/2012	10/29/2012–10/31/2012

Data Collection Procedures

According to Stake (1995), a collective case study should seek to get multiple perspectives on the issue of study. In order to capture these multiple perspectives, this study had seven main components: 1) assessment of the team's ACT fidelity via the Tool for the Measurement of Assertive Community Treatment (TMACT); 2) in-depth, semi-structured interviews with the team leader; 3) in-depth, semi-structured interview with the team psychiatrist; 4) in-depth, semi-structured interview with the agency leadership/supervisor of the ACT team leader; 5) direct participant observations of the team leader and ACT team (including team and treatment planning meetings); 6) review of team and agency documents that are supportive to the operation of the team; and, 7) a focus group of ACT team members. These seven components provided a rich and holistic description from multiple perspectives on the roles and contributions of ACT team leaders on high fidelity ACT teams.

Prior to any data collection, informed consent was obtained from all study participants (See Appendices 9-12). The data collection procedure included one on-site visit of three days with each ACT team. This was in line with case study methodology as I was seeking an understanding of cases set in their "real world" contexts (Yin, 2003; Creswell, 2007). In order to collect multiple perspectives on ACT team leadership in high fidelity ACT teams, an adequate amount of time with the team was necessary. While there can be debate on what is an adequate amount of time, I chose three days as I felt that would provide me with an adequate amount of time and information to inform the study's aims. By the third day, I did feel that much of my observations and subsequent findings were becoming repetitive. Below is a detailed description

of the sources of information I collected in order to meet the aims of the proposed study. I followed this data collection framework systematically for both teams and made the deliberate effort to follow identical data collection methods.

Semi-structured interviews. Semi-structured interviews are ideal for a case study, because they involve the implementation of a number of predetermined questions (Miller, 2010; Ayres, 2008), but allow for flexibility to probe beyond the prepared questions to meet the study aims (Berg, 1998). I used open-ended questions and probes that were conversational in nature, and focused on the study aims ("What challenges have you faced in running a high fidelity ACT team?") while also following unexpected topics that participants brought up. All interviews followed the respective interview guide, but participants largely dictated the course and content of the conversation. Below I will discuss how the questionnaires were developed, and the process I completed for interviewing the team leader, team psychiatrist, and agency leadership. Additionally, I will review the pilot phase of the interviews and the role of informal interviewing of the team leader while on site.

Questionnaire development. For this study, original interview and focus group guides were developed. Appendix 4 outlines the conceptual framework that contributed to the design and development of all interview guides, including how theoretical and a priori concepts were integrated. Questions were first created according to the specific aims of the study asking specifically about whom the team leader is, what experiences she has had, what she does as a leader, and what role she may play in promoting high fidelity ACT, including any identified challenges.

After questions that specifically addressed the three study aims were developed, additional questions and probes were developed to incorporate Bass's theoretical framework,

identified salient concepts from the literature, and a priori knowledge that warranted exploration (See Appendix 4). The addition of several possible probes allowed me to follow other lines of inquiry that may have relevancy to the study aims (e.g., Bass's components of transformational leadership such as idealized influence, and/or individualized consideration). Each interview began with open-ended questions that asked broadly about the participants work with the agency/team to add some context to responses. Then other open ended questions ('What is it like to be an ACT team leader?') were asked to obtain views on who team leaders were and what they did before limiting informants' responses with more specific probes.

Pilot phase. Pilot interviews were conducted for the team leader, team psychiatrist, and agency leadership interviews as well as the focus group in order to identify and modify any poorly worded or confusing questions, or those that reveal my own biases, personal values, or blind spots (Berg, 1998). These pilot interviews were conducted between August 10th and September 24th, 2012 with individuals I knew from my practice and consultant experiences in ACT. Pilot participants were an ACT team leader, ACT team psychiatrist, agency leader who had oversight of an ACT team, and two ACT team members. All participants were interviewed separately with the corresponding questionnaire guide, with the exception of the two ACT team members who were interviewed together to simulate a more focus group-like setting.

Individuals were asked to provide feedback across several areas. Areas included language of the survey, whether any question was strange, unusual, or confusing, the order of questions and probes, any suggested improvements, any deletions or redundant question, problems they think might be encountered during the interview process, or length of interview including fatigue (Gattis, 2010; Bowden, Fox-Rushby, Nyandieka, & Wanjau, 2002). As an example, Appendix 8 outlines changes that were made to the team leader interview after

incorporating the pilot interview feedback. Since there was consistency and substantial overlap between all the interview guides, by the last interview with the agency leader, there was nothing that resulted in any changes. The pilot interviews also served as practice for me as the principal investigator and allowed me to get familiar with the flow and pacing of the interviews. Pilot information was not used for the study, but only to refine or modify the interview questions or procedures.

Team leader interview process. Prior to on-site data collection, I worked with each team leader to create an agenda for the three days I would be with the team. We mutually chose days that would work for the team, along with allowing me the maximum chance to observe events that were meaningful (e.g., consumer treatment planning meetings, days the team psychiatrist is with the team). Team leaders chose times most convenient for them and other team members for the interviews and focus group. In all cases, I was able to participate in all scheduled team meetings and consumer treatment planning meetings while on site. I worked collaboratively with the team leader to build the on-site agenda to minimize the disruption to the team's work flow and to maximize participation by working around schedules.

In regards to team leader interviews, originally two in-depth, semi-structured interviews (See Appendix 13) were planned. However, during the on-site data collection with the first team in Lincoln, I realized that would not allow enough time to get through the interview guide. The Lincoln team leader adjusted her schedule to accommodate this additional interview time and a subsequent change to add another two hour interview with the team leader was made in the agenda for the remaining team. Hence, a total of three in-depth, semi-structured interviews with the ACT team leader that lasted approximately two to three hours each was needed to complete the questionnaire guide and conducted while at each site.

On Day 1 of the onsite visit, I obtained the team leader's written consent for participation in the study. I made the deliberate attempt to not begin the "official" interviewing of the team leader on Day 1, but instead immerse myself in just observing and asking questions of the team leader and team members. By following this protocol, it was my hope that the team leader would be acting in as natural way as possible, not being privy to interview questions that may influence her behavior. This protocol also allowed me to be a observer and follow up with the team leader on behaviors and processes I was witnessing. All formal team leader interviews were then conducted over the course of Day 2 and Day 3 using the Questionnaire Guide for ACT Team Leaders (See Appendix 13). At the end of the final interview, the team leader completed a demographic form (See Appendix 14).

Informal interviewing. In addition to the more formal, semi-structured interviews, team leaders allowed some informal interviewing time throughout the three days I was on-site. At the end of team and treatment planning meetings, team leaders agreed to give me time to ask questions and gain clarification on phenomenon I observed. While every effort was made to follow up with questions/clarification in "real time" and as things occur in the field I balanced this with being respectful of the team leaders' and team members' time and work flow processes. I found the team leaders to be extremely gracious with their time and they were all very willing to be available. The information shared during these more informal interviews was either audiotaped and transcribed, or documented in written field notes, depending on the situation and location of the discussion.

Psychiatrist interview process. A separate, in-depth semi-structured interview with the ACT team psychiatrist, scheduled prior to the on-site visit at the convenience of the psychiatrist, lasted approximately 60 minutes (See Appendix 15). The team's psychiatrist written consent was

obtained prior to the interview. The interview addressed the roles and contribution of the ACT team leader from the perspective of the psychiatrist. I had determined the team psychiatrist interview should be separate from other team members as the psychiatrist also assumes a leadership role within the team and in the ACT model is more of a peer to the team leader than a subordinate. The team psychiatrist provided insight into various aspects of the team leader's role that other team members were not privy to (e.g. management issues with staff). Additionally, my concern was the presence of a leadership figure such as the psychiatrist in the focus group of team members would inhibit the "openness" with which the team members communicated. For these reasons, I interviewed the team psychiatrist separate from other team members. Both sites (Lincoln and Ramsey Co.) had a team psychiatrist and a nurse prescriber. In both cases, I interviewed only the team psychiatrist and not the nurse prescriber.

Agency leadership interview process. One in-depth, semi-structured interview with agency leadership was conducted per team (See Appendix 16). This interview lasted between 60-90 minutes. The agency leaders, identified by the team leader, all had clinical and/or administrative supervisory responsibility for the ACT team leader. In all cases, the agency leadership knew the ACT team leader very well and had worked several years with their respective team leaders. The agency leader's individual written consent was obtained at the beginning of the interview. The value of interviewing the agency leader was that he/she was somewhat "outside" of the team and able to inform the study aims from a more macro level perspective and to offer yet another perspective on the roles and contribution of the ACT team leader. Additionally, as the individual who supervises the team leader, his/her perspective on how the team leader approaches leadership, may promote fidelity, or overcomes challenges was unique from other study participants.

All previously described interviews were audio-taped and professionally transcribed.

Focus groups. Another data collection method utilized in this study was conducting a focus group of ACT team members at each site. Focus groups are typically groups of 7 to 10 people, who are recruited on the basis of similarity, who engage in a discussion, led by a moderator, of a particular topic (Greenbaum, 2000). The focus group is a discussion-based interview that produces verbal data generated via group interaction (Millward, 2012). A naturally occurring group for this study was the ACT team itself, given ACT team members already function as a "group", and are all in direct and continuous engagement with the ACT team leader. This group of ACT team members was well positioned to provide input on roles and contributions of the ACT team leader as all team members interact with the team leader and can identify, first hand, what the team leader does and how she does it.

The conventional aim of focus groups is to capture content in the form of understandings, perspectives, stories, discourses and experiences not otherwise meaningfully expressed by numbers (Berg, 1995; Hoepfl, 1997). Focus groups are appropriate to use to supplement more traditional methods of data collection, to invite a uniquely different perspective on an issue, or to generate conversation worthy of analysis in its own right (Millward, 2012). Morgan and Krueger (1993) along with Krueger and Casey (2009) discuss instances when focus groups are appropriate to choose as a data collection strategy, including when 1) security provided by the group allows members who are lower in the "power hierarchy" to express feelings and experiences they might not otherwise share; 2) the desired information about behaviors and motivations is more complex than a questionnaire is likely to reveal; 3) the researcher is looking for the range of ideas of feelings that people have about the topic; 4) the researcher is trying to understand differences in perspectives between groups of people, recognizing that some

individuals in decision making positions (e.g. team leader) may view a situation or issue differently than those who are not; or 5) the researcher wants ideas to emerge from the synergy of the group interaction.

There are many noted advantages to utilizing focus groups. One main advantage is that focus groups, when well-managed, can produce a broader as well as more in-depth understanding of an issue or topic because of the interaction process that stimulates memories, discussion, debate and disclosure in a way that is less likely in one-to-one interviews (Wilkinson, 2003). Indeed, I witnessed this happen during data collection when a team member would mention something like "what you said just made me think of something else". Focus groups can be useful as they draw on the synergy between group members as a group possesses the capacity to become more than the sum of its parts (Krueger & Casey, 2009; Padgett, 1998), and focus groups are suggested for exploratory research, where the participants are relatively free to discuss the topic as they see fit (Morgan, 2008). For this study, I chose to utilize the focus group methodology as it aligned with my social constructivist position, in that the 'reality' represented by the group was collaboratively produced through a process of context-specific meaning making (Wilkinson, 2003). I was interested in how the team's reality of the team leader was constructed and perceived, and empowered team members to guide the direction and flow of the discussion in order to meet that goal (Wilkinson, 2003; Glitz, 1998). Through the use of a focus group, I hoped that the interaction of all team members provided a broader answer to the study aims.

Other advantages of using a focus group methodology include that this mode is less threatening to many research participants, and the group environment is helpful for participants to discuss perceptions, ideas, opinions, and thoughts (Krueger & Casey, 2000; Onwuegbuzie,

Dickinson, Leech, & Zoran, 2009); that groups are more economical, fast, and an efficient method for obtaining data from multiple participants (Krueger & Casey, 2000) thereby potentially increasing the overall number of participants (Krueger, 2000); and, the environment itself is socially oriented (Krueger, 2000). Moreover, the sense of belonging to a group can increase the participants' sense of cohesiveness (Peters, 1993) and help them to feel safe to share information (Vaughn, Schumm, & Sinagub, 1996). In the design of this study, I was acutely aware that richer data would come from more versus fewer participants, but that ACT team members are extremely busy and rarely in the office given the nature of the work. I felt that by gathering information from team members in a focus group setting, I would maximize the number of participants and minimize the burden of data collection for each site.

Despite the benefits of collecting data in a focus group setting, there are some criticisms of their use that should be addressed. One such criticism of focus groups is that group interviews are rarely preferable to individual interviews in academic social science research as individual differences in viewpoint within the larger group may be blurred and under-reported (Bloor, Frankland, Thomas, & Robson, 2001). However, in focus groups, the objective is not primarily to elicit the group's answer, but rather to stimulate discussion and better understand (through subsequent analysis) the meanings and norms that underlie those group answers (Bloor et al., 2001). Another potential weakness of focus groups may occur with members who do not express their personal opinion or acquiesce to a particular team member (New York State Teacher Centers, 2008). Similarly, dominant group members can influence results in a focus group setting. However, a skillful moderator can use strategies for increasing the comfort of group members, encouraging other members to share ideas or offer differing perspectives, and moving the conversation away from the dominant talker (Krueger & Casey, 2009). I chose to

utilize a focus group data collection method as I was interested in how the ACT team perceived and socially constructed the role of their team leader and felt the synergy of the group members would provide that given the direct interaction members have with the leader and one another. I deemed that the benefits of employing a focus group method outweighed the potential limitations and it added a valuable and different data source in comparison to the 1:1 interviews, which also enhances the study's rigor.

For this study, every ACT team member (excluding the team leader and psychiatrist) was invited to participate in the focus group. The ACT teams selected as cases for this study have between 10 to 12 team members (excluding the team leader, psychiatrists/nurse prescribers and interns). The number of participants aligns with the guideline that an optimal focus group is between 7 and 10 participants (Krueger, 1994). The focus group should be large enough to generate diversity of opinions, but small enough to allow everyone to share in the conversation (Padgett, 1998; Krueger, 1994). In this study, Lincoln had 7 actual focus group participants and Ramsey County/St. Paul had 9 total focus group participants.

The focus group at each ACT site was conducted by using the method described by Krueger (1994). Under this method, the group met for a predetermined amount of time, 90 minutes. At the beginning of the focus group I thanked participants for agreeing to participate, reviewed the purpose of the study and obtained written informed consent for all ACT team members who agreed to participate (see Appendix 11). I then laid the ground rules, emphasizing that there were no right or wrong answers to the questions and encouraged differing perspectives to best inform the study aims. I explained and that I would facilitate rather than direct the discussion, following unexpected ideas as they arose. To ensure accuracy, the group's dialog was audiotaped (with participants' permission) along with me taking field notes. Team members

were instructed that at any time, they could request to have the audiotape recorder turned off. Using the interview guide (see Appendix 18) I facilitated the discussion of the focus group.

I used between 10-15 open ended questions that guided the focus group discussion (see Appendix 18). The open ended questions were elaborated upon with additional possible prompts and related questions that sought to better understand the roles and contribution of the team leader from the perspective of the ACT staff. This strategy matches the goals that emphasize exploration and discovery and aligned with the study's aims (Morgan, 2008). As similar to the protocol for the team leader, team psychiatrist, and agency leadership in-depth interviews, the focus group questions were created based on the study's conceptual framework and incorporated Bass's theoretical framework, salient concepts identified in the literature, and a priori knowledge.

At the end of the focus group, I distributed the form that offered participants to share any other information with me privately and to rate their comfort level in sharing information within the focus group context (see Appendix 19), as well as gathered demographic information on the group participants that contributed to the description of the case (see Appendix 20). The results are described in Chapter 4 of this paper.

One issue I was cognizant of during all interviews and the focus group was the issue of participant confidentiality. Given the nature of case study design, the leader, the team psychiatrist, agency supervisor, and team members know and closely work with one another. When I asked questions about the ACT team leader, all responses clearly were directed towards that one individual. The fact that all participants need to continue working with one another could have an effect on the comfort level people had in disclosing information, especially information that could be construed as negative. The study's design and use of interviews and a focus group may have contributed to issues of social desirability and acquiescence, and made

participants more likely to present the team leader in a favorable light or just agree with other team members.

My effort to minimize these issues related to a lack of meaningful confidentiality was three-fold. First, I was able to offer some degree in confidentiality to team members within the focus group setting. While findings from the focus group are reported, no specific team members were identified. In that respect, the focus group setting provided a small degree of anonymity (although other team members knew who said what). I attempted to stress in the opening dialog of the focus group that all information should be kept confidential within the group. Second, I offered team members the chance to submit information to me that they did not feel comfortable sharing in the larger focus group (see Appendix 19). This form, distributed at the end of each focus group, offered a chance to provide me with additional information that participants did not share in the focus group. Additionally, this form asked participants to rate their level of comfort in sharing information about the team and team leader within the focus group. This rating helped me to contextualize information obtained in the focus group. Third, it was my intent by offering all participants the ability to review and verify findings (via a member checking process) they would be comfortable to disclose sensitive information. Team members could feel more confident that their ideas were not misinterpreted or reported incorrectly. Similarly, I offered to team members the option that information could be omitted from final reports prior to dissemination in effort to increase team members' comfort in disclosing sensitive information. While it was impossible to eliminate all barriers to participants feeling comfortable in disclosing information about their work and interactions with the team leader, it was my hope that these instituted processes minimized the effect on the data collected.

Direct participant observations. Another source of data for this case study was the direct observations of the team and team leader. Creswell (2002) defines participant observation as "an observational role adopted by researchers when they take part in activities in the setting they observe" (p. 200). Direct observations attempt to capture life as experienced by the study participants rather than through categories predetermined by the researcher (McKechnie, 2008). Direct observation allowed me to capture behavior as it occurred in the real world and see in real time what team leaders on high fidelity ACT teams did, and how they did it. Additionally, observing the team and team leader allowed me to uncover unanticipated phenomena or processes that contributed to the rich description and understanding of team leadership (Stake, 1995; McKechnie, 2008). This form of data collection also supported my constructivist approach as it emphasized meanings that the participants attached to their activities and events (McKechnie, 2008).

The majority of my time on-site, with the exception of the in-depth interviews and facilitation of the focus group, was spent in direct observation of the ACT team and team leader. The days I chose to be on-site included days when the psychiatrist was present and weekly treatment planning meetings were held. At each site, I was able to see the daily team meetings with the psychiatrist present, and attend several treatment planning meetings (with consumer consent). In all cases, I situated myself in a place where I was best able to observe the majority of the team leader's activities, while attempting to be the least disruptive.

Additionally, I accompanied the team leader into the field to observe her behavior when away from the office and with her permission (exceptions to this were a few consumer contacts where it was deemed not in the best clinical interest of the consumer). During these times out in the community, I asked for clarity on my observations, or documented questions in field notes to

ask the team leader at the end of the day. This clarification of my observations allowed me to move back and forth between inductive and deductive reasoning and helped me to identify themes through the analysis of observed behavior (McKechnie, 2008). While on-site, I was constantly checking and re-checking the consistency of my findings from different as well as same sources. This process helped make my findings as robust as possible (Yin, 2012; Duneier, 1999). I utilized Merriam's (1998) checklist of elements to structure my observations, including participants, activities and interactions, conversations, non-verbal and/or subtle behaviors, and physical surroundings (Merriam, 1998; Cloutier, Lilley, Phillips, Weber, & Sanderson, 1987) in effort to identify any trends and patterns (McKechnie, 2008).

Data for participant observation was most frequently recorded in the form of fieldnotes (Padgett, 1998; see Appendix 17). Fieldnotes represented an attempt to record everything about an observation period in the field (Berg, 1998). While my fieldnotes always included written descriptions of what was observed (McKechnie, 2008), they also included insights about what I had observed. These thoughts were recorded as theoretical or analytical memos (McKechnie, 2008). During this study, I strove to follow best practice of recording low inference descriptors and "thick description"–logging as much precise and detailed descriptions of people and situations as possible without an interpretative filter– while tracking any insights that developed while observing the team leader and team (Padgett, 1998, pg. 57; McMillan & Schumacher, 1997). I completed field note templates during direct observations of the team leader and team members, including for every team meeting and treatment planning meeting (see Appendix 17). Furthermore, I had a spiral notebook for each team that I recorded observations and insights as they were occurring in the field.

Within this study, I kept multiple memos and did reflective journaling. Memoing is the act of recording reflective notes about what the researcher is learning from the data (Groenewald, 2008). These memos add to the credibility and trustworthiness of qualitative research and contributed to my audit trail by recording the meanings derived from the data (Groenewald, 2008). I had a spiral notebook with me at all times and documented my thoughts as they arose and in tandem with what I was observing. On a few occasions, I would audio record reflective ideas. In addition, most nights after the day of data collection, while still fresh to improve the accuracy, I reviewed all my notes from the day and wrote reflective and analytic memos including any patterns or themes that I saw emerging, (Stake, 1995). These memos/notes were documented in the spiral notebook and labeled as "reflections".

Review of documents. Documents are defined by LeCompte and Preissle (1993) as "symbolic materials, such a writing and signs and non-symbolic materials such as tools and furnishings" (pg. 216). The use of documents to supplement data from interviewing and observation is a common strategy among qualitative researchers (Padgett, 1998). While on-site, I reviewed several team and agency documents. Documents included program policies, orientation and training protocols, internal memos, strategic planning or team goals, team leader position descriptions and salary information, and other documents that supported team functioning (e.g. team logs, templates of performance evaluations, organizational charts).

An ACT team also utilizes several tools for the effective implementation of ACT (i.e., daily schedule), and I reviewed these documents to see if they informed the study aims in any meaningful way. Documents of the ACT program provided a rich and reliable source of data concerning attitudes, beliefs, and behaviors, and reflected different participants' perspectives (Merriam, 1998). Data found in documents furnished descriptive information, verified emerging

ideas, and advanced new hypotheses for the issue under study (Merriam, 1998). The authenticity and accuracy of the documents were scrutinized as part of the research process (Merriam, 1998; Burgess, 1982). While on site, I also gathered information on the work space and furnishings. I found there were many objects, such as artwork, inspirational sayings, homemade gifts from consumers, and food that provided some data on the culture of the team and contributed to better understanding some concepts about the team leader.

Data management. Considering the volume of data I gathered (estimated over 1000 pages of transcripts from interviews and field notes), I used Microsoft's Word software (Microsoft Office, 2011) to assist with data management. All interviews were audio-taped, transcribed verbatim by a transcriptionist, reviewed for accuracy within Microsoft Word. During the coding process, data was entered into tables created in Microsoft Word including some field notes from observations, and on-site memos.

Data Analysis

Case study analysis takes many different forms, and none yet follow strictly routine procedures as exist with other forms of qualitative research methods (Yin, 2012). Merriam (1998) proposes that case study methodology can be used with a variety of methods of data analysis, including the constant comparative method of grounded theory, phenomenological analysis, content analysis and narrative analysis. However, since there is not a definitive data analysis choice for case study designs, there is a heightened burden upon the researcher to assure some methodological congruence between the study design and analytic strategy chosen (Merriam, 1998).

Because I am coming from a social constructivist paradigm, I elected for this collective case study to use a constructivist grounded theory (Charmaz, 2006) approach for data analysis.

Previous literature suggests that a collective case study design (Stake, 2000; Yin, 2003) and a constructivist grounded theory data analysis approach are highly congruent (Lauckner et al., 2012). Lauckner and colleagues (2012) highlight that both case study and grounded theory approaches can be placed in constructivist paradigms. Because a qualitative case study approach described by Stake (1995; 2006) seeks out the multiple perspectives of those involved in the case and aims to gather collectively agreed upon and diverse notions of what occurs (Lauckner et al., 2012) this design supports the idea that reality is local and specifically constructed (Lauckner et al., 2012; Lincoln & Guba, 2000).

Grounded theory is an inductive, comparative, iterative, and interactive method of data analysis (Charmaz, 2006). A constructivist grounded theory approach emphasizes the studied phenomenon and sees both data and analysis as created from shared experiences and relationships with participants (Bryant, 2003; Bryant & Charmaz, 2007; Charmaz, 2009). In this viewpoint, data analysis is seen as constructions that locate data, time, place, culture, and context while reflecting the researcher's social, epistemological and research positions (Charmaz & Belgrave, 2012). A constructivist grounded theory approach takes implicit meanings, experiential views and grounded theory analysis as constructions of reality of the studied phenomenon (Charmaz & Belgrave, 2012).

Data analysis procedures. Charmaz (2006) suggests several strategies of constructivist grounded theory analysis. Based on the overall purpose and goals of this study, the following four strategies of constructivist grounded theory analysis (Charmaz, 2006) informed the examination of data collected from each case: line-by-line opening coding; focused coding; development of core categories, and memo writing. Grounded theory analysis also depends on using constant comparative methods between data, codes, and categories to advance the

conceptual understanding (Charmaz, 2006). Therefore, within each of constructivist grounded theory strategies employed for this study, a constant comparative method was applied where I compared data with data but then also progressed to comparisons between their interpretations translated into themes and categories (Mills, Bonner, & Francis, 2006).

Data analysis for this study occurred in two stages: Stage 1 consisted of the independent, in-depth analysis of each case (within-case analysis) and is reported in Chapter 4 "Findings" of this dissertation. Stage 2 involved a cross-case analysis of the two cases and is reviewed in the "Discussion and Conclusions" chapter of this dissertation. Data analysis began immediately following the on-site visit with the first team, and was organized by cases/teams, beginning with Lincoln ACT and ending with the Ramsey Co. ACT team. The outlined data analysis procedures were followed for each team.

Stage 1: Within-case analysis.

Individual case descriptions. In this collective case study, each case was analyzed and written up separately, providing the reader with a contextual description and interpretation (Lauckner, 2010). This descriptive write-up is important to a case study design because according to Stake (1995), the researcher should provide the audience with the "opportunity for vicarious experience" of the case (p. 86). This can best be accomplished by giving a rich narrative account of the story, a personalistic description, and emphasis on time and place (Stake, 1995).

Line-by-line open coding. A code is an abstract representation of an object of phenomenon (Strauss & Corbin, 1998) and coding is a way of linking data to ideas and, iteratively, from ideas back to supporting data (Richards & Morse, 2007; Miller, 2010). Codes are the “most basic segment, or element of the raw data or information that can be assessed in a

meaningful way regarding the phenomenon" (Boyatzis, 1998, p. 63). Line-by-line coding is designed to inquire broadly and to identify emergent themes from the raw text (Berg, 2004) that inform the study's aims. Coding involves constructing short labels that describe, dissect, and condense the data while preserving their essential properties (Charmaz & Belgrave, 2012). This analytic method is a way of reducing data into manageable categories, making sense of them, and deriving meaning (Julien, 2008; Klenke, 2008). Line-by-line open coding allows us to study the interviews, preserve processes and determine sequence of events, illuminate participants' implied and explicit meanings, and make comparisons between data (Charmaz & Belgrave, 2012).

Within this study, coding analysis actually began with the professional, verbatim transcription of the data, including recorded team meetings, face-to-face interviews, focus groups, and discussions with the team leader. A professional transcriptionist was hired to transcribe all the recorded interview data verbatim. In order to verify the accuracy of the transcription, I made a word-by-word comparison between the transcript and the recorded interviews, including the correction of any mistakes and addition of comments the transcriptionist was unable to discern. All written transcripts were then corrected (both in hard and electronic copies) and combined with my hand written field notes and memos for analysis.

For each case, I read the transcripts and coded extracts of data inclusively, making efforts to keep the context of the data, and coded extracts of data in as many different "themes" as they fit into as I did not know what might be of interest later on and wanted to remain open to emerging, new ideas (Braun & Clarke, 2006). As I was coding the data, I also indicated what specific aim they may inform (e.g., Aim 1; Aim 2 & 3). This strategy allowed me to begin to draw connection to similar codes and categorize events with common elements related to the

roles and contributions of team leaders on high fidelity ACT teams. I looked for tacit assumptions, explicated actions and meanings, compared data with data, and identified gaps in the data in alignment with a constructivist grounded theory analysis framework (Charmaz, 2006). At this stage, a second researcher began line-by-line coding of all transcripts in order to identify and discuss with me potential emerging concepts, processes, and patterns that she independently identified. As is consistent with a constructivist approach, the analyst triangulation facilitated further reflexivity and deeper questioning of the data as another individual researcher less familiar with ACT was asking for further clarification and shared impressions of the data (Lauckner et al., 2012; Stake, 2000). As part of my initial coding process, I went through transcripts, then my field notes, then on-site observation document sheets, then finally team and/or agency documents. This helped me reach a holistic idea of codes and brought me to a point of saturation.

Focused coding. Focused coding is the second major phase in coding (Charmaz, 2006). These codes are more directed, selective, and conceptual than word-by-word, line-by-line coding (Glaser, 1978). During focused coding, codes are examined to uncover the relationships that exists between them (Gilliland, 2010) and reveals the answers to questions such as when, why, how come, and under what conditions (Gilliland, 2010; Strauss & Corbin, 1998). Questions are asked about the conditions, actions/interactions, and consequences of emerging categories, thus making links between the ideas being conceptualized from the data (Mills et al., 2006). The dissected data (codes), resultant from the line-by-line coding phase, are sorted and reassembled as the research develops. Broader themes are then selected that seem to be most promising for further elaboration and that best inform the study's aims (Klenke, 2008; Benaquisto, 2008).

For the focused coding phase of analysis, I began to organize my initial codes to synthesize and explain larger segments of data. I used the most significant codes to sort through large amounts of data and began to make decisions about the initial codes and how it made sense to categorize the data to best inform the study aims. I contemplated the relationship between codes, between emerging themes, and between different levels of themes in order to differentiate the properties of the various themes derived from line-by-line coding and determined how they varied in terms of their dimensions (Benaquisto, 2008; Klenke, 2008; Braun & Clarke, 2006). Additionally, I began to relate themes to tentative categories and subcategories and defined properties and dimensions of various categories as they emerged from the analysis (Strauss & Corbin, 1990). This process of focused coding was highly iterative and I completed multiple reviews of the initial codes and data as themes and categories began to emerge.

Development of core categories. In this strategy, coding is taken to a higher level of abstraction (Klenke, 2008). The goal of this step is to link themes together and integrate them to form a larger core category, theoretical scheme or story (Gilliland, 2010; Klenke, 2008). This linking and integrating of smaller themes into the larger, core themes is key to developing the story about "what is happening" in the data and is accomplished by discovering commonalities and contrasts in relationships between themes identified (Gilliland, 2010; Benaquisto, 2008). This core category "conceptual label" must fit the stories and data it represents (Strauss & Corbin, 1990, p. 121).

During this stage of data analysis, I defined each core category including the themes that were contained within the core category. These core categories specify the possible relationships between themes and subcategories that were developed in the focused coding phase (Charmaz,

2006). I also used quotes from the actual transcripts to support the definition and themes integrated during the development of the core categories.

Memo writing. Memo writing is a integral method in any grounded theory approach because it prompts the investigator to analyze the data and codes early in the research process (Charmaz, 2006). Writing successive memos during the research process keeps the investigator involved in the analysis and helps to increase the level of abstraction and connections between the data (Charmaz, 2006). According to Charmaz (2006), through this "conversation" with yourself, new ideas and insights arise during the act of writing.

Memos were continuously written during data collection and data analysis stages of this study. During data collection, memos were written following interviews and observations to summarize key ideas, highlight themes that were emerging, and raise potential questions to consider for follow up and further exploration. Additionally, at the end of each day, I would write theoretical memos that would specifically tie back to study aims, or to the theoretical framework of the study. Within these memos I would document anything that seemed relevant, including how I saw some data connected to other pieces of data, when data was or was not triangulating, potential codes, or how the data aligned (or not) with my theoretical framework.

Memos were helpful during the data analysis stage as they assisted me in making comparisons between data and data, data and codes, codes and codes, codes and themes, themes and themes, themes and categories, and categories to categories (Charmaz, 2006). Writing memos allowed me to identify patterns and offered evidence to support my definitions of categories. Several times, memos were helpful to how I was conceptualizing categories and provided insight into processes of team leaders on high fidelity ACT teams. During the analysis process, I reviewed the data and memos that related to a category and posed the following

questions: In what ways is this category the same as, or different from other categories? What is the connection between this category and other categories? Writing memos and this constant comparison allowed me to explore my ideas about the categories and how various factors connected or did not connect to one another. These memos written during the data analysis phase significantly contributed to my theorizing on the roles and contributions of ACT team leaders to high fidelity teams.

Although each case was analyzed separately, concepts from previous cases inevitably influenced subsequent data analysis and interpretation though comparison (Lauckner et al., 2012). Individual case analysis continued during writing and revision for each of the two case descriptions where I was constantly examining and clarifying themes and category definitions. During this stage of analysis, main processes and factors were identified and documented in a memo that connected common elements across cases (Lauckner et al., 2012) such as the team leader's focus on the wellbeing of team members. These broad common elements provided a general structure for examining how cases were similar or where they varied (Lauckner et al., 2012) and set the context for Stage 2 of the study's data analysis.

Stage 2: Cross case analysis.

In a collective case study, cases are of interest because they belong to a particular collection of cases and the investigator seeks to understand this collection of cases. A cross case analysis allows the investigator to look at what is similar or different about each individual case in order to study the collection better (Stake, 2006). According to Stake (2006), most researchers doing cross case analysis are emphasizing the common relationship across cases.

Findings, or assertions in case study methodology, typically look at commonalities among the cases (Stake, 2006). These commonalities can contribute toward an understanding of

the collection of cases and evidence from more than one case is highlighted to support the assertion (Stake, 2006). In the final report, the section reporting the cross-case analysis is expected to be shorter than the sum of the case studies, yet it should convey the most significant findings from each case and combined together as assertions (Stake, 2006).

Following Stake's (2006) framework for cross case analysis, my first activity was reading the case reports, applying their findings to the broader question of what the collection of cases had in common, and recording my tentative assertions. After this, I compared each case's core categories, by aim, to explore how different contexts and processes were similar or varied across the three cases (Lauckner et al., 2012). I re-examined the original data, codes, and memos to find commonalities across cases or to re-acquaint myself with the contextual features that may explain the variations across cases (Lauckner et al., 2012). Additionally, I continually reviewed my written memos to integrate ideas generated during data collection that may inform the cross case analysis. Through a process of comparing and merging salient case-specific findings and tentative assertions, I examined core categories to identify those issues that had high importance across cases (Lauckner et al., 2012). Then, organized by study aim, I decided on what assertions to emphasize, which to subordinate, and what to drop all together (Stake, 2006) based on my decision of what carried importance for understanding the collection of cases.

Trustworthiness and strategies for rigor. In qualitative research, a key issue to a robust content analysis is the validity or trustworthiness of the study (Lincoln & Guba, 1985; Given & Saumure, 2008). Trustworthiness is defined as a study "that is carried out fairly and ethically and whose findings represent as closely as possible the experiences of the respondents" (Padgett, 1998; pg 92; Steinmetz, 1991). The trustworthiness, or a study's soundness, is based

on its transferability[10] (i.e., the likelihood that the findings have meaning in other similar situations), dependability[11] (i.e., the ability of the study to account for variability over time), confirmability[12] (i.e., the extent to which the process of collecting data and coming to conclusions is clear and can be followed by another), and credibility[13] (i.e., the extent to which the findings accurately describe and capture the phenomenon studied; Lincoln & Guba, 1985; Streubert & Carpenter, 1999; Lauckner et al., 2012).

I used several specific strategies to ensure rigor and enhance this study's trustworthiness including:

1) Inclusion of a rich description—In the individual case descriptions, a rich and detailed description of the setting and interactions aimed to provide the readers with enough information for a "vicarious experience", allowing for naturalistic generalizations to be drawn (Stake, 1995). Providing a thick description for each of the ACT teams enhanced the transferability of the study.

2) Creation of a carefully documented audit trail—Following a case study protocol, throughout the research process I wrote methodological, reflective, and theoretical memos, along with general insights, questions and confusions that arose. I utilized an organized record keeping system to keep track of research processes and data. This strategy contributed to the confirmability of the research.

3) Member checking— Member checking involves the activity of seeking the reactions of participants after data analysis to determine whether or not the researcher's interpretations are accurate with their various perceptions (Manning, 1997; Jensen, 2008; Minkler, Brechwich-

[10] Transferability parallels the quantitative idea of external validity
[11] Dependability parallels the quantitative idea of reliability
[12] Confirmability parallels the quantitative idea of objectivity
[13] Credibility parallels the quantitative idea of internal validity

Vàsquez, Warner, Steussey, & Facente, 2006; Klenke, 2008). The preliminary case descriptions and findings were forwarded to all participants for review and comment from September 2013 through September 2014. Participants were asked to complete a worksheet as a method of documenting and communicating issues found during a review of findings (see Appendix 21). Within a constructivist paradigm, the goal was not to determine if the research's interpretation was "correct" –which would be challenging because the interpretation integrates multiple perspectives—but rather to provide an opportunity to explore the tensions and complexities of the proposed interpretations (Charmaz, 2006; Lauckner, 2010). Member checking has a positive effect in reducing the threat of reactivity, and researcher and respondent bias (Padgett, 1998), which enhances the study's confirmability.

4) Analyst triangulation—Throughout the entire coding process, a second researcher conducted independent line-by-line coding, focused coding of the raw data, and contributed to the development of categories. At each stage of analysis, we would meet and reach consensus on coding and data interpretation. Additionally, team findings were discussed with my dissertation advisor and a member of my dissertation committee in order to deepen first level coding and category creation and to raise additional questions for consideration. Finally, I engaged in peer debriefing which was a way to reduce researcher bias, and included regular meetings with people who were not directly involved in the research. Peer debriefing was with 2 members of my qualitative dissertation support group. I was able to share my research, including codes, memos, and excerpts of text/data in order to assure they accurately reflected the participant's experience. These forms of analyst triangulation improved the confirmability of this study.

5) Multiple sources and methods—A range of viewpoints from multiple individuals, including team leaders, agency supervisors, psychiatrists, and team members were obtained.

Additionally, data triangulation, defined as "using multiple sources of data, or multiple methods to confirm the emerging findings" was utilized (Merriam, 1998, pg. 204). A variety of data collection methods were used at each site (e.g., interviews, focus group, direct observations, document review). I used the process of data triangulation to seek convergence in the data and to corroborate or refute emerging categories and themes (Tinkler, 2004; Creswell & Miller, 2000). By giving voice to multiple perspectives within the study and using a variety of methods the credibility, dependability, and confirmability of this study was strengthened (Lauckner, 2010).

6) Prolonged engagement in the field—I was onsite for data collection with each team for three days, during which time extensive data were collected from multiple sources. I also had the opportunity for follow up call with the team leader for further clarification when needed. This strategy increased the study's credibility.

7) Reflexivity of the researcher—As described previously, during data collection, I kept a field journal and wrote memos including reactions while on-site with the teams, as well as after each day of data collection. In addition, I wrote theoretical and analytical memos during the data analysis phase that captured emerging interpretations. These field notes and memos promoted my own reflexivity and thus added to the credibility of the study.

Chapter summary

In this chapter, I described the study's design as a qualitative, collective exemplary case study design situated within a social constructivist paradigm. I reviewed case study protocol that provided rationale for why this design was optimal for answering the study aims directed at ACT team leaders of high fidelity ACT teams. I offered my positionality as a researcher, including my statement of reflexivity, and biases and assumptions I hold.

Processes around sampling, along with the recruitment of the two exemplary cases (ACT teams) from Lincoln, Nebraska and St. Paul, Minnesota were outlined, including how teams were assessed for high fidelity according to the TMACT tool. After the development and the piloting of all questionnaires, I conducted interviews, focus groups, direct observations, and agency document reviews at each site between October and December 2012. This totaled six interviews, two focus groups, 48 hours of direct observation, and produced over 1000 pages of transcription and fieldnotes across the two cases.

Within this chapter, I described my data analysis plan and how my choice of employing a constructivist grounded theory strategy provided congruency between my study design and analytic method. My data analysis occurred in two phases, both within case analysis (Chapter 4) and cross case analysis (Chapter 5), and was guided by the use of the constant comparison method, through coding, memo writing, and the creation of core categories. I worked to maintain the data's contextual situation and participants' voices during data collection and analysis (Lauckner, 2010). Lastly, I presented strategies that I used to strengthen this study's trustworthiness and rigor. Next, I will present the findings from this collective, exemplary case study.

Chapter 4: Findings

Introduction

This chapter will provide a within case description and analysis of each team (Ramsey County ACT and Lincoln PIER ACT team) followed by a cross case analysis of the two ACT teams. The within case analysis of each team is organized first by providing a brief overview and description of the case's context including physical setting. This case description is followed by an overview of the participants, including a description of the team leader, team members, team psychiatrist, and agency supervisor. The description of participants is followed by within case findings for each team, organized by the core categories and themes that are thought to best inform the study's specific aims. Core categories and themes are presented, elaborated upon, and summarized within this section, with evidence provided in the form of quotations and narrative descriptions.

The second stage of analysis of this study on exemplary ACT team leaders was the cross-case analysis. This cross case analysis is important as "a qualitative, inductive, multicase study seeks to build abstractions across cases... [and] can lead to categories, themes, or typologies that conceptualize the data from all the cases; or it can result in building substantive theory offering an integrated framework covering multiple cases" (Merriam, 1998, p. 195). The cross case study revealed notable commonalities shared by both ACT team leaders. Those commonalities are presented below as themes grouped by the study's three aims. The study's cross case analysis emphasizes the common relationships across the two ACT team leaders.

Within-case Findings[14]

Case one: The Ramsey County ACT team in St. Paul, Minnesota[15].

[14] Within this chapter, any names used in relation to consumer information are pseudonyms and were changed to protect the confidentiality of the individual. Likewise, to offer the most confidentiality to general members of the ACT team, the generic descriptor of team member was used rather than naming a specific individual.

Case context, setting and descriptions of participants. Approaching the Ramsey County Human Services building on December 4th, 2012, I was immediately confronted by a high energy of hustle and bustle around the building. Located in St. Paul, Minnesota, nestled on the west side by the Mississippi River, the older but distinguished 10 floor brick building stood prominently against the skyline. Within the building, the high, chaotic energy did not subside. There were several lines announcing different benefits, and the waiting room, with too few chairs, hosted a multi-cultural clientele. Individuals representing different genders, ages, races, and presumably religions, based on attire, were scattered about the room,

I found the bank of elevators, entered, and hit the button to take me to the 8th floor. Once there, I was confronted with hallways that were minimally marked and doors that were locked and without instructions. I phoned Alyssa Shoemaker, the ACT team leader, and she came and escorted me past the doors, explaining they were locked for safety reasons as they serve a wide variety of individuals throughout this building. ACT is one of those offered services within the larger array of mental health services that Ramsey County offers. Alyssa toured me around the office space, where the ACT team shares space with other services, including targeted case management and substance abuse services. The space and layout reminded me of a warehouse as it had large open area, with windows lining the outside walls and the natural sunlight beaming in and warming the interior. In the middle of the open space were dozens and dozens of gray fabric and plastic cubicles aligned in rows where staff had their work stations. ACT team members had cubes scattered amongst different program staff members' cubes, not giving a clear

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[15] In my description of the Ramsey County case, I will include descriptions for Alyssa, the team leader along with the team psychiatrist and agency supervisor separate from the other team members. I felt the case was more richly described by reporting the aggregate demographics on the actual team members to give the reader a better idea of what the ACT team looked like, minus leadership.

delineation of where ACT staff were located. Alyssa did not have a cubicle, but rather an office (with a door) that faced north and afforded an awe-inspiring view of the city and State Capitol.

We reviewed the agenda for the three day on-site visit. This included on the first day (today) observing both the daily team meeting and client treatment planning meeting, reviewing team documents and beginning the semi-structured interview with Alyssa at the end of the day[16]. On the Day Two, we would continue with Alyssa's interviews along with continuing to observe the daily meeting and facilitating the focus group when the majority of team members could attend if they chose. Finally, on Day Three, the interviews with the team psychiatrist and agency supervisor would occur, along with another observance of the team meeting and finishing up the interview with Alyssa. She agreed this agenda would work.

Her office was well organized, although she debated this. Two of the walls were made of brown brick, which gave the office a warm and rustic feel. She had file cabinets and bookcases filled with binders such as the SAMHSA toolkits, the most recent version of the DSM, and various books on cognitive behavioral therapy (CBT) and clinical treatments. She had some art work and I commented on a black and white photograph on a wall adjacent to her desk. It was of a flower, but the back of the flower. Alyssa stated that the picture reminds her that there are always different perspectives and that to see something from a different perspective can be just as beautiful. The space was conducive to work, yet appeared friendly and lived in.

As a way of orienting me to the ACT team, Alyssa provided background on the history of this team, which officially began in January of 2005, when it was converted from an intensive targeted case management (TCM) team to an Assertive Community Treatment team. The intensive case management team had begun around 1999, and several of the team members made

[16] My placement of the team leader's first interview was intentionally scheduled at the end of Day One or beginning of Day Two to allow me time to observe the leader's behavior prior to asking questions about her leadership that may have altered her behavior.

the transition from TCM to ACT in the 2005 switch. Alyssa, at the time of the conversion, had been the mental health planner for Ramsey County and so was quite familiar with the theoretical underpinnings of what the ACT service delivery model should look like. Alyssa explained that she was very drawn to the ACT model and found her previous experience as the planner tremendously beneficial as she had the "mental picture of what it should look like". She went on to explain that this understanding of the ACT model was also helpful because if she would not have had that, it would have been easy to get pulled into the team's culture of intensive case management because she would not have known any differently. She described that over the first year, two nurses, one vocational staff, and one generalist staff left as they did not like the changes and did not necessarily "fit vision-wise". Alyssa explained that practicing ACT at high fidelity has always been important to the leadership at Ramsey County. They supported fidelity and wanted to do it right in order to get desired outcomes for consumers. She illustrated the commitment of Ramsey County leadership by sharing they had secured outside expert ACT consultation in effort to improve. More recently, the ACT team served as a "shadow" program for the State of Minnesota, helping other ACT teams see how to operate in a high fidelity manner by shadowing staff.

Alyssa has been this ACT team's leader since 2007. She is a 36 year old, white, female who holds a Master's degree in the field of social work. She described in rich detail how she went straight from undergraduate school to graduate school for social work and did so purposefully as she wanted to do more clinical level work, or systems level work versus case management. During an internship for school, she was placed in a mental health agency doing psychiatric rehabilitation, in a social skills development program. Alyssa described how this training was great for her in terms of learning to love the SPMI population but also in promoting

recovery values and rehabilitation principles. Per Alyssa, these principles and values "were really instilled in me kind of as the core philosophy". Alyssa remains passionately driven to serve this population and promote recovery and rehabilitation.

She has worked a little over 14 years in the mental health field, five of those in ACT as the team's leader. Alyssa identified herself as a social work leader. According to agency records, the monthly gross salary range for a supervisor with Ramsey County is between $5,125.00 and $7,619.00 and she confidently acknowledged that she is worth that payment for all she does. She reported that she does not think she would stay for less money given the enormous responsibility she carries. Alyssa also delineated that the enormity of the job was more of a challenge in the earlier years of the program, when she worked many nights and weekends. Without adequate compensation, she opined that she likely would have not stayed in the job.

Alyssa described an important part of her identity, and one that influenced her leadership, as practicing principles of Buddhism. Specifically, she worked to integrate the practice of mindfulness or higher awareness, with the cultivation of higher wisdom. She felt that these principles helped her give up issues of being in control of the team and allowed her to accept things as they are.

The ACT daily team meeting. Upon entering the team room, I saw a rectangular table with pens, paper clips, a clock, and the team's cardex on top of it, and chairs placed around it. The majority of the chairs were taken by team members who had laptops open and were working independently and quietly, waiting for the meeting to begin. Conversations were also in progress, some related to work and others related to personal issues and checking in from the weekend.

People sat in close proximity to one another, but not so close that it was uncomfortable. The lighting was good and conducive to work. Around the large team table and the perimeter of the room were file cabinets that held consumer records and several dry erase and bulletin boards that organized and were a visual presence of the team's work. One dry erase board announced upcoming treatment planning meetings; another had a list of activities related to the vocational tasks of the team and still another appeared to have some brainstorming notes regarding an ACT process. Adorning the walls of the team meeting room were recovery-promotion oriented posters conveying respect and the idea that recovery from mental illness was not only possible but the goal of the team. "Portraits of recovery" of some of the consumers the team has served were also on display.

Currently comprised of 15 individuals, this ACT team includes Alyssa as team leader, one psychiatrist, one advanced practice nurse prescriber, a psychiatric resident, three nurses, two vocational specialists, three mental health practitioners/professionals, one certified peer specialist, a social work intern, and the program assistant. Table 4 summarizes relevant demographics of the Ramsey County ACT team members (minus leadership; N=12) who agreed to participate in the study. All team members scheduled for this shift, including the team psychiatrist, were present at the meeting and on time.

Table 4: Descriptive Characteristics of Ramsey County ACT Team Members[17]

		N (%)	Mean	SD	Range	Notes
Gender	Male Female	4 (33.3) 8 (66.7)				
Age		11	39.5	10.45	25-57	
Ethnicity	Hispanic/Latino Not Hispanic/Latino	1 (8.3) 11 (91.6)				
Race	White Asian	10 (83.3) 1 (8.3)				
Highest Education Level Completed	Trade/Vocational School Some College BS/BA Degree Master Degree MD/PhD/JD Degree	1 (8.3) 1 (8.3) 4 (33.3) 4 (33.3) 1 (8.3)				
Field of Highest Degree	Social work Nursing Psychology Other	2 (16.7) 3 (25) 2 (16.7) 5 (41.7)				Other fields: Admin support, counselor education, Certified Peer specialist, medicine and sociology
Length of time worked in mental health field (in months)			119.1 (9.9 years)	115.8	3-390	
Time spent with Ramsey Co. ACT program (in months)			48.9 (4.1 years)	38.3	3-109	
Worked in ACT previous to being on this team	Yes No	1 (8.3) 10 (83.3)				
Comfort Level in Focus Group			8.44	1.13	7-10	Rated on Likert scale from 1-10

This meeting was somewhat atypical, as Alyssa began by calmly sharing news that a team member, who had been with the team for the past eight years, had put in for her retirement

[17] It is important to note that these summary demographics exclude the team leader, team psychiatrist, and the agency supervisor as their information is reported in narrative form. One individual team member declined to participate fully and another was out on extended leave so their demographic data was not included on all demographic dimensions.

and would be leaving in March. Alyssa was calm, smiling, and provided support to staff who shared mixed emotions, including shock and sadness. Alyssa was direct, shared some memories, and assured the team they would be able to move forward. After a few minutes, she brought the team back to the task at hand, and directed how and when she wanted the team to disclose this information to consumers. Onto the next item on the agenda, Alyssa then presented a change she will implement regarding the treatment planning process. I noted that while Alyssa was presenting this information, all team members were giving direct eye contact and their full attention to Alyssa. Alyssa acknowledged that the change in process could be rough at first but eventually it would be a positive change. After these announcements, the daily team meeting[18] began, where each consumer's name was read out loud and staff supplied a clinical and rehabilitation summary of the consumer's status from over the weekend. Despite the majority of team members' multi-tasking, they were also highly attentive and no one needed prompting to report or be involved.

The team's dialog throughout the team meetings was highly respectful of both consumers and of each other. I noted that team members did not use disparaging descriptors to describe consumers or family members at any time. Additionally, all team members listened and did not interrupt each other during the meeting; when there were differences of opinion, team members would indicate so professionally and share another perspective. The energy in the team room was one of calmness, and the meeting never became overly chaotic, but rather maintained a relaxed climate (with laughter and joking), that was also very business-like and efficient. Alyssa set the tone for how communication occurred amongst the team members. She frequently nodded

[18] There are four primary functions at an ACT daily team meeting: (1) briefly review the service contacts which occurred the previous day and the status of all program consumers; (2) review the service contacts which are scheduled to be completed during the current day and revise as needed; (3) assign staff to carry out the day's service activities; and (4) revise treatment plans and plan for emergency and crisis situations as needed.

and validated staff providing input. She reinforced team members with verbal and non-verbal praise, when they were person-centered in their reporting and focused on problem solving, and was quick to correct any type of language or discussion that veered from this person-centered approach. In doing so, Alyssa integrated a lot of teaching with the staff.

Alyssa valued collaboration and the input of others as expressed by her willingness to be challenged and seeming comfort with being wrong at times. I witnessed a team member challenge a comment about consumers' goals and she thanked the team member for correcting her. She led team members in a fair and equitable manner and pointed out in the meeting the strengths of various team members. She never expressed negativity or a hopeless stance on an issue, but rather exuded optimism and reframed challenges with consumers as opportunities. She appeared to be a skilled clinician, truly understanding issues around diagnosis, treatment, and rehabilitation for individuals with mental illness.

As the team meeting came to a close, the focus turned to organization of the team's activities. The team's shift manager read out loud individual team members' schedules for the rest of the day. Alyssa verbally validated the team's schedule, and asked clarifying questions to determine if additional contacts for some ACT individuals were warranted. Alyssa assisted the team with scheduling issues and conflicts, and reminded staff to inform consumers of some upcoming changes. As soon as all the scheduling and consultation finished, team members dispersed. Before leaving herself, Alyssa consulted with the team psychiatrist about several treatment issues such as medication delivery schedules and get directive plans in place.

The team members appeared very cohesive, and there were no observed instances where any direct conflict was noted. On the first day, I was unable to discern which discipline (e.g., nurse, vocational specialist, mental health professional) various team members were trained in,

given that all team members seemed cross trained and practiced within a teamwork paradigm. Alyssa related that she had excellent team members and indicated that one facilitator to hiring qualified staff was that Ramsey County had created an infrastructure that paid higher salaries compared to other local ACT teams. Alyssa felt that she had the luxury of attracting more qualified workers because of this county's pay scale.

Ramsey Co. ACT focus group. The focus group was held on the second day I was on-site. Nine team members agreed to participate in the focus group. Reasons provided by those members who did not participate included one team member being on medical leave, and another individual who simply stated he/she did not prefer to participate. The focus group was held in the team's meeting room. Overall, during the focus group I observed the team to have good synergy evidenced by a calm and relaxed demeanor and the use of humor. Team members also "fed" off of one another in their answering of the questions posed and all participants shared comments to questions. Comfort levels of team members (N=9) after the focus group were assessed on a Likert scale ranging from 1 (not at all comfortable with sharing team information) to 10 (extremely comfortable with sharing team information) and were found to be moderately high with scores ranging from 7-10 (Mean=8.4; SD=1.1; See Appendix 19). No individual chose to follow up with me after the focus group regarding concerns despite the offer. The focus group lasted approximately 1.5 hours.

Interview with team psychiatrist. Next, I spoke with Dr. Steve Harker, a 45-year-old Caucasian male, who serves as the Ramsey County ACT team psychiatrist. He has been a psychiatrist since 2000, when he came to the Ramsey County system after education and training at the University of Wisconsin-Madison. Part of his education and residency included working with a nationally recognized ACT psychiatrist from Madison, Wisconsin, hence Dr. Harker came

to Ramsey County with a greater than usual understanding of the ACT model. Dr. Harker started working with the Ramsey County ACT team in January 2005, the day the team switched from an intensive case management team to an ACT team. Additionally, he was the medical director for adult mental health services of Ramsey County at the time of the study.

Dr. Harker provided some team history and indicated that the team had struggled with effective leadership prior to Alyssa taking over the team leader role. He stated that Alyssa took a more academic look at the ACT model and was a great planner, which was why she was targeted for the ACT team leader job. There were many instances in which I observed Dr. Harker co-lead the team with Alyssa and rely on her opinion to make decisions. Dr. Harker indicated that Alyssa was “really good at taking my ideas and making them into plans carried out by the team”. According to him, despite Alyssa initially having less knowledge about some things (e.g., cognitive interventions for schizophrenia), Alyssa "could be told once and was better than I am taking the ideas and putting them into action". Team members stated that the two of them (Alyssa and Dr. Harker) were cohesive and collaborative leaders with a shared value system around helping consumers make progress.

Interview with agency supervisor. Kirk Fowler, who is a Caucasian male social worker in his mid-60s, manages adult mental health and chemical dependency services for Ramsey County and is Alyssa’s clinical supervisor. He was highly involved with initially bringing ACT to Ramsey County and talked about how at one time in the program’s history, this team served as a shadow team; a program that other ACT teams could "shadow" for training on how to implement a high fidelity ACT team. As Kirk discussed the history of this team, he seemed very passionate and proud of where the team has come from. Kirk asserted that for an ACT program to have fidelity, the agency leadership must also be willing to support the team, and he indicated

his boss has been very committed to making sure ACT worked and would "not water down the program for expedience sake, or for money". He noted that the Ramsey County wage scale illustrated the commitment of the agency.

Kirk has known Alyssa for 14 years when she began as an intern with his previous boss. His present assessment was that the team was functioning well, and attributes much of the success to the work Alyssa has been doing. He stated he implicitly trusts Alyssa and her leadership skills, and opined she was an exceptional clinician. Kirk sees Alyssa as a leader for the entire agency.

Core categories and themes. The next part of this chapter offers a graphic representation and discussion of the core categories and themes discovered for the Ramsey County ACT team based on analyses of data from (1) on-site observations, (2) semi-structured interviews with the team leader, team psychiatrist, and agency supervisor; (3) focus group, and (4) review of documents/policies/procedures/tools utilized. The discussion is structured along findings for each of the three study aims. Appendix 22 is a visual representation of all findings, presented as categories and themes, for the Ramsey County ACT team.

Study aim 1: Describe the ACT team leader. For the Ramsey Co. ACT team, two core categories were revealed that helped capture the description of the ACT team leader: (1) notable attributes; and (2) personal job match. Figure 2 visually outlines Study Aim 1 findings.

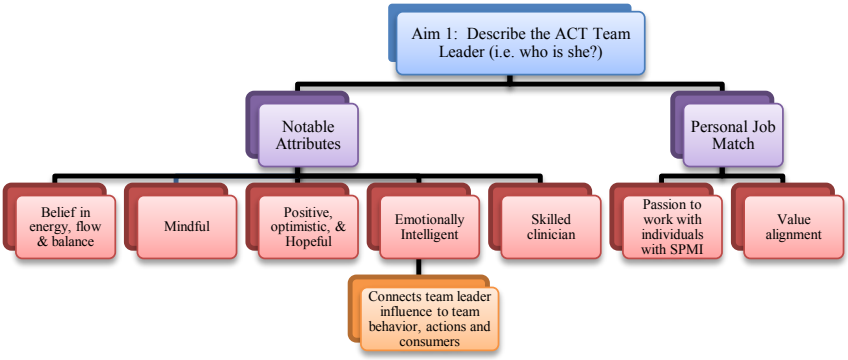

Figure 2: Ramsey County ACT Findings for Aim 1

Notable attributes. Throughout the data collection process, there were repeated descriptors of Alyssa from most data sources; these helped draw a picture of this individual. The attributes in this section are not meant to represent an exhaustive picture of Alyssa, but rather to highlight descriptors that were repeatedly referenced. The attributes included (i) a belief in energy, flow, and balance; (ii) mindful; (iii) positive, optimistic, and hopeful; (iv) emotionally intelligent; and, (v) skilled clinician.

Belief in energy, flow, and balance. The first theme under notable attributes was a belief in the concept of energy, flow and balance as important to the work she and the team did. "One of my underpinning philosophies is, all around, concept of flow. And that, to the degree possible, you shouldn't do anything that impedes energy flow".

Alyssa discussed how this attitude of energy flow influenced her leadership and management philosophy. She saw this notion of energy flow important to the mental well-being of team members and critical to their ability to perform their jobs.

> [Team Leader] I think about, the overall world as a whole, I really think that everything is interdependent energy-wise. And that the energy that people put out gets absorbed and transmitted. And effects things in ways that we might be aware of and not aware of....

> Um, but I think it's also easily influenced and changed. You know, because it's this fluid state. And so if you don't get attached, I mean that goes back to the concept of flow, if you don't get attached to a specific feeling or a specific reaction that a person might be having, including your own, you can kind of affect where it goes. Like in facilitating a meeting, a team meeting or any meeting, if you're noticing an energy that you don't like or that doesn't fit with values or philosophy I think calling that out, you can do it gently. But bringing awareness to it being there and, and then kind of saying, "Okay, let's move beyond that. Or what do we need to do to move beyond that, um, could really influence how a group responds. But most people, in terms of, I mean if you put energy into categories of energy that feels calm or peaceful or kind of tumultuous, not even calling it "good" or "bad" energy. It's like I think people have a natural desire as humans to want the calm or peaceful. So I see part of my job is helping to create an environment where people can have that. Because I think then they can actually do their job.

Mindful. A second attribute discovered in the analysis involves mindfulness. Alyssa was constantly conscious and aware of herself, others, and the environment. She was intuitive, calm, and perceptive. She indicated that she was "really aware of how I decide to present things"; and per her supervisor:

> [Agency Supervisor] She's able to step back and realize that those day-to-day crucial decisions or issues that some staff think, it is that end of the world decision. The world is falling apart. She's quite capable of stepping back and saying—at least to herself I think—that's not really happening. So that calmness that she brings to decisions or crisis is quite evident and I think it just takes everybody down a notch which is really good.

As part of being mindful, Alyssa was very self-aware of how her ideas, behaviors, and energy influenced team members. She expressed her belief that her energy, personally, can impact team mood, behavior, and actions.

> [Team Leader] I'm also highly aware of how the group responds to my energy. When I was newer to the team, if the energy that I had on any given day, you could see it directly impact the quality of team and how the team flowed for the day. And the group was much less stable at that point in time and much more susceptible, I'd say, to influence.

Alyssa asserted that the energy that she exudes can transfer to team members and ultimately consumers, which is one reason she remained mindful of her behavior and energy and deliberate with how she approached team and consumer interactions.

Positive, optimistic and hopeful. The third theme identified under notable attributes was that Alyssa had a positive, optimistic, and hopeful outlook on work and life. This optimistic outlook permeated all aspects of her work. Alyssa summarized her outlook in the following way:

> [Team Leader] The other thing is I think from the unconscious perspective, is that's just kind of my outlook on life. You know, overall I don't see things really from a dramatic perspective. Um, and am hopeful and optimistic that things will be just fine. And I really trust that. So even if a staff makes a mistake or if it's news for the team, I think I typically present it in a way that it's like it's gonna be okay. We're gonna be okay. Our clients are gonna be okay. It'll be fine.

Alyssa reported this trust that things will work out influenced some of her behaviors. Because of her hopeful and optimistic outlook, she indicated embracing a philosophy of perseverance and not being easily stopped by obstacles, but instead reframed obstacles as

challenges and opportunities. Others noted that she provides positive reinforcement to team members and encourages staff to avoid getting stuck in the negative aspects of a challenge. Participants reported of Alyssa that "she never gives up", and " I think she just always looks at things as an opportunity. It's an unique perspective I think to not look at things as more work all the time, but to look at them in a positive way". Alyssa herself stated "you know, there's all sorts of things in this system we can't do, so we'll do the little things we can".

Finally, team members shared how her optimistic outlook contributed to the overall work atmosphere in a positive way. Alyssa role modeled a positive outlook and the positive work atmosphere she set motivated staff members. According to one team member:

> When you come into work it's never doom and gloom. I think that just makes a big difference. We can all laugh a little bit. Alyssa would never be, come in and say, "Oh, today is a terrible" you know. It's just not a negative atmosphere, so I think that makes a big difference when you come to work. That you're just not surrounded by people who don't wanna be there.

Emotional intelligence. Another notable attribute of Alyssa's was that she was described by a team member as "emotionally intelligent". Team members described how she was extremely aware of and managed her emotions. Alyssa described placing a high emphasis on her interpersonal relationships with team members and being empathic ("always put myself in their shoes").

Connects team leader influence to team behaviors, actions, and consumers. Alyssa talked repeatedly on how she felt that her energy, emotions, behaviors, and reactions influenced how the team received, processed and were affected by information. She reported working hard to manage and control her own emotions; this focus on self-control connected to her overall

philosophy and idea that her energy influenced both the team's work environment and individual workers. Alyssa described this idea as "parallel process" or "mirroring". In her own words:

> [Team Leader] I also really love the concept around parallel process. We talked a lot about it when I was in social work school, just around, the concept of, what you do in one place ends up paralleling or mirroring in other places. So how I interact with my staff or my team, will impact how my staff interact with their client.
>
> [Team Leader] I'm also highly aware of how the group responds to my energy. When I was newer to the team, if I, the energy that I had on any given day, you could see it directly impact the quality of team and how the team flowed for the day. And the group was much less stable at that point in time and much more susceptible to influence.

Alyssa's asserted that her actions, attitudes, and behaviors influenced the actions, attitudes, and behaviors of team members and subsequently how those team members influenced consumers. Alyssa felt that her actions and attitudes made a large difference to the team's work and wellbeing: "How I interact with my staff or my team will impact how my staff interacts with their client"; and, "The more oppressive or controlling [I am], that a lot of time ends up then getting translated to the client interaction, but it comes out a lot of times more, I think, in the form of burnout". Finally, she stated:

> [Team Leader] If they're [team members] in a place where things are tense or tumultuous, they're gonna pass it on to their teammates, and they're gonna pass it on to their clients. And they're not gonna do their work as well. The second thing that I would value or see as important is that we're doing good work or that our clients be healthy. But I think if, if the teams not healthy we can't do that. And I think healthy, meaning that not everything is perfect but that things are functional and that there's a balance.

In many ways, these quotations also support Alyssa's ideas of energy, balance, and flow suggesting that all things are tied together and mutually influence one another. Additionally, this connection between Alyssa's behaviors and demeanor and the impact on staff and consumers tied into her very intentional communication style, where she approached her team leadership in a calm, persistent, assertive, systematic, and non-dramatic way. These are the behaviors she wished her team members to model for their work with consumers.

Skilled clinician. The fourth theme that was identified under notable attributes for Alyssa was that she was a skilled clinician. Participants highlighted how Alyssa was the clinical leader of the team. Team members saw Alyssa as equally knowledgeable about clinical issues as the team psychiatrist, "the clinical knowledge base is there and if one suggests something, they have established that trust where if she suggests something to Dr. Harker, what she's been seeing, she's probably on to something". Alyssa also sees herself as a clinical leader, explaining that part of role is to "help people differentiate based on a person's symptoms what approach will work". She has the clinical ability to do this and her team trusts her ability.

Personal job match. The second core category that emerged for describing the ACT team leader involves an overall personal job match. The available data indicated that Alyssa was a good "fit" with the description, roles, and duties of an ACT team leader. Two particular themes contributed to the creation of this core category: (i) a strong commitment to serve individuals with SPMI; and, (ii) value alignment.

Passion to work with individuals with SPMI. There were many comments, across all participants that highlighted that Alyssa had a passion or a "draw" to working with individuals with SPMI in the community. Alyssa's passion for her work with individuals and her admiration for these individuals was highlighted by all colleagues and Alyssa herself:

> [Team Psychiatrist] I think she was driven to this work and driven to actually serve, probably this population, for a good reason. Again that's, kind of that set of personal values that are real strong. And I think she uses that a lot, in her own view of clients, in her own decision making.
>
> [Team Leader] I really see it as kind of an opportunity and a privilege to partner with people in the community to achieve their wellness and, recovery goals. To me that is really exciting.

Value alignment. The ACT model works specifically with individuals with SPMI and focuses on recovery based principles, helping individuals reach recovery through treatment and rehabilitation and to have a healthy team with a positive work environment. Alyssa's values aligned well with the ACT model and the role of the ACT team leader, and she found this job professionally fulfilling. She described her and the team values in this manner: " and this goes to values thing – I mean I try to filter all decisions based on that question of, 'what makes the best sense for the people that we're serving', and,

> [Team Leader] [Values include]...hope, curiosity, creative thinking or kind of thinking outside the box, open communication, so kind of being open to ideas, challenging each other, and that not being seen as a criticism but a reflection of the team's desire to do their best possible... liking to laugh, attention to different elements of our work, like, not letting things drop. So being attentive and intentional would be a couple of them. Being non-reactive and thinking about the big picture, having confidence in each other, psych rehab principles, team learning, kind of that cross-training and skill-building, and then keeping team members healthy. So kind of promoting self-care, burnout prevention, and keeping work interesting.

Study aim 2: What does the team leader do and how does she do it? For the Ramsey County ACT team, four core categories were revealed that contributed to the understanding of this question: (i) prominent functions; (ii) communication style; (iii) deliberate attention to team members' wellbeing; and (iv) attention and effort to setting team culture.

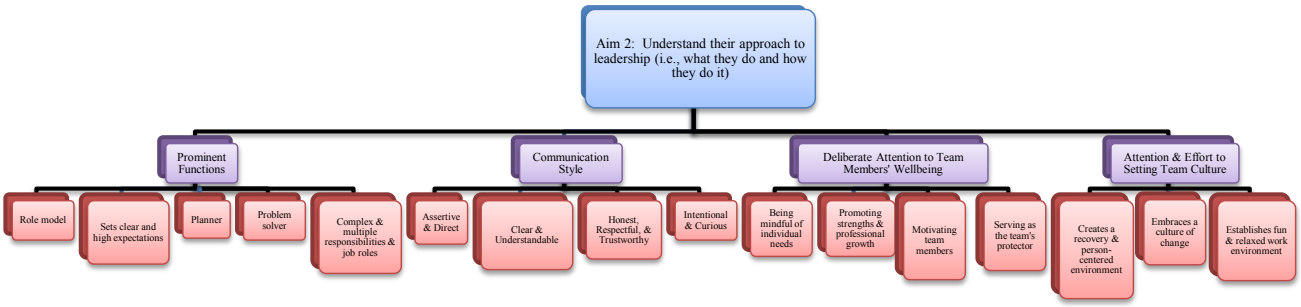

Figure 3: Ramsey County ACT Findings for Aim 2

Prominent functions. When asked the question of "what does Alyssa do"? participants indicated there were certain functions or roles that Alyssa performed that were important to her leadership. There were five distinct themes that contributed to this core category: the team leader (i) role models for the team members; (ii) sets clear and high expectations for team members; (iii) plans for the team; (iv) problem solves including anticipating and planning for challenges and change; and, (v) had complex and multiple responsibilities and job roles as an ACT team leader.

Role models. First, Alyssa served as a role model for others. She exhibited desired behaviors and served as an example of behavior and activities team members should, want to, or do emulate. Team members described Alyssa's role modeling and the influence it had on them: "I think she's a good role model, in just how she works with people and her creative thinking and openness and, so I think that has an influence on this team and work that I do".

It was repeatedly brought up by the majority of participants, including the agency supervisor and team psychiatrist, that Alyssa led by the example she set and influenced the team via the tone she established: "She selectively gets involved with the care of clients at times to specifically model things like illness management and recovery", and,

> [Agency Supervisor] ...again the way she models the work, her passion and also her, the way she lays out expectations, indicates to the team a lot about the way they go. I think to her credit though, they'll listen to her. She influences the team a lot, but it's appropriate. And I think she also will admit that a real success for her will be, and I think it is occurring, is that the team also functions somewhat independently of her. They do this self-monitoring. They can challenge one another, um, they can call each other out if they have to, and compliment if they have to.

Alyssa recognized herself as a role model and described a responsibility to do this as a leader. She felt that demonstrating the behavior she desired her staff to emulate positively influenced the work they did with consumers.

> [Team Leader] So, one of the things I have responsibility for doing is really playing similar roles. So if I want my staff to be coaching and teaching and really doing rehab work I've got to apply those same principles every day and in supervision around coaching, teaching, helping elicit their desire for growth, their inner strengths, you know, bring those out, so that they can in turn do the same thing with the people they're working with.

Sets clear and high expectations. Another prominent theme repeatedly raised by the majority of participants was Alyssa's high expectations of them. According to the agency supervisor, this had positive consequences:

> [Agency Supervisor] She does have high expectations, and even some of her peers have noted, they're probably higher than even some of her peers. She probably tolerates less, as far as performance. Um, but I think she does it in a very, very fair way. I mean, the expectations are very clear for the staff yet she's also very flexible at listening to input and so on. And so I think, out of that, again it builds trust and openness.

Other respondents also highlighted and confirmed that Alyssa set high expectations for them and held all team members accountable to those high expectations. She did this in a way that participants did not find pejorative or authoritarian or rigid. Team members were motivated by the setting of expectations as the expectations were in line with important consumer needs and overall team philosophies. Meeting the expectations set forth by Alyssa was viewed as

tantamount to being accountable to the team's work and ultimately the consumers' desires and recovery.

> [Team Psychiatrist] She can tell the team when they're getting sloppy, and she's not okay with it too as a general rule. "We're getting sloppy lately. We're not showing up for team meeting right on time" or this or that. "I'm not okay with that" or, "I'm hearing a trend in conversations about this. I'm not okay with that". She communicates direct but not demeaning.
>
> [Team Member] She won't forget either if she's asked you to do something or given you an idea that she wants your follow up on. She's not gonna forget it either, so you can't just let it slide and maybe look the other way or forget to do it, because you know she is gonna follow up about it. So that's a motivation to just do it.

Additionally, Alyssa continually kept a high degree of emphasis on the evidence-based practice of ACT and set expectations that staff would learn, understand, and operate from a high fidelity ACT perspective. I directly observed during the treatment planning meeting, Alyssa explaining the ACT model to the consumer and team members in the room. Alyssa was strategic with how she obtained buy-in from others for high fidelity ACT. She did not preach or demand fidelity, but rather presented high fidelity ACT practice to a means of getting the team to where they wanted to be and improved consumer care. When asked how team members learned about ACT fidelity and its importance, numerous examples were given:

> [Team Member] A couple of years before we had the TMACT, we actually went through the fidelity scale as a team and talked about where we were strong and where we were weak at our retreats, so you know I think we've, it's always been focused around that.

The team psychiatrist stated: "I think that it [ACT fidelity] was acculturated by trainings, but it was also acculturated by a very intentional and very strong focus in team meetings".

Planner. The third theme that emerged and contributed to the core category of prominent functions involved Alyssa's functions as a planner, including anticipating and planning for challenges and change. Participants highlighted how she developed tactics and strategies for achieving outcomes, including how to accomplish team and consumer goals. Along with her planning, Alyssa acted as the team's visionary, looking forward into the future, determining where she wanted the team to be, and helping others to understand the vision and how to get there together in a planful and deliberate way.

> [Team Member] I think this has pretty much been said, but she's such a planner. She just, she's such a good planner. And she plans, like, short term and she plans really far out. She'll vision, six months, nine months down the line – where do we wanna be? Um, and just always keeping that perspective in her mind I think really helps us to be organized and intentional in our practice.

Alyssa identified herself as a planner. She saw planning as an important component of her work and as a central part of her job as the ACT team leader. Alyssa talked about planning in terms of helping the team step back and scrutinize the services they provided.

> [Team Leader] And I think, going through the planning process helped me see that ACT is really supposed to be a highly structured, planful, you know, a planful system that does help people move towards recovery. I think that's part of the reason that when I came into the job too I was very intentional about, we can't operate in this intensive kind of crisis mode. We need the structures in place. And honestly, if I hadn't been successful at getting the group to conform to that, I don't think I'd be in the job. I wouldn't like it.

In many ways, this idea of being planful connected to Alyssa's ideas of energy and flow.

She reported trying to stay focused on the larger picture and actively planned in order to be non-reactive and to keep the team out of crisis mode. To illustrate, Alyssa made this comment: "and if you're noticing [energy of the team] you can teach the group as a whole to notice little things earlier so that then they can respond earlier and have less of a dramatic response".

The team psychiatrist agreed that Alyssa attempted to minimize the level of crisis that occurs and pointed to the strategy of planning and putting systems into place:

> [Team Psychiatrist] She doesn't like responding to crises throughout the day. She is naturally somebody who wants to be planful, have systems in place that are able to respond to crisis appropriately. She has a certain energy that is focused on a larger plan at all times, and it's not that she wants to ignore crisis but that she wanted to create a system that was always moving forward while also being able to be flexible and manage crisis without freaking out.

Because the team was not functioning in crisis mode, and because of Alyssa's emphasis on planning, the team operates within an organized infrastructure. Many participants commented that Alyssa was a very organized individual "she's highly organized"; "she's very well organized";, and, "we have had yearly retreats and she approaches them in a very organized fashion". Similarly, according to the team psychiatrist:

> She [Alyssa] organizes the team schedule really well around the treatment planning process which is one of the core features of the model–that you are organizing yourself around the life-goals of the clients. She attempts to have a highly effective daily team

> meeting with crisp reporting on the last twenty-four hours and tries to have that be a clinically effective meeting, which is another element to fidelity.

Moreover, Alyssa was described as having the skill to see both the big picture along with small details, which can be crucial for longer-term planning. Alyssa had the ability to break down the "big picture" and provide her team with the steps on how to accomplish certain goals in an organized way. According to both the team psychiatrist and agency supervisor, this helped in getting buy-in from team members. Participants felt she had the capability to set and meet both short and long term team goals and identified that her systematic follow through toward those goals was part of what made her an effective ACT leader. According to the team psychiatrist:

> [Team Psychiatrist] I noticed right away how she was able to take elements of ACT that were written about, say the ITT, the individual treatment team, and kind of known in complex details, in a detailed way almost intuitively how to bring that into our system much more to meet specific needs that I didn't even see. So she connects the dots. And that kind of skill to balance the big picture with the little picture and connect all those dots day-to-day.

Problem solver. Closely tied with her planning functions, participants identified Alyssa as a good problem solver. Team members discussed Alyssa's approach to problem solving as organized and systematic. She sought to understand all facets of a problem and critically considered multiple sides of the issue while continually evaluating outcomes. As one team member said, "she thinks through problems very methodically, and sorts things out". The agency supervisor stated this "She has a real good understanding of the consequences, I think, of

the decisions that she makes. She thinks about what the fall-out could be. What's the upside, what's the downside"? Finally, another team member reported:

> [Team Member] I also really find that, her intentionality and constant evaluation of how things are going is really part of what makes her effective too. I mean, if something's not work she's not really a person who just lets it go, you know, she addresses it. She makes sure that we figure out what's wrong and then do something about it.

Alyssa recognized barriers as a part of the work and subscribed to the idea that there was a solution for every issue. Alyssa asserted "I think solutions can be figured out for just about everything, you know. There's always a way". Participants also viewed Alyssa as persistent in overcoming obstacles. As described, she did not get stuck in the processing of a barrier, "very seldom is she stuck", and participants described Alyssa's persistence in the following examples: "She's just got that stick-to-it-iveness, I mean as far as when it comes to working with clients"; and,

> [Team Psychiatrist] She pushed it to the point that she was starting to upset them [human resources department], but she got what she wanted. And she knew how to do that in a way where ninety percent of people I've run into in the county would have given up.

As part of her role-modeling and setting of expectations, she encouraged and motivated other staff to be active and persistent problem solvers as well. A team member reported it this way: "I think just how solution focused she is really, like, I know she's going to want a solution from me, so I tend to think more that way because I know it's expected".

Alyssa gave this example of problem solving within the team in regards to a new program issue:

> [Team Leader] Due to pressure from the State, we were needing to move quickly to increase our census, needing to enroll about 25 people in about 6 months. As would be expected, new admits had high service needs. To be able to meet these needs, as well as the needs of current clients, we needed to change our perspective. Staff were feeling very worried and at times overwhelmed, causing less risk tolerance than I'd like to see. To manage this, we went through a series of structured conversations about values, risk tolerance, recovery principles, practices that were helpful that we needed to keep, and practices that we might need to let go of to meet the client needs and stay healthy ourselves. In doing so, staff were able to come to a place where they embraced the practice of holding dignity of risk as associated with recovery goals, empowering people to act on their own behalf (verses feeling like they had to do everything for them). They had to learn to trust that not everything would go perfectly for people, and that was okay. Our job wasn't to be paternalistic in keeping people safe, but rather to help people trust us so that as they made decisions about self-care and recovery goals they could learn from their experiences and over time learn to make choices that supported their goals.

Her problem solving approach also applied to handling problems that arose with team members. When asked the question of how Alyssa handled conflict among team members, participants indicated that Alyssa was available for them to solve personal and professional problems and they were comfortable to approach her to dialog about these issues. She was seen as a non-judgmental and highly approachable leader; staff trusted her rather than being fearful of retribution. Rather than blaming staff for the problem, reportedly she instead acknowledged the situation and spent time on helping find a solution. One team member provided the example of Alyssa's reactions when client-related tasks involving paperwork or clinical objectives were not

met: "If you're behind on work or paperwork, she works with us to try to get back on track which is more of a solution to the problem instead of criticizing that we're behind".

One final factor that contributed to Alyssa's effectiveness as a problem solver was her belief that part of her job was to make definitive and timely decisions. She indicated her belief and subsequent action helped explain why she did not get stuck in over processing information in order to make a decision. While information from team members and administrative staff suggested that she was a great critical thinker and was able to weigh consequences of different decisions, she was still able to be decisive and direct. While on-site, I observed that she displayed a good balance between autocratic and democratic decision making. Alyssa stated when time allowed, she included team members in decision making; however, not everything is up for a group decision. For example, hiring decisions were hers alone to make or if a crisis arose and a definitive decision was necessary for the safety of the consumer. Alyssa stated she was at a point in her leadership where she was comfortable and confident in her decision making ability. She summed up her approach to decision making in this way:

> [Team Leader] I think being able to listen and change opinions based on information probably makes a difference. Um, comfortability [sic] – and this fits with confidence a little bit – but comfortability [sic] in making a decision. Like there are a lot of things with ACT, especially structurally and from a triage perspective that you just have to make a decision. Some decisions I just have to make.

Has complex and multiple responsibilities and job roles. The final theme that elucidates prominent functions of the Ramsey County ACT team leader relates to complexity and multiple responsibilities. Comments constructing this theme illustrated the multitude of complex and varied job roles and responsibilities that an ACT team leader must perform. For Alyssa these

challenging and multiple responsibilities were considered a positive, desirable factor. She valued the creativity within the multiple job duties.

> [Team Leader] Part of the reason I like the job is that I think there's just so much room for creativity. There's so much room to just say, "This is what we need to do. Let's do it". And I feel like other mental health service areas, especially in supervisory functions or positions, it's very technical.

One area I found absent in much of the ACT literature is a rich description of the nature of tasks and responsibilities of team leaders. In order to address that gap, I asked questions about the tasks Alyssa did. Based on these questions, I discovered that that there were a multitude of tasks that ACT team leaders were responsible for. That was aptly summed up by a participant who stated "She just has a lot of hats to wear with that one assignment".

Tasks fell into several larger categories, such as (1) clinical tasks (i.e., seeing consumers; making diagnostic admission decisions; conducting treatment planning meetings; facilitating daily team meetings); (2) administrative/manager tasks (i.e., managing team resources such as billing, hiring and firing; creating job descriptions and policy; reviewing team productivity; acting as a liaison to larger agency; coordinating the team); and, (3) leadership tasks (i.e., serving as planner/visionary for team; functioning as teacher, role model and motivator for team members; supervising clinically). Team members referred to Alyssa's various responsibilities: "She sees clients I think almost every day"; "...a ton of administrative things she has to do..."; "a lot of attention and time to making sure that that team meeting is efficient"; and, "a lot of clinical supervision". The agency supervisor and team psychiatrist added specific examples of Alyssa's administrative duties: "But all that work, especially in a county bureaucracy like ours when we, for instance, posting and hiring and things like that, she's not directly responsible for it, but she

has to do the vast volume of work for that"; and "She's totally responsible for productivity reviews, and making sure outcomes are met".

Alyssa talked about her thought process in juggling all the pieces of information to make the program run smoothly. She described being an ACT team leader as similar to being an "orchestrator" or a "director" or a person who is putting together a puzzle:

> [Team Leader] I really kind of think of it as almost putting together, a big puzzle. Being a puzzle-putter together, and really kind of looking at what are the needs of the group of people that we're serving at any given time, and what are the resources we have as a group, and figuring out how to get those needs met.
>
> [Team Leader] I think in terms of, like, roles or functions, I mean I think there's definitely kind of the director type function or, like I was saying earlier, kind of an orchestrator function. There's the clinical function around looking at really what makes the most sense. There's the, kind of supportive function, around I think just being a, a real person for your staff and for your clients and there's… I mean it kind of goes in, you know kind of a teacher function.

Input from all participants supported the ideas that an ACT team leader job is multi-faceted and requires a high degree of "juggling" of multiple tasks for team effectiveness. Alyssa indicated she was enjoying the variety of tasks she performed as the ACT team leader.

Communication style. The second core category for Aim Two was communication style. Alyssa had some distinct features to her communication style and how she disseminated information to others. The ability to accurately communicate and exchange a high volume of complex clinical information across team members, consumers, agency leadership, and family members is important for an effective ACT team leader. Within this category, I identified

several themes that described Alyssa's communication style, including: (i) assertive and direct; (ii) clear and understandable; (iii) honest, respectful and trustworthy; and (iv) intentional and curious.

Assertive and direct. In response to the question 'in what ways does Alyssa communicate with you about ACT fidelity'?, participants were quick to point out that, in general, Alyssa communicated in an assertive, direct, and proactive manner with a calm demeanor. Alyssa stated she tried to avoid making assumptions and usually asked for clarification. The team psychiatrist shared this example of how she might communicate with a team member who was expressing negativity during a meeting:

> [Team Psychiatrist] I think she's very willing that if once she observes something, whether it's showing up in the performance outcomes or just somebody – and I've heard this more from her than anything rather than performance – someone's just not doing well in the team meeting. You know, they're, being very negative. They're giving up on clients. They're barking a lot. And the team's not calling them on it, I think the team would be more likely to talk about it now, but she'll [Alyssa] be very willing to separate that out and talk to that individual. She won't shy away from that whatsoever. One because she would be concerned for the staff person and then two, it's just disruptive to the process of the team.

Alyssa described encouraging all team members to communicate with one another and consumers with the same assertive, direct, and calm approach. I observed her support an environment where staff was expected to manage and address their issues with one another (i.e., "have you talked with her about it"?). In response to the question of how she handled conflict among team members, participants said:

> [Team Member] She generally will encourage you to address [a conflict with another team member] with the other person directly rather than going through her or really even being a part of it very much. She's much more of a face to process, and then she'll encourage you to be direct.

Finally, participants highlighted that Alyssa encourages and models direct and assertive communication specifically on the topic of team members' personal well-being. She encourages individual team members to be physically and mentally healthy and to be self-aware of their own needs. Alyssa does this by asking staff to be direct with her in communicating their needs, and modeled that with her own communication: "I think another way that I kind of get through that is just by telling people 'I need you to tell me what you need. Or I need you to tell me what's going on'".

Clear and understandable. The second theme that was evident in Alyssa's communication style was that she was clear and understandable in the information she was conveying. For example, I observed during the daily team meeting and treatment planning meeting that she spoke in plain, non-jargon language and asked questions in a cogent manner. Additionally during the team meetings, she communicated in a concise, clinically-relevant way that team members understood based on verbal agreement or gestures (i.e., such as nodding). Alyssa directly asked during a team meeting "does this make sense" and "do you understand what I mean?" to another staff to assure her directions were understood. In the review of the team's policy and procedures manual, documents were understandable and laid out in an accessible way, thus allowing team members to clearly understand the program's mission and expectations of service delivery.

When asked to provide an example of Alyssa's clear communication, the team psychiatrist described Alyssa's approach in telling team members about a change: "She just tells them why, what the changes are, what we're hoping to achieve with them, what the purpose of doing it is, and how it's gonna happen. And then she lays it out in pretty good detail".

Alyssa also communicated clearly with staff about the parameters of the program, and her own boundaries, including her availability. Participants indicated that Alyssa communicated in a way that was not offensive and helped them better understand when and where certain information was to be communicated to her. Alyssa described this structure was helpful for program efficiency and facilitated her ability to budget time for all the activities she needed to perform.

> [Team Leader] So I'm technically on call 24/7 and I think doing some work with the group around what needs, what can be discussed where – not only in terms of after-hours stuff, but, you know, somebody's coming into my office to ask a question, and I'm trying to work on something. Kind of be, like, "That'd be a good thing to bring up in team tomorrow". And I may or may not answer the question directly then, but trying to condition or train people that yes my door is always open. But that doesn't mean you have to walk in.

Honest, respectful, and trustworthy. The third theme was that Alyssa had a communication style that was honest and respectful, which promoted others' sense that her information is trustworthy. For example, this honest and respectful communication extended to conversations with team members who were not performing well, or for whom an ACT job was not the best match. Alyssa stated that she did not shirk from challenging or unpleasant conversations with others. At the end of describing a personnel challenge she needed to address,

she stated: "I think kind of sorting through staff, honestly, and encouraging people who weren't the best fit to move on has been helpful".

Along with her honest approach, according to team members, Alyssa made conscious decisions to inform team members with new information as soon as possible, which also built trust. She worked to tell any news in advance and foreshadowing information in an effort to prepare the team. Alyssa described telling staff news as a group and stayed away from disseminating information one team member at a time. According to Alyssa, this approach was meaningful to supporting healthy group dynamics as it created a sense of equity or fairness and respect. Participants were asked how Alyssa approached telling them unpleasant news. One team member responded with: "She just tells us...direct...but in advance. A lot of the times we will know it is coming".

This foreshadowing and keeping team members 'in the loop' with information that was both clinically relevant and/or important to their work lives contributed to Alyssa's trustworthiness. Team members indicated they were not worried about surprises or crises sprung on them. Further, this approach aligned with Alyssa's philosophy to be as planful and deliberate as possible so that the energy of the team was calm. In her own words:

> [Team Leader] I try to do a fair amount of foreshadowing of what to expect, which I think helps create a little bit more calm within the group. I think it helps they are not feeling like there's a lot of surprises.

Intentional and curious. Alyssa was a very purposeful, engaged communicator. This intentionality consisted of a curious and exploratory communication style along with being a good listener. She said she deliberately sought to understand the other person's perspective

through active and deliberate listening. Several times I observed her asking clarifying questions and probing for deeper information others were sharing with her.

Alyssa paid deliberate attention to how information may be perceived by others. She reported intentionally using the tenets of motivational interviewing within her staff interactions and altered her approach based on the information she was sharing and how she believed it would be received. Per Alyssa, several pieces of information factored into her assessment of how information may be perceived, including, but not limited to, characteristics of individuals, current team dynamics, personal factors of the individual's life, and other relevant work or agency issues. She described assessing the information and if it may be overwhelming, she would communicate about it differently to the individual. Alyssa identified this as a skill she has: "I'm extremely sensitive to, I'd say, little changes or nuances or how other people might be experiencing things". The team psychiatrist identified this skill of Alyssa's as well: "It's kind of observing personal attributes and working her communication style around those attributes of people or situations".

Deliberate attention to team members' wellbeing. One of the most interesting findings for the study aim of describing what the team leader does was the very deliberate attention Alyssa gave to the wellbeing of individual team members. Multiple quotations from all participants illustrated that she constantly thought about and took into consideration her staff's personal and professional needs and promoted their growth. Alyssa's attention to team members' wellbeing motivated team members and kept the team involved and well-functioning, which was a key focal point for Alyssa. In addition to this focus, she spoke about actively working to buffer the team from outside influences that distracted them from the work they did with consumers. She reported shielding team members from some challenges as a protective factor against stress and

burnout. Finally, she described being cognizant of how her own emotions may influence team member wellbeing and ultimately the consumers, and managing her own reactions and emotions as a strategy for keeping the team well. Under this core category, several themes emerged: (i) being mindful of individual needs; (ii) promoting strengths and professional growth; (iii) motivating team members; and, (iv) serving as the team's protector.

Being mindful of individual needs. Illustrations of Alyssa's attention to team members' wellbeing included that she was very mindful of individual team member needs and overall team/group dynamics. During the majority of interactions, both with individual team members and in groups, I observed that a priority of Alyssa's was to pay deliberate attention to team members' emotional needs and directly inquire about how team members were doing. She did this with naturalness suggesting it was a regular occurrence that she and team members were accustomed to the behavior. She provided an example of this awareness:

> [Team Leader] So if the group is having a hard time, I'll intentionally stop and take breaths for the whole group. I don't say that to them. But I'll do that. Or if we're in a treatment plan meeting and the person's having a hard time to just be comfortable acknowledging that and just be like, 'Let's all just take a, take a breath and kind of recollect'.

According to Alyssa, the idea of being attuned to what individual team members' needs are and keeping individual team members connected and grounded to ACT work was integrated into her daily practice and originated from her values and philosophy about energy flow.

> [Team Leader] If somebody needs to flex time – and not a lot of time requests come up for that. But on occasion if somebody needs to, sure, go for it. Let's just figure out how to make it work. If your life is working for you, you'll work better at work... and so really

> pay attention to trying to meet, help people feel comfortable to articulate their needs, and then to the degree possible, respond to them.
>
> [Team Leader] When I think about flow, it's like, each staff person to the degree possible should be happy in his or her job. And they should have their individual needs met. So, an example of how that plays out, unless it's not absolutely, not possible, if somebody asks for a day off, they will get the day off.

When asked why she prioritized the well-being of staff members, she confirmed that it was one of the most important things for her as the team's leader: "I think the things that are most important to me is really honestly that the team is healthy, just from that standpoint of, it is the resource that we have".

Through many participants' statements and personal direct observations while with the team, it was apparent that Alyssa provided individual consideration to each team member; engaging with team members on a one-on-one basis. She reported focusing on developing and mentoring individual team members and expressing genuine concern for individuals' needs. Additionally, she described utilizing her leadership position to attend to those work-related personal and professional needs and strive toward their fulfillment.

Promoting strengths and professional growth. Team members identified that along with Alyssa's ability to identify and meet their individual needs, she also promoted their individual strengths and emphasized their professional growth. For example, team members said the following: "And she's mindful of our individual strengths too. And empowers us to use those, and utilize those"; "I feel like she lets me continue growing too. I'm not stuck in one spot"; and, "...there's a spirit of growth. It's like this really positive expectation that you can grow as a practitioner".

Alyssa believed that it was part of her job to not only identify a team member's individual strengths but to also promote their own individual leadership:

> [Team Leader] An overarching philosophy for everything, is that all team members, should do as much as they can and that everybody should be a leader wherever they are able to be, you know, wherever it fits for their strengths and skill set.

She had the ability to not only identify a person's unique strengths but also had an understanding of how to partner with that person to help them utilize the strengths for further professional growth. The team psychiatrist shared this example:

> [Team Psychiatrist] She recognizes what the strengths are of the individual team members and then kind of encourages them to utilize those strengths to make either recommendations or create a curriculum or something that in some ways show they're independent.

Team members commented on how this focus on their strengths and professional growth contributed to keeping them energized and lessening burnout from a sometimes challenging job.

Motivating team members. As part of her deliberate attention to her team members, Alyssa reported trying to motivate team members to do their best. She worked to empower team members with the resources necessary and fostered a positive work environment. Alyssa offered her own perspective when asked how she motivated team members:

> [Team Leader] So I think that [motivation] is important. I think effectiveness is probably also influenced by, I think my staff see me as being aligned with their values. I think they see me as really having the clients' best interest in mind. And that's what's usually most important to them is the outcome for somebody.

Serving as the team's protector. Another way that Alyssa illustrated her awareness to her team members' wellbeing was evidenced by how she acted as a buffer between her team members and various outside, stressful influences. According to Alyssa, she intentionally assessed and made deliberate decisions on what and how information was disseminated to team members. She was highly cognizant of the team's stress level and what they could handle at certain points in time. Alyssa's protectiveness aimed to ensure staff could be freed up to do their best work with the consumers. She saw this as a significant role of the ACT team leader: "I see myself as a buffer really between the team and the state or management"; and,

> [Team Leader] I kind of get described sometimes as kind of like a, I have bear nature. I get described as a Mama bear. You know, it's kind of like the team and the group, they're like my cubs. I get protective of the group and, in terms of agency crap or DHS or whatever. I really will kind of try to shelter and filter and think about planning for how changes happen.

Team members also recognized this leadership behavior of buffering from Alyssa:

> [Team Member] Sometimes I think that she's talked to us about pressure that they've [Department of Human Services (DHS)] put on for us to take on more clients than maybe she feels like we should. If she feels like we're really full, then she'll sort of try to buffer us from it as much as possible.
>
> [Team Member] She is very protective of the ACT team. And she, I think she protects her workers against other systems. She tends to support us first…I think like with crisis or hospital she really has your back.

Attention and effort to setting team culture. Along with a keen awareness and deliberate attention to the well-being of her staff, Alyssa also focused her attention on the creation and

maintenance of a desired ACT team culture. This fourth core category captures the deliberate intention to create a recovery and person-centered environment within the team, and avoid any deviations from this mindset. Culture building and maintaining practices began at the hiring phase, continued during a team member's training and was maintained over the course of the team member's participation on the team. Alyssa indicated that she establishes and actively promotes the idea that the team is ever changing and encourages behaviors that supported a fun and positive team work environment. Again, focused on her own her behaviors and attitudes as the team leader, Alyssa sought to set the tone for team members and ultimately the program's consumers.

Creates a recovery & person-centered environment. It was clear through all interviews, observations, reviewed documents, and the team's office space that the team subscribed to a philosophy of recovery for individuals with mental illness. Alyssa built, promoted, and sustained a work philosophy that focused on people with mental illness having choice and control in their lives as well as the belief that individuals with SPMI could move toward greater mental and physical well-being and personal recovery. She began creating this type of environment during the hiring phase of new team members.

Alyssa described a major challenge for her, as the ACT team leader, was having the right staff on the team. She had a very deliberate strategy of hiring the "right" people onto the team and looked for a goodness of fit between potential staff, the ACT model, and the philosophy of recovery. Alyssa described her strategy of hiring as follows: "So it worked because then too as people have come in, I was able to hire people who fit with my vision of how it should look"; and, "Even a lot of personnel changes and specifically in my first couple of years, where people who weren't gonna change were…they found it mutually beneficial to leave". Alyssa reported

that she has counseled individuals that did not fit the team's philosophy or person-centered practice off the team.

All team members recognized that the recovery and person-centered philosophy was an overarching contributor toward their work as an ACT team. In the focus group, participants described Alyssa's role in creating and maintaining this recovery philosophy, including setting parameters as to what was acceptable or unacceptable behavior within the team:

> [Team Member] I think she's worked really intentionally to create a recovery culture on our team. So it's because that's the culture that we work on building both directly and just through focus on language and things like that you know, that if you're saying something that's not in the culture that's not okay here, which is great. I think that's part of her effectiveness.

Participants also reported that Alyssa sets a culture where consumer strengths were identified and celebrated. She focused on a person's strengths and abilities rather than deficits or weaknesses:

> [Agency Supervisor] I don't know if she would say it this way, but I learned a long time ago, and I think she functions this way, she sees clients as heroes. I think that really is reflected, I think the way she's really taught the team that as well. Ah, so she really champions that cause so to speak.
>
> [Agency Supervisor] She really works from a strengths perspective. And... I think she came to that real naturally. With that strengths perspective and so on. She definitely sees the clients as people that can recover....without a doubt.

Another clear example of this strengths perspective was evident during a person's treatment planning meeting. I had received a client's consent to observe his treatment planning

meeting. I noted that Alyssa, along with the team psychiatrist and team members, solicited, listened, and incorporated the individual's ideas for his own treatment plan. They allowed the individual to have a say in his treatment goals, and treated him with respect and dignity. In this meeting, all ACT team members focused on the individual's strengths rather than deficits and encouraged him to view his life in positive terms. I observed that each team member promoted the individual's independence and empowered him to direct the team in what he wanted through the questions asked and the praise they gave him. For example, I observed team members ask the individual what his wishes/hopes were and indicated "that's awesome" to his reply. Alyssa suggested a treatment plan goal, to which the individual replied "no thanks" and all team members respected that and did not push. I observed Alyssa summarize the individuals goals at the end of the meeting and ask "do we have that right?"

When asked to describe her approach for gaining the individual's input for his treatment plan, Alyssa described it as follows:

> [Team Leader] At the meeting with the client, it's more going through, "You said this is what you wanted. Is that correct? Did we hear it correctly? And then based on you saying you want that, this is how we think we could best help you move forward. Does that work for you"?

Similarly, I observed that the majority of Alyssa's treatment decisions were based on the ideal of what was first and foremost in the best interest of the consumer. For example, if something was hard for the team, but in the long run was for the betterment of the consumer, the decision was made based on the consumer's needs. An example of this is if a person wanted to begin a new job, but the job began early in the morning and required a change in a staff person's schedule, the team would alter their schedule to accommodate the person. The team decided that

making the schedule change was necessary as the consumer required it for movement toward a goal. A team member summed up this ideology: "No matter what perspective, if it's from the doctor's perspective or Alyssa's, they always make sure that it's about the client, that whatever they decide is gonna be the best for the client". This ideology did not mean that Alyssa was not mindful of her resources. She reported carefully debating and balancing the desires and treatment needs of consumers with her finite staff resources. However, a driving principle according to Alyssa was to make decisions that were person-centered and what individuals served by the team wanted.

Alyssa also described actively promoting the belief that every individual with SPMI had rehabilitation potential. According to team members, she was not easily fazed by obstacles and often viewed individuals not making progress as a signal that the team needed to offer different services or treatment in an alternate way. Team members were acutely aware of this belief and found the notion to be a highly motivating factor for their work:

> [Team Member] Okay, for me the reason I work here is because I believe in people's ability to get well. And I believe in people's ability to succeed, and I believe in seeing people's strengths and supporting that self-efficacy. And the fact that that's Alyssa's whole philosophy really, that makes me thankful to work here, and it makes me feel like I'm doing what I'm supposed to be doing. And I think that if I had a supervisor who didn't share that philosophy, I would not love work at all.
>
> [Team Member] ...she's kind of got that whole idea... where, if a client's not doing well, that's because of the program, because of the service, the team, whatever it is. And I, I don't know if she's intellectually adopted that, but that's the way she does function.

Embraces a culture of change. Along with this theme of creating a recovery and person-centered work environment, a second theme was the idea of a "change culture". Alyssa actively encouraged team members to see change as a natural and inevitable part of the work flow and team environment. These quotations illustrated this culture of change idea: "she likes change"; and,

> [Team Leader] I embrace and I have gotten the group to embrace this concept of, we have a culture of change and that change happens all the time and that's just part of life. I mean, that's just an essential component of life, and so the group is really familiar with that.

As an extension of this culture of inevitable change, Alyssa encouraged team members be adaptable, and to move forward with the work, rather than getting stuck or being reactive:

> [Team Leader] ..so more I think kind of my approach with that is to not get too attached to it [your idea]. You have to be attached enough to it that you'll actually use it, but not so attached to it that it can't change.

All study participants highlighted that Alyssa framed change and challenges for the team in positive terms and did not look at changes negatively, but instead as opportunities. She reminded staff that changes and challenges must be met and overcome for the good of the consumer. A team member gave an example of how Alyssa frames a change that initially may have been viewed in negative terms:

> [Team Member] I think Alyssa makes it positive in that it's, you feel like even though it's more work, at least it's rehab oriented and you're trying to get a better idea on how you can help this person by addressing functional deficits, that it hopefully will lead to better outcomes for this person in the end.

> [Team Leader] That it is something that we can deal with and we can get through. You know, and I might say that I do not like it or disagree with it. But still wanna present it as, "let's just do it".

Additionally, Alyssa efforts to anticipate changes and challenges and deal with these proactively, helped team members be less reactive or less taken off guard.

Alyssa encouraged and sought input from team members as a strategy to overcome barriers and find solutions, an approach team members found to be empowering, and helpful for moving forward with their work. Alyssa set expectations for team members that everyone, including herself, should be willing to listen and to change opinions in a fluid way: "I think being able to listen and change opinions based on information probably makes a difference. I have to be okay with adjusting that [a decision] if it's not the right one". Likewise, a team member said this: "I think when we're making change too; she always wants our input and our thoughts".

Establishes fun and relaxed work environment. A third direction for setting the team culture relates to Alyssa playing a major role in shaping the preferable team work environment. The team environment was fun, relaxed, and calm, and team members indicated this was how they wanted it to be. The team environment and culture was described as follows:

> [Agency Supervisor] She does humor and celebrations, um, very good about that. They take time at that team meeting, to make sure people are recognized for their hard work, whether it's a success for a client, success for themselves, sometimes a birthday.

Study aim 3: Understand the roles the team leader plays in promoting high fidelity ACT. There are four core categories identified that informs this third study aim of understanding the team leader's strategies for assuring higher ACT fidelity. These include that the team leader: (i) plays a critical role in promoting high fidelity to ACT; (ii) believes and trusts in the EBP of

ACT; (iii) uses ACT fidelity as a program guide; and, (iv) integrates high fidelity into daily team practice and culture (see Figure 4).

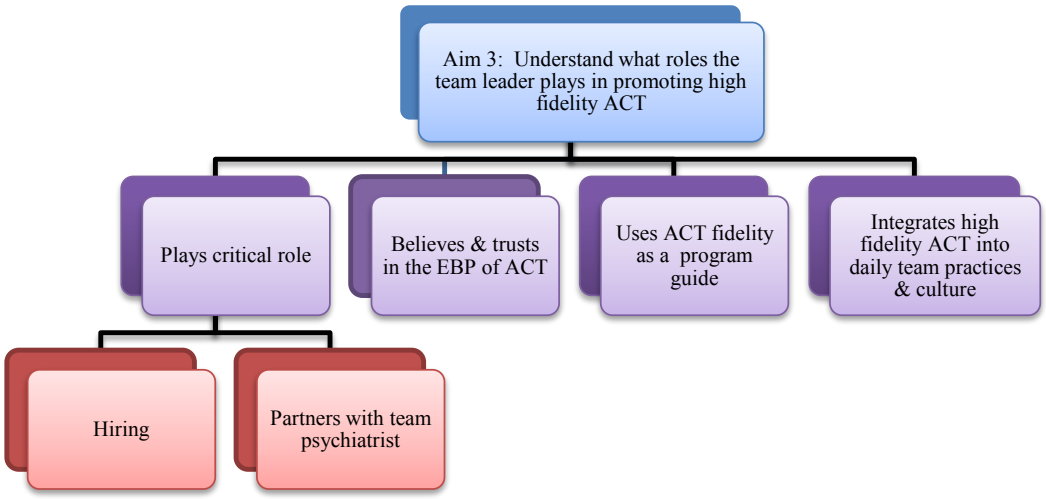

Figure 4: Ramsey County ACT Findings for Aim 3

Plays critical role. All participants commented that the team leader played a significant role in promoting and sustaining high fidelity to ACT. Alyssa and the team's psychiatrist were identified as being the key leadership that promoted high ACT fidelity. When asked what role Alyssa played in promoting high fidelity to the ACT model, participants said: "oh, big role". Alyssa shared her philosophy that achieving high fidelity to ACT is a key role of an ACT team leader, and very important to her personally and that promoting it is one her team's key long-term goals: "Well, honestly, I think it's [fidelity to ACT] pretty critical", and:

> [Team Leader] And then I would say long term for the team, you know, obviously a goal would be to be practicing at kind of the highest fidelity possible, not only for ACT but then also other evidence based practices.

Alyssa played a critical role in a few ways. She was focused on hiring and educated her human resources (HR) department and various other stakeholders on what was necessary for a

good ACT worker. Alyssa also partnered with the team psychiatrist to promote high fidelity ACT.

Hiring. Alyssa's focus on and promotion of ACT fidelity for her team originated during the hiring process. Alyssa set expectations with her agency's HR department in regards to the type of individual that needed to be hired for an open ACT position. The agency supervisor described Alyssa's approach with hiring and how ACT fidelity was integrated into the practice of hiring:

> [Agency Supervisor]…that wasn't always easy for HR to hear that we need to, we can't break the rules, but we need to really be creative in who we're looking for. So that was partly because I think she [Alyssa] was just driven by evidence. If we're gonna get our outcomes, we gotta have the people that can carry that out.

This statement supported the idea that ACT fidelity and the implications for desired outcomes for the program was on Alyssa's mind while looking for qualified team members and creating position descriptions.

Partners with the team psychiatrist. All participants highlighted how the team leader, in conjunction with the team psychiatrist, communicated about and focused on ACT fidelity. Team members, as well as agency leadership, communicated that Alyssa and Dr. Harker were a cohesive team and set clear expectations that the team would operate as close to fidelity as possible: "Well, she's [Alyssa], besides Harker, she's the key one [in promoting fidelity to the ACT model]", and,

> [Team Member] It's [ACT] an evidenced based practice, and it's a good way for us to hold to a standard that's not arbitrary, you know. And so I think that they, both Alyssa and Steve, value that and, they'll talk...about research and its value....

Alyssa identified having the support of Dr. Harker, who was also recognized as a national ACT expert, made a difference for the expectations she set for the team and the support she received for her role in emphasizing high ACT fidelity.

Believes and trusts in the EBP of ACT. The second core category for Study Aim 3 was Alyssa's belief and trust in the ACT model. Alyssa reported that she has faith and fully believes in the ACT model of care, primarily as she sees it align with what is best for consumers. She asserted the belief that ACT helps people recover from the effects of mental illness and gave examples of this recovery. Multiple participants emphasized how Alyssa believed in and had confidence and faith in the evidence-based practice of ACT. Participants made comments such as:

> [Team Member] And they both really believe in ACT. Like Steve, you know, breathes ACT and so does Alyssa basically, so they kind of speak the same language.
>
> [Team Member: Why do you think your team has stayed focused on ACT fidelity?] Probably because the leadership believes in it strongly.

Because of this trust in the model, Alyssa said she remained focused on data and reviewed team and consumer outcomes as a way of measuring progress toward ACT fidelity. She expressed her views:

> [Team Leader] I respect the fact that a lot of research has been done around it. Honestly, to some degree, I don't even care what all that research is, but I respect the fact that a lot of intentionality and research as gone into saying that if you do these things you will get good outcomes.

Team members also addressed ACT fidelity in very positive terms, and seemed to espouse the value in following an evidence-based practice like the ACT model as closely as they

could and being aware of outcomes: "Steve and Alyssa will look at our hospitalization at times and our rates and they will bring it to the team and show it to us, like, how we're doing the last few years". Alyssa reported using some data and outcomes to measure the team's progress and provide feedback on how the team is functioning; although data is only one tool she utilizes to measure team effectiveness.

Uses ACT fidelity as a guide for the program. Alyssa used the ACT model guidelines and the TMACT fidelity measure as a blueprint for her program's operations. She made deliberate clinical and program decisions based on the evidence based practice of ACT and stated that knowledge about ACT fidelity contributed to her strategic plan and overall direction of the team:

> [Team Leader] The first one [strategic plan] that I created–I had been here probably about six months and had been listening and observing–and actually that [first plan] was really more based on what the model said we should be doing versus what I saw us doing.
>
> [Team Leader] I think some of the fidelity tools kind of look at, okay, you're at this step, this is the next one. It doesn't tell you exactly how to get there, but it gives you some idea of how to get there... And so you don't have to try to imagine it, which I appreciate. You know, 'cause then I can imagine the little details, and I can think about how will my team best respond or what do the people we work with need most.

Alyssa also shared her belief that the ACT model provides a solid infrastructure, both processes and practices, which she appreciates and did not stray from. There were elements of the ACT model that she opined were non-negotiable such as days of operation, person-centered treatment, or admission criterion but there were also areas of operation where she felt there was

room for creativity and flexibility to meet consumer needs. She described holding the belief that fidelity to ACT could be a fluid process, that there were multiple ways of achieving fidelity:

> [Team Leader] The more that you can create structure, I kind of see ACT as being, structure, structure, structure, then complete flexibility. I see it as part of my job to really help the group step back and think about the larger picture. Think about what do we want to do next in terms of change or growth and then what do you need to do that?
>
> [Team Leader] In my mind there are things that are negotiable and not negotiable. And some of those structure things are not negotiable. There are things that are non-negotiable, like, this is who you're gonna see for the day. If you think this route is gonna work better than this route, fine. We can be flexible with that. But it's not gonna be open to you to decide kind of the who and the when.

Alyssa was asked what advice she would provide to a new team leader regarding ACT. This sums up her opinion on ACT fidelity:

> [Team Leader] I would probably also encourage them to look at what some of the different research is around the structure, because one of the lucky things about it being an evidence based practice is there's a bunch of information out there on how you can do it well and do it right. And it really provides a blueprint that you can follow and just take it one step at a time, to help your team kind of function in a healthy way.

Integrates high ACT fidelity into daily team practice and culture. Participants identified that Alyssa had integrated ACT fidelity components into the daily operation of the team, which influenced the way the team operated. Additionally, it was identified that Alyssa broke down the concept of ACT fidelity into manageable and understandable ways for the team to implement.

She had a definitive knowledge of how to take theoretical components of ACT fidelity and operationalized those components into successful team processes:

> [Team Psychiatrist] I noticed right away how she was able to take elements of ACT that were written about, say the ITT, the individual treatment team, and kind of know in complex details, in a detailed way almost intuitively how to bring that into our system much more to meet specific needs that I didn't even see. She organizes the team schedule really well around the treatment planning process which is one of the core features of the model–that you're organizing yourself around the life-goals of the clients.
>
> [Team Leader] I think about ACT as it being a lot about task break-down. From being the team leader to how we work with people, it's all about breaking things down into manageable steps, I think some of the fidelity tools kind of look at okay, you're at this step, this is the next one.

Alyssa was asked if this integration of ACT fidelity into daily practices and processes of the team was intentional or intuitive. She responded that it was both intentional and intuitive as it factored into her decision making, and each way was equally important. Alyssa stated her intuitiveness was driven by her knowledge of the ACT model, and decisions about ACT fidelity were almost reflexive. Alyssa stated: "I think it [ACT fidelity] provides more of an underlying, like the information has been integrated enough that it provides an underlying touch point for decisions that I am not even always aware of". She provided some examples of decision making that supports ACT fidelity, is more intuitive or internalized, and integrated in small, almost unnoticeable ways:

> [Team Leader when asked how fidelity to the ACT model factors into daily decisions] In some little ways, I mean...Are people being seen enough by enough people? That came

> up in, there was a staff person who a couple people that only she sees. And for different reasons, but I was like you need to be aware, we need to be aware that you've got two of these people right now. That's not good practice. You know, from a fidelity perspective, that shouldn't be the case.

On the other hand, Alyssa also stated that at times the incorporation of ACT fidelity in her decision making was very intentional. She provided the example when she and the team went through the TMACT evaluation and had direct conversations about where the team was at and where they wanted to be. However, Alyssa was quick to say she did not "obsess about" ACT fidelity. She communicated to the team that they would likely never be perfect as described by the TMACT or ACT model, but instead promoted the team to move as close as possible, given the realities within their system.

> [Team Leader] We're never gonna have a program just like they describe. We're not going to have staff probably available to facilitate the groups that they recommend and do the follow-up, but it [TMACT] gave us some ideas. It did two things. Gave us some ideas that we implemented, and some we're continuing to implement. And… made the group aware of, we really do need to be reaching out to families more.

According to team members, Alyssa did a good job setting expectations for how ACT fidelity would be integrated into daily practice. These expectations both motivated the team members to be the best ACT program they could be, yet set very realistic and attainable goals about what could be done and when.

Overall Ramsey County ACT team summary. This section focused on the Ramsey County ACT team and provided a case description along with the findings that I believe best inform the study aims pertaining to characteristics of the team leader, her approach to leadership

and role and contribution to developing and maintaining a high fidelity ACT team. The following section will follow the same framework for the description of the findings from the second case study—the Lincoln PIER[19] ACT team in Lincoln, Nebraska.

Case two: The Lincoln PIER ACT team in Lincoln, Nebraska.

Case context, setting and participant descriptions. The Lincoln PIER ACT team's office is located on P street, just on the eastern outskirt of downtown Lincoln, Nebraska. It was an unusually warm and sunny day on October 29, 2012, with temperatures in the low 70's. The ACT team's office was located in an older, well-maintained two-story, stand-alone building. Walking in, I went a few feet down a brightly painted yellow hallway and found a sliding glass patio door on the right hand side, and the ACT program assistant sitting behind her desk, facing me. She led me near the main team room by continuing down the same hallway, and passing more sliding glass patio doors that housed individual office spaces for the psychiatrist, and small but comfortable rooms for private meetings with consumers.

At the end of the hallway behind a set of double doors was the team meeting room. Walking into the semi-dimly lit, open room, I was surprised to realize the office space was a loft. The main space was large with multiple individual offices both on the first floor as well as on the upper floor loft, on two sides of the main room. In the room's main space, there were rectangular conference tables arranged in a large square that took up most of the room. The configuration of the tables seemed logical to promote collaboration and communication. The table was littered with the necessary "tools" that ACT teams would be expected to have: the daily log book, the consumer weekly schedule cardex, pens, staplers, the main phone line, and sticky notes along with personal items such as hand lotion, hand sanitizer, food, and resources such as an *Nursing*

[19] PIER= Partners in Empowerment and Recovery

Drug Handbook and current *Physicians' Desk Reference*. While not feeling too cluttered, the wall space was also utilized, holding several calendars, and dry erase/white boards that organized the team's work such as scheduling/hospitalizations/on-call schedules. On the opposite wall from the white boards was a map of the county and next to that the various mailboxes with clipboards and artwork. The space gave the impression that it was "lived in" as well as highly functional.

Only a few staff were in the office, and the program assistant explained that some staff were already out in the community meeting with clients. Catherine entered the room and announced she was headed out to visit a client. She explained that on Monday mornings, she sees two individuals for therapy. However, she stated she always comes into the office first to check the "pulse of the team"–making sure no one needs her, there were no crises that arose over the weekend she is not aware of, and that nothing needs additional coverage. After completion of the client contact in the community, Catherine returned and went into her office that was situated directly off of the larger lofted team meeting room, and also had a sliding glass door with a curtain. She indicated that she rarely closed her door and pulled the curtain as she liked to maintain the perception that she had an "open door policy".

Catherine's office was a large space with a desk, rows of shelving, a bookcase, and a round table that seated four. While the walls were made of concrete cinder blocks and painted a pale yellow, I was struck by all of the photographs and cards that were hanging up. She had many photos of nature that she took herself, along with photos of family and friends closest to her desk. She had a mental illness awareness week declaration framed along with her social work license and two inspirational, social work pictures/quotations. There was also a row of cards that she had received over the years from staff, thanking her for various things. She indicated that their presence reminded her she must be doing something right.

She sat down at her desk and immediately began to check her email at her computer. She stated that she attempted to do this every morning, again in an effort to prioritize any immediate issues. After checking her email we reviewed the agenda for the three day on-site visit, and she agreed this agenda would still work for her and the team. Catherine began to discuss her history and the history of her team. She shared this story.

> It's kind of funny, you know when you're a senior in high school you have to do a little research paper but it can be on anything at all, right? I picked schizophrenia. Didn't even know what it was really. But that was my high school research paper. So I've always worked with this population. My first job was as a psych tech at St. Joe's in Omaha. And that was before I finished my undergrad. So it's always been this population. This population has always been what I've enjoyed the most.

Catherine had previously worked while in graduate school with an agency called Community Alliance in Omaha, Nebraska which provided her first internship with ACT. However, after graduate school, she took a job providing office-based, mental health therapy to individuals, but always "knew I needed to come back to this population". Later, Catherine applied and was hired for the lead clinician position on the Lincoln ACT team that was just starting up. The Lincoln PIER ACT team officially began in 2005 and started out as, and still is, a collaboration between three agencies: Community Mental Health, CenterPointe, and Lutheran Social Services. Catherine remained in the lead clinical position for a year but eventually became the official team leader shortly thereafter in 2006.

Catherine is a 42 year old, white, female, who holds a Master's in social work degree. She has worked 20 years in the mental health field, the most recent 6.5 of those years as the ACT team leader. She enthusiastically stated that she loves ACT because she found it hard to be

strengths based in a hospital setting as the setting alone is a "box" and the benefit to the client is short-lived. In ACT, she likes the "intimacy" of the work and the fact that it is long-term. She feels the connection with the client is much more authentic and a "dance". She loves how the client responds when he/she "is respected and heard".

Catherine stated that she found this ACT work as "fun" and that she enjoyed even the "worse moments". She liked how she has had to build something, and stated it was fun to hold a vision and try to bring it to fruition. She was quick to point out that it was a challenge to have multiple and varied tasks that she needed to juggle, but she was good at it. Additionally, she loves teaching, "part of me is a teacher", and she gets the opportunity to do that in this position. Catherine is an employee of Lutheran Social Services and the gross monthly salary range for her social work supervisor status with Lutheran Social Services is between $4500.00 an $5000.00. While she joked that she would like to get paid more, she indicated that she did not stay at the job due to the money, but that she found this to be a good fit for her talents and she enjoyed coming to work every day.

The daily team meeting. All team members that were scheduled for this shift were present at the meeting and on time. The program assistant was already at the table and beginning to flip through the consumer cardex, a large metal index card holder that contained daily schedules for the consumers according to his/her treatment plan. The nurse had brought a bin of medications that were ready to be handed out to staff. Another member of the team took a binder, and began to say consumer names alphabetically, out loud, prompting team members to report. Catherine sat at the table and gave her full attention. She participated in the meeting, listening but also asking for clarification when needed, providing praise/validation to team members, directing the work of the team (i.e. 'is it on the cardex?'), injecting some laughter and

reminding the team of how far some consumers have come in their recovery. I observed Catherine provide teaching and training to team members on symptoms and treatment modalities of schizophrenia, and express empathy for struggles a consumer was going through. Team members asked several questions, provided answers for one another, and focused on client care. Never once did the team meeting get off track. The conversation remained very positive and consumer-centered. At the end of the roll call of consumer names, the program assistant read out loud the tasks all team members were responsible for over the next 24 hours. A fair amount of adjustments were made to the schedules, Catherine made a few announcements, and the team dispersed to do their work.

Currently, the Lincoln PIER ACT team is comprised of 13 individuals, which includes Catherine as the team leader, one psychiatrist, one advanced practice registered nurse, two nurses, three mental health workers, two therapists, one peer support specialist, one vocational specialist and a program assistant. Table 5 summarizes relevant demographics of the Lincoln PIER ACT team members. Again, it is important to note that the table summary demographics exclude the team leader, team psychiatrist, and the agency supervisor as they are described in narrative form further on in this section. Moreover, one participant was absent from work this week, so did not participate in the study.

Table 5: Descriptive Characteristics of Lincoln PIER ACT Team Members

		N (%)	Mean	SD	Range	Notes
Gender	Male Female	3 (30.0) 7 (70.0)				
Age		10	41.4	14.86	28-65	
Ethnicity	Hispanic/Latino Not Hispanic/Latino	0 (0) 10 (100)				
Race	White	10 (100.00)				
Highest	Trade/Vocational School	1 (10.0)				

Education Level Completed	Some College BS/BA Degree Master Degree	1 (10.0) 4 (40.0) 4 (40.0)				
Field of Highest Degree	Social work Nursing Psychology Other	1 (10.0) 2 (20.0) 2 (20.0) 5 (50.0)				Other fields: History/English, Computer Systems Admin, Educational Psychology, Counseling Psychology, Human Services.
Length of time worked in mental health field (in months)			147.2 (=12.3 years)	107.8	29-369	
Time spent with Lincoln PIER ACT program (in months)			50.3 (=4.2 years)	31.6	14-93	
Worked in ACT previous to being on this team[20]	Yes No	0 (0) 10 (100.0)				
Comfort Level in Focus Group		7 (100%)	9.43	.79	8-10	Rated on Likert scale from 1-10

Lincoln PIER ACT focus group. The focus group was held on the second day I was on-site. Seven of 10 team members agreed to participate in the focus group. Reasons provided by the three members who did not participate included one team member having a scheduled week off, one individual calling in sick for the day, and another individual who had an emergent consumer crisis come up. The focus group was held in the team's large meeting room. As indicated by the post-focus group data, individuals felt highly comfortable (X=9.43/10) in sharing information during the focus group. The overall atmosphere was relaxed and jovial as evidenced by laughter throughout the interview. There was a good synergy within the focus group evidenced by several team members adding comments to the same question posed and a high level of interaction among all team members. All team members spoke up, and there were

[20] I did not count internships or practicum experience in this category.

times when team members offered different perspectives on the same question. The focus group lasted approximately 1.5 hours.

Interview with the team psychiatrist. After the focus group, I met with Dr. Dianna Clyne. I had attempted to get a meeting with both Dr. Clyne and the Advanced Practice Registered Nurse; however, the latter was unavailable during the 3 day on-site visit. Dr. Clyne, as the psychiatrist, is considered the medical director and primary prescriber for the ACT team. She is a 53 year old, white female, who has been a psychiatrist since 1990 (22 years). She has been with this ACT team for five years, supervises the APRN on the team, and gives approximately 12 hours of time each week to the team. Dr. Clyne described some previous experience with an ACT-like team in Arizona.

Dr. Clyne provided information about how she saw the team as presently functioning. She indicated it was cohesive and that everybody was "willing to pitch in". She highlighted that the team was good with "educating, and working on building up the client more than trying to solve the problem". She described Catherine as "fun-loving, caring, but a very serious side" and that she has good leadership and organizational skills, but also has the skill of being able to listen and trust the ones she's put into the positions on the team.

When asked to describe what their relationship as co-leaders was like, Dr. Clyne indicated she thinks it's "pretty good". She indicated she and Catherine never have disagreements, but that they discuss issues from different perspectives and Dr. Clyne thought they both respected the other's input. If they didn't see eye to eye, they still came up with a solution. This report from Dr. Clyne was supported by team members. In the focus group participants indicated Dr. Clyne and Catherine didn't have disagreements but worked any issue out collaboratively as the main focus was on client care. Dr. Clyne indicated that she enjoyed her

work here on the ACT team and a main contributor to that satisfaction was Catherine's leadership.

Interview with the agency supervisor. Michelle Nelson, a white female, is the clinical director for Centerpointe. She oversees all clinical services at Centerpointe and as the clinical director she meets with Catherine and provides clinical supervision and support. They meet when needed and Michelle reported she tries to not overburden Catherine with meetings as Catherine had two other leadership agencies that she must juggle due to the unique circumstances of having three agencies contribute to the ACT team. Michelle gave Catherine all the credit for making the collaboration work, as she had to balance three different agencies' policies, procedures, salary structures, etc. to work for one team. She has known Catherine for around five years.

One observation that Michelle shared was of the team's cohesiveness. She indicated that the team was not just cohesive, but also took a great amount of pride in what they do. Michelle opined that comes straight down from Catherine's modeling and her encouragement of team members. Michelle described Catherine as "energetic" and "compassion-driven", and that she always had the consumer's best interest in the forefront. Michelle indicated she completely trusted Catherine's decisions and leadership of the team.

Appendix 23 visually presents a summary of all the findings for the Lincoln PIER ACT team.

Study aim 1: Describe the ACT team leader. For the Lincoln PIER ACT team, two core categories emerged from the data that addressed this study aim: (i) personal job match; and (ii) notable attributes. Figure 5 represents the findings for Aim 1.

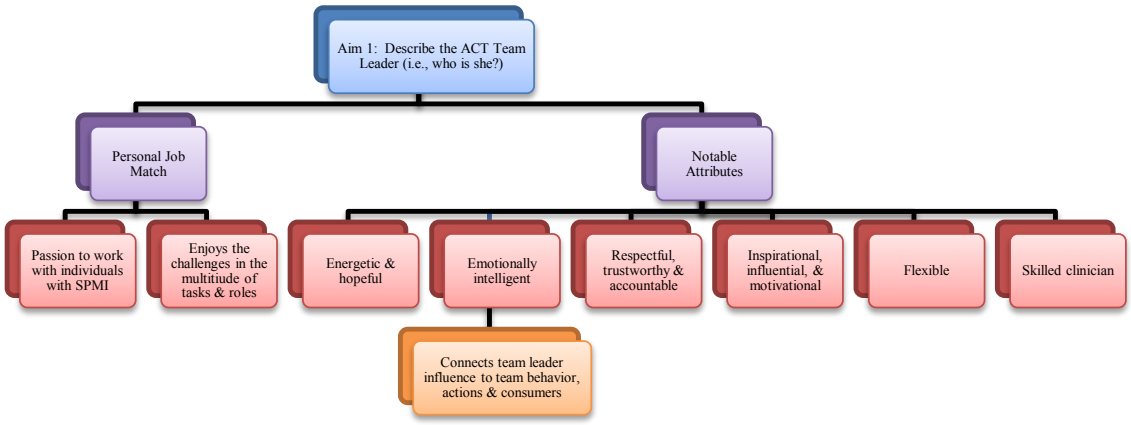

Figure 5: Lincoln PIER ACT team findings for Aim 1

Personal job match. The first core category that emerged for describing whom the ACT team leader was, was "personal job match". This category was created based on comments and observations that Catherine was an excellent "fit" for the description, roles, and duties of an ACT team leader. Two particular themes contributed to the development of this core category, Catherine: (i) had a passion to work with individuals with severe and persistent mental illness; and (ii) enjoyed the challenges in the multitude of tasks and roles of an ACT team leader.

Passion to work with individuals with SPMI. The first theme described for personal job match was that Catherine had a passion to work with individuals with severe and persistent mental illness. She stressed that she always had this passion. She felt gratitude to work with individuals toward their personal recovery. This was how she described that passion:

> [Team Leader] I've always felt a passion for this population. Always, always, always. And leaving it kind of reinforced that, it just really reinforced that for me that how much I missed it. And how much more I just enjoy this population…to working with those with SPMI. I knew I wanted to get back to ACT….I really came to the conclusion that I can

> work in any setting as long as it's this population. It doesn't matter. It just has to be this population.

Team members also recognized Catherine's passion for her work: "she's very passionate about this work", and "she loves her job".

One main reason that Catherine felt so passionate about working with individuals with severe mental illness was that she believed they deserved the best care possible. She expressed compassion and empathy for consumers and what they go through because of their illnesses and societal stigma. She indicated that she handled the stress of the job because she reminded herself that every task she did was on behalf of the people served.

> [Team Leader] ...And I just simply enjoy... I find them enjoyable to spend time with. I just feel really, it almost feels like a calling for lack of a better word for me. There's such a pull there. There's difficult days and there's bad days. You know they're not all rainbow and butterflies. Maybe it was a really tough day, because a client's in jail again. Another client is homeless, and someone else is at the door screaming because they're so irate and psychotic, right? But, I always come back to… 'Well, why the heck do you do this, you know'? That's hard, …how could I not? That, if Suzie Smith lives with that, the least I can do is work with it, because I will get to go home, and I will turn it off. And when I need to, I can take two weeks off of work and completely get away from it. Then that's the least that I can do because that night Suzie isn't getting a break. So there's that component of it for me. And that's why I don't think it gets that overwhelming for me. I think that's why. Because nothing that I deal with, *nothing* [emphasized] is in comparison to what my clients deal with. I mean, it doesn't even come close. So there's that piece of

it. And if I feel that passionately about serving clients, I can't screw it up that badly, you know, what I mean?

For Catherine, part of the "pull" or calling to this work related to the intimacy of working relationships with clients and the longevity of work, allowing staff to witness meaningful changes.

[Team Leader] I love the connection and the intimacy that we get. And then the challenge, it's much more of a dance than other work is I think in navigating that I find really rewarding. I love the long-term aspect of it [ACT]. I love how clients just bond when they feel respected and heard and their little light bulbs go off like, 'Oh my gosh it could be different'. I think that's amazing 'cause you get to see the whole journey. And in other settings you don't. With ACT you get to see the whole journey.

Enjoys the challenges in the multitude of tasks and roles. The second theme that explains the personal job match was the team leader's enjoyment from the challenges associated with the multitude of tasks and roles she had as an ACT team leader. The team leader made various comments indicating she found the variety of roles, and the overall job of an ACT team leader as both personally and professionally fulfilling.

As one example, Catherine shared that she enjoyed and functioned very competently in crisis situations, actually experiencing some of her best moments when managing in these instances:

[Team Leader] I love it when I'm bombarded with five people at once. I love that feeling. 'cause that kind of gets in a little bit, you know it gets you in a little of crisis mode, right? I've got to, quickly, you know, triage and quickly prioritize and, 'okay, this one needs to wait. Okay, what's going on here? Okay, Suzie's called in sick'. You know? I think I'm

> at my best when I've got ten things going on at once. Crisis, for some reason it doesn't bring me up notches, it brings me down. That I just like, I feel often calmer in crisis than I do not in crisis.

Similarly, Catherine described how she enjoyed having to balance clinical, supervisory, and administrative tasks and how her personality lent itself to having multiple roles. She described her love for the complexity and challenge of the management piece of her work with team members in this way:

> [Team Leader] I didn't know until I became team leader how much I love the management piece. My fire gets as lit by team dynamics and that puzzle as it does the puzzle of helping the client. I didn't know that, but the idea of how, how do you become a good leader. What is that? You know, no one teaches this. How do we do this? And I've got twelve different personalities out there that I need to somehow help work together so they can go work with clients and partner with them one minute and then, then their clinical supervisor, and now I'm the asshole that's doing a probationary letter. I love that puzzle 'cause I think it is insanely complicated and challenging, and I absolutely love that tightrope and continuously trying to understand that. And trying to think, 'how do I navigate this?' So I love that piece as much. They really are equal. I absolutely love clinical work, but that management team leadership piece I think is so much fun and so hard. I think my personality simply lends to it.

Catherine also expressed liking that her job was harder compared to many other jobs and took pride in the challenging work she did as an ACT team leader:

> [Team Leader] That's one thing I like about my job. I like that what I do is hard. I like that I don't think a lot of people can do it. And I take some pride in that 'cause I kinda

> wanna smirk and say, 'Give it a try. I'll give you thirty days. 'Cause right now you're even too scared to sit down and talk to someone who's psychotic, so . . . you know, give it a try'. So I take a warped pride, and I think I do something pretty well that most people can't.

In sum, Catherine enjoyed the various components of her job, which required direct clinical practice with individuals with SPMI and juggling multiple tasks for team effectiveness.

Notable attributes. The second core broad category that emerged to help understand who the team leader was on a high fidelity ACT team was labeled 'notable attributes'. Throughout the data collection and analysis, certain descriptors of Catherine as the ACT team leader repeatedly came up across the majority of data sources. The attributes that are described in this section are not meant to represent an exhaustive picture of Catherine but rather to outline salient descriptors. The attributes noted were: (i) energetic and hopeful; (ii) emotionally intelligent; (iii) respectful, trustworthy and accountable; (iv) inspirational, influential, and motivational; (v) flexible; and, (vi) skilled clinician.

Energetic and hopeful. First, Catherine was described as being highly energetic as well as dynamic. The majority of participants, when asked "describe Catherine to me", identified these as some of her most notable strengths: "She's very energetic. That comes across every day you come to work", and:

> [Team Psychiatrist] I think with her, just that energy that she has is very motivating, and she uses that. I mean, you'll see staff come in and kind of . . . and she'll come in all smiley, laughing and, and it just kind of gets them going. But it's not too much.

Team members also described Catherine as very hopeful and holding a cheerful, confident outlook; "She keeps driving hope, you know, for our clients. [Second Team Member]

So not necessarily optimistic, but driving hope. Hopeful", and "…Catherine's always the one that is, like, strong and makes you believe that you can do it and that they can do it".

Emotionally intelligent. Catherine was described in ways that suggested she was emotionally intelligent. Emotional intelligence referred to Catherine's ability to recognize, understand and manage her own emotions while also recognizing, understanding, and influencing the emotions of others (Goleman, 1996). Comments from participants indicated that she had the capacity to be aware of, control, and express her emotions and handled interpersonal relationships with others in a manner that was empathetic and judicious. Participants reported the following:

> [Agency Supervisor] Now I will say, when I told her it [Dr. Clyne was leaving] was hard. But she blew me away by how she reacted. I mean, she didn't go to pieces. And I don't really know why I thought she would go to pieces because I've never seen Catherine go to pieces, but I just thought it would be pretty difficult for her. Her concern went to 'how's this gonna affect consumers? How's it gonna affect staff'?
>
> [Team Psychiatrist in response to what helps Catherine maintains such a great ACT team?] You know, a lot of it is her personality and how she relates to other people. I mean, as I said, it's, not only do her team respect her, but she respects them. And that makes people wanna work for her. You know, when you're feeling respected.

Catherine supported the other participants' comments about her own emotional intelligence and described how she remained self-aware and mindful of her interactions with others:

> [Team Leader] I am . . . conscientious of my relationship with different team members and how I manage that. I'm conscientious of not having a hierarchy on the team. That

each member has different strengths and different gifts but there's not much, I mean there's some hierarchy. It's as even as it can be.

[Team Leader] I'm almost six-foot tall. I use my size when I need to. I'm well aware of when I'm standing, when I'm standing up straighter. I know over the years I've learned how to use that.

[Team Member] …it's exhausting some days to meet with clients back-to-back. But for her to come in here and be deliberate and thoughtful about every interaction she has with us and . . . She's just impressive.

Connects team leader influence to team behaviors/actions and to consumers. As part of her emotional intelligence, and being self-aware, Catherine revealed the idea that the team leader influenced team members in many different ways. This influence, in turn, contributed to the behaviors and attitudes of team members, which subsequently influenced consumer interactions. According to Catherine, "I'm absolutely aware that I always set the tone and that how I respond is how they will follow. I am very, very aware, in those moments particularly, that eyes are on me", and,

[Team Leader] I also think I have the responsibility of setting the tone with my emotions. And I think if the leader is, you know, in the corner in a fetal position, then how's the team – not that it isn't worthy of being in the, you know, in the corner fetal position. You know, it's a completely worthy response. But I can't lead from the fetal position.

Catherine provided a specific example of how she knew that team members were continually watching her. She replied this way to the question of 'in what ways do you influence staff? Can you provide an example'?:

> [Team Leader] I think I influence based on how they see me interact with a client. That's what I mean when I say you never get a day off. You can't have a freaking bad day, because you're always on display. That's the power of the influence that I'm aware if I'm talking to a client on the phone, what's my voice tone because they're watching me. There was a moment where that became really clear, where I was on the phone in my office here with my door, always open. I didn't really think about it. Talking to a guardian who's a very challenging guardian to work with, right? It was a very challenging conversation. Then there was a moment when I hung up and there was applause. I'm like, they really are listening all the time and watching all the time. So if I had gotten snarky with that guardian . . . then that too would have held power.

Catherine expressed that the team was a "microcosm" and the team members' attitudes impacted consumers. She asserted the work environment played a role in how team members went out into the world and worked with consumers.

> [Team Leader] This (the team) is a microcosm to me. If they're not being client-centered here, they're not being client-centered out there. I don't believe that is possible, to complain and moan about a client here and then to go be therapeutic with them. Don't believe it's possible.

Respectful, trustworthy and accountable. "Respectful", "trustworthy", and "accountable" were additional attributes used to depict Catherine when participants were asked to describe her. She was characterized as taking responsibility and ownership for getting tasks done in a reliable, accurate, and credible manner. Interactions were observed to be polite and considerate. Not surprisingly, comments from participants indicated that team members have confidence and trust in Catherine, a respect for her decision making. This trust extended to all team members who

counted on each other, along with Catherine, to follow through and get their jobs done. Per a team member "I guess my big selling point on what a good leader Catherine is that, she's always there when it's rough. She's right there when it's rough". Others had this to say of Catherine:

> [Agency Supervisor] They very much respect her. They trust her. They feel that they can come to her. Whether it is good or bad. I really do believe that they view her kind of how I described her earlier with the consumer always client-centered, to do no harm, the ethics. I think they very much respect her clinical practices.
>
> [Team Member] I think mine is just knowing that I can always talk with her about anything….I felt open that I could come to her and discuss that [conflict] with her. Um, without any judgment, you know? She has my back, and I know that, and I know that I can talk to her about that.

Catherine herself recognized the importance of the team having respect for her leadership– that it is necessary for optimal team functioning and providing good services. I asked Catherine why she felt so strongly that team members had to have a high degree of respect for and trust in her and one another.

> [Team Leader] I expect people to work, work, work, with autonomy. They have, this work requires autonomy. So I have to trust. I'm not in the room with them. I'm not in, in with a client with them. I'm not here every second of the day. There has to be trust.
>
> [Team Leader] . . . somehow I have to formulate a relationship where I am respected. Where I can have influence over, right? There needs to be some level of respect so if I give a directive it will be done. There needs to be some level of respect where, um, I love it when team members joke that if I'm not around and something comes up and the joke is they say, 'Well, what would Catherine do? What would Catherine say'? I like that. That

> means that I've got influence. That means that there's a level of respect where the conversation . . . actually they'll say those words. 'What would Catherine say right now'?

Inspirational, influential, and motivational. The fourth theme identified that the team leader was inspirational, influential, and motivational. Much of this was accomplished by Catherine encouraging, exciting, and provoking staff to think of their work differently, and perform their work in ways that meet her standards. For example, instead of getting stuck in certain behaviors of individuals who were not doing well, Catherine was heard encouraging team members by saying "this helps us think about what else we can do. What haven't we done yet that may work'?, and,

> [Agency Supervisor] She has a way of getting others to want to follow what she is doing. Now don't get me wrong. When she needs to put her foot down and say 'this is the way it needs to be folks' she can do that. But she does it in the way that it's not demeaning to them or that people feel they don't have a say or that she's not being respectful.

While on-site, I observed Catherine using positive recognition as a motivator and stimulated and generated enthusiasm for the work of the team. Others' input supported this observation:

> [Agency Supervisor] I think one aspect that I've seen her, one thing that I've seen her use to motivate staff is recognition. You know, giving pats on the back, really recognizing the hard work. I also think that she…I think when she meets with her staff, she really tries to figure out what does motivate them. I think sometimes she just asks them 'what motivates you? What do you like about being in this position? What's kept you working here in this ACT program'? and using that feedback that she receives from them.

Participants were asked 'how did Catherine inspire or motivate team members'? She was repeatedly described as a great role model for a variety of issues including work-life balance and

general wellness: "Kind of an inspiration. I mean, because there's high burn out in this field. And so to see that somebody can manage it and be successful and happy and have a full life...".

Is flexible. The fifth sub-theme of notable attributes was that the team leader was adaptable and open to change. She encouraged and accepted suggestions and constructive criticism from others and modified her style (e.g., calm versus energetic) or decision given the context of the situation. Her flexibility extended to her leadership style, where she tried to be flexible with staff and their schedules. Several participants noted Catherine's flexibility in some way.

> [Team Psychiatrist] You know, she's flexible to the extent that she can be flexible. I mean, she's still running kind of a business and a program. And, the care is critical – if you think about it can be life and death in some of the clients at times – so it's very high stress at times.
>
> [Team Leader] I'll give flexibility when I can. That it'd be easier to be the straight black and white. But I don't want that work environment. So if I'm asking people to potentially be available to stay late, if there's a client crisis going on, then I can give the same in return.

I observed Catherine's flexibility as she switched topics or roles, and adjusted her focus quickly and effectively throughout the day. Her flexible thinking was evidenced in how she thought and carried out the ACT model of care. She was rigid with some things about the model, trying to assure the team was following the evidence-based practice, but was highly flexible within the parameters of the model, helping staff be creative in their thinking and work with consumers.

Skilled clinician. The final theme for notable attributes highlighted that Catherine was an exceptionally gifted and skilled clinician. She was described by many participants as an excellent clinician, with astute clinical skills and judgment. Her agency and clinical supervisor stated this:

> [Agency Supervisor] I am comfortable saying this, but she is probably one of the top clinicians within the Centerpointe system. Her clinical skills are very sound…I've never been in a conversation with her where I went "Whoa, Catherine, you're way off base". Never.

In the focus group, team members also stated this:

> [First Team Member] But she's, clinically she's good. [Second Team Member] Very skilled. [Third Team Member] She's a great clinician.

I witnessed first-hand her ability to tailor the intervention to fit the needs of the consumer. During the team meeting, Catherine assessed a consumer's situation and asking team members which treatment interventions have been tried and reminding the team member to alter the intervention based on current symptoms. I witnessed her ability to tailor the intervention to fit the needs of the consumer.

Study aim 2: What does the team leader do and how does she do it? For the Lincoln PIER ACT team, there are four broad core categories emerged from the analysis that contribute to our understanding of what the team leader does and how she does it. These include: (i) performed prominent functions; (ii) notable communication style; (iii) paid deliberate attention to team members' wellbeing; and, (iv) paid attention and effort to setting team culture.

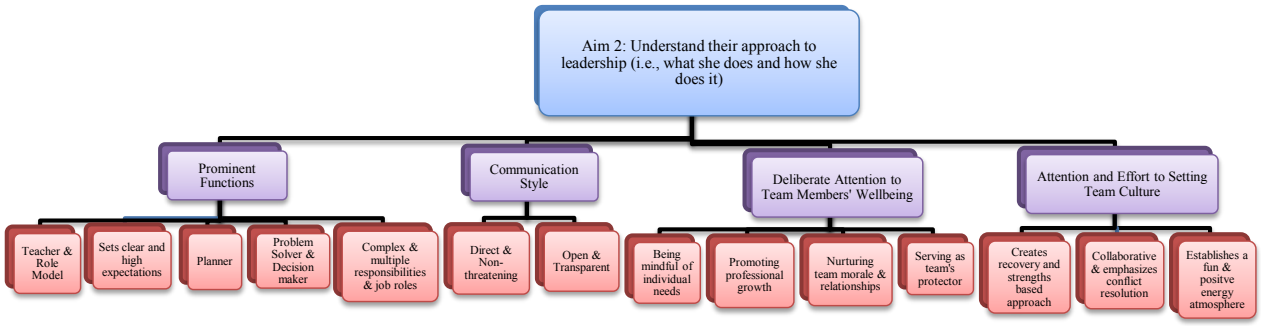

Figure 6: Lincoln PIER ACT Team Findings for Aim 2

Prominent functions. This core category was created to account for several prominent functions that the team leader performed throughout the course of her daily work. These functions included, but were not limited to, being a teacher, a role model, a problem solver, a decision maker and a planner. Additionally, Catherine set clear and high expectations for staff. These prominent functions were singled out due to the impact they appeared to have on team members, or because they helped to understand core components of the team leader's capacity to lead the ACT team. Also discovered was that the team leader performed complex and multiple responsibilities as a team leader.

Teacher and role model. Comments from participants indicated that Catherine was a good teacher and coach, helping people develop knowledge and skills for their work assignments. She enjoyed this part of her job and found it rewarding.

> [Team Leader] Team members joke that, the frustration of when they do call me or if I'm at home or seek me out here at the office with a dilemma, and my general response apparently is 'What would, what feels good to you? What makes sense to you? What are you thinking'? I think I'm good at helping folks sort through information and come to effective conclusions rather than just handing the answer to them. 'Cause I want them to be able to sort through things independently. It's no good if all they can do is what I direct because they're out in the field by themselves, right? Which means you have to be able to sort through it in that moment. So I'm not just gonna say, 'Okay, this is what you do'. What, how can we do this? I think I do well with that teaching component.
>
> [Team Member in response to how clinical supervision is approached] It really feels like an opportunity to learn. It feels like an opportunity to ask all these questions or to hash

things out in a way that feels like you're working with a colleague who's just very, very wise.

Catherine also led by example, exhibited desired behaviors, and served as an example of behavior and activities team members should or want to emulate. I observed her, during the daily team meeting and in informal consultations with various team members, modeling and demonstrating her belief in the basic values of the organization, ACT model, and ideology that people with mental illness can recover and have choice in their treatment. This leading by example was captured by the agency supervisor, as she described below:

[Agency Supervisor] I believe that the way she leads is by role-modeling. She's also able to communicate, model to them that when there's something that needs to be decided, and it needs to be her to make that decision, that she's able to do that without, making them feel less than.

Team members also acknowledged that Catherine led by example and they found this very valuable to their clinical work.

[Team Member] She's very dependable. If she's gonna be late for a client or if we're gonna be late for a client she reminds us, it's important to have that communication… So we can continue to be dependable. And she's very dependable. So leads by example.

[Team Member] I still think it's at least important for me to note that she takes the same number of on-call shifts as every other team member. She's in the weekend rotation just like everybody else. She works just as many holidays. So I mean, she really . . . [Second Team Member] Yeah. [Third Team Member] Once again, leads by example.

In addition to leading by example with her clinical work, team members also noted that Catherine led by example how she balances work and personal life. Catherine herself acknowledged that she tried to role model healthy work/life balance.

> [Team Leader] I also feel that's (how she balances her outside life with work) role modeling for the team too. Um, I think that's, that's an important piece. I feel just as it is for me of looking at this, is, is this a sprint or a marathon, if I want my team to stay, then they have the same question to ask. That is this: do we want this to be a good sprint or do we want it to be a good marathon? And I think there's a role modeling piece there. That if I'm at the office sixty hours a week, what message am I giving them?

Clear and high expectations set. Based on my observations and input from interviews with agency and team members, it was evident that the team leader not only set but also clearly communicated high expectations for the team around work behavior and consumer outcomes. Catherine described that holding herself and team members more accountable led to everyone having greater trust in one another: "I knew that would provide accountability that I think it's a good thing". Catherine admitted to having a competitive nature and wanted to "be the best" and she indicated one way she did this was by attaining as much fidelity to the model as possible. Catherine acknowledged her behavior:

> [Team Leader] I think first of all I set the bar. My staff knows that, the kind of program that I want, the kind of client care I want. They know that I'm a little bit competitive. Um, so there's a bar that's being set, and I think it's communicated even just based on knowing me and my personality, my temperament. Things are being communicated. So hopefully, so if I've set the bar here and not here [demonstrates with her hands], right, then that's gonna create some motivation that, "Crap, we're not here yet".

> [Team Leader] What do I want to accomplish – broadly, big picture is I want a really freaking good ACT team. That's what I want. I want the best ACT team that we can possibly have, and we're helping clients have the absolute best lives that they can have. That's what I want. I want to be an ACT team. I don't want just a good program. I want a good ACT team.

Team members commented that they knew the expectations of the team leader and how that contributed to the overall team, and several times those expectations were very influential: "She's open and honest about what she expects, and she's consistent in her expectations. You know, with us and from the other agencies", and "I was just gonna say her expectations of us are influential. She expects each one of us to be a leader in some way. So that's clear to all of us".

Catherine also explained how, at times, she found it hard to hold team members accountable to her high expectations. She described this challenge and explained why she found it necessary so not to sacrifice the program or work of the team, which was part of the overall vision.

> [Team Leader] I didn't know how I'd ever be able to manage that [corrective action with a team member] 'cause it's not a natural part of my personality. I like to be liked. I'm a social worker. I work really hard to be strength based and to capture people's strengths and focus on those and all that piece. So, how do you do the other when you have to. How have I done that? Um, because I have no choice but to do it. Because I will not give up my position of leadership. Because I will not, um, sometimes there's a bar in the sand, there's a line. I literally, I dread that meeting. I take a deep breath. And whether it's letting a person go, whether it's just, putting a person on probation again, whether it's okay, there's now a formal letter being placed in your personnel file; this will change in

> the next three months. This is what can happen. You know, all those are the same thing in my mind they're all yucky. None of them feel good. I do it because, I'm not gonna sacrifice my program. I'm not gonna sacrifice my leadership position. I'm not gonna sacrifice what could impact my team and what could impact clients. So this is one of those things where I have no choice.
>
> Team members acknowledged this goal and stated "We're gonna be the best in the nation. I mean, she's so damn competitive [Laughter]".
>
> [Team Member] And her competitiveness drives us to be the best we can. And fidelity, high fidelity basically is our measuring stick. [Second Team Member]I think she also ties that back to our clients, these are the best. And, you know, we aren't doing well in this department, we can do better because they deserve better. That's the way it is.

Planner. Catherine was also described as a planner. Typically in collaboration with others, she developed tactics and strategies for achieving the team's goals. She described emphasizing the necessity of being planful and deliberate when possible and felt this helped her be organized in all she did. Part of being planful included an organized framework to do the work and be non-reactive. While on-site, I witnessed how she anticipated situations and created plans in a preventative manner. I heard her comment that her motto was "be prepared". When things did not go as planned, she was tolerant of frustration and acted calmly and patiently per participant reports.

> [Team Psychiatrist] A lot of times when people may have a leader that does it all and that leader goes on vacation the place tends to crumble. And this place doesn't. I mean, she has it set up . . . even that she'll have it set up ahead of time. Need to report to this person. This is who, you know, any questions, any issues.

> [Team Leader] I do a lot of research first and come with my ducks in a row. I have it laid out before, even if it's just, you know, having my thinking clearly organized. And not just, 'Well, this sounds like a good thing. Let's do this'. You know, I, I actually think ahead of time, 'What opposition might I get to this? And, and how can I manage that'? So I make sure that I can communicate clearly as to why this is a good thing to do. You know, I wanna make sure that I have my arguments in line.

Problem solver and decision maker. The team leader was also identified as a problem solver. She effectively identified, analyzed, and resolved challenges and uncertainties to arrive at a decision. She was intelligent and displayed pragmatic judgment. She had the ability to think about the outcome she wanted and how to go about getting it. I observed during the team meeting and in discussions with staff, Catherine demonstrating the ability to critically think about various outcomes to manage risks better. She was assertive in solving problems and did not delay decisions. Comments from participants indicated that the team leader supported the idea that all challenges have solutions, and she encouraged team members to actively work to overcome barriers. The following quotation from the agency supervisor is an example of this: "I feel that she's pretty, most of the time I would say she's pretty head-on, you know, if there's a problem, let's identify it, let's get it addressed, let's move on".

The team leader also confronted and solved problems in a professional manner, helping the team move past hardships by often reframing challenges, and taking opportunities to "educate". A team member had this to say:

> [Team Member] I know sometimes I get really frustrated if I feel someone has not served one of our clients professionally or treated them well. I get really frustrated sometimes with having verbal communication with that person. And just having Catherine reflect

> and say, you know, there is a way that we can still advocate for this person and maybe still try to help provide education to the individual who is struggling with those things. Just making sure that our interactions with others amongst different agencies, that we keep trying to educate on how, what we do and leaving on a good note instead of, ah, a not so good note. Just so that communication's still there and not broken.

Catherine modeled for staff how to reframe negative situations into positive ones, and often did this behavior in the spirit of quality improvement. When asked the question of how she frames challenges to the team, she replied:

> [Team Leader] This is gonna be a fun challenge…or sometimes I'll say, 'It sucks. But we've gotta do it anyway'. But generally if it's something that this is about our program getting better, this is a good thing. You know, it can be scary, it can be frightening, it can be overwhelming, but this is a cool thing.

Catherine reported the strategy of breaking down big problems into manageable parts: "so start and at each hurdle you problem-solve it as you get to it".

Catherine was also a decisive decision maker and adapted her style of decision making based on different contexts. She made timely decisions that were in the best interest of the client, team, or organization by analyzing all available information, distilling key points, and communicating clearly to execute her decisions. She indicated it was important to share the rationale of why she made a certain decision with the team. In her decision making she followed a flexible framework, where at times she was very democratic, asking for collaboration and shared decision making with co-workers but at other times, practiced an autocratic style, making decisive decisions when needed. These comments highlight some nuances of the team leader's decision making processes:

[Team Member] I mean as much as she is kind of in the trenches with us there are certain things that you go to Catherine for her approval. Like, somebody needs to access fifty bucks to get a pair of shoes, like, she's the one that has to approve that. That you have to present your case to, like, the person needs new shoes. Or the ultimate decision about whether we do med observations on somebody or phone prompts or something. I mean that all gets run by her. And usually she'll go with the consensus decision, but, like, on admissions and stuff, she'll tell us 'This person is coming'. So that piece isn't, I guess, shared with the team.

[Team Leader] It comes back to that ability to do multiple tasks and to sort through information quickly and to prioritize quickly when necessary. I don't need to think a decision over. You know, in that moment of crisis when it's like, 'Oh, crap. We have to do something now.' I have no problem sifting through the information quickly and going, 'Okay, this is what we're doing.' You know, that there's times when there's time to process and sort through, and times to let it simmer. And there's times when you can't let it simmer and there's not room for discussion. There's not, it's, 'Okay, what you're doing right now is this, step one, two, and three'. And I think I'm good at kind of deciphering that.

Another important quality in the decision making process for Catherine was that she had come to realize that she needed to make the tough or unpopular decisions in order to effectively lead the team. This means that, at times, some individuals may not like her or may be angry with her decisions. She summed it up in this way:

[Team Leader] I have gotten more comfortable with not being liked, and that's a piece I had to learn, but I learned pretty quickly. There was an epiphany moment somewhere

> during year one. I can't even recall the details of it now. All I know is I remember sitting there thinking, 'Someone's going to be pissed. And there's nothing I can do. I have to make a decision". There's not an option that's pleasing everybody. It's either my leadership's gonna be upset, my team's gonna be upset, a client's gonna be upset . . . that there's nothing that I can do that isn't gonna piss somebody off. And I have no choice but to make a decision. I've gotten more comfortable 'cause I realized that I have no choice. I cannot please everybody. Not everyone's gonna like me. And if I want this job I have to be okay with that. I just have to be. That piece I knew I had to get comfortable with or at least – not uncomfortable with – had to do anyway. I knew I couldn't ignore it.

Catherine indicated for her decision making, she relied on her intuition and was very comfortable with ambiguity—not needing to have an answer for the sake of getting something done. The team leader comfortably handled vague and difficult situations where there were neither simple answers nor a prescribed method or protocols for proceeding. She felt there is a big difference between being impulsive and gathering information quickly, versus sorting and prioritizing the information, and making an informed decision.

Complex & multiple responsibilities and job roles. The final theme under prominent functions that described what Catherine did was that she had complex and multiple responsibilities and job roles that she performed. Catherine had a myriad of job roles and responsibilities in the daily operation of ACT that answered "what she does and how she does it". Moreover, Catherine switched between all these various roles fluidly and efficiently. In order to be successful, she needed to be flexible and adaptable to any situation. Participants reported that the team leader juggled multiple responsibilities and wore multiple "hats". Catherine summed up this idea in the following ways:

> [Team Leader] So, it's challenging, simply just the absolute number of different tasks and responsibilities and juggling you have to do. You know, there's a piece, like we talked about yesterday of juggling, okay, in this moment I'm in the office being a supervisor, in this moment I'm being an administrator, then I'm out being a clinician. And that switching hats, that quickly, you know during the day. That, when I'm with a client I can't be thinking about a personnel issue. You know, so that's challenging.
>
> [Team Leader] There's a multitude of kind of different tasks associated with that [clinical supervision]. Again that comes, that's balance again with clinical supervisor/administrator, right? That, that they're two different hats that, it really, I kind of mix and match both of those hats within that time depending on what's going on.

Participants described responsibilities and roles that blended a combination of clinical, supervisor, and administrative tasks. Her clinical responsibilities and/or tasks included, but were not limited to, direct client care, outreach and screening of referrals, initial assessment and on-going provision of treatment and rehabilitation, on-call, and crisis management. Catherine found great value in the clinical piece of her work with ACT. The following quotations give a sample of the clinical responsibilities Catherine had and her opinions on those clinical responsibilities.

> [Team Leader] I like if I could get out of the office every day with a client. I like that because that is my break. It's just I get to turn that piece [team leader/manager] off for that hour. I get to focus on just the client, in that moment. It's kind of a break. Hence, why I can't imagine a job where that's not available. Where it is just the management piece. I think that provides for me an absolute balance that would be really missing as much as it adds some challenge. You know it [seeing clients] just adds a lot to my work satisfaction. I don't think I'd be happy if I was that far removed from direct care. Like

> you can do just direct care, or you're doing just management. And you don't have that blend of both that I get to have.

Along with the clinical tasks, Catherine and other participants described administrative tasks that were the responsibility of the ACT team leader. These administrative tasks included, but were not limited to, coordination between three separate agencies, liaison with upper management, team management, hiring and training of staff, conducting performance reviews and corrective action with staff, and scheduling all activities across the team. According to the agency supervisor, Catherine was good with the business side of the program: "You know in leadership there's the clinical side and the business side of running a program. I think she does a really good job of... she doesn't ignore the business part of it".

Catherine also provided a supervisory role. This role was intertwined with the administrative role; however, she described it as a separate activity that the team leader performed.

> [Team Leader] I kind of separate it [the roles and responsibilities] out in my head I have the administrative piece which is the program as a whole. And that's my relationship with my leadership, that's the budget piece, that's the day-to-day functioning of my team. It's, are the wheels – it's the big picture. Are the wheels turning? Is the program functioning? Is every cog in the wheel doing what it needs to do? It's the, for me administrative is the really big, big picture. Um, and then, with that, if I separated out supervisory is then, there's this other level. And that's about providing the management of my team directly. Are they getting the guidance, the support, the feedback, the structure that they need to then provide the direct care. So for me I, I feel they're quite separate.

Catherine practiced a consistent guidance to her staff and provided overall supervision to team members. This supervision was observed throughout the three days on-site, both in a more formal manner at the daily team meetings and consumer treatment planning meetings as well as informally in “chats” with individual team members throughout the day.

In weighing the personal weight of the various roles, the team leader indicated that she believed that administrative work and overall leadership was harder than the clinical work due to the constant emphasis and awareness of overall relationships among team members (amongst themselves and in relation to her), and larger agencies' leaderships. However, she also noted that having a blend of clinical, administrative, and supervisory job components was highly rewarding for her.

Communication style. The second core category that highlights what the team leader does and how she does it was her communication style. Catherine expresses her ideas and directives in a direct and non-threatening manner. She worked to be open and transparent with her communication, using plain language that was clear and understandable. Additionally, when possible, Catherine detailed disclosing information to the entire team when it affected the work, and saw this as important to keeping harmony between team members. According to a team member, "She's [Catherine] got good communication skills".

Direct and non-threatening. While on-site, I saw several examples of Catherine's candid and honest communication style in team and treatment planning meetings, as well as with other, more impromptu staff interactions. While Catherine's style included direct and straightforward communication she was very respectful, such that the recipient did not seem to feel attacked or belittled. Participants illustrated the direct and open communication with the team leader with several examples. One example from a team member was "But I think also direct…. When

that's needed…. And in a way that is not authoritative, divisive or confrontive [sic]". Per Catherine:

> [Team Leader] ….and I think I can give feedback in a way that's not attacking, not demeaning, not, you know, I think I'm good with my words, and there's a tact there that helps with my relationship with the team. But, and it's also directness. The team members know where they stand, and I think that assertiveness piece helps too.

Participants relayed that the work environment was non-threatening and thus promoted the psychological and emotional safety of team members. Team members felt accepted, respected, and willing to take interpersonal risk within the team. All team members were able to speak up without fear of retribution and encouraged to celebrate difference of opinions as they knew this concept was supported. Team members stated "I guess I would say though, too, she's taken steps maybe to address the group to make sure that everybody feels safe and respected in this environment. [Second Team Member] Very true".

Open and transparent. Participants identified that the team leader encouraged an environment that promoted open and transparent information transmission with one another. The team leader invited this open communication along with knowledge sharing via her transparency of information and communication directly with the team. Catherine was observed to be transparent by disclosing the rationale behind her decisions, articulating steps as to how she arrives at certain decisions, and avoids backdoor discussions with individuals. For example, I witnessed her disseminating information in a very equitable manner (e.g., telling team members information all at once versus separately) about a program change.

> [Team Member] We had a situation where we had to have a staff member not be with us anymore. And that was, really hard news, and it was, 'This person is no longer with you.

> I'm going to respect their confidentiality, and I'm not, if you ask me questions, I will not answer them. And everything will be okay. We'll move forward, and I will be reassigning clients later'. [Second Team Member] And everybody, the entire team was, she's very conscious. She had the entire team in the room and said, this is what it is. Nobody had to hear it second-hand.
>
> [Team Leader] My whole communication style is very open. I'm trying to think of examples, you know with that. We've had clients pass away and I communicate very directly and very matter-of-fact. I think that any other way is disrespectful.

When asked why she promoted this open and transparent communication style and process, Catherine indicated that she felt that this style shared knowledge and power in an equitable way among all team members. Team members rarely heard about significant issues second hand, and the team leader felt this improved the dynamics of team work and the cohesiveness of the team because she was respectful to the collective group.

> [Team Leader] You know, that I'm sharing that power. I'm sharing that knowledge. I'm saying, 'This is yours as it is mine'. You know, if we're going down, we're going down together. You know, it's not just me. You know, and if we're doing well, we're doing well together. That's not just me either. Um, and so that shared – you know, that this is, we're in it together now.

A positive outcome from the open and transparent communication of the team leader and team members was that gossip, office politics, and "silliness" are minimized. Catherine's leadership had promoted open discussions between each team member, addressing concerns before they became more problematic. The minimizing of gossip and politics in the work place led to improved job satisfaction among some team members. According to one participant:

> [Team Member] The one thing that I think about often when I think about this organization is an absence of silly political gains in terms of our relationships with each other. And that work environment is due to her leadership, in many, many ways. But at the heart of it, I don't think it's, frankly I don't think this happens so much now because she's so steady. But one of the things that I observed some time back was that when a team member had an issue with another team member, there's a lot of people who talk about teams, and very few people who do it well. When a team member had an issue with another team member, what Catherine would consistently do, if they came to Catherine is, 'Well, have you talked to that person'? And, and frankly she does the same thing with individual clients. 'Have you talked to them'? So that she just consistently, as a matter of course, encourages straight-forwardness and directness. And that contributes a great deal to, to my satisfaction with the job and to the lack of silliness in this place. We don't have time for silliness.

Deliberate attention to team members' wellbeing. This third core category illustrated that the team leader paid deliberate attention to and nurtured the individualized needs and well-being of each team member. She showed genuine concern for and fostered each team member and his/her well-being (both personally and professionally). Within this core category, four themes emerged including (i) being mindful of individual needs; (ii) promoting professional growth; (iii) nurturing team morale and relationships; and, (iv) serving as the team's protector.

Being mindful of individual needs. The team leader understood and recognized the unique needs of each team member and actively and intentionally worked collaboratively to develop and advance team member's personal and professional needs. Catherine was described

as being highly attuned into her team members' feelings and concerns. Team member participants stated:

> [Team Member] I think she cares about us as individual people, like, outside of work. I mean she'll always ask, 'Well, how was your weekend? How are your kids doing? How are you feeling today'? Or, she'll notice that you're not feeling well, she'll say, 'You look like you're not well. Are you doing all right'?

The team leader recognized the attention she focused toward identifying and paying attention to the needs of individual team members. The information she learned was used for fine tuning her supervision or management style. Catherine stated that she continually challenged herself to adjusting her work style to reach individual team members.

> [Team Leader] But then there's also this challenge, it's different for each team member. And working on identifying what is that for each team member. How do I know which team members the personal notes mean everything to them 'cause they have them plastered on their office walls. You know, I don't think that holds meaning for [team member name]. For [different team member name], for [another different team member name], every personal note I've ever written them is on their bulletin board. Okay, mental note to self, that means something for them. But figuring that out for each team member is a really fun challenge. That what works for one person isn't gonna work for the next.

Catherine worked hard to provide professional and intellectual stimulation for team members and saw this as a strategy for retaining great staff:

> [Team Leader] Each team member, regardless of their discipline is bringing a skill set, an area of strength and area of expertise. And that's what I want to build upon with them. And with that each team member is bringing an area of weakness, right? Based on their

discipline... I'm managing a group of individuals that bring unique gifts to the team that I wanna draw upon.

When Catherine was asked if there was a reason for her heightened attentiveness to the individual needs of each team member, she said this:

[Team Leader] …and I think, with every passing year, I recognize of equal importance to caring for the clients that we serve is me caring for my team. And if I don't care and nurture them, you know, they're kind of right up there for me with the caring and nurturing that I provide my clients. That if I don't nurture and care and give feedback, then they're gonna go. I think they'll go. I don't think they'll stay. 'Cause I don't think just knowing that you're doing a good job is always enough.

Promoting professional growth. Catherine extended her concern for team members' lives and needs by also showing genuine concern for their professional growth. One example of attention and development of individual team members was relayed by the agency supervisor: "She's always very interested in looking at growing her people, as I kind of term it… and helping them strengthen their abilities and working with the consumers", and further examples were highlighted by team members:

[Team Member] When I said she's trustworthy of us, you know, and everybody's kind of said she'll step back and let us grow and develop. I mean, she expects us to navigate our own issues with our own clients, but she'll offer guidance or ideas if we need it.

[Team Member] She kind of picks up on subtleties. She'll kind of say, 'it looks as though maybe you're asking a lot of questions about the admission-side of ACT. Do you wanna go with me some day to do an assessment'? So, kind of asking, what are your professional goals, and how can I help you meet those? Even if it's not here in this

> moment. 'But what information can I give you that will make your life as a professional better'? That's . . . definitely the key to my job satisfaction here.

Nurturing team morale and relationships. The theme of nurturing team morale and relationships included comments that highlighted that Catherine had an intentional and primary emphasis on assessing the team's status and/or energy and worked to build and support bonds between team members and also between the team leader and team members. Along with these ideas, comments highlighted the significance the team leader placed on the nurturing of team members. This deliberate focus on nurturing the team demonstrated how she put forth effort to create a desired work environment.

The team leader described the idea of team energy and how she paid attention to staff and the overall team morale in the following ways:

> [Team Leader] I came in with the belief that if my team isn't functioning here, we're not going to be providing good client care....You know, I think there's a natural ebb and flow. When it dips a little I don't worry too much. How do I track it? Um, it's the energy in the room. It's the vibe. It's very subtle. You know, no one is saying, 'Morale sucks around here'. You know, no one's that generous unless they say, 'We need a potluck'. It's, it's the feel. It's the energy. It's the vibe. It's, is there laughter out there? It's who's talking to whom. Who's communicating with whom? Is someone in someone else's office with the door shut, and why is that? Like sometime, but is it happening every day? So [team member name] going into [team member name]'s office with the door shut, you know. No big deal. If I'm seeing it on a daily basis . . . well, that's kind of odd, you know, 'cause we have open door policy. You know, pending those, every now and then you have a private conversation but day-to-day it's an open door policy. So it's looking at

those subtle things. There's the same people, you know, tardiness, late, absenteeism. Those are pieces that you're really just not happy with your job. That you don't want to be here….so that's how I take the pulse.

I asked Catherine how she kept the team morale. She responded:

[Team Leader] I keep it [morale] up by acknowledging this is hard work. I keep it up by [saying] what they do is impressive and they do something that not everyone can do. I keep it up by allowing laughter and allowing some silliness. Um, because that doesn't hurt anything. I keep it up by letting them know that I appreciate them, whether that's by telling them directly, whether that's by listening to them tell me about their kids, whether that's by approving a potluck. That's why I celebrate, celebrating anniversaries and baking a cake myself and bring it in. I keep morale up by encouraging them to attend a training or a conference, I think those are not just educational, those are morale-boosting.

[Team Leader] I've let team members know that I'm glad they're here. It is always in my awareness that if I'm feeling how much I'd like to get support and feedback, then it keeps me on my toes, you know, that—am I giving that to my team? I have learned I think to almost overdo it (support and praise).

Catherine expressed how important it was for her to pay attention to the relationship team members have with one another and with her. This deliberate attention allowed her to nurture the team and to make sure all team members were following a shared vision for their work. She described it like this:

[Team Leader] So that's super important to me. That I somehow make sure that we have effective working relationships. That we're, to some degree, enjoying each other. That we can communicate. That we're respectful. That we're strength-based within these walls.

> Um, and then what happens is then you get, that becomes a shared vision too because so many folks have said, so many team members have said how important that is to them. That now that they've had that, they don't want to lose that. That they've not had a team experience before where it feels like that. And so now they've got buy-in to that piece of the vision too. And they're gonna work to make sure we don't lose that piece.

Catherine reported that she directly asked team members why they stayed with the team or what they needed in their work lives. Many answered a major reason was because of the team they worked in.

> [Team Leader] I ask people directly 'why do you stay?' and the top couple (of responses) are A) I love the clients; B) I love the team…that I love not working alone. I've never had this kind of camaraderie, this kind of team.

As noted before, Catherine saw nurturing the team and its members as equally important as nurturing the clients. The deliberate attention she placed on team issues/dynamics and relationship sustenance among team members was more work that she ever predicted, and it was a constant focus of her attentive leadership. She indicated that managing the team was harder work in many cases than managing clients. It was a "constant job within itself", and,

> [Team Leader] I had no idea how much work that part [leading a team] would need. Because we're all professionals, we're all skilled, we're all just here to serve clients. Good. I had no, I guess I didn't know that that was a job in and of itself. That it's not, yeah, we're all a group of professionals who are skilled and mature and, that the time that I realized I had to devote to that piece was a shock.

Team members were able to see the value of Catherine "checking in" and being intentional with keeping focused on team members' wellbeing and health relationships. One participant put it this way:

> [Team Member] When you talk about her checking in to see what's going on with other people's lives, and we get to have that exchange with her about what's going on in her life, I think that does give us permission to feel like, you don't have to be this kind of stereotypical burnt-out social worker.

These relationships with team members and her ability to handle personnel issues while being very supportive were identified by Catherine as essential to her leadership. She expressed enjoying the challenge of helping team members love their jobs. Importantly, Catherine indicated that while she was friendly, everyone was respectful of team boundaries, and she did not consider herself friends with any team members.

Serves as team's protector. Catherine functioned as a fierce and politically-savvy advocate for her program and the consumers. She advocated for both ACT and recovery based treatment, supporting these causes strongly and publicly. Additionally, she was a strong advocate for the team and described herself as a "mama bear", shielding team members from outside challenges as a protective factor. A team member described Catherine's protectiveness in this way: "beauty is we've been shielded from it [state pressures] so we can go on and do our job and not worry about it". Catherine described that she gets most irritated at the mental health system that was not client-centered and stressful for the consumer.

The team leader showed a high degree of political acumen, being quite good at judging other situations and/or people and showing intelligence, insight and sound judgment in sensitive situations that helped facilitate protecting the team. Given the fact that Catherine ran a reputable

program, she had built up trust and political capital for her consumer and program's advocacy. Over time, she had created and fostered many program allies, which she reported helped her to protect the team.

> [Team Member] She's an advocate on all different levels. People are committed by the mental health work because of the apparent reason for that, she'll fight for that if other agencies aren't able to see things the way we do here she'll prod them forward, I guess you could say. In a, in a non-threatening, pleasant way.

Catherine decided what to spend time, energy, and resources on versus what to "let go". She often stated "It is what it is", which highlighted that some challenges she assessed and determined to accept without compromise.

> [Team Leader] I can't control those (outside) systems, I can't change those systems, I can't change those individuals that are managing those systems. There's nothing that I can say or do that will impact that, so it's purely what do I need to do to work with it. And now what do I need to do, you know, to get the outcome that I want? There's not a lot that frustrates me. There's not, because it just is.

Catherine summed up her advocacy for the team in this way:

[Team Leader] …so I wouldn't let it go. I think that's where it comes down, I think the other piece is I pick my battles. That's a big thing that I, I'm always aware of. That . . . if I'm putting down my ace I want it to really matter. And I think you do only have so many cards in your deck and you want to use them wisely. Um, 'cause if I'm constantly butting heads and constantly picking a battle then I think what I want to say will hold less meaning. So exactly what is most important to me, what, okay, I can let this one go.

Attention and effort to setting team culture. The fourth and final category that addressed understanding the team leader's approach to leadership was that she paid attention and effort to setting the team culture. This category documents observations and reports indicating that the team leader paid deliberate and constant attention to the team's work environment, culture, and relationships with one another. She questioned how to establish and keep the work environment positive and cohesive with effective working relationships among team members. Catherine focused attention on the maintenance of a desired ACT team culture. She directed deliberate intention to create a recovery and person-centered environment within the team. When asked the question of 'what are you trying to accomplish as a leader'?, Catherine replied with this comment on work environment:

> [Team Leader] The other piece . . . I want to accomplish is the work environment is big for me. I think it's an amazing piece of the puzzle. I find it fascinating that work environments take on a culture of their own, and how are they created, and how are they changed, and how are they sustained? And how do these really crappy work environments happen? And why did it happen? And how has it been allowed to happen. I find it fascinating…how do you get all these different people to buy into something and to work together every day and to not wanna kill each other. How, do you do that and how do you keep it going? 'cause again, I think that's another one that could go at any time. As much as I'm really pleased with where we're at, I don't ever exhale on it. So how does that stay for ten years? Is that possible? You know, what do I need to do? What do my team members need to do? We're at a comfortable place now and that will change.

Within this primary theme of attention and effort to setting team culture there were three subthemes. These subthemes included (i) creates recovery and strengths based approach; (ii) is

collaborative and emphasizes conflict resolution; and, (iii) establishes a fun and positive energy atmosphere.

Creates recovery and strengths-based approach. Catherine focused on creating and maintaining a recovery and strengths-based philosophy within the team. Material included under this theme illustrate how the team leader's vision built, promoted, and sustained a work philosophy that focused on people with mental illness having choice and control in their lives as well as the belief that individuals with SPMI can move toward greater mental and physical well-being and recovery.

I saw several examples of how the team leader solicited, listened, and incorporated consumer choice and input into treatment. I witnessed this behavior most prominently during the treatment planning meetings where Catherine deliberately engaged the consumer in dialog asking several questions about desires, goals, satisfaction with ACT services, and soliciting the individual's opinion on his/her health. When I asked Catherine about her behavior at the treatment planning meeting, she replied:

> [Team Leader] This is my one opportunity to get information. I don't see this client every day, every week, every month even. Here's my one opportunity, to get information that I want. Here's my one opportunity to engage with this person, to interact with him.

Catherine continually promoted the independence of the individuals served in ACT and worked hard to keep services from being paternalistic or controlling, although she admitted this was a challenge given attitudes from others/outsiders. According to her "Yeah. It's client-centered. And, you know, the long journey. Allowing a client to try and fail. Not being paternalistic, not being protective, not – and you some days you feel really alone", and "the lack

of control that we put over a client I think is hard for some [community providers] to understand. That it's, 'you just need to keep them safe'".

The team leader also focused on consumer strengths rather than deficits and never interpreted consumer behaviors in a negative way (e.g., blaming the consumer for having control and not exercising it). I observed Catherine reframe negative situations by highlighting the positives or strengths of individual consumers. Team members commented on how Catherine highlighted consumer strengths: "She starts out with strengths of individual clients", and,

> [Team Member] You hear her say 'reframe' a lot. Like, 'Reframe it.' You know, the client doesn't have work. Reframe, they've been out of the hospital for two years, they are increasing natural supports, and they've maintained independent living.

All team members expressed the belief that individuals with SPMI had the potential to get well, live full lives of their choice, and spoke of consumers with sensitivity, admiration, and respect. This team philosophy was supported also within the physical environment of the team, by the posters on the wall and with team documents, such as the mission statement of the program that promoted recovery.

Collaborative and emphasizes conflict resolution. Another way that the team leader established and supported her desired team work culture was through the creation and support of a collaborative atmosphere that emphasized conflict resolution. Comments suggested that the team leader worked to build a cooperative and collaborative work environment where team members worked toward common objectives. The team leader promoted finding amicable ways for team members to work out disagreements directly among one another. The team members were described by outsiders as being very collaborative.

> [Agency Supervisor] I will say one of the things that I've really recognized with this ACT team is the cohesiveness. We had a CARF[21] surveyor that came to survey this program say she just loved it because she sat at that table and couldn't tell who was who, but knew they were all working together because of the way they communicated to each other and how they were talking about consumers.

One contributor toward the team's cohesiveness was that the team leader promoted a non-hierarchical paradigm among team members. One team member described this equality in this way:

> [Team Member in response to question of 'what makes this team be one of the top that you've participated in over the course of the seven years'?] But I think a lot of it is just the culture that's been created in the team. For example, we hired [team member name]. She's a therapist, but you're a therapist in quotation marks because you're no better nor worse than the nurse and the case manager and the team leader. And so I think that the culture that's been created is one of, like, we're all in this together. The client is the most important. Hang your credentials up on the door on your way into the building because once you are here you are an ACT team member, not a therapist or a team leader or this or that. You are a member of this team.

Along with this idea of equity, the team leader set the presumption that team members would have different opinions, collaboration was important, and having different perspectives were not defined as "right" or "wrong". Diversity among staff was described as a desired aspect of the team.

> [First Team Member] I think that longevity of the team members too . . . we've had just enough time together to appreciate each other and work together. [Second Team

[21] Commission on Accreditation of Rehabilitation Facilities

> Member] We're equals. Yeah. [Third Team Member] I think the group's real healthy in terms of being able to confront and solve problems. [First Team Member] And the, I guess, we're in Lincoln Nebraska so we're not that diverse, but the diversity of the team, you know, is valuable. Just the different ages and backgrounds and genders.

The benefits of nurturing positive and healthy relationships among all team members had significant benefits. One participant summed it up this way "I think the relationships that are created between us generate loyalty and job satisfaction".

Establishes a fun and positive energy atmosphere. The team leader worked to create an enjoyable and pleasurable work environment. Catherine acknowledged that ACT work was hard and that it was important for the team to have some balance between the seriousness of their work, and enjoying the work and one another. She believed that using humor lowered the stress of the staff and built community.

> [Team Leader] My team right now has a good balance. I would hate for that to go because I think it leads to a work environment that's, more enjoyable. This is freaking hard work. It's hard work and I think being able to joke and laugh is super important. And I have a team right now who knows that, who can find that balance on their own really well. I can jump in and get them back on track pretty easily if needed. I don't think the laughing/joking piece really ever crosses a line. I just think it adds to a work environment that's more enjoyable and more, this team is tight.

Catherine used several strategies to create and maintain a positive work atmosphere including validation, positive reinforcement of desired behaviors, and staff acknowledgement. There were several examples observed where the team leader recognized, motivated, appreciated and celebrated team members. She sent notes to individuals for a job well done, or

acknowledged a particularly difficult situation the team member managed, or gave encouraging words to a staff member. She openly acknowledged the reality of the work, difficult situations and the positive work of team members during the team meeting. Team members shared they felt valued by Catherine:

> [Team Member] I think too the way she recognizes and celebrates, like, our little accomplishments is huge. She does it in a personal way, like, she'll bake a cake and say, 'You've been here three years. That's phenomenal". [Second Team Member] Notes. Write little note cards to you. [Third Team Member] Sticky notes. Yeah, note cards.
>
> [Team Member] We have a lot of clients that are sick at the same time that, and it might be, um, just feel like really heavy or difficult month. I think what makes the difference is I feel supported by my team members and that helps. And then it goes back to being valued, that I feel really valued by Catherine and my team members. But I think Catherine does a good job of expressing that.

Catherine also made time and supported the celebration of certain rituals that contributed to a positive work place. The most notable and frequent to come up when I asked about ways of celebration was that the team held potlucks. I asked Catherine about these events, which clearly had significant value to the majority of team members.

> [Team Leader] The purpose [of having a potluck] is, it's to celebrate. Sometimes they make me find things to celebrate. If we don't have one for a few months, it's brought to my attention that we've not had a potluck for a while, and we really should be scheduling a potluck. When I was doing the assessments, with my team on, on why do they stay, more than a few mentioned the potlucks [LAUGHTER]. There's some legend behind our potlucks. It's important to my team that we take that break from time to time and during

> potlucks we don't talk about work. We take a full hour lunch. Sometimes team members will bring it up and I take that as a cue that we need to exhale as a group. And a potluck is a group exhale. So if a team member says to me, 'It's time for a potluck' I generally trust that it is time for a potluck...You can feel the energy in the room go [SIGH] okay, it's grounding, it's exhaling.

The idea of keeping the "pulse" of the team's energy was brought up once again within the context of promoting a fun and positive work environment. Catherine deliberately monitored the energy of the work environment to assure it was not tense and remained a place that workers wanted to be in.

> [Team Leader] …regarding the team's energy. If it's tense—and I came from an ACT team with a lot of tense energy on it. Um, I remember on the other ACT team that I worked on, dreading team meeting. And not wanting that because you didn't know who was going to be attacked on that day. So it's been a very conscious decision to always monitor, to always have a pulse on it [team energy]. I think what has happened as each new team member comes in, they get that it feels good. And they get that it feels different than most other work environments.
>
> [Team Member] I'm thinking that there's a, it's pleasant to be here. It's not a, when you go to work sometimes you can have a job that you kind of feel eaten up. This job, it's just, really enjoyable to see people grow, and they hook into us pretty well. And that kind of can, we hook into them. It's kind of like I'm gonna miss something, you know, not being here. There's a real positive part of your life that, ah, makes the rest of the world seem, you know, doable. This has been a pretty healthy work environment.

Catherine herself was seen as a fun person that others found uplifting. While she worked hard to make team members feel valued and intentionally worked to extend her gratitude to them for their work, it was noted that this was reciprocal. Catherine's office was littered with cards of gratitude and notes of thanks and I witnessed several verbal interactions where staff members were validating and thanking her for her leadership. Team members said this:

> [Team Member] She's very fun.[Second Team Member] She's very fun, and I've heard more than a few clients comment on, 'Well, look there's Catherine smiling again'. Like, even the twice a year contact they have with her at treatment planning, they know that she's gonna be smiling and laughing and that it's gonna be an uplifting experience to be around her I guess.

Study aim 3: Understand the roles the team leader plays in promoting high fidelity ACT. There were four core categories identified that informed this third study aim with the Lincoln PIER ACT team. The core categories included that the team leader: (i) plays a critical role; (ii) has knowledge, faith, acceptance of the ACT model; (iii) practices assertive advocacy for high fidelity ACT; and (iv) reinforces a high sense of accountability specific to ACT fidelity.

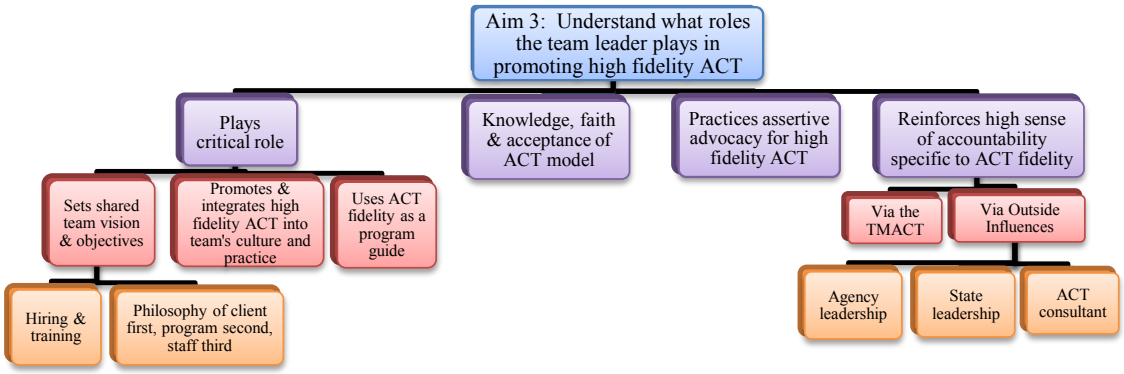

Figure 7: Lincoln PIER ACT Findings for Aim 3

Plays a critical role. Lincoln ACT team members indicated that Catherine played a essential and full role in promoting high fidelity ACT services. She was identified as a key person in promoting the team's ACT fidelity. The agency supervisor summed up Catherine's role promoting fidelity to the ACT model in this way:

> I would say all the times [she promotes fidelity].100%. I mean, she, it isn't just when, when somebody's coming to do the fidelity role or review. I think throughout her work she's looking at that so that it doesn't just all at once come down crashing. Because as I know, it sounds like up-front there's quite a bit of preparation for the review. And if you aren't already doing a lot of the fidelity stuff, there's no way you're gonna pull it all together. So I think day-to-day work.

When team members where asked during the focus group when Catherine communicates with them on fidelity to ACT, one response was "When doesn't she [Laughter]"? Again, highlighting that Catherine keeps a constant focus on fidelity and the ACT model.

Catherine shared that fidelity to the EBP of ACT was important to her and her leadership. When asked about the EBP of ACT, Catherine replied: "On that. For me it's been an important piece since day one. I've been committed to that".

Three themes emerged from the data that explain Catherine's critical role in promoting high fidelity to the ACT model. She set a shared team vision and objectives for high fidelity ACT services within the team and continuously promoted and integrated high fidelity ACT components into the team's culture and practice. She used ACT fidelity as a program guide and fidelity factored into the decisions she made.

<u>Sets shared team vision and objectives.</u> Comments contributing to this core category of playing a critical role articulated how the team leader both set the team's dream and goals for the

future on what and how high fidelity services were to be provided to individuals with mental illness, and promoted that strategic vision in the day-to-day work. Participants indicated that much of Catherine's vision drove the ACT program's design and implementation. She was described as having the ability to step back and see a bigger picture for service delivery, and felt a responsibility to hold the vision for all aspects of the model. She replied:

> [Team Leader] I have a responsibility to hold the vision for my team. That, as ACT team leader, I have to have a clear picture – what I do is I hold the picture of where we're going, where we want to be, and I have the responsibility to hold that vision… and have some idea of how we might get there. You know, the paths can change, but I need to have some ideas. And that's been my responsibility since day one –to hold that vision. So that's what I do as an ACT team leader.

In addition to feeling like it was her responsibility to create and sustain this vision of ACT for her team, Catherine described this function of her leadership as a fun challenge and embraced this task. She expressed viewing this responsibility as a positive versus negative aspect of her work: "It's fun to build something. It's fun to hold a vision and to try and make that come to fruition. To try, that's really fun. It's….challenging, but even that, see, I find the challenge fun". However, she pointed out some negative consequences for the team's work and client outcomes if she did *not* have a clear future direction articulated to the team members. If her vision for the team's future was unclear, the team suffered by not having clear direction and movement. Ultimately, she felt she must wholeheartedly believe in the vision for the future and get every team member to believe in it as well. Catherine used the following example of how her vision and clear direction may impact the work of the team:

> [Team Leader] Why isn't the progress slow and steady in that [vocational] area for us? I think it's a challenging part to implement. I think it's one of the more challenging pieces of the puzzle… I think the ultimate reason it [integrating vocational services into ACT] is challenging, is that I don't hold a clear vision of how it looks. And if I don't hold a clear vision, it doesn't matter… If I am the ultimate keeper of the vision, then I have to hold that vision too 'cause that way . . . then it's my responsibility to hold [team member] to that vision as well.

Finally, Catherine indicated that a key facilitator to her acting on her vision and creating a high fidelity ACT team was that her agency leadership provided her with autonomy. She indicated that autonomy was key to her ability to move the team forward according to her strategic vision based on ACT: "That autonomy piece gives me the reigns to implement, to act on my vision".

One strategy that Catherine used to keep the team moving cohesively forward while providing high quality services was to promote a shared vision. Keeping the team members all on the same page built some momentum and structure for the services provided. Within this thematic construct of 'set a shared team vision and objectives,' there were two processes (subthemes) that contributed to the overall theme's generation. These subthemes included (i) hiring and training; and, (ii) philosophy of client first, program second, and staff third.

Hiring and training. One way that the team leader set a shared team vision began at the selection and subsequent training of any new team members. Comments from participants highlighted the importance placed on hiring a person with the "best fit", one who shared the vision of the team. Catherine was very intentional in her hiring practices, looking for individuals who would be good team players, who would support the existing work of the team, and who

had a recovery orientation. She relied on her intuition or "gut" in hiring decisions and if a person was skilled but would not fit in with the team's vision of recovery, she would not hire them.

> [Team Leader] I definitely take into consideration, I mean that's a part of the interview process, you know, for me and also a gut-feeling process for me. That's definitely a piece of the puzzle that I look at. Through the interview questions, what's their experience with teams. You know, how do they feel about working with the different team members and it not being hierarchical? What's my gut on how they'll fit in with the group that I have. I think that's actually really quite easy to detect.

Likewise, after a person was hired, the team leader invested time in training so to disseminate knowledge that supported the team's vision through team building and functioning. Again, this practice of training was very deliberate as Catherine believed it created cohesiveness, and kept all team members educated on the shared vision and goals of the work; an essential ingredient of a well-functioning team in her opinion. Based on comments from participants, they recognized that the team was cohesive and all team members had the same shared vision and goals for the clients.

> [Team Member] Yeah, we all have the same goal for our clients. We're not working against each other. We are working with each other. And I know that. I mean, my team members are consistent and reliable, and they don't make my job difficult.

<u>Philosophy of client first, program second, staff third.</u> A second sub-theme and practice employed for intentional team building and maintenance under setting a shared team vision and objectives was that Catherine held an overriding philosophy and vision of "client needs first, program needs second, and staff member needs third". This hierarchy of priorities was communicated multiple times a day based on my observations, to all team members and

outsiders. Further, this ideology placed the highest importance on the needs of consumers served by this ACT team. This philosophy was one of the main contributors to the team leader's overall vision for the work. As noted illustrated in the following quotations, this philosophy has been very well inculcated: [Team Member in response to question of the principle that she really guides this team] "Client. Team. Self", and, [Team Member in response to question "what principles does she abide by"?] "Client first…"[Second team member]. "Client first". [Third team member] "Every time". Finally, another team member reported this: "I don't know if I've seen anything that's been serious enough for her to step in. But I have heard her say, 'Client first. Your... your stuff comes later"'.

Catherine was asked why this philosophy was so permeated within the team culture. She indicated that clients deserved the best. She had an unwavering principle that consumers and their best interest came first and saw this philosophy as the umbrella that all the team's work came under.

> [Team Leader] What is important is that we provide the best care we possibly can to the clients. That we help our clients have the best life possible. That is important. And that is the umbrella for everything else. And everything else is then underneath that.
>
> [Agency Supervisor; in response to the question of what principles guide the team leader's work] I definitely would say it's always client-centered, focused. Best possible care, quality for the consumer, families, their supports…anyone involved with them. I think also ethics plays a huge part into that. She really looks at situations, with that ethical kind of eye, you know, determining, is this ethical? Always taking that into consideration.

Staff expressed that being united over this philosophy and caring about the clients was a rewarding part of the job: "That's very rewarding and it, it is wonderful 'cause I know I can come in here and each one of these people, including Catherine, care as much as I do about the people that we serve".

Promotes and integrates high fidelity ACT into team's culture & practice. Comments from various participants reflected that the team leader communicated and promoted high fidelity ACT practice through her inspiring passion to help individuals with mental illness recover (and connecting recovery to practicing high fidelity) and her behaviors (e.g., goes to the hospital to see consumers, assertive, keeps focus). It was observed throughout the three days that Catherine continually discussed about high fidelity ACT with others. She was in constant communication and "teaching mode" in regards to the ACT evidence-based practice. When she made decisions, she shared with others her rationale which often times considered high fidelity of ACT standards. Participants had this to share about Catherine's promotion and education on ACT: "She does a lot of education of what the model actually is. She really took time to talk to me [agency supervisor] about what it, what it meant for her and her team".

Catherine shaped the team to be conscious about fidelity issues and the team and agency made this a priority. Catherine talked about shaping the team culture through education and promotion of ACT beginning at a new person's interview:

> [Team Leader] I always have them read the ACT manual. Most folks come aboard really knowing very little. During their first interview I tell them to go online and Google ACT so they can start formulating questions and get some ideas if this work is of any interest to them. You know, once you start realizing what it involves. So I always start with having them sit down and read the manual.

Participants reported that Catherine supported the integration of ACT into the team's practices regularly: "The decision making that she makes every day fits for the model", and "She oversees all the treatment plans and basically provides feedback on how to get these moving toward better and better fidelity". Another team member described the integration like this:

> And she has been supportive in helping me to kind of find a balance between doing what can be done to achieve the most fidelity to the model that we can right now with the pieces that we have. And working with that. But also keeping an eye toward the future and where we might be able to go.

Catherine routinely used high fidelity measures such as TMACT (see below) to provide the framework and continual guidance for how the team and program operated.

Uses ACT fidelity as a program guide. Catherine stated that she felt that ACT fidelity guided the program and team: "I think I've created a foundation, a network that has fidelity to the model. You know, that kind of guides us". She explained that she kept a constant vigilance toward ACT fidelity, looking at ACT as pieces and components (e.g., integration of specialists, operation and structure, core practices, person centered planning and practices) that each required attention. Further, Catherine stated that monitoring fidelity was an on-going process. She described her continual watch over the team's fidelity in this way:

> [Team Leader] And then there's some pieces that we need to keep doing the same and not lose track of. That, 'cause I think that's a danger, right? That you can – if something's going well, but it's not being reinforced you will lose it. Which means you're never, ever done. You never get to sit back and exhale. My team does awesome with getting clients housed independently. That's one of our strengths. If I don't keep that on the radar and keep focusing on that, we'll lose that. You know, like for a while we were several years

> back, if a client was hospitalized they'd be like, 'Okay, yea. They're safe. Okay, done'. How easy is it to fall into that trap? That's not a hard trap to fall into. So just because we're there where we're, now where we're staying engaged it doesn't mean that I have to relax on that at all. Because there's some things that are so hard that you have to stay on top of it all the time.

She made mindful and calculated decisions for the team and program based on ACT fidelity. She described that while she was rigid with some things of the ACT model, she also had great flexibility within the parameters of the model to make the program successful for the individuals served. She described how the standards of ACT influenced her decisions:

> [Team Leader] I mean there's things that I won't bend when it comes to the fidelity pieces. And I think… of admissions that no matter how much this person needs services, they're not a fit here. I'm not negating that they need services, but "no" 'cause that's gonna mess with my program, that's gonna mess with who we can serve, that we're designed to serve. So I'm not giving up that slot.

Knowledge, faith, and acceptance of ACT model. The second core category for Study Aim 3 was that the team leader had strong knowledge and understanding of the evidence-based practice of ACT. It was clear while on-site, Catherine had vast knowledge of the ACT model of care, what constituted high fidelity and the national standards of ACT. She accepted the ACT model as an evidence-based practice and asserted her faith that higher fidelity to ACT equated to better client outcomes. In her own words "There have been moments of, you know, 'Okay, I'm gonna trust blindly. I'm gonna not understand this big picture piece, but I'm just gonna do it anyway. And then if it doesn't work then I can re-evaluate".

In response to the question if there was a shared vision that guided the work of the team leader, the agency supervisor and team members had this to say: "The ACT model, she really believes in it. She very much believes completely in the model and protects that, I would have to say", and, "I think she genuinely believes that fidelity to the model is equivalent to what's best for the client".

Catherine was asked to share her perspective about fidelity to ACT and leading a multi-disciplinary team as part of the model, and replied:

> [Team Leader] ...'cause it's so important that, so I've got these guidelines that are given by the evidence-based practice. That I wanna look at those parameters 'cause if I follow those parameters I might get better outcomes. And then with that I wanna really overlay a very client-centered, strengths perspectives piece.

Participants also indicated that the team leader did not modify the EBP of ACT. Catherine showed faith that if she practiced ACT with high fidelity that the desired outcomes would come along. She promoted team and agency buy-in around high fidelity by framing the ACT model of recovery as a way for consumers to meet their self-identified recovery goals.

> [Team Member] She's a huge believer in evidence-based practice. And in that belief it's very much that, no, the evidence-based practice says this. I'm not in the position to question that or to modify it because it says this. And so that's stressed.
>
> [Team Leader] ...there is an EBP here which gives us something. That I don't want to reinvent the wheel. I don't want to create something different. I want, it's evidence-based for a reason, which means if you do steps one, two, and three, you've got a good chance of getting an outcome that you want.

Practices assertive advocacy for high fidelity ACT. The third core category for Study Aim 3 was that the team leader assertively advocated for high fidelity ACT practices with stakeholders external to the program. As noted earlier, Catherine is a fierce and politically savvy advocate and she described her skills often being directed toward protecting the team and/or retaining resources and practices that impact high fidelity ACT. Using rationales based on her ACT knowledge, she fought the system or offered resistance if pushed to adopt practices that would contradict the ACT team's high fidelity. When asked ' in a hypothetical situation, let's say the agency asks Catherine to adapt the model in a certain way, what would happen'?, participants had this to say:

> [Agency Supervisor] And she's [Catherine] very much advocated for: do not take the psychiatrist; don't change the psychiatrist's role. There has been a lot of discussion about the psychiatrist is way too expensive to be having them drive back and forth to houses. And Catherine, in a very professional way, but in a very strong way, said 'that is against the model'. And that she feels that would really impact the care.
>
> [Team Member] I get the sense that she will dig her heels in to maintain the fidelity.
>
> [Team Leader] I will in a diplomatic fashion explain why that can't be done. And why we don't want to do that. So I just went down my checklist and there's things that I won't budge on. And it's difficult for me 'cause I know ultimately there's people above me who can say, 'Too, too bad'. I'm aware of that I have bosses that could respond with, 'Thank you very much for your input. And now you're doing this'. I had things in my head I would do when necessary.

Team members saw Catherine as a protector of ACT and this extended to protecting model fidelity. She would not bend on the majority of components of the ACT model and her strategy included connecting ACT fidelity to agency and consumer outcomes.

> [Team Member] Yeah, I think when the [agency] leadership team is making certain decisions, ...she was very strong in advocacy. And basically saved us from a nightmare. We need to stay close to what we can provide as opposed to 'wouldn't it be nice if you could add five more people'.

I observed Catherine display a great deal of confidence in her knowledge around ACT and what high fidelity looked like. This confidence seemed to allow her to feel prepared to present her arguments and rationale to others. However, she indicated that if she was pushed to operate the program in a way that was too distant from fidelity, this would be difficult for her.

> [Team Leader]…but I think I struggle with the idea that in this arena I do know best. So don't come in and tell me that you know best because you don't. I know this model. I know my program. I know my clients. I know what's best. And when someone comes in who doesn't have all that knowledge and wants to reinvent something and let's do something ACT-lite. So, I don't know what I would do if the gauntlet came down. You know, after I had made every argument I could, after I'd rallied the troops that I could to support my argument, and it was still 'No. We know that's the model, but that's not what you're going to do anymore'. I don't know if I could watch as what I built was torn down.

Fortunately, Catherine had agency support for leading a high fidelity ACT team, which she indicated made a huge difference. Team members also noted this support from agency leadership: "I think that we do have leadership above Catherine that believes in the model. And they do allow us to have resources available that have helped us".

Reinforces high sense of accountability specific to ACT fidelity. The fourth core category explaining the ACT leader's role in promoting high fidelity ACT programming involves her reinforcement of a high sense of accountability for operating a high fidelity ACT team with her team members. This reinforcement was facilitated by two processes: using explicit measures (TMACT) to provide feedback on services the team was providing, and using outside influences to reinforce the need to be a high quality program.

TMACT. To recall, the TMACT is a tool that helps a team gauge their status on a fidelity continuum. The Lincoln ACT team had participated for a number of years in TMACT reviews, sanctioned by the state, and before that with the DACTS (Dartmouth Assertive Community Treatment Scale). Catherine has utilized the TMACT tool to provide data and feedback to her, agency leadership, and the team in regards to specific practices of the ACT team and to measure the level of ACT fidelity within their program. She has found the TMACT as helpful for the team's accountability:

> [Team Leader, in response to question how do you know that you're meeting your objectives from an ACT perspective?] I mean the most obvious one is the fidelity outcomes, you know, review that we do for the state. That's more meaningful with adopting the TMACT, since that's just a much broader tool, and gives you more information.
>
> [Team Leader] I think the accountability piece is important, right? That, I believe it is important as much as we might want to eye-roll, with having to go through another TMACT. I think that on-going expectation is important because it keeps you on your toes. And there's a natural… as time goes on there's a drift that happens if you don't stay on your toes.

Taking the accountability piece further, she suggested that ongoing support from the state would be helpful as well.

> And that, I think with the state supporting, that is important. But I think with that then, the state needs to continue to step up with the, helping with the [TMACT] recommendations. That there's no point in doing or using that tool, getting this information if…I really feel that if there's something I'm not doing, it's because I'm stuck, you know. And I need help getting unstuck.

Outside influences. Catherine named her agency leadership, state mental health authority leadership, and an outside ACT consultant as important factors in supporting her to be accountable for high fidelity ACT services.

Agency leadership. One outside influence for Catherine's program was her agency leadership. Catherine described being very accountable to her outside agencies (all three of them) for operating a high fidelity program, and they had complete trust in Catherine to do so. She reported knowing their expectations and they gave her autonomy and support to operate the team as she saw fit. She described it like this:

> I do feel I have a lot of autonomy and support to do it [fidelity]from my leadership. They really have given me the space to say: 'this is what we're going to do'. 'This is how we want this to look'. There have been times of question, but it's backed up pretty quickly. I don't get that pressure. So, I have a lot of space to do what I think will give us the highest fidelity.

State leadership. In similar fashion, a second key supporter identified was the State of Nebraska Mental Health authority. Catherine posited that having accountability to the State of

Nebraska was also important for the team. Per Catherine, "I'm thinking, you know, first off, the state has been invested in fidelity audits", and:

> I do think we have good support in the state, with the region. I think we have some champions for us there. There's folks above my leadership that if it came down to it, would be like, 'Wait a minute. We've worked too hard for this. We've come too far for this'. I don't think it would be allowed to crumble easily or quietly. That doesn't mean I don't think it's possible. I think there are folks that I could call, that I think would go to bat with the powers that be, with systems, and be a voice for me as to why we want to keep doing it this way.

ACT consultant. Finally, Catherine identified an ACT consultant, who was arranged by the state mental health authority, as part of what had helped her with accountability to high fidelity. This consultant had worked with the team consistently since its inception and continued to be available to Catherine for ongoing consultation and fidelity reviews. Discussing this consultant, Catherine said:

> Being accountable is always a good thing. That having a consultant come in periodically to keep you on track with that. Having the expectation of the region and the state, that this is an expectation that we continue on this path.

Overall Lincoln PIER ACT team summary. This section focused on the Lincoln PIER ACT team and provided a case description of the team leader, team psychiatrist, agency supervisor and team members, along with findings that I believe best inform the delineated study aims that look at the role and contribution of ACT team leaders to high fidelity ACT teams. The next section of this chapter will describe the cross case analysis and findings.

Cross case Analysis and Findings.

Themes.

Overall study aim 1. There were several commonalities between the team leaders from the Ramsey County ACT and the Lincoln PIER ACT teams that lend to the overall understanding of the question "who are high fidelity ACT team leaders"? First, similar demographic characteristics the two leaders shared are described. Then, seven main themes identified as common between the two team leaders for study aim 1 are presented. The themes are outlined in Table 6.

Table 6: Cross-Case Common Themes for Study Aim 1

1) Personal job match
2) Optimistic and hopeful
3) Emotional intelligence
4) Recognition that team leader influence connects to team and to consumers
5) Respectful and trustworthy
6) Belief in energy
7) Skilled clinician

Demographics. Both team leaders were females, between the ages of 36-42 and had Master's degrees in social work. Each led programs that were in the Midwest, had been in the mental health field for a substantial amount of time (14 years for Alyssa and 20 years for Catherine), and had been ACT team leaders for 5-6.5 years. Team size was relatively the same for the Ramsey Co. ACT in St. Paul having 15 team members and Lincoln PIER ACT having 13 team members. The average tenure of team members on both teams was almost identical (St. Paul $\overline{X}$=4.1; Lincoln $\overline{X}$

=4.2 years) suggesting team stability across both teams. One difference between the two teams was with the number of individuals served, as Ramsey Co. served 85 consumers and Lincoln PIER served 69 consumers. This resulted in different client-to-staff ratios between the teams (Ramsey County client-to-staff ratio=10:1; Lincoln PIER ACT client-to-staff ratio=7:1), although this range is allowed by ACT standards.

Personal job match. Each team leader I interviewed had a personal job match and described a great "fit" with the description, roles, and responsibilities of an ACT team leader. Both leaders spoke passionately of their work with individuals with SPMI and talked about a pull or a passion to work with individuals with SPMI and looked at their work with consumers as a privilege. They both expressed their personal fulfillment from continuing their direct clinical work with consumers. Both team leaders' values aligned well with the ACT model of care. Each woman had a strong social justice philosophy with a strong desire to fight oppression or exploitation by way of giving individuals with mental illness the best possible care and treatment in a person-centered way. The ACT treatment modality allowed these team leaders to help individuals reach recovery through person-centered treatment, rehabilitation and support. Hence, each leader found the role to be personally and professionally fulfilling.

Both team leaders indicated that they were highly drawn to the management/leadership component of being an ACT team leader. They both found enjoyment and professional fulfillment in developing and sustaining the ACT program. Each team leader acknowledged that they found managing team members and dynamics as a challenge. Alyssa described the challenge in this way:

> I think our resource as a group, our main resource is people. And, I've got a great group of staff so that, overall it's a wonderful thing. But there is the reality that people are

> people. [LAUGHTER] And because of that, it can at times be difficult to manage attitudes, energy... if a group is going in a direction, kind of shifting, that process. And deciding when it's just an okay, normal thing and when it's something that needs to be addressed.

However, each team leader found professional value in nurturing the individuals on the team in order to facilitate team work. According to Catherine: "if I don't nurture and care and give feedback, then they're gonna go".

Optimistic and hopeful. One notable attribute that the team leaders shared was they were seen by others as optimistic and hopeful. This hopeful outlook permeated all aspects of the work environment. Each team leader had the attitude of "things will work out fine" and that no matter what occurred, the team would be okay. One team member in Lincoln expressed this idea by saying Catherine "drives hope for our clients". Each team leader set the team's environment to be one of positivity, optimism and reframed challenges as opportunities. Moreover, because of this outlook, the team's environment was not "gloom and doom" and produced a workplace where team members wanted to come and work hard for one another. This likely contributed to lessening staff turnover, a real challenge for implementing evidence-based practices into real world settings (Woltmann et al., 2008).

Emotional intelligence. Another notable attribute between Alyssa and Catherine was that each had a heightened sense of awareness about others and the environment, including how their actions would influence the environment or others. Each team leader was remarkably mindful and self-aware of how her ideas, behaviors, and energy influenced team members and/or the environment. Each team leader had high emotional intelligence, which refers to how individuals

handle themselves in their relationships; it is defined by high ratings on four domains: self-awareness, self-management, social awareness, and relationship management (Goleman, 2002).

During the Ramsey County ACT focus group, one participant, in response to asking to describe Alyssa stated: "I'd say she rates high on emotional intelligence". While the Lincoln ACT participants did not actually refer to what Catherine did as expressions of emotional intelligence, they, along with Catherine herself, did draw attention to several behaviors she performed that can be categorized as high emotional intelligence. Catherine identified "the leadership that I have is based on relationship". As noted above, both Catherine and Alyssa were very self-aware; a domain of emotional intelligence.

Both Alyssa and Catherine were mindful of relationship management and displayed competencies such as inspirational leadership, developing others, building bonds, and cooperative team building. They each displayed these competencies in various ways, with the result that each team was described as cohesive and well-functioning. Additionally, each team leader recognized worker's individual strengths and used those strengths to promote professional growth. Team members from both the Lincoln ACT and the Ramsey County ACT teams supported that there was a spirit of growth and the team leaders developed others. For example, this was said of Alyssa: "There's a spirit of growth. It's like this just really positive expectation that you can grow as a practitioner".

Each team leader exercised good emotional control, monitoring their reactions to make sure they were responding to staff and situations appropriately. They kept disruptive emotions under control, displayed honesty and trustworthiness, and were consistent with their emotional responses. Both team leaders were described as level-headed and were noted to "not fall apart"

in situations. As Catherine stated: "I don't think I'm overly emotional at all. I think that's the matter-of-factness. This is what we're dealing with..and then I become a cheerleader". Likewise, each ACT team leader had strong social awareness skills. They were able to sense others' emotions, understand the other person's perspective and the context, and act in an empathic manner.

Recognition that team leader influence connects to team and to consumers. Yet another common theme across the two team leaders relates to their ability to draw links between their influence, the work of the team, and ultimately to services the consumers received. Each subscribed to the idea that if the team was not healthy and functional, then client care would be impacted. Catherine provided this example about this trickle-down effect when asked why she sees holding staff accountable as an essential team leader role.

> We can't function as a team, we can't serve clients. And that's how I can do it. I can have a team member in my office, and if it's at the point where I'm doing a probationary letter because you've been tardy, we've been addressing your attendance in supervision, it's not changing, you were an hour late again today. I'm now doing a formal letter to put in your file. How can I do that? How I make myself do it is the big picture, that if you're not here on time, that's impacting other team members and that's impacting clients. So that means I can do that role that I don't like to do. I can make myself do those things because if you're impacting this machine, then that's not gonna happen. But that's the least natural role for me...you know 'cause the motivation that I can do that is because this impact on the team, which is then impacting... I'm not having [program assistant] call Susie Smith again explaining that you're not here. That's not happening and that's how I can do it because Susie Smith needs you there to see her at nine o'clock.

Alyssa held the same ideal, commenting: "How I interact with my staff or my team will impact how my staff interacts with their client". The hypothesis both women seem to support is that the health of the team matters to how individual team members then interact and treat the individuals the program serves.

Respectful and trustworthy. Another key commonality across the two ACT team leaders was that they were described as respectful and trustworthy. Each team leader was characterized by taking responsibility and ownership for getting tasks done in a reliable, accurate, and credible manner. Team members respected the leaders' decision making and clinical and leadership skills. The Lincoln agency supervisor indicated that the team members "very much respect her [Catherine]". All interactions observed while on-site were respectful. For example, I watched Alyssa talk with a team member and disagree without being impolite or demeaning. Similarly, I witnessed all communications between Alyssa and team members to be authentic and respectful, which lent to her trustworthiness as perceived and reported by others. In Lincoln, Catherine conveyed her respectfulness by actively listening to her team members during all team meetings, providing them with eye contact and validating nods.

Belief in energy. Another interesting similarity between the two team leaders was around the notion and belief in energy. While Alyssa articulated this idea more directly, Catherine also shared this philosophy. Alyssa indicated that one of her underpinning "philosophies, are all around, concept of flow. And that, to the degree possible, you shouldn't do anything that impedes energy flow". She discussed noticing the energy in the room or with the team, and doing her best to call it out and make changes if need be. She saw it as part of her job to "create an environment" where people can have "calm or peaceful energy" so then "they can actually do their jobs". Catherine also talked about taking the "pulse of the team's energy" and

stated "it's been a very conscious decision to always monitor, to always have a pulse on it [team energy]".

At the same time, there was a notable difference between descriptions of team leaders and the energy they brought to the team. For example, Alyssa was described as very calm and intentional. Extending this idea of energy, Alyssa's calm demeanor included being very proactive and stepping back and helping the team "take breaths" during the crisis. While on-site, it was observed that she had a calm and quiet demeanor. In comparison, Catherine was described as highly energetic and dynamic. Team members from Lincoln indicated that her energy was "very motivating" and that she entered the work place "smiley, laughing, and it just kind of gets them going".

Catherine, on the other hand, indicated she actually enjoyed crisis situations and being bombarded with many things at once as she finds her skill level was even better in these situations. Despite having very different styles (calm versus highly energetic), each leader effectively managed crisis, negativity, and overall level of stress within the team.

Skilled clinician. Each team leader was noted to be a strong and exceptionally competent clinician. Agency leadership indicated that each ACT team leader had sound clinical knowledge and judgment which led to trust. Each team leader was seen as capable of assessing and handling the complex interplay of mental illness with co-occurring substance use or medical challenges.

These descriptions of commonalities across the team leaders in the study are not meant to be exhaustive. In fact each team leader had several pages of single-typed descriptors that were used to relate who they were over the course of the data collection. Instead, the commonalities

delineated are meant to highlight the most salient themes identified for Study Aim 1 and that best contributed to understanding who high fidelity ACT team leaders are.

Overall study aim 2. The second study aim sought to gain an understanding of the team leader's approach to leadership (i.e., what she does and how she does it?). This study aim provided a rich picture of the ACT team leaders' behaviors on the job. Within this study aim, three core categories–prominent functions, communication style, and deliberate attention to team members' wellbeing– were shared by both team leaders. Eleven similar sub-themes aligned across the two cases within this study aim (See Table 7).

Table 7: Cross-Case Common Themes for Study Aim 2

1) Functions as a role model and teacher
2) Sets high and clear expectations
3) Is a problem solver & decision maker
4) Is a planner
5) Has and enjoys complex & multiple responsibilities
6) Has direct, open, transparent, and understandable communication style
7) Is mindful of individual needs
8) Promotes strengths and professional growth
9) Serves as team's protector
10) Creates recovery and person-centered environment
11) Establishes a fun and positive work environment

Functions as a role model and teacher. Both Alyssa and Catherine had a prominent function of being role models. Both leaders served as an example of the values, attitudes, and behaviors associated with being a great ACT team member. Team members talked about watching the leaders passionately work with people with SPMI, being creative and open and

"being in the trenches" with them. Team members across both sites noted that the team leaders' expectations of them do not diverge from the leaders' own work in scope or level of difficulty. For example it was said about Alyssa: "She will not ask her team members to do something that she's not willing to do or she hasn't already done before. So she does a lot of providing that service, but I also believe modeling it".

Additionally, each leader embraced teaching others. One participant stated of Catherine "She's a teacher. I mean, she just has that in her. She loves to be able to see one of her employees develop into this excellent worker and helper". Likewise, when asking Alyssa about her various functions she stated: "you know kind of a teacher function. Kind of model, I think there's a lot of modeling that goes on around the balance between compassion and assertiveness or, limit setting". Each team leader indicated this teaching function, via showing or explaining how to do the work, was important as what they emulated or modeled influenced how staff worked with ACT consumers. Both team leaders also indicated they role modeled for staff healthy boundaries between work and outside life.

Sets high and clear expectations. The team leaders certainly shared this commonality– they each had high expectations for the team and for program and client outcomes. Each team leader offered they had a very competitive nature. According to Alyssa: "I think I've mellowed a lot, but underlying am pretty type-A personality and have a desire, have always had a desire to be the best and do good. I, and I don't very easily just sit back. Catherine stated something similar: "to be the best ACT team, –I'm a little competitive if you can't tell".

Each leader planned the course of action, set high expectations for how the work would get done, and what outcomes were the targeted goals of the team. In each team, team members participated in the setting of these team goals and the respective team leader communicated

expectations clearly and consistently. Additionally, each leader provided structure and set up team processes that supported her expectations, helped team members see what their roles were, and kept the team on track to meet those goals.

Setting high expectations afforded Alyssa and Catherine the ability to hold team members accountable to the overall process and outcomes set. For example, a team member expressed this about Catherine's expectations when asking for a change in treatment course for clients: "And her expectation is that we have a clinical rationale". Additionally, this was said about Alyssa:"If we, in the long run aren't doing what we're suppose to do, we'll find out".

Each leader employed a method of keeping team members on track which included giving and receiving feedback on how things were going, and being open to feedback themselves. This setting of expectations was viewed in mostly positive terms by team members. A Lincoln ACT team member indicated that Catherine's expectations were influential: "..her expectations of us are influential. She expects each one of us to be a leader in some way".

Is a problem solver and decision maker. The third commonality between the two team leaders' approach to leadership was that each served the prominent functions of being a problem solver and decision maker. Each team leader had a process for working through details of a problem in order to effectively identify, analyze, and resolve difficulties in a timely way. Part of the process included asking team members to "reframe" obstacles or challenges as opportunities to do things differently or find creative solutions. Each team leader avoided looking at challenges in negative terms. For example, an ACT team member from Ramsey County stated this about Alyssa "I would say [she's] a good problem solver. Oftentimes, she'll think or challenge us to think outside of the box to solve certain problems and obstacles with our clients".

One benefit of the team leaders' attitudes about obstacles was that it promoted an attitude of hopefulness and persistence within the team. There seemed to be a philosophy of perseverance and tenacity set by each team leader, which was accepted by the team. The team didn't focus on how hard things were or blame consumers for behaviors or lack of progress. Alyssa team members indicated if things weren't going well for the consumer, the team would look at what they could do differently.

This "obstacles as opportunities" ideal helped staff feel more comfortable to bring issues they were struggling with to the leaders. They voiced being less concerned they would get in trouble for having a problem (e.g., behind on paperwork), and confident they would receive help from the leaders in problem solving options for resolution.

Additionally, each team leader was noted to have good decision making skills. They both made timely decisions that appeared to be in the best interest of the organization, team, and consumers. Both Alyssa and Catherine made decisions after requesting and clarifying information, analyzing all available data, defining key points, coming to relevant conclusions, and then communicated their decisions clearly to others (Moss & Laing, 1990). I observed a balance, for each leader, between autocratic and democratic decision making styles. For example, Alyssa described her decision making style like this:

> There are times where I just need to make a decision. But overall, I think to the degree that the team can collaborate around putting ideas together and coming up with solutions, that’s the ideal or the standard that I would work towards. But then when I need to assert authority, being okay with that. I think that’s just the reality, sometimes the job of a leader is making decisions that the group might not like or that not everything is a group decision.

Both Alyssa and Catherine seemed to discern which context required what type of decision making (autocratic or democratic). Typically, in times of crisis, each leader would make autocratic decisions, feeling comfortable to forego consultation with others in order to make a quick decision. At the same time, each leader fully appreciated the value of gaining other's input and working towards consensus when time allowed. The following example illustrates Alyssa's democratic approach: "I see it as part of my job to really help the group step back and think about the larger picture. What do we want to do next in terms of change or growth, and then what do you need to do that"?

Planner. The function of being a planner was also a similarity with both team leaders. Each leader had a deliberate focus on planning for the team, developing strategies and setting policies that supported the vision and goals of the agency. For example, the Lincoln ACT team leader described how she utilizes the TMACT fidelity tool for planning:

> I go through it, and then I write my own plan kind of based on those recommendations. I go through and highlight where the scores weren't as high as what I want them to be and look at those recommendations and then develop an action plan of what pieces that I can do. I kind of break it down.

Likewise, the Ramsey County ACT team highlighted Alyssa's skill at planning: "She's such a good planner. And she plans, like, short-term and she plans really far out. She'll vision, you know, six months, nine months down the line – where do we wanna be"?

Has and enjoys complex and multiple responsibilities. Another prominent function recognized across both team leaders was that their responsibility for complex and multiple roles and responsibilities associated with the daily operation of ACT. Each team leader moved between all these various roles fluidly and efficiently and seemed very flexible in changing roles.

Across both teams, responsibilities appeared to fall into one of three categories: clinical, administrative/managerial, or leadership. When asked to describe what team leaders did, participants from each team gave a wide breadth of answers, indicating that the team leader was responsible for a huge number of tasks. Participants from each team reported that the team leader wore multiple "hats": "She just has a lot of hats to wear with that one assignment" [Ramsey Co. ACT team member], and from the Lincoln team leader, "They're [clinical supervisor and administrator] two different hats that, I kind of mix and match both of those hats within that time depending on what is going on". Moreover, each team leader talked about juggling of tasks and described the job of meeting staff and client needs as putting together a giant "puzzle".

Importantly, both Alyssa and Catherine discussed how they derived work satisfaction from the varied roles of the leadership job and the challenge of retaining agility and perspective. Each pointed out they enjoyed the fact they could be working in direct clinical practice with clients in addition to their leadership position, and if they were more removed from direct care their job satisfaction would suffer.

Has direct, open, transparent, and understandable communication style. Both Alyssa and Catherine had remarkably similar communication styles. Each team leader promoted open and transparent information transmission. They indicated this was important to team dynamics and showed respect.

Each team leader was described as communicating in a very direct manner and worked to be understandable in their communication. Alyssa's team members had this to say: "She communicates it [expectations] very directly in terms of putting forth protocols when there are

new standards or procedures implemented". Each team leader solicited opinions from others and were noted to be open to feedback.

This direct and transparent communication style was also encouraged among team members. If team members had disagreements with one another, each team leader prompted team members to handle conflict with one another as a first step. If this did not culminate in resolution, then each leader indicated they stepped in to mediate, but only when necessary. Catherine illustrated her approach this way:

> If a team member's coming to me with a concern about another team member, I will allow them to use me as a sounding board..to sort it out. I will encourage them to talk to that team member directly themselves, if that's appropriate and to communicate what their needs are or to communicate to that person, you know, how they're upsetting them or offending them. And managing it that way. If I need to intervene, then I'm okay doing that.

A Ramsey County ACT team member said this about Alyssa's approach:

> I wouldn't go into her office about, like, irritation with another staff member. I just don't think that she would invite that kind of... the drama. I don't think she would go for that ...if it was something serious, I think she would help you with it, but like [team member] said, she'd want you to talk to that person first.

Because of this viewpoint on direct communication, neither team leader avoided unpleasant conversations with and among team members as they view open and direct communication as being in the best interest of the team and consumers. The viewpoint set a high bar for professionalism.

Is mindful of individual needs. Paralleling some of the domains in emotional intelligence, a common theme for each team leader was that they were very mindful of team members' needs. Catherine and Alyssa each worked to acknowledge the needs of individual team members, but not at the expense of the "collective" team. Likewise, Catherine provided these examples: "I think I'm pretty direct with asking that [individual needs]. Um . . . I, I often end supervision with, 'Are you getting what you need from me?'"; and, "I do make an effort with that personal relationship piece of learning each team member's interests and what they do". Additionally, on both teams, all team members were treated as individuals but felt they were also treated equitably.

Promotes strengths and professional growth. Stemming from the assessment of a worker's individual needs, assignments were delegated on each team that considered professional growth opportunities. Both Alyssa and Catherine valued their ability to help other team members grow within their professional ACT roles. A Ramsey County team member affirmed Alyssa's skill at assessing and facilitating professional growth: "At one point I wanted to be a manager, and she really helped me pick up some tasks that would maybe work on those manager skills, so she took right on and helped me".

Each team leader recognized the strengths of individual workers, and utilized these strengths for professional growth. According to one team member at Ramsey County ACT Alyssa "is mindful of our, each, individual strengths too". Likewise, a team member in Lincoln reported "She starts out with strengths of individual clients and she also starts out with strengths of each one of us". Not only did each team leader promote individual worker strengths, they each viewed this as part of their ACT team leader roles.

Serves as team's protector. Another theme that was shared across the two team leaders was that they both paid deliberate attention to taking care of the team. The team leaders set the tone for how team members treated one another and consumers. Participants made several comments indicating that each team leader nurtured team members through support, recognition, creating a healthy and functional work environment, and putting an emphasis on personal health and well-being. Alyssa reported this one example of focusing on the well-being of the team:

> Obviously to the degree possible, encouraging people to take some time, you know, a minute for social chatter at the beginning or end of team. We need that. We need that from work. We need friendships and connections. Um, but try to put some parameters around that, which I think it actually helped morale both in terms of building relationships amongst people, but also, that they were able to focus and get their stuff done.

Furthermore, each leader served as a buffer or protector between their team members' well-being and outside pressures. Team members indicated that their respective team leaders would go to the wall for them and back them up. The following was said about Catherine: "We know that she'll stand by us, and we know what to expect from her". According to Alyssa, protecting the team from outside influences and being supportive helped with team morale: "I think that when there are little things that I can do that buffer them from the system and they are aware of that, I think that helps with team morale".

This protecting of the team occurred in Lincoln as well. Curiously, each team leader made reference to being a "mama bear" when it came to protecting the ACT team and its members. As Catherine said " I was momma bear on that one... ".

Also part of taking care of the team was to encourage staff to have good work/life balance. Each team leader recognized this as important to keeping their largest resource healthy and tried to model this within their work life as well. Catherine indicated that she directly addresses issues of team member well-being during clinical supervision times: "I also include in supervision talk about self-care and will often check in with how they're managing the stress".

A final component of protecting the team was that each leader had a highly invested hiring process, to select the people for the team. While this may not seem to be related to "taking care of team members" it was– in the sense that, from the team leaders' perspective, if a new person did not fit into the vision and work of the team, that would be disruptive and less beneficial to the positive work environment. Across the two teams, this idea of hiring came up in two slightly different contexts. For the Lincoln ACT team leader, hiring the right person came up in the context of needing to find the correct individual based on fit with the team's work. The Ramsey County team looked more at the context of finding individuals who would fit based on the EBP of ACT and share a recovery vision. Alyssa described her hiring practice as follows:

> The first interview I usually keep to about ten to fifteen minutes. In part because I think so much of hiring is really intuitive. The first question I always ask people is if they could give me three words or short phrases that describe their perceptions or beliefs about mental illness. And usually I can tell pretty quickly a couple things. One, you know if they kind of have some of the same values around recovery and seeing people's potential. And if they don't have those values, they're instantly out of the running. The other thing is I can pretty quickly tell how they are at concisely organizing their thoughts and sharing information, which I see as a really critical feature of being part of a team. You know, you need to be able to summarize things.

Each team leader pointed out how the careful vetting involved in hiring new staff influenced the work, the focus on fidelity, and the morale of the team. Both team leaders reported relying on their gut or intuition when hiring new team members.

Creates recovery and person-centered environment. Both teams had a remarkable environment that emphasized recovery that incorporated a person-centered treatment and rehabilitation approach. While this type of atmosphere is an expectation of the ACT model, many teams fall short in the actual implementation of these salient qualities of care. It was clear in both teams that the team leader built, promoted, prioritized and sustained a work philosophy that people with mental illness have choice and control in their lives, and that these are key processes that contribute to recovery.

Furthermore, each team leader asserted the belief that individuals with SPMI can and do move toward greater mental and physical well-being. Alyssa and Catherine shared this value system, and behavior and attitudes contradicting it were not acceptable. Part of this recovery vision was that Alyssa and Catherine both supported the idea of person-centeredness– that is the client's needs came first. This was more prominently reported within the Lincoln ACT team, but it was also evident within the Ramsey County team. According to the Lincoln ACT team's agency supervisor, she reported this in regards to Catherine's stance on client first: "How does she always say this to me? It's client first, program second, staff third. She sees all three of those as very, very important. But if she had to kind of put it one, two, and three, that's kind of her thinking".

In a consistent vein, the following example highlighted how Alyssa reframed situations to be more person-centered:

> Well, I think for any given individual, you know, it's [the goal] really recovery. Um, and so, if somebody is going through a period of crisis or hospitalization, or behavioral characteristics are coming out that are less appealing, you know, that those aren't the person and that those experiences are, hopefully time limited and are just a small piece of the larger person.

Establishes a fun and positive work environment. Having fun was another common aspect of both teams' work environments. Neither team had much, if any turnover, in the previous year. It could be hypothesized that having a positive and enjoyable work environment may have contributed to the low turnover.

The Lincoln ACT team work environment was described as fun, and one where team members were very cohesive and wanted to be. Catherine outlined her perspectives on her team's work environment and camaraderie in the following ways: "... I don't think the laughing/joking piece really ever crosses a line. I just think it adds to a work environment that's more enjoyable. You laugh, you joke because it builds cohesiveness".

Each team leader tried to create team cohesiveness through this fun and relaxed environment and provided psychological safety among team members. This example was provided from a Ramsey County team member about the work environment: "I know that I won't have an angry boss if I don't get something done. She makes the environment very comfortable and easy to approach if there's any issues . . . and makes the job a lot better". Alyssa shared her perspective that this fun work environment was motivating: "I'm okay with people being goofy or joking around. I think that's a motivating thing. Encouraging people to take care of themselves". Both team leaders seemed happy; both had a good sense of humor.

Alyssa's agency director described her behavior like this: " I feel like Alyssa really uses humor. She's funny and she's open to laughing and stuff, but she's very serious when she needs to be".

Each team leader worked to provide validation, positive reinforcement and acknowledge the good work of individuals that helped sustain this positive work environment. I observed multiple interactions where Catherine provided positive reinforcement, including validating a frustrating situation: [Team member] "I was so angry when I pulled that message off. I'm like, really, Friday at 5:00... on a Friday". [Catherine nodding] "of course". I also saw evidence of sticky notes with praise and words of encouragement or gratitude given to staff by Catherine. Similarly, I witnessed Alyssa give positive feedback and praise to a team member who handled a treatment planning meeting via phone with an individual who was hospitalized and symptomatic: "Nice work, that was not easy".

Overall study aim 3. Study Aim 3 sought to understand what roles the ACT team leaders play in promoting high fidelity ACT. Five main themes were identified as common occurrences between the two team leaders in this study aim (See Table 8).

Table 8: Cross-Case Common Themes for Study Aim 3

1) Plays a critical role
2) Uses ACT fidelity as a program guide
3) Integrates high fidelity ACT into daily team practices
4) Knowledge of and trusts in EBP of ACT
5) Outside Support

Plays a critical role. Both team leaders were seen as having an essential role to play in promoting and sustaining the team's focus on high fidelity ACT. Each team leader recognized their critical role, and asserted the input of a team leader is necessary in order to have a high

fidelity program. While they each played this necessary role to high fidelity, they had slightly different support systems to assist them.

Alyssa had more of a "co-role" with the team psychiatrist in promoting the team's fidelity while Catherine had less overt leadership from the team psychiatrist. However, both team leaders had positive relationships with their respective ACT psychiatrists that were built on respect and trust, and minimized power and hierarchy. The positive relationship between the team leader and psychiatrist is important to fidelity because it can send one clear and consistent message to the team members and solidify the team's direction. This relationship with the psychiatrist facilitated both leaders to play a critical and influential role in the absence of power struggles between leadership figures over the direction of the team and client care.

Both Alyssa and Catherine noted ambitions to improve services and deliver treatment and rehabilitation with higher fidelity to the ACT model. Both believed that doing so would lead to improved consumer outcomes. In fact, when they advocated for higher fidelity, they did so in a way that reframed the issue at hand into a consumer issue. Connecting a change in fidelity to a client outcome appeared to be an effective strategy for each team leader.

Uses ACT fidelity as a program guide. Both team leaders used ACT fidelity measures and standards as a program guide. Several similar examples between the two programs were observed while on-site. One notable example was how the leaders conducted themselves during the treatment planning meetings. Each modeled person-centered principles and implemented what was important to and for the consumer into a staff schedule. They each tied concepts of fidelity to program and staff decisions. For example, a Lincoln ACT team member had this example to illustrate how ACT fidelity factors into program design: "And she'll [Catherine] say,

'Does it suck working the weekends? Yeah. Does it, is it fun to have to work Christmas morning? No. but that's what has to be done. That what they need".

I also observed an example while with the Ramsey Co. ACT team of Alyssa making a decision that impacted fidelity. The program assistant was working with the psychiatrist's schedule. As a solution to a time challenge, the program assistant suggested that perhaps clients could come into the office. Alyssa said "I kind of told her...that I didn't think it would necessarily work... being I think we'd miss too many people... it's part of fidelity too". Seemingly small decisions such as making the decisions to have client comes into the office may have large implications and could lead to more fidelity drift. Alyssa understood this nuance and made the decision to problem solve this challenge differently.

Each team leader also deliberately took information and feedback about ACT fidelity and incorporated that into how the program was directed. This was done in both formal and informal ways. Informally, this happened during team meetings and informal discussions, when the leader directed a staff member based on ACT standards or fidelity considerations. The more formal information typically came via some type of audit or review. Each team leader had been through TMACT reviews and utilized the outcomes and feedback from that assessment to create a strategic plan for improvement. Here is how Alyssa described their strategic planning process:

> We've done creating it [strategic plan] out of things like TMACT ideas or ACT structure principles, as kind of more of the anchor. And so really when we review it, it's more of just a self-assessment of this is where we were saying we needed to be.

Both team leaders agreed they found the TMACT a helpful tool, because, as Alyssa said: "I like the TMACT tool because it is specific with what the next step would be and I can wrap

my head around that". In other words, the tool helped both leaders to understand and implement steps to take to improve the fidelity of their respective programs.

Another notable point in regards to program design was that each team leader took the approach of "we can improve" and viewed feedback from these tools in the spirit of quality improvement. Each of them had a style that did not belittle or create fear among the team for not reaching certain benchmarks. Instead, they worked to problem solve issues and encouraged an open and honest environment so that barriers could be resolved and keep the team moving forward. This non-threatening climate likely facilitated the team's buy-in to work toward ACT fidelity as team members were more willing to openly discuss and fix problems.

While the ACT model was used as a structured guide for evidence based practice; both team leaders discussed having some flexibility in terms of the means to achieving desired outcomes. Both noted the importance of being able to be creative within the model. Alyssa related this idea in this manner:

> I see ACT as being, like structure, structure, structure, then complete flexibility. I see it part of my job to really help the group step back and think about the larger picture, and then 'what do you need now to do that'.
>
> ACT standards and fidelity created a guide/framework for their leadership.

Integrates high fidelity ACT into daily team practices. One action employed by each team leader to improve fidelity was that each integrated fidelity into their daily decision making. This was observed in team meetings, interactions with staff, and per report, during clinical supervision meetings. Catherine indicated that daily team practices such as "going to the hospital to see a difficult to engage individual, the structure of the day, the tools we have in place" all illustrate that high fidelity practice is integrated into the team's practice.

Both team leaders acknowledged that at this point in their leadership, they integrate high fidelity practices into the team more unconsciously as high fidelity practices are ingrained within their daily decision making. For example, Alyssa stated this:

> I think it [fidelity] provides more of an underlying, like, the information has been integrated enough that it provides an underlying touch-point for decisions that I don't even always, I am not even always aware of that sometimes. It provides a foundational base, but then you don't have to think about it so much.

Catherine indicated that she also does not think about it [ACT fidelity] much anymore and it's an "almost inherent piece now".

Knowledge of and trusts in EBP of ACT. Alyssa and Catherine showed absolute faith in the ACT model and talked about their belief and trust in the evidence based practice. For example, Catherine stated this: "There is an EBP here which gives us something. It's evidence-based for a reason, which means if you do steps one, two, and three, you've got a good chance of getting an outcome that you want". Both women promoted fidelity and served as an ambassador for the model.

Outside support. Each leader had the support of their direct agency leadership to strive towards high fidelity, a finding that is supported by prior literature. Both felt the support of their agency leadership and had autonomy to run the program as they saw fit. Alyssa had this to say of her agency leader: "I feel like my manager does a really good job of both creating a protective little space for me to do my thing and to follow fidelity".

However, the team leaders diverged in the amount of state support they received. As previously noted, Catherine felt very good support from the state mental health authority; whereas, Alyssa from Ramsey County identified the guidelines by the state mental health

authority as a barrier to high fidelity services. Per Alyssa, "the state has some standards for ACT that I don't think are specific enough" and she voiced displeasure and found the state leadership to be unhelpful, actually identifying DHS as a barrier to her high fidelity program. Each leader had ACT consultants early on in their leadership careers although in the Ramsey County team this did not come from outside the team but rather from the team psychiatrist who was also a nationally known ACT psychiatrist. Both leaders acknowledged the importance of outside support in helping them create and sustain high fidelity ACT.

Contrasts/Differences. This chapter outlines the similarities between the two team leaders in effort to illuminate commonalities for the purpose of generating hypotheses; however, there are a few salient differences that lend to better understanding the study aims as well. While Alyssa and Catherine share many similarities and work styles (e.g. transformational), they were also very different in regards to demeanor as well as certain perspectives. Alyssa was reported by all participants, and observed by me, to be extremely calm. She talked in a calm voice, very articulate and never appeared rushed. On the other side of the spectrum, was Catherine who had extremely high energy, including talking a little louder and in a very positive, almost infectious way. Each team leader was highly effective and team members reported that each team leader was enjoyable to be around. Alyssa also upheld the notion of change and deliberately prepared the team for change; reframing change as a positive thing. This was observed with how she handled telling news of a staff departure, allowing for some sadness, but reminding individuals it is inevitable and they will manage. The team seemed prepared for handling the "ups and downs" because of this philosophy. Catherine was less inclined to emphasize the idea of change being inevitable or actively promote this concept. At the same time, each leader had a similar style for

handling change when it loomed ahead with a positive, "can do" attitude and with an active problem-solving approach.

Catherine was a fierce advocate for the ACT model and for her team. She took more "ownership" of the team, stating "my team" or indicating that if the team failed to meet an objective, then that was her responsibility. She spoke of her team with a great deal of pride and talked about what "they" had built. Alyssa appeared to share that ownership across the team more and never referred to the team as hers. She was proud of the work that had been done, but never vocalized her independent pride in the role she played in having a high fidelity team. Team members did not appear to function or thrive better in either environment, but equally well.

The team leaders differed in how they viewed accountability to the program. For example, Alyssa seemed more driven by inside accountability. Alyssa described needing to answer to her fellow team members, colleagues, and consumers, more than to her overall agency or state mental health authority. While she respected all stakeholders, she felt more responsible to the team and consumers served; which motivated her work. This internal accountability may be due in part to her solid partnering with the team psychiatrist and having challenges with the state mental health authority. In contrast, Catherine seemed to rely more on outside accountability to her agency, state mental health authority and ACT mentor. She spoke more about the influence these outside entities had on her drive to operate a high fidelity program. This seeming difference between direction of accountability may be tied to differences in the level of state support for the promotion of their program. Catherine was able to partner with the state mental health authority to support a high fidelity program, while Alyssa figured out strategies to "work around" some of the state-induced barriers.

Both team leaders expressed a fundamental belief in and understanding of the ACT model, but Catherine spoke of the model with sincere passion and reported stricter adherence. While both team leaders has a strong belief in the ACT model of care, it was noted that Alyssa believed in the ACT model, but reported not becoming "obsessed" or even caring about the details of the evidence base. On the other hand, Catherine dove into the literature and became a fierce advocate for following the model with few adaptations. Catherine followed the model more "by the book".

This suggests that there are some attributes, behaviors and perspectives that may not influence effective leadership in terms of the functional outcomes for clients and staff commitment. In the end, what seems to matter most was the majority of similarities in characteristics, philosophies, and behaviors these two team leaders shared, and how these all contributed to their successful leading of high fidelity ACT teams.

Chapter 5: Discussion, Contributions, and Future Implications

Introduction

My interest in understanding who ACT team leaders on high fidelity ACT teams are, along with what they do, how they do it, and ways in which they may promote fidelity is based on my professional experience as a previous ACT team leader/social worker, an educator, a consultant and now as a policy specialist. My hope in conducting this study is to provide more understanding of how ACT could be successfully implemented, with less struggles than in the past, by focusing on the role and contribution of the ACT team leaders. As this topic has just begun to be explored empirically, in my opinion, the lack of research in effective leadership within ACT programs is a serious omission. Leadership is a key importance in implementing complex and rigorous evidence based practices with high level of integrity; and yet very little is known about this critical variable. This case study illuminated that the team leaders of high fidelity ACT teams had remarkable similarities, including attributes, values and behaviors which largely confirms insights gleaned from the broader organizational and leadership literature.

Drawing on the information provided in this study, it is my vision that Schools of Social Work might consider additions to graduate degree curricula, moving beyond general teachings on clinical supervisory roles, in order to better meet the needs of the future mental health work force. It seems critical to teach the principles, skills and actions necessary to lead multi-disciplinary mental health teams and implement EBPs with high quality. Finally, I hope this information can inform policy makers to look further at what micro-, mezzo-, and macro-level factors most successfully promote implementation of ACT in our mental health systems. The matter of individuals with SPMI having ready access to this and other EBPs that promote meaningful recovery, in an important social justice issue that we face.

In order to effectively cover the breadth of new knowledge generated by this study, this chapter will discuss findings in relation to prior leadership and EBP research and highlight unique contributions of the study. I will describe how the findings connect to the conceptual framework– Bass's Multifactor Model of Leadership– and highlight how that theory is applicable to this current study of ACT team leaders. Then, I will describe how general themes align with previous literature on the subjects of EBP implementation and mental health team leadership. I will conclude this chapter by discussing the limitations of the study, as well as a review of my study's contributions and implications for social work practice, social work education, mental health policy. This chapter ends with a discussion of directions for future research.

Alignment with Bass's Multifactor Model of Leadership

The findings from the current collective case study are largely consistent with insights from Bass's Multifactor Model of Leadership. Bass's model helps interpret some of the results of this case study and contributes to answering questions about what the ACT team leader does and how does she does it. To recall, this model describes leadership behavior as falling within two broad categories: transformational and transactional (Burns, 1978; Avolio & Bass, 2004). Bass posited that a leader could embody both types of leadership and identified the actual behaviors leaders demonstrated along these two dimensions (Conger, 1999).

Most leadership experts suggest that the two leadership styles—transactional and transformational—should be integrated to maximize effective leadership and that transformational leadership augments the effects of transactional leadership (Bass, 1985; Dems, 2011). Many experts also agree any given leader will demonstrate a mix of these leadership approaches, but research has convincingly demonstrated that highly effective leaders use transformational approaches more frequently than transactional approaches (Garman & Corrigan,

1998). The mix of leadership styles, with a heavier weight on transformational leadership, is certainly reflected in the findings of this study about exemplary ACT team leaders.

Transformational leadership in ACT. Transformational leadership is characterized by the ability to bring about change or transformation in followers to meet the needs of the organization (Daft, 1999). With this type of leadership style, followers have an emotional and motivational attachment to the leader based on the leader's behaviors (House et al., 1988). Bass (1985) identified four components that describe the transformational leadership style: (1) idealized influence; (2) inspirational motivation; (3) intellectual stimulation; and, (4) individualized consideration. Both team leaders in this case study exemplified all four components of transformational leadership. To start, in idealized influence, the team leader serves as a role model and embodies the values that the leader wants team members to be learning and internalizing (Bass & Avolio, 1993). The leader promotes a consistent vision and values and provides the team members with a sense of meaning. The team leader promotes a vision, leads by example, shows a strong commitment to goals, and creates trust and confidence in followers. According to Bass (1985), transformational leaders have attributes including trustworthiness, respectfulness, determination, and confidence; these are used to inspire and motivate others. The two ACT team leaders in this study were described as having these qualities by their interdisciplinary colleagues and team members. Both leaders were depicted as honest which contributed to their trustworthiness and had high levels of respect from team members and other stakeholders. Both team leaders set the vision for the ACT team's work and led by example. These ACT team leaders emulated strong commitment to having a high quality program and held power and influence over their team members because team members trusted, respected, and had high levels of confidence in their leader's ability.

The second component of Bass's transformational leadership style is inspirational motivation, which is described as a leader who exhibits optimism and excitement about goals and future states (Bass, 1985). Repeatedly, each ACT team leader was described as optimistic and enthusiastic about the future. Both team leaders sent consistent messages about the value of their work, which included seeing clients as heroes and working hard every day to help people with SPMI live better lives. The clear and persistent message that the clients' needs come first, above all team or individual needs was "infectious" and embraced by the team members. Team members attributed a higher value to their daily work based on this philosophy. The team leaders set high expectations that their team would be the best and insisted on excellence in all they did.

The third component of transformational leadership is intellectual stimulation, whereby followers are encouraged to question their own beliefs, assumptions, and values, and when appropriate, those of the leader (Avolio & Bass, 2004). As a result, followers develop the capacity to solve future problems, unforeseen by the leader and team (Avolio & Bass, 2004). Findings suggested that the ACT team leaders in this study very intentionally maintained a work culture that valued new perspectives, and open dialoging as a means to finding new perspectives and solutions for solving problems. Team members indicated they felt comfortable in raising issues with the team and leader as that was the expectation set, and the environment was safe to do so.

Likewise, another key measure of a leader's effectiveness is how capable the followers are in the absence of the leader or without the leader's direct involvement (Avolio & Bass, 2004). This goal of avoiding things falling apart in the absence of the ACT team leader was evident in both teams. The team leaders promoted team members' capability and confidence for problem

solving challenges and making independent decisions. For instance, the inclusion of team members in decision-making, can be understood as, in part, a way of promoting and practicing members' collective ability to function autonomously.

The fourth component of transformational leadership is individualized consideration, which refers to an emphasis on development and mentoring of followers by the leader who attends to the individual needs of the members (Bass, 1985). According to Avolio & Bass (2004), this sort of leader understands and shares in followers' concerns and developmental needs, and treats each individual uniquely. The leader not only recognizes and pays attention to their followers' needs, but works to develop and advance those needs in an effort to maximize individuals reaching their fullest potential (Avolio & Bass, 2004; Yammarino & Bass, 1990). As reported in Chapter Four, the ACT team leaders communicated being attuned with their staff focusing deliberate attention on the individual needs of team members. They frequently asked individual team members what they needed, both for personal and professional growth, and took steps to provide opportunities that promoted this growth.

Having a leader that is mindful of individuals' needs serves to generate a caring, empathic, and cohesive organizational culture that empowers team members, contributes to higher levels of worker satisfaction, and is negatively associated with burnout in the field of mental health services (all factors which presumably influence less worker turnover; Corrigan et al., 2002; Van Wart, 2003). In a study of community nurses, Onyett (2011) found that effective team work, good leadership, management, support, and supervision appeared to be protective factors from stress, dissatisfaction and burnout. In the current study, each ACT team leader set the tone for how team members treated one another and clients and nurtured team members through support, supervision, recognition, creating a healthy and functional work environment,

and emphasizing health and well-being. Some team members indicated that the attention to their needs and individual support from the team leader were reasons for their work satisfaction and retention. Subsequently, each team experienced low turnover. Low turnover is a highly important factor as literature suggests that turnover is a hindrance to implementation of evidence based mental health service interventions and that behavioral health workforce stability plays a vital role in delivery of high-quality services (Woltmann et al., 2008).

Transactional leadership in ACT. I also found that these exemplary ACT team leaders are proficient in performing some behaviors that are considered transactional; day-to-day tasks necessary for the program to operate effectively. Bass (1985) listed two components of transactional leadership: contingent reward and management by exception. Contingent reward is defined as the leader clarifying for the follower through direction or participation and indicating what the follower needs to do to be rewarded for the effort (Bass, 1999). The emphasis of contingent reward is on the use of rewards and penalties to motivate followers and achieve compliance with organizational goals and norms (A Dictionary of Business and Management, 2006). Management by exception refers to the idea that leaders are less interested in changing or transforming the work environment, but rather seek to keep everything static except where problems occur (Bass, 1999). In management by exception, leaders wait for mistakes before taking corrective action (Bass, 1999). This type of leadership is considered to be effective in crisis and emergency situations, and may be a good fit for work that needs to be implemented within specific guidelines that are preset.

The team leaders in the current study had leadership behaviors that aligned with the idea of contingent reinforcement but not with management by exception. Both team leaders clearly laid out for team members what needed to be done in order to accomplish the team's work.

Team members in the study were very clear on the day to day tasks that needed accomplishment, and seemed to have clear ideas on how to accomplish those tasks.

The team leaders in the study were extremely invested in change and transforming the system to better serve individuals with SPMI–lending a sort of value-driven, activist feel to their work. By selecting team members who have similar values, modeling how to work with clients with integrity, and inspiring a high degree of enthusiasm for the work and the target population–the team leaders in this study defied the bounds of transactional leadership in many ways. They were proactive in their approach to planning and solving problems, and did not simply wait for problems to arise before coming up with a solution. Likewise, both team leaders expressed a desire to be the best and set high expectations, which contradicts the "only do what is essential to get the work done" principle of transactional leadership (Bass, 1990).

Because the findings of this case study suggest that the team leaders seemed to be more focused on transformational leadership aims and activities than transactional, the question raised is whether or not this leadership theory "fits" for an ACT team leader in general or if another theory (e.g., charismatic leadership) would be helpful to incorporate into future studies of ACT team leadership. There are some research design related factors that may have inadvertently biased the data collection or data input to toward less transactional and more transformational content. First, both team leaders were mature leaders and well into the tenure of leading an ACT team. This issue of maturity was raised by each team leader, each commenting that how they operated in the first years of their leadership was different than their current leadership styles. The team leaders indicated that they were less focused on the transformational activities of the team early on in their tenure. Instead, they were more focused simply on the "exchange" relationship and getting work done. Early in the leaders' tenure, they were more focused on

building trust with and gaining knowledge of the team members, the ACT model, and clients served. They used more contingent reward and management by exception as means of reinforcing their new leadership and setting expectations. Both team leaders described being more of a "manager" during those first years of leadership versus inspirational leaders. This finding suggests that the stage of development of an ACT program may matter in the types of leadership and strengths that are considered optimal and desirable. For example, transactional leadership may be important for the goal of getting a new team up and running, and to assure the practical aspects of the work are being completed.

Within this study, transactional leadership was less evident in my observations. This may be due to the nature of data collection, design of the study questionnaires and an emphasis on transformational leadership, and/or perceptions of team leaders and members as to what the nature of the study was. This lack of transactional leadership observations may also be related to the fact that each team leader had a length of tenure as a team leader, and less transactional leadership was required based on that fact; team members were well aware and skilled at carrying out the expectations set for them and needed less managing.

To further operationalize how ACT team leaders do their daily work, the primary concerns, and the personal attributes that help them in negotiating their tasks and concerns, the following section discusses some of the key findings.

Characteristics and Behaviors of a Great ACT Team Leader

Understanding what characteristics, skills, and behaviors of ACT team leaders lend themselves to better leadership and higher service fidelity is of key importance. This collective case study confirmed that many of the descriptors used to define the ACT team leaders aligned with previous general literature on effective leadership characteristics. As an example, Liberman

and colleagues (2001) reported that effective leaders have realistic optimism. Both women in the study had optimism and were realistic in the expectations and goals that were set. Within the ACT teams, optimism led to an environment that inspired the team members in their work with ACT consumers.

Comparing the current study's findings to the EBP literature on leadership (Torrey et al., 2012; Maister, 1993), it is evident that ACT team leaders' behaviors and actions are similar to those of effective leaders in other different service contexts. For example, EBP implementation literature found that active, involved, and visible leadership strongly influences successful EBP implementation, regardless of the type of specific evidence based practice (i.e., supported employment or illness management and recovery, etc.; Torrey et al., 2012). Maister (1993) indicated that interdisciplinary teams needed someone who is well respected by colleagues across the disciplines, a people manager, a person who understand the pressures of work, a colleague who is interested in each individual and is able to question, probe, and gently challenge an individuals' contribution to the team in a non-threatening way. My observations and others' input indicated that Alyssa and Catherine fit all such competencies of a great leader of an interdisciplinary team as outlined by Maister (1993). As just one example, both leaders assumed responsibility for all of the tasks assumed by other team members–thus avoiding picking and choosing tasks, or leaving challenging direct practice work to others.

Skilled clinician. Prior literature has also documented that interdisciplinary health care and mental health care teams need experienced and skilled clinicians as leaders (Maister, 1993, as cited in McCallin, 2003; Corrigan & Garman, 1999). Having a skilled clinician is important so that the leader has the knowledge to work with the clinically complex treatment and rehabilitative needs of individuals with SPMI. Leaders must possess a knowledge base and skill

set in order to be viewed as dependable, exert influence, and be seen as trustworthy. In this study, both ACT team leaders were noted to be exceptionally skilled clinicians. The concept of an experienced and skilled clinician is something that may be assumed; however, this requirement receives less emphasis in the ACT implementation literature. As described, they both had personal qualities and clinical skills (e.g., knowledge, fine-tuned assessment skills, problem-solving, goal setting, self-awareness, collaboration, decisiveness), some of which were directed toward team members, that generated others' respect for their clinical work with clients.

However extending findings further, this study suggested that other characteristics are important to consider for an ACT team leader as well. For example, both Catherine and Alyssa had a passion to work with individuals that had SPMI and found an exceptionally good fit with the roles and responsibilities of an ACT team leader. Because of this, each team leader brought with them the philosophy that individuals with mental illness are "heroes" and deserve the best possible care. This philosophy helped them to be more open-minded, tolerant of risk, and creative within their team's clinical assessment and treatment approach. This study suggests that looking at further characteristics such as passion for the work, a person's attitudes and treatment philosophies, and overall alignment with the roles and duties of an ACT team leader (e.g., clinical, supervisory, and leadership functions) may afford a better opportunity for implementation of high fidelity ACT.

Emotional intelligence. One major discovery in my case study was that both team leaders in these high fidelity ACT teams had the attribute of high emotional intelligence. Emotional intelligence is the ability to monitor one's own and other people's emotions, to delineate between different emotions and label them accurately, and use emotional information to guide thinking and behavior (Goleman et al., 2002) – all skills crucial to building and

sustaining positive working relationships. Each team leader in my case study had the skills and ability to perform all these tasks, and did so on a daily basis. Both leaders were highly self-aware that they set the tone for the rest of the team and practiced good emotional awareness and control because of that awareness. They were described as relatively unflappable and disliking team "drama". Each was inclined to assess other individuals' emotional temperature or stress levels on an ongoing basis, and adjust her style, communication, or actions to best meet the needs of the other individual (staff or client) –evidencing keen perceptiveness and personal agility.

While prior literature on general leadership has noted the importance of the relational dynamics of leadership (Wells & Jinett, 2006), very little, if anything, has been directly written about how this manifests within the mental health EBP settings. It seems that if team managers have an important role in containing difficult team emotions (Rosen & Callaly, 2005), the concept of emotional intelligence may assist us in more fully understanding how ACT team leaders handle their own emotions and reactions along with team member issues and how that action contributes to the successful implementation of ACT. My study adds to the EBP literature by suggesting that further exploration into the team leader/team member relationship may contribute to better understanding the processes by which EBPs are implemented. Further, this study's findings highlight that the team leader/team member relationship may be important in bringing high fidelity, high quality ACT services to consumers sooner and work to close the gap between science and "real world" practice.

Role modeling. Previous literature identified that being a role model (i.e., taking responsibility for actions, acting in a way that incites admiration in followers, being passionate about and personally invested in the organizational goals) is also important and aligned with

Bass' concept of idealized influence (Bass, 1985; Bass & Avolio, 1989; Packard, 2003; Fischer, 2005). The team leaders in this study served as role models, working alongside other team members and providing the full range of ACT services. Moreover, this study confirms previous findings indicating that team leaders can affect relational dynamics among members in a number of ways including through the norms they model in their own behavior (e.g., how to manage such conflicts proactively themselves; Wells et al., 2006). Each team leader utilized this strategy for ongoing training and enrichment of staff, ultimately shaping the quality of services.

Vision, goal-setting, and upholding high expectations. The importance of the team leader's role in constructing a vision and environment that is focused on recovery and person-centered principles is highlighted in this study. Each of these team leaders in the present study honored the daily choices of consumers, helping individuals steer their own treatment with the team. Furthermore, the team leaders believed and promoted the idea that every individual served had recovery potential. These findings support prior literature that identified that effective rehabilitation teams have a common frame of reference (e.g., a common treatment philosophy, a commitment to implementing and evaluating evidence based services; Liberman et. al., 2001). This study sheds light on the role of the team leader in developing and sustaining that frame of reference (i.e., a recovery and person-centered approach to ACT).

Along with the vision of recovery and person-centeredness, a clear goal for both team leaders in this study was to offer high quality, excellent services so that consumers could attain the best life possible (e.g., obtain meaningful employment, integrate into community, improve life satisfaction). This goal provided the vision and rationale for the outcomes of services provided to consumers and a road map for team members in terms of how to get there. This idea is consistent with Bass's transformational leadership factors of idealized influence and

inspirational motivation, where transformational leaders arouse and inspire others to put forth extra personal effort to accomplish the vision or mission as they see it (Corrigan et al., 1998; Avolio & Bass, 2004). Leaders motivate followers to have and uphold high expectations and commit to the organization while articulating, in understandable ways, shared goals and mutual understanding of what is right and important (Mary, 2005; Avolio & Bass, 2004). Team members in this case study spoke of how inspirational the team leaders were and that their values and vision aligned with what was important to the team members (e.g., good client care, strength-based ideals). Because of the setting of higher expectations and facilitated by the direct and clear communications, the team leaders motivated the team members "buy into" the vision of ACT, person-centeredness, and recovery-based treatment. Through their actions and behaviors, they helped team members see a clear path to meeting team and consumers goals.

Research on EBP implementation has found that effective team leaders set clear and high expectations while also allowing practitioners to develop their own style or sense of how to do their jobs (Rapp et al., 2010). An emphasis on excellence by team leaders provides practical and social support to integrate innovations, and encourages team members to challenge and debate each other's ideas (West et al., 2003). This emphasis on excellence was found in these ACT teams. Both team leaders in the present study set high expectations of their staff and aimed to provide high quality ACT services. Each team leader reported being competitive, wanting the "best" team, a goal that was shared with team members. Both team leaders encouraged staff members to dialog or share differing opinions with one another on issues of clinical treatment; team leaders prompted this behavior as a means to improved outcomes for the clients (e.g., more discussion generated more possible solutions for a client's challenge).

According to prior literature, effective ACT programs had team leaders that held team members accountable to set expectations (Mancini et al., 2009). Findings within this case study replicate the findings by Mancini and colleagues. This accountability was observed or articulated in many ways including the leaders prompting team members to report on activities assigned/completed and reports of disciplinary measures taken when a team member failed to follow through with a task or assignment. The in-depth qualitative studies on the implementation of specific EBPs suggest that training and supervision, though important, must be linked to actual changes in work processes; setting expectations and holding staff accountable facilitate such changes (Brunette et al., 2008; Rapp et al., 2010, Torrey et al., 2012). This study's findings suggest that the team leader, via holding team members accountable for the actual work flow, may be part of a successful implementation strategy.

Overcoming barriers and problem solving. While the implementation literature finds that barriers are common when implementing a new evidence based practice, effective leaders actively confront and overcome these barriers (Torrey et al., 2012). Both Alyssa and Catherine have taken a very assertive and proactive approach to problem solving and extended this further to help the team look at obstacles or barriers as opportunities. They both constantly asked team members to "reframe" barriers and set expectations that no problem was unsolvable. Each leader indicated that part of their role as a leader was to teach team members to be able to independently solve problems by thinking creatively and "outside the box". This philosophy parallels the literature by Avolio & Bass (2004) where followers of transformational leaders learn to tackle and solve problems independent of the leader by being creative and innovative as the leader has previously encouraged them to contribute, learn, and be independent.

Effective communication. The ACT team leaders in my case study were found to have a direct, open, transparent and understandable communication style. They provided feedback and managed conflict in a way that promoted growth and did not demean individuals. Findings from research on supervisor deficits in the national EBP Implementation Project by Rapp and colleagues (2010), reinforce the leadership value of these abovementioned communication skills. The latter study found that ineffective leaders provided consultation around service delivery only when confronted with difficulty, that leaders went out of their way to avoid conflict, and team leaders did not provide meaningful feedback on staff practices. Understanding what leadership behaviors result in failure helps to illuminate what approaches may be more successful (opposite of ineffective may shed light on effective strategies). As noted throughout, Alyssa and Catherine's communication styles wholly diverge from those found in the study on supervisory deficits. As an example, both leaders encouraged team members to discuss and resolve conflicts directly and professionally with one another. However, both leaders monitored and mediated conflicts with team members quickly and did not let arguments persist as they felt this impacted client care. Neither team leader avoided conflict, but instead intervened early on to mitigate disruption to the work.

Taking Care of Team Members

In addressing the question of 'what do ACT team leaders do' to promote highly effective ACT services, a set of themes emerged that relate to taking care of the team members and ensuring a positive and productive work environment. The two team leaders in this study each communicated that this was a main responsibility and actually consumed more time and effort than focusing on the consumers. This activity took more time as the team leaders had been trained to work with consumers, but came into the ACT team leader job with little education on

how to lead a multi-disciplinary team of professionals. This finding of the attention and energy directed toward taking care of team members, and the emphasis placed on this activity, was a major finding of this study. This suggests that a great deal of a successful ACT team leader's work on behalf of consumers entails efforts to nurture team members. The following section discusses these key findings.

Emphasizing relationships. The emphasis on the relationships with team members, ensuring their inclusion in decision-making, ensuring their professional growth and welfare, and ensuring their professional needs were met was a key finding of this study that expands knowledge within the ACT implementation literature. Each team leader directly asked team members about their work satisfaction and inquired as to what else team members needed for professional fulfillment. Findings also revealed that each team leader made it a priority to know and understand each team member as an individual and altered their approach to motivate that team member based on that understanding. The team leaders assessed the strengths of each individual team member and highlighted those strengths as being critical to the effectiveness of the team and key to the work being done. Team members then were able to identify their unique contribution to the overall team, which reinforced cohesiveness. With a keen awareness that team members' experiences at work directly impacts client outcomes, each leader saw it as her responsibility to focus on the relationships among one another in order to have an effective program. Both team leaders possessed the attribute of emotional intelligence, which fostered their capacity to take care of the team and focus on leader/team member relationships. Wells and colleagues (2006) identified that the relationships between leaders and followers are highly important for understanding effective influence of leaders.

Positive team work climate. A new finding from this study was that both ACT team leaders worked to establish and maintain a fun and positive team work climate. Both team leaders expressed that having a fun and positive work environment led to team cohesion and improved morale among team members, a finding supported by the general leadership literature (Liberman et al., 2001). Each team leader worked to build a spirit of collaboration and encouraged team members to directly deal with any conflicts (Wells et al., 2006). Similar to findings from prior research, the ACT team leaders in this study emphasized that it was important to promote morale within the team and did so by working to sustain camaraderie and introduce some levity–which they indicated as necessary fuel for doing the difficult work of ACT (Mancini et al., 2009). The team leaders were able to set a positive and fun work culture but not at the expense of taking care of important business.

The team leaders each described their team environments as having their own "energy" or "pulse", which reflected a high degree of awareness of the group climate. "Taking the pulse" seemed to relate to monitoring and assessing the emotional and psychological health and well-being of the collective team. In these ways, the ACT team leaders articulated their attention to intragroup conflict versus harmony, low versus high morale, or low versus high stress. To my knowledge, prior literature on ACT has not raised this idea.

Finally, as part of setting and maintaining a positive team work climate, the ACT team leaders in this case study also connected the care of the team to very careful hiring practices. The team leaders carefully selected staff with the personal and professional characteristics that supported team work (e.g. collaboration, open to different opinions) and a recovery vision. Findings from the Mancini et al. (2009) study also indicated that higher fidelity teams vetted

prospective employees very carefully, and actions such as this had a clear and positive effect on morale.

Team satisfaction: The link between leadership and client outcomes. Recently, Bowers and colleagues (2011) found in their study on an acute inpatient psychiatric ward, that leadership impacts teamwork, teamwork impacts structure, structure influences burnout, and burnout influences attitudes towards difficult patients. My study supports these findings in a general way as a major theme from this case study was that the team leaders felt their attitudes and behaviors influenced the team members and ultimately the clients. Corrigan and colleagues (2000) looked at the relationship between types of leadership and levels of satisfaction with the program and quality of life for consumers within mental health teams. They found that subordinates who viewed their leaders as charismatic, inspirational, and considerate of others, worked in programs with consumers who reported higher quality of life (Corrigan et al., 2000). They concluded that leadership was an important variable for understanding a team's impact on its consumers (Corrigan et al., 2000).

Another study, focused on psychiatric treatment teams, highlighted how leaders within different disciplines may influence client outcomes by examining the relationships between the team leader's discipline, mutual respect among team members, and improvements in patient quality of life (Wells et al., 2006). The findings indicated that when mutual respect among staff was greater, patients improved more over time in perceived quality of their housing, relations with families, social life and finances (Wells et al., 2006). As another example from the EBP implementation literature, Aarons (2006) found that the relationship within the team leader and team member dyad affects team members' attitudes towards EBPs. Specifically, he noted that the leadership of the direct supervisor actively promotes front line staffs' acceptance and

adoption of innovation and change which is critical to the success of implementing EBPs. Although the present study does not tie leadership styles and behaviors to client outcomes, the Wells (2006) study lends support to our team leaders' own working hypotheses that their behavior influences the team's overall wellbeing, which ultimately trickles down to client care.

Protecting and buffering. As part of taking care of the team as a whole, and ultimately protecting the integrity of service delivery, both team leaders worked hard to buffer the team from outside influences that threatened the work of the team and/or consumer outcomes. For example, the team leaders advocated with DHS against admitting many consumers quickly into the program and with their agencies for having consumers seen by the psychiatrist only in office. The leaders argued either situation would jeopardize client care and be negative for staff. Data from this study reveals how planful and forward thinking both team leaders are such that they are vigilant and proactive, which serves to protect and buffer the team from outside stressors.

These findings align with prior literature on implementing EBP and ACT (Mancini et al., 2009; Rosen & Callaly, 2005; Belling et al., 2011). According to Rosen & Callaly (2005), team managers have an important role in consistently articulating and advocating for the team and for the needs and safety of the clients. Likewise, an effective team leader will maintain a cohesive team by reducing outside pressure and creating supportive environment for staff to operate and develop (Belling et al., 2011). In their study looking specifically at the EBP of ACT, Mancini et al. (2009) found that a strong leader was often able to promote reasonably effective team functioning by serving as a buffer between the team and agency management. Each team leader in this study articulated how they advocated for the program or clients with their agencies or state mental health authorities, especially if priorities differed. Each team leader was seen as a champion for their program and team due to this assertive, yet professional, advocacy.

Leadership Commitment to the Evidence-based Practice of ACT

A major goal of implementing an evidence based practice is to do so with adherence to the original model, in order to attain the desired outcomes. Given the two ACT teams were designated as "high fidelity", an aim of this case study was to examine what roles the team leaders may play in promoting high fidelity to ACT. Findings highlighted that both team leaders played a critical role to the team's commitment to ACT, followed the infrastructure of the EBP, believed in the model and utilized various tools for outcome monitoring.

Critical role. As I expected, when exploring the roles played by team leaders in promoting high fidelity ACT, I found, that each team leader played a critical role. Both leaders promoted and set clear and high expectations for the team that high fidelity was the team's "measuring stick" and organized the work flow and team members accordingly. In a systematic review and meta-regression of randomized controlled trials of intensive case management including ACT, researchers concluded that the way in which the teams organize their work is the most important factor in reducing the need for inpatient services (Burns et al., 2007).

Structure, structure, structure...creativity. In the current collective case study, the ACT team leaders used the ACT framework as a program guide to both make decisions, and organize the service delivery of the system. While using this framework, the team leaders indicated they both use flexibility and creativity within the EBP framework to meet consumer needs and agency requirements. This suggests that one can implement a high fidelity program while allowing for some adaptation of the model to fit local or consumer needs.

Trust and faith. I found that each team leader possessed a strong trust or core faith in the EBP of ACT and believed that the ACT model could help them achieve the team's goals of recovery for the individuals served. Along with this core faith in the service model, findings

from this study highlighted both team leaders had ample knowledge of the ACT model, as can be expected based on prior literature (Mancini et al., 2009). However, positive attitudes and extensive knowledge of the EBP, that is, belief in the practice, wanting to offer the practice, and understanding the practice are not enough for successful implementation (Torrey et al., 2012). Prior literature states practices must be implemented actively and that there must be adequate levels of resources, organization, and support (Torrey et al., 2012). The findings from this case study convincingly highlighted that the team leaders implemented several practices daily to sustain high fidelity ACT services (i.e., doctor making community visits, daily team meeting) and problem-solved and removed barriers that would impede high fidelity ACT.

Monitoring outcomes. Additionally, this study found that both team leaders promote high fidelity ACT via outcome monitoring and designing strategic plans that incorporate fidelity measures. Each team leader was very open to using various methods, sources, and tools to provide both qualitative and quantitative feedback to the team that could then be used to improve services. This behavior aligned with literature on the implementation of EBPs that indicates that implementation success is correlated with active leadership strategically committed to strengthening implementation through measurement and feedback (Torrey et al., 2012). Monitoring and using outcomes for continuous quality improvement was also noted to be a key supervisory behavior for the implementation of EBPs (Carlson et al., 2012). Both ACT team leaders were highly committed and used feedback from fidelity tools and other sources to make necessary changes to achieve higher fidelity and removed barriers to high fidelity by discontinuing services that were at odds with the EBP (Bond et al., 2009).

While the team leader's commitment and behavior can go a long way toward promoting EBP with a high level of fidelity, a common theme across the implementation literature is that

various levels of leadership must also be invested in this (Bond et al., 2009). In my case studies, each leader had agency leadership that provided autonomy and promoted ACT fidelity, enabling the team leader to operate the program using the ACT framework as a guide. Moreover, both teams in this case study had resources found in the EBP implementation study by Bond and colleagues (2009) to be critical: ongoing consultation and technical assistance, adequate funding mechanisms aligned with the goal of implementing the EBP, onsite leadership that bought into the EBP, routine feedback re: fidelity, and a dedicated and competent and stable work force. As this study is narrowly focused on the team leader as the agent of transactions and transformation, as discussed below, future research can expand the focus of inquiry to include the contributions of other levels of administration and the broader policy context to the quality of ACT implementation.

Limitations of the Research

My findings should be interpreted with the acknowledgment of study limitations. For an exemplary collective case study, cases are chosen because they represent strong positive examples of the situation of interest (Yin, 2009). In this study, the cases selected were of exemplary, high fidelity ACT teams. The selection included two variables–expert identification and a fidelity review with the TMACT–each of which present challenges.

First, relying on expert identification of exemplary ACT teams and leaders increased the bias for identification based on personal opinions or prejudices. I tried to remediate this by choosing teams where there was some consensus among the experts who included respected state mental health administrators, TMACT authors and evaluators, and ACT consultants; however, the risk for bias still remains. To reduce the risk of expert opinion bias, I utilized a more objective fidelity measure, the TMACT, to confirm a team was exemplary and high fidelity.

While my study puts much weight on the fidelity scores of the TMACT to identify these ACT teams' high level of fidelity, it must be noted that the TMACT is a relatively new tool for which there are not yet established empirical norms. In order to address this limitation, scores were calculated using the Dartmouth Assertive Community Treatment Scale (DACTS) to lend more validity to the teams being defined as "high fidelity". Similarly, while I was personally involved in both the Lincoln and Ramsey County TMACT team fidelity reviews, the co-reviewers were different and this may have introduced variance and issues with inter-rater reliability across the two fidelity reviews. There was no way to ascertain if the first co-reviewer in Minnesota was similar to the second co-reviewer in Nebraska. Finally, this study did not examine outcome data from the ACT programs. Had this occurred, this would have bolstered confidence that the exemplary ACT teams selected were indeed high fidelity ACT teams based on client outcomes.

For this study, only two exemplary ACT teams and their leaders, both who happened to be in Midwestern states, were chosen. This presents two potential limitations. One, the design of the study, by only including two teams, may be considered very narrow, in so much as it provides a very small sample size, and limited snapshot of high fidelity ACT team leaders. Second, the study lacks regional diversity. For example, there may be regional differences between the Midwestern state policies compared to other, more populous states. Client demographics, especially the level of diversity across race and ethnic backgrounds, may vary quite a bit in a different regions of the country as well. Based on differences in staff and client demographic make-up across sites, findings may change. For example, both team leaders in this case study identified within the same majority population as most of their team members (i.e., race=white). In a more racially diverse part of the country, if a team leader was of a different race than the majority of team members, one might find that the leadership dynamics may differ.

For example, this heterogeneity may create conflicts that were not observed within this current case study. The interactions between contextual factors such as the demographic characteristics of leaders, staff, and clients and leadership methods or outcomes is an important area for further research (possibly using quantitative survey methods that would be suitable for larger studies).

Although a larger number of cases in this study might have allowed for a broader applicability of findings to a wider range of teams, this study prioritized depth over breadth. Studying two ACT team leaders in their natural contexts enabled in-depth exploration of each exemplary team leader in order to address the study aims and generate future hypotheses. Further, data of this kind provide a window into ACT implementation processes that are simply not afforded or accessible by other means (Mancini et al., 2009). However, given the possibility for selection bias and unique regional influences, information gained from this study cannot be transferred to a broader population of ACT team leaders without further study. While I caution my findings are not based on a representative sample of highly successful ACT teams, I assert the findings still hold clear implications for better understanding ACT team leaders and the processes they utilize to operate high fidelity ACT teams (Mancini et al., 2009). Future research could include more team leaders of exemplary, high fidelity ACT teams in multiple regional areas or with different agency structures or reimbursement mechanisms to assess similarities or differences compared to this case study's findings. Also, investigating and comparing ACT team leaders from high fidelity versus low fidelity teams to better delineate differences in leadership style, characteristics, or practices may be an area of future research worthy of investigation as well.

My analysis relied on individual and group interviews as one of the primary sources of data, such that the data are subject to biases associate with social desirability, recall difficulties,

selective perceptions, and idiosyncratic interpretations of the participant's own experiences. Such biases as potential sources of false information are quite common among studies designed from the social constructionist paradigm. Using this paradigm, what participants chose to share and how they construct meaning about the team leader is of key importance. Still, from a credibility or validity standpoint, the quality of information collected relied largely on participants' willingness and comfort, especially in the focus group setting, to share their personal stories and perceptions of their team leader. It is quite possible that the team leader was described in a more favorable light given these modalities of data collection than would not have been the case using other methods of data collection. Within the transcripts of this case study, there were a limited number of negative comments about the team leaders. This raises the possibility that individuals did not feel comfortable describing negative aspects of their team leader. Future research could address this by introducing more confidential means to obtained this nuanced information such as use of individual surveys or questionnaires (versus focus group), where individuals would have more "safety" (i.e., less social pressure) to answer questions as truthfully and comprehensively as possible.

It is also important to note that the labels and descriptors that were used by agency staff to describe the team leader and her actions are subjective, and cannot be easily validated. I tried to remedy this by asking participants to provide examples, so that the reader could judge the information. However, discretion is advised in the interpretation of the verbal descriptions provided. Further study is warranted to deconstruct what the different labels mean.

Although I was immersed in each case for three days, this time period is limited considering the activities of an ACT team and likely did not allow for the most comprehensive picture of the team leader as possible. Because of this findings must be considered a snapshot of

what high fidelity ACT team leaders do. In addition, the short-term stay with the team may have been problematic and introduced other threats to the trustworthiness of the findings. For example, my presence may have changed the behaviors and actions of the team and team leaders (participants' reactivity) or created a situation where participants felt the need to report on their team leader in socially desirable ways. Additionally, the short-term stay may have not been enough time to fully view "transactional" leadership since it is based on rewards and punishment when things go wrong, as well as a host of mundane administrative tasks that are not observable or particularly remarkable To observe transactional leadership in a real world setting likely demands more time. A three day stay is likely not enough time to witness certain leadership behaviors. s Individuals (i.e. team members) are likely to be on their best behavior during a short span of observation (Hawthorne effect). In future research, investigators might consider the value of an extended period of observations (i.e. ethnographic fieldwork).

Further, my own practice as an ACT team leader may have influenced how I perceived and interpreted the information. This limitation was addressed through member checking all findings with each study participant and clarifying interpretations; thus enhancing the study's confirmability. Additionally, a second researcher conducted coding and contributed to the overall development of categories. From discussions with this second researcher, we were able to reach consensus on coding and data interpretation. These specific strategies were employed to strengthen the credibility of the findings.

Finally, this study, largely informed by Bass' Multi-factor Model of Leadership, describes only proximal leader behavior and interpersonal dynamics. It is not inclusive of several other variables that are known to influence high fidelity ACT implementation such as organizational context or agency or state mental health authority support. Hence, a limit of this study in terms of

overall contribution to understanding high fidelity ACT implementation more broadly is the relatively narrow focus on the individual leader. Future research could address this limitation by including other known variables that are important to ACT implementation and expanding the conceptual framework of the study.

Study Contributions

Overall study contributions. The findings of this study make several contributions to the literature on how social service agencies implement evidence-based practices, as well as to the literature on the implementation of Assertive Community Treatment more specifically. Moreover, the findings certainly have implications for social work practice, social work education, and mental health policy. The following section details these specific contributions and implications along with suggested areas for future directions of inquiry.

The current qualitative study of ACT differed from previous studies with its very in-depth examination of two ACT team leaders who led exemplary, high fidelity ACT teams. New discoveries were made that may have specific implications for the implementation of ACT. For example, while Mancini and colleagues (2009) have pointed out that having the right education and qualifications for an ACT team leader is not enough for successful implementation, my study further suggests what qualities and abilities are likely tied to effective ACT leadership. The two team leaders had a drive and passion to serve individuals with SPMI and understood how to do so in a community-based context. Further, the ACT team leaders not only embraced but required a very specific team philosophy that included a recovery-oriented approach to treatment and upheld a person-centered, strengths-based, rehabilitative ideal that inspired team members to serve consumers with dignity and respect and honored choices.

This case study contributes to the wider knowledge base as it is the first known empirical study that begins to identify, describe, and categorize the breadth of tasks and roles that an effective ACT team leader has. It is a first step in better defining the role so that more attention can be paid to a personal job match for prospective team leaders. As the actual job roles continue to be defined and refined, agencies may be in a better position to delineate actual job responsibilities and identify who best matches with the variety of clinical, leadership, and management roles of the position.

Some of the primary concerns and tasks of the ACT team leader, as discussed by the focal team leaders, involve attending to individual team members and overall team 'health'—these job tasks have not been identified in the formal ACT literature. Previously, only minimal connection has been made between the importance of ACT leadership and the deliberate and ongoing attention to the needs and wellbeing of ACT team members and how this likely impacts high fidelity ACT implementation. For instance, Mancini and colleagues (2009) had pointed out that a poor hiring process and the failure to quickly address personnel problems was an implementation barrier. My study confirms that effective leaders must engage in a careful hiring process and avoid ignoring personnel problems, if they wish to promote highly successful ACT programs. Both team leaders highlighted that a majority of their energy and focus is spent on nurturing and being mindful of individual team members' needs, emphasizing professional growth, and creating and sustaining a positive work environment. They are constantly aware of the team's energy and how that influences interaction with clients. These findings provide new insights into the practices and processes that are utilized in order to create a healthy and functional team, while calling for future research on the actual mechanisms for accomplishing

these objectives. These findings could be applied to the issue of staff turnover in hopes to partially eliminate this implementation barrier.

This study also highlights that a successful team leader must be able to move fluidly and proficiently through all various job tasks. The effective ACT team leaders in the study were able to switch these "hats" effectively, but more so, identified this as a major source of job satisfaction. The research conducted here suggests that, in order to accurately reflect the scope and complexity of this important role, and match the role with job candidates who have a good chance of being successful, the job descriptions as well as job training for ACT team leaders must be more elaborate.

In sum, this research incorporates the ACT team leader as of key importance to ACT fidelity. This study finds that various qualities, abilities, and work-related foci that have not been examined in the ACT or EBP implementation literature, may make the difference between an ACT team leader that successfully maintains a high performing, high fidelity ACT team, and an ACT team leader who is less successful. Both of the exemplary ACT team leaders had high emotional intelligence and a transformational style of leadership. This suggests that when looking at questions of ACT/EBP implementation we should integrate research from other fields (e.g., management studies, organizational psychology) to enrich and supplement our understanding of effective leadership. As some examples, the management literature acknowledges that, at the team level, the study of emotions and the effects of emotions on team performance is a relatively new avenue of inquiry (Koman & Wolff, 2008). Since teamwork is an inherently social actively, the latter scholars assert emotions play an important role in team effectiveness. Similarly, effective work teams have been described as communicative, cohesive, innovative, and grounded with individual member support (Prati, Douglas, Ferris, Ammeter, &

Buckley, 2003). The literature on emotional intelligence has suggested that leaders possessing high levels of emotional intelligence are well suited for undertaking and fulfilling these specific job processes (Prati et al., 2003). In other words, there is room for more interdisciplinary scholarship and training that integrates insights from fields that may seem removed from social work or mental health practice. As we continue to search for answers of how to implement EBP for individuals with SPMI, and close the gap between our knowledge of EBPs and actual high fidelity practice as well as positive consumer outcomes, paying attention to the 'art and science' of effective leadership and teamwork, and more specifically to emotional intelligence and transformational leadership holds promise.

Implications for Social Work

Practice. This research has significant implications for social work mental health practice. As earlier noted, social workers play a major role in the delivery of mental health services, making up approximately 60-70% of the mental health work force and providing more mental health services in the community than any other professional (Stanhope, Tuchman & Sinclair, 2011; U.S. Department of Health and Human Services, 2004). Social workers are typically the largest represented discipline employed on most ACT teams. In addition, a large proportion of ACT team leaders in the United States, including both team leaders focused on in this study, are social workers.

Another major implication of this study's findings for social work practice is the fit between the behaviors demonstrated by the team leaders and the generalist social work approach/practice that emphasizes the need for skills across various levels of practice and the fluid movement between these levels depending on the client's assessed need. For example, each team leader promoted a strengths-based approach with the consumers and team members. The

social work generalist model aligns with the behaviors the team leaders had in working with both consumers and team members. This suggests that social workers, trained in the generalist practice model, have a foundational knowledge base for great leadership. Even more broadly, findings suggest there is a link between necessary team leader behaviors and the general aims/orientation of social work practice. For example, core values of social work practice are to challenge social injustice, respect the inherent dignity and worth of the person, and behave in a trustworthy manner (NASW, 2008). Both team leaders displayed behaviors that reflected these core principles. This fit between the generalist model and alignment with social work principles may account for the gravitation of social workers to ACT team leadership roles.

The findings from this case study may have immediate application for current practicing ACT team leaders, in terms of important considerations or skills that they may begin to incorporate into their practice. Immediate applications could be to look at Bass' framework and explore how current leaders could adopt more components of a transformational approach. Bass's framework has been used as a platform for teaching leadership skills in other contexts (e.g. business, nursing), and could easily be adapted to fit a social work, or mental health team context. This work was started by Garman & Corrigan (1998), who created training modules for mental health team leaders, but these efforts have discontinued. Findings from this study suggest that creating a curriculum for current and aspiring ACT team leaders on the development of effective leadership is a worthy endeavor.

Social work education. Master-prepared social workers often take on leadership positions within the mental health field. Findings from this study suggest that social work education could prepare future mental health practitioners with some additional skill sets that focus on leadership (especially team leadership) as well as on the challenges of implementing

EBP. The attention given to the team members and the deliberate focus on the health of the team that the successful ACT team leaders described is not a common topic in social work curriculums. Each ACT team leader in this study felt they learned these leadership skills and behaviors "on the job" or from specific mentors after graduation. Based on the results of this case study, social work curriculums could consider offering classes or more deeply integrating leadership skills and behaviors into mental health curriculums. One suggestion is to include topics such as group work dynamics and emotional intelligence, or introduce Bass' Multifactor Model of Leadership as these may add great value to social work syllabi and better prepare future social work leaders. Previous literature found that social worker-led multi-disciplinary treatment teams facilitate mutual respect among staff better than other disciplines (e.g. physician-led) and that clients served report improved satisfaction (Wells et al., 2006). This suggests that social workers already possess some necessary characteristics and skills and social work education may be wise to offer more than a passing lecture or two on the importance of leading others successfully.

Findings from this case study suggest that team leaders who lead high fidelity ACT teams have the ability to see the bigger, macro picture in terms of understanding the implications of policies or broader service system constraints on agency practices, to understand the importance of nurturing team members and setting a positive team climate (e.g. mezzo level), while having equal competence in dealing with individual team members and clients. To accommodate the need for this complex skill set, social work education could more consistently and seamlessly integrate the micro (individuals), mezzo (groups), and macro (broader systems and policy) education curricula (i.e. the generalist model). Some schools of social work have a curricular commitment to generalist social work practice, which systematically orients students to work in

all three levels of practice. However, often times, social work curricula focus on a "either or" paradigm, with students needing to choose one track of practice. This collective case study revealed an effective team leader must possess a complex skill set that calls for an equally complex and integrated professional curriculum. Findings from my study suggest that all tracks would be equally important to teach, in an 'all/and' manner for the purpose of improved implementation of EBPs. For example, connecting how advocacy at an agency or state level translates in some meaningful and understandable way to the well-being of the client served deserves more attention.

Evidence based practices mental health policy. In my current professional role, I am an agency policy specialist, setting mental health policy, specifically Assertive Community Treatment policy, for the State of Minnesota. Additionally, part of my responsibility is to provide technical assistance to the ACT leaders at both agency and team levels. Findings of this study can greatly enhance my ability to perform these responsibilities. As one example, from a policy perspective, this study can inform my development of a policy that outlines a minimum skills set that team leaders must have in order for programs to be certified. This study identifies what knowledge and skills are important for ACT team leaders to have in order to improve fidelity, target consumer driven outcomes, and implement ACT with better success. Additionally, I can rely on the findings to consider the necessary agency resources that would support the functioning of a healthy, multi-disciplinary team (e.g., less direct care requirements and more individual supervision).

As someone who works closely on a national level with ACT experts, I can foresee how this study's results may influence how fidelity is conceptualized and measured –changes which would be implemented at the State level. At present, fidelity tools do not integrate criteria

targeting team health or dynamics into the measurement, and findings here suggest that discussions about this omission are warranted. There is room for defining and operationalizing what a 'healthy and effective team' looks or behaves like. Recently, the possibility of including the role of team processes in the evaluation of ACT performance has just begun to receive empirical attention (Wholey et al., 2012). This project contributes to the growing recognition of the need for future inquiry into this aspect of ACT functioning.

Likewise, there are implications from this study for the technical assistance the mental health authority provides for ACT teams. Trainings or workshops that are state sponsored can focus on issues of transformational leadership, emotional intelligence, importance of recovery and person-centered principles, or managing the dynamics of team members. So much of training for ACT team leaders focuses on the "nuts and bolts" of the model–ratios, 24/7 care, fixed point of responsibility for consumers– with virtually nothing about *how* to actually lead a multi-disciplinary team.

This is a highly timely study as many state mental health authorities are focusing on issues of fidelity with their ACT teams due to external pressures. In some states, ACT fidelity is so low, that the question becomes: are consumers offered services at a basic/minimum level or are they afforded services to live in the most empowered and community-integrated manner possible? Several states have entered into settlement agreements with the Department of Justice, in which the quality of their ACT teams must measurably improve (Retrieved on 5/31/15 from http://www.ada.gov/olmstead/olmstead_cases_list2.htm#smithsoi). From a state perspective, trying to operationalize the practical components that are needed to improve fidelity of teams already in existence is an important mandate to assure the continuance of ACT programs.

Directions for Future Research

In addition to the recommendations for future study that have already been discussed in this chapter, further investigation is necessary to extend and replicate the description of ACT team leaders who run high fidelity ACT teams in different states, countries, or contexts. The findings from this study highlighted what two successful ACT team leaders did. However, results are not generalizable to the population of all ACT team leaders and further exploration is warranted with a higher number of ACT team leaders and teams who represent more diversity. Future study could look at including a larger number of ACT team leaders to refine a model of desired ACT team leader qualities and range of roles.

Future research could compare and contrast different ACT leaders so that a better delineation of characteristics, skills, behaviors, and leadership styles could be drawn. This would allow us to see similarities and differences in another way and be able to generate additional hypotheses about high fidelity ACT team leadership. Another important step toward understanding the role of the team leader would be to empirically examine the relationship between team leaders and various outcomes (e.g. to examine if a high degree of concordance with these traits and leadership styles are associated with the fidelity score a team gets, worker or consumer satisfaction, retention of staff or consumers, etc.).

The applicability of Bass' Multifactor Model of Leadership and the concept of emotional intelligence should be investigated to empirically test if ACT team leaders who possess certain attributes and behaviors are associated with indicators of higher fidelity ACT programming. Research designs assessing such relationships can be borrowed from the management literature/field.

This study supports the premise that the attention paid to team members and the work environment is important for successful implementation of ACT. Continuing to deconstruct the processes that the team leader employs will continue to be important when discussing how the successful implementation of ACT occurs. This studying of process has been identified as another vital step in building an evidence base from a research and practice perspective in the implementation of evidence based practices (Stanhope & Solomon, 2007). For instance, future studies could examine how the vision that ACT team leaders set for the team influences consumer outcomes. How specifically they set this vision and sustain it via daily practices may help us understand better how to facilitate consumer recovery via ACT. Any efforts to translate research into practice will be less successful unless our methods and processes can reflect how social workers effect change 'on the ground' (Stanhope & Solomon, 2007).

Additionally, organizational culture and climate have been identified as factors important to reducing staff turnover (Aarons & Sawitzky, 2006), a major barrier in the implementation of any EBP. Further inquiry into how the team leader influences the organizational culture and climate, including how barriers to optimal culture are overcome may extend our knowledge of how to successfully implement ACT. Relatedly, further exploration of what agency resources, policies and administrative functions, ACT team leaders and team members identify as important for supporting their work environment would prove fruitful. More inquiry is warranted to better understand what state/local level institutional/policy supports are needed by ACT team leaders to function optimally and how these may shape team leadership behaviors and exigencies.

Finally, we can extend the scope of inquiry to look at how preliminary findings from this study apply to leadership implementing other EBPs. For example, the EBP of First Episode Psychosis (FEP) utilizes a multi-disciplinary team with a team leader. Exploring parallels in

leadership skills and qualities between ACT and FEP (or other EBPs) can promote our understanding of more global tasks and requirements of treatment team leaders (across various evidence-based mental health programs), as well as the identification of leadership qualities and tasks unique to the implementation of specific EBPs. This sort of research increases our understanding of the theory of change as well as the technology of change underlying different EBPs.

Conclusion

Leadership is a highly complex relationship that changes with the times (Roussel & Ratcliffe, 2013). It is viewed as a dynamic, interactive process that involves three dimensions– the leader, the team members and the situation– that influence one another (Roussel & Ratcliffe, 2013). This collective case study was able to answer important unexplored questions related to ACT team leaders from the perspective of two exemplary high fidelity ACT teams. Information gained from this study continues to form a picture of ACT team leaders, including what they do and how they work to lead an ACT team. Further, this study raises several questions, has clear implications for social work, and presents a foundation for future research in this area of ACT implementation.

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Appendix 1: Description and Elements of ACT

	ACT Services		
	Treatment	**Rehabilitation**	**Support**
Description and rationale for service	Treatment refers to the process of relieving symptoms and minimizing the time clients spend in the hospital. Emphasis placed on lessening or extinguishing symptoms, prevention of reoccurrence or worsening of symptoms, and helping clients cope with symptoms when medications or other interventions are only partially successful. Treatment facilitates successful rehabilitation and recovery.	Rehabilitation refers to the process of assisting clients to decrease the effects of the symptoms and impairments of mental illness on major life role skills and develop greater competencies in employment, social and interpersonal performance, and activities of daily living. Supporting clients to participate in typical adult activities in the community increases the likelihood they do not miss out on significant developmental and personal growth opportunities.	Support refers to the hands-on practical support provided to help clients meet the necessities of daily living. Supportive activities are labor intensive for clients and so must be provided continuously.
Element of specific ACT service	• psychopharmacological treatment • individual supportive therapy • crisis intervention • psychiatric hospitalization	• structuring time including use of leisure time • employment and work related rehabilitation • activities of daily living (e.g., personal care, safe housing, financial management) • social and interpersonal relationships	Supportive services include advocating, coordinating, side by side individual support, problem solving and direct assistance in obtaining the following: • medical and dental care • legal and advocacy services • financial supports including entitlements • supported housing • financial services • transportation

Description and Elements of ACT (Allness & Knoedler, 2003)

Appendix 2: Tool for the Measurement of Assertive Community Treatment

(Document is available upon request from author)

Appendix 3: Literature on Community Mental Health Teams or Teams in Other Psychiatric Settings

Appendix 3: Literature on Community Mental Health Teams or Teams in Psychiatric Settings Table

Literature	Type of Team & Study Information including Research Design	Study Aim(s) & Location	Definition of & Information Provided on Team Leader	Summary or Findings
Belling, Whittock, McLaren, Burns, Catty, Jones, Rose, & Wykes, (2011)	Community Mental Health Teams Random sample of 113 health and social care professionals, including identified team leaders. Survey design using in-depth, semi structured interviews. Random selection Qualitative analysis of themes	Identify and explore facilitators and barriers perceived to influence continuity of care by health and social care professionals working in and closely associated with CMHTs. London, England	Consulting psychiatrists mentioned. No definition of team leader provided Largest group of professionals was nurses (46.0%). Social workers represented 20.3% of total participants.	• Positive experiences of teamwork support, leadership and decision making were identified as facilitators to continuity. • New models of team leadership emerged which were seen by some to be more empowering and democratic in terms of impact on decision making, with leaders drawn from a range of professional groups and consultant psychiatrist retaining clinical responsibilities. • Limitations included generalization outside of London. • Concluded that team leadership is a critical component with team leaders fulfilling pivotal roles in maintaining cohesive teams, reducing outside pressures, and creating supportive environments in which staff are able to operate and develop. Yet, in many cases within this study, team leaders had not received any training or development for their crucial roles.
Bowers, Nijman, Simpson, & Jones (2011)	Leaders and Teams on acute psychiatric wards 136 acute psychiatric wards with staff in 26 NHS Trusts in England. Distribution of 5 different questionnaires Multivariate cross sectional design. Three part analysis: Principal components analysis; SEM; Cluster analysis	To understand the relationship between leadership, team working, structure, burnout and attitude to patients on acute psychiatric wards, and assess how that relates to rates of conflict and containment. England	Ward manager (person rated in the project); consultant psychiatrist, senior qualified nurses, and managers at a higher level than ward staff were defined as leaders.	• Leadership impacts team work, teamwork impacts on structure, structure influences burnout, and burnout influences attitudes towards difficult patients. • Efficacy of leadership did not show much direct relation to feelings of burnout. • Poor leadership may retard the development of a well-functioning team.
Burns (2004)	Community Mental Health Teams (case loads up to 35) Descriptive Literature	To describe community mental health teams in UK UK	Clinical team leader most often the consultant psychiatrist A team manager was also identified No further definition given	• Necessary to have clarity around leadership. • Leader should maintain clinical focus, resolve dispute over clinical priorities, and have clinical oversight and authority. • Team manager carries a reduced clinical load. • Team manager is responsible for the routine management of the team and supervision of non-medical staff. • Clinical team leader and team manager must see "eye to eye" and work closely together.

Corrigan, Diwan, Campion, & Rashid (2002)	54 US mental health teams providing services to SMI population (236 leaders and 620 subordinates) Teams worked in state hospitals and community mental health settings Correlational study Team leaders and subordinates completed three measures that assessed perceptions of leadership style, organizational culture, and level of burnout.	Examine the relationship between leadership styles (transformational, transactional, and laissez-faire) and measures of organizational culture and staff burnout. Midwest states	Team leaders defined as individuals who had direct responsibility for supervising a group of staff members who provide clinical or rehab services to persons with severe mental illness	• Results showed transformational leadership was positively associated with a cohesive organizational culture and negatively associated with burnout. • Leaders and subordinates differed in their ratings of transformational leadership, with leaders viewing themselves as more positively (both intellectually stimulating and individually considerate). • Transformational leadership seems to have an overall positive effect on team functioning. • Transactional leadership failed to show any clear association with organizational culture and burnout.
Corrigan & Garman (1999)	Interdisciplinary teams of professionals and para-professionals providing services to persons with severe and persistent mental illnesses. Descriptive Literature	Purpose of article was to illustrate the applicability of transformational and transactional skills for leaders of mental health teams No location given	Definition of leader not provided	• The team leader is essential to accomplish the incorporation of psychosocial treatments into vital and effective programs. • Studies have shown that models of transformational and transactional leadership are especially relevant to teams that serve individuals with severe mental illness. • Leaders who learn to incorporate transformational and transactional skills will produce a better functioning team.
Corrigan, Garman, Canar, & Lam (1999)	Rehabilitation team members who worked at departments of vocational rehabilitation (DVR) Administered questionnaire called Team Atmosphere Questionnaire	Purpose was to determine whether rehabilitation staff members reported the same factors in describing team leaders as mental health team members. Illinois	No definition of team leader was provided.	• Previous study of mental health teams (Corrigan, Garman, Lam, & Leary, 1998) identified six leadership factors (autocratic leadership; clear roles and goals; reluctant leadership; vision; diversity issues; supervision) that describe effective leadership in mental health teams. (See study listed in table below). • Four factors found in the mental health survey were replicated in the survey of DVR team members (autocratic leadership; clear roles and goals; reluctant leadership; and vision). • These four factors are the same ones that overlap with Bass's multifactor model. • These four factors suggested that team members find problems with a leader who communicates with them only when they make mistakes; that they want their leaders to clearly define the goals of the team as well as the individual roles needed to accomplish these goals; they clearly called for leaders who assumed responsibility and made appropriate decisions and reported dissatisfaction with leaders who could not make difficult decisions or control obstreperous colleagues. Finally, team members wanted to understand the rationale for their work in terms of some higher order goal or vision provided by the leader.

(continued) Corrigan, Garman, Canar, & Lam (1999)				• Leaders helped team members transcend the normal limits of their job so they had a greater sense of accomplishment at work. • Team members viewed managing a demographically diverse team as an essential task for the leader.
Corrigan, Garman, Lam, & Leary (1998)	3 year study developing a skills training curriculum for MH leaders 389 staff members of MH teams who provided team based clinical or rehabilitative services to persons with SMI generated responses to a survey about effective leaders. Second sample of 346 team members were given a Team and Leadership Questionnaire. Mixed methods	Phase 1 goal: to identify factors that MH team members seek in their leaders and assess the applicability of Bass's leadership model to MH settings. No location provided	No additional information or definition provided on who team leaders were.	• Six factors were identified as important leadership factors (autocratic leadership; clear roles and goals; reluctant leadership; vision; diversity issues; supervision). • Autocratic leadership suggested team member disliked leaders who regularly punished or belittled them and don't want a leader who communicates with them only when they make mistakes. This aligns with Bass' management by exception factor. • Clear roles and goals suggest team members want leaders to clearly define goals of the team as well as the individual roles needed to accomplish these goals. This seems to replicate Bass's contingent reward factor. • Reluctant leadership was defined as team members reporting dissatisfaction with leaders who could not make difficult decision or control disruptive colleagues. Team member want leaders who assume responsibility and make appropriate decisions. Team members were likely to report emotional exhaustion and feelings of depersonalization when supervised by a reluctant leader. This aligns to Bass' non-leadership (laissez-faire) factor. • Vision referred to team members wanting to understand the rationale for their work in terms of some higher order goal or vision provided by the leader. This is consistent with Bass's transformational leadership factor. • Diversity issues suggest that team members view managing a demographically diverse team as a discrete task for the leader. This does not align with any Bass factor. • Supervision draws attention to the leader's role in staff development. This was seen as a vital leadership function but that it can get lost in the competing demands placed upon leaders. This also does not align with any Bass factor.
Corrigan, Lickey, Campion, & Rashid (2000)	143 leaders and 473 subordinates from 31 clinical teams rated the leadership style of the team leader. 184 consumers served by these teams rated their satisfaction with the treatment program and their quality of life.	To determine the association between leadership styles of leaders of MH treatment teams and consumers ratings of satisfaction with the program and their quality of life. Midwest states	Team leaders were defined as individuals who have direct responsibility and who supervise a group of staff that provides clinical or rehabilitation services to persons with SMI. Most teams had more than 1 leader who commonly included	• Consumers in programs led by leaders who rated themselves as laissez-faire reported lower satisfaction and diminished quality of life. • Leaders who rated themselves as using passive management by exception worked in programs with consumers who reported less satisfaction. • Results suggest that transformational leadership is related to benefits for consumers. • Subordinates who viewed their leaders as charismatic, inspirational, and considerate of individuals worked in

(continued) Corrigan, Lickey, Campion, & Rashid (2000)	Teams worked in state hospitals and community mental health programs and served adults with SPMI. Community based teams provided skills training, supported employment services, ACT, and drop in services. Quasi experimental		a lead psychiatrist, charge nurse, or a clinical manager. 70% were women; 81.8% European American 21.7% had BA; 18.9% had Master's degree; 12.6% had doctoral degree.	programs with consumers who reported a relatively higher quality of life. • Leadership as rated by leaders and by subordinates accounted for separate variance in consumers' satisfaction. • Leadership variables accounted for 40% of the variance in consumers' satisfaction and quality of life. • Leadership seems to be an important variable for understanding a team's impact on its consumers.
Garman & Corrigan (1998)	Literature on developing effective MH team leaders Descriptive literature, that comes in part from focus groups on leadership training needs	Conducted by faculty of the University of Chicago Center for Psychiatric Rehabilitation Purpose was to provide effective leadership development programs for first time leaders who emerge from clinical and direct care roles.	No definition provided	• Describes the three phases of developing this curriculum. • Based off previous study (Corrigan, Garman, Lam, & Leary, 1997). • Suggest the following training modules (Introduction, Orientation, Transformational leadership with a relationship focus, transformational leadership with a task focus, transactional leadership, leading diverse teams, putting it all together, follow up).
Liberman, Hilty, Drake, & Tsang, (2001)	Multidisciplinary team work in psychiatric rehabilitation Descriptive	To describe the properties and functions of the multidisciplinary team and key attributes of effective teams.	No definition of team leaders provided although some focus in article on psychiatrists as leaders of teams.	• Some of the important group dynamics of a team are cohesion, leadership, distribution of responsibilities and authority, participation in problem solving and decision making, and empowerment through participation in meetings and professional growth. • When the team's leadership encourages members' participation and shows respect for their expertise in goal setting, problem solving, task assignments, and decision making, members experience job satisfaction, challenge, control and productivity, which often go hand in hand with clinical excellence. • Effective rehab teams have a common frame of reference (e.g., acknowledge the importance of using consumer oriented treatment, have a common treatment philosophy, and share a commitment to implementing evidence based services and evaluating them. • Teams must be empowered by agency managers and policy makers to make their own clinical decisions. • Team leaders must possess leadership skills that include being able to organize and lead productive team meetings and maintain cohesion and morale among team members. • Leaders must help meet the personal and professional needs of team members, making decisions about clinical assignments, scheduling work and helping team members avoid burnout. • Leaders must provide team members with mechanisms for discussing concerns and differences of opinion, solving problems, and sharing their expertise. • Leaders must be capable of addressing system-wide economic and sociopolitical challenges to the delivery of comprehensive and coordinated services. • Leaders have skills such as persistence, realistic optimism, a collaborative style, teaching ability, and

(continued) Liberman, Hilty, Drake, & Tsang, (2001)				networking and system coordination skills. • Leadership requires role modeling.
Onyett (2011)	Community Mental Health Teams (although it was "permissive" in the terms of the types of teams covered and no further definition was provided). Descriptive Review of literature between 1997 and 2010.	To update findings on burnout, job satisfaction, and sources of high and low morale in teams since a national survey of community mental health teams in 1997. UK	No definition provided. Likely large diversity in leadership given the parameters of definition for the CMHT.	• The reviewed literature presented contradictory findings and used inconsistent methodologies. • Although many studies report high levels of emotional exhaustion, there was no evidence for a decline in morale. • Morale tends to vary across discipline and location. • Effective team working and good leadership, management, support and supervision appeared to be protective factors. • No framework for assessment and analysis promoted meaningful comparisons. • Discusses effective leadership but does not delineate what this is.
Rosen & Callaly (2005)	Interdisciplinary teamwork written for psychiatrists Descriptive Literature	To examine the constructs and applications of interdisciplinary teams in mental health services, specifically to ascertain the most effective types of teams and their leadership. Australia	Team manager defined as the person held responsible for specified management functions, with delegated authority to ensure that the team applies operational policy, and overviews all clinical work allocation, assessment, operational practice review and case termination.	• Defined interdisciplinary teams as teams that involve service providers from several professional disciplines (e.g. medical, nursing, allied health) working simultaneously with the same service used with labor coordinated by one designated case manager. • Effectiveness of the interdisciplinary team in mental health services is supported by an extensive literature that is more qualitative and descriptive than quantitative and empirically rigorous. • Effective interdisciplinary teamwork in mental health services involves both retaining differentiated disciplinary roles and developing shared core tasks. • Effective teamwork requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices. • Effective team managers need to be both internally in touch with the state of the team and externally aware of the demands on the team as a whole. • Team managers have an important role in containing difficult team emotions and in articulating and standing up consistently for the team and service values and vision based on the experienced needs and safety of clients.
Toseland, Palmer-Ganeles, & Chapman (1986)	Teamwork in Psychiatric Settings Exploratory study. Mixed methods	To examine the functioning of teams in psychiatric settings in order to identify those factors that contribute to effective teamwork and to raise issues about team functioning.	Various disciplines were considered team leaders (no further delineation offered)	• Team members who reported being dissatisfied with team functioning focused on the autocratic manner in which team leaders or unit chiefs made decisions without considering the opinions of team members who were expected to implement these decisions. • Some reported that less team effectiveness was related

	Purposive sampling 15 of 18 teams participated for a total of 77 team members.			to a lack of leadership and direction.
Wells, Jinnett, Alexander, Lichtenstein, Liu, & Zazzali (2006)	Subjects for Model 1 were 78 (51 inpatient and 27 outpatient) VA psychiatric treatment teams operating in units serving individuals with SMPI. 53% of participants were from nursing; 14% of participants were social workers. Subjects for Model 2 were 1638 individuals with SPMI in 44 US psychiatric treatment settings. Quasi-experimental	To examine associations between team leader discipline and mutual respect among treatment team members and mutual respect among team members and improvements in patient quality of life. US	Team leader was defined as the person who "provides the strongest leadership on your team".	• Mutual respect was highest in social worker led teams and lowest in physician led teams. • When mutual respect among staff was greater, patients improved more over time in their satisfaction with the quality of their housing, relations with families, social life, and finances. • Results imply that mutual respect may improve patient outcomes and that leadership by some disciplines may facilitate such dynamics. • Fostering mutual respect among team members falls within the relational dimension of team leadership. This function has been termed "group maintenance" in the team literature and "initiating consideration" in the leadership literature. • Team leaders can affect relational dynamics among members in a number of ways: by structuring rewards so that people win by collaborating rather than competing, by intervening when conflicts begin to develop; by teaching staff how to manage such conflicts proactively themselves; and through the norms they model in their own behavior. • Supports the general contention that interpersonal dynamics among treatment team members can affect patient outcomes.
West, Borrill, Dawson, Brodbeck, Shapiro & Haward (2003)	Sample of 3447 respondents from 98 primary health care teams, 113 community mental health teams, and 72 breast cancer care teams. The CMHTs consisted of psychiatrists, psychiatric nurses, social workers, and administrative staff. Self reported questionnaires Correlations reported	The relationships among leadership clarity, team processes, and innovation were examined in health care contexts. UK	Leadership is defined on a team level and leadership clarity pertains to the shared perceptions of group members about the extent to which leadership roles are clear within the team.	• Leadership clarity (who is responsible for team leadership) is associated with clear team objectives, high levels of participation, commitment to excellence, and support for innovation. • Team leadership predicted innovation with CMHTs. • Supporting innovation includes developing clear objectives and encouraging participation, a focus on quality, and support for innovation. • The leader brings task expertise, abilities, and attitudes to the team that influences the group design and group norms (Hackman, 1990, 2002) and through monitoring, feedback, and coaching develops these processes, which enables the team to achieve its tasks and to innovate. • Team leadership is most critical for success of effective team performance (Zaccaro et al., 2001). • The extent to which the leader defines team objectives and organizes the team to ensure progress toward achieving these objectives contributes substantially to team innovation. • The team leader has to ensure that the team develops an emphasis on excellence so that team members are able to challenge and debate each other's ideas and provide

(continued) West, Borrill, Dawson, Brodbeck, Shapiro & Haward (2003)				the practical and social support to develop innovation. • Team processes mediated the relationship between leadership clarity/conflict and team innovation. • The team leader has a key role in ensuring that team members are clear about their shared objectives and are provided with feedback on the achievement of these objectives and processes are in place within the team to ensure team members can share information and ideas and contribute to decision making. • The effects of clear leadership occur at least partly because of the influence of leaders on team processes.
Yank & Barber (1994)	Theoretical	To describe the MH treatment team and leadership from a systems model perspective. Addresses structural factors and communication processes relevant to both health and pathological team functioning.	No definition or description of team leader provided	• Team leaders must be mindful of the many factors that affect the ability of other team members to provide accurate feedback, which include team members' wishes to please the leader, other factors affecting members' relationships with the leader, the responses and reinforcement (both verbal and non-verbal) of the leader and others to different types of messages, and the congruence of messages and meta-messages. • The ability of the team leader to promote team identity and "teamness" involves the utilization of the members' attitudes and feelings evoked by and about the leader. • Effective leaders must delegate leadership functions to other persons and groups, and empower them to set priorities, make decisions, and take necessary actions. • Leaders must balance their own accountability and responsibility with the need to involve and empower other team members. • Leaders must be aware of boundary issues that require balancing (they are both inside and outside the team). • Effective leadership requires actively attending to system pathologies, constantly assessing the adequacy of matter/energy and information resources, and planning that encompasses both ST and LT efficacy and survival issues for the team. • These tasks are facilitated by modeling and predicting processes that address both the team and its organizational and external environments.

Appendix 4: Interview Design: Development of Questions and Incorporation of Conceptual Framework

Appendix 4: Interview Design: Development of Questions and Incorporation of Conceptual Framework

	Questions from Interview Guide	Mapped onto the Study's Conceptual Framework	Literature Examples /Notes
Q1.	**Can you start by telling me a little bit about how you became an ACT team leader?**	None-exploratory question to meet study aims	
	Any professional or personal experiences that matter?	None-exploratory question to meet study aims	
	Mentorship from others?	None-exploratory question to meet study aims	
Q2.	**What is it like to be an ACT team leader?**	None-exploratory question to meet study aims	
	Can you tell me a little more about ___?	None-exploratory question to meet study aims	
	How do you prevent burnout?	None-exploratory question to meet study aims	
	What do you find difficult as a team leader?	None-exploratory question to meet study aims	
	What do you find enjoyable about your job?	None-exploratory question to meet study aims	
Q3.	**How would you describe yourself as a leader?**	None-exploratory to meet study aims	
	How would you describe your leadership style?	Bass's theoretical framework	Transformational, transactional, or laissez-faire styles may be described.
Q4.	**As an ACT team leader, what is important to you?**	None-exploratory question to meet	

		study aims	
Q5.	**What do you do as an ACT team leader?**	A priori knowledge	The team leader has a multi-faceted job and so I expected a wide variety of responses here.
	What types of tasks (clinical or administrative) do you do?	A priori knowledge	Some experts have delineated the team leader's job into the domains of clinical, administrative, and leadership. Question created to explore that idea. Also the prompt was created to help the team leader think about the tasks they do in different domains.
	What are your responsibilities and roles?	Concepts from literature	Mancini et al., 2009
	How do you approach hiring and training of new staff?	Concepts from literature	Mancini et al., 2009; Carlson, Rapp, & Eichler, 2012
	What tasks do you find unpleasant to do?	None-exploratory question to meet study aims	
	What do you do in these situations?	None-exploratory question to meet study aims	
Q6.	**What are you trying to accomplish as leader?**	Exploratory question to meet study aims & Concept from literature	Garman & Corrigan, 1998
Q7.	**What is your approach to leading a multidisciplinary team?**	Bass's theoretical framework	Bass, 1985; Bass, 1990
	What is important?	Concept from literature	Corrigan et al., 2002; Liberman et al., 2001; Wells et al., 2006
Q8.	**Tell me about your interactions with team members.**	Bass's theoretical framework	Bass, 1985. Seeing if the leader defines activities that could be labeled as transactional,

			transformational, or laissez-faire behaviors.
	What do your clinical supervision sessions look like with staff?	Concepts from literature & a priori idea	Rosen & Callaly, 2005. I am aware that ACT processes are to include clinical supervision sessions, which is where I would think individual interactions may be different between staff.
	How do you know what individual staff need?	Bass's theoretical framework & Concept from literature	Bass, 1985 (the individualized consideration & intellectual stimulation components of model). Corrigan et al., 2002
	How does the team psychiatrist inhibit or promote your leadership?	A priori knowledge & Concepts from literature	In ACT implementation, the relationship between the leader and team MD appears important both for treatment decisions and with setting the vision of the team. Burns, 2004
	What is important for you as the leader in this relationship with the MD?	None-exploratory question to meet study aims	
Q9.	**Tell me what you take into consideration when interacting with staff?**	Bass's theoretical framework	Bass, 1985 (the individualized consideration component of the model)
	What are the ways you influence staff? Motivate staff?	Bass's theoretical framework & Concepts from literature	Bass, 1985 (All four components of transformational leadership: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration) Corrigan et al., 1999; Corrigan et al., 2000.
	How do you promote team morale?	Concepts from literature &	Mancini et al., 2009. Bass, 1985 (all four

		Bass's theoretical framework	components of transformational leadership).
	In the team meeting I saw you do __? Can you tell me more about why you did it this way?	None-exploratory question to meet study aims	
	Tell me about the independence staff has to make decisions.	Bass's theoretical framework & Concepts from literature	Bass, 1985 (the individualized consideration component of the model) Mancini et al., 2009
Q10.	**Can you describe how you approach handling conflict with your team? Can you give an example?**	Concepts from literature	Rapp et al., 2010; Mancini et al., 2009; Corrigan et al., 1999
	What was the resolution?	None-exploratory question to meet study aims	
	How do you hold staff accountable?	Concept from literature	Mancini et al., 2009; Rapp et al., 2010
	How do you prepare your team for changes or share news that you know the team will not like?	Concepts from literature	Aarons, 2006; Mancini et al., 2009
Q11.	**Can you share with me your perspective about fidelity to ACT?**	Concepts from literature & exploratory question to meet study aims	Mancini et al., 2009; Swain et al., 2010
	How did you learn about ACT fidelity?	None-exploratory question to meet study aims	
	In what ways does fidelity factor into your daily decisions about the team? Examples?	Concepts from literature & exploratory question to meet study aims	Carlson, Rapp, & Eichler, 2012
	In a hypothetical situation, let's say your agency asks you to "adapt" the model in a certain way, what would your	None-exploratory question to meet study aims	

	approach be to this?		
Q12.	**What helps you facilitate high fidelity ACT services?**	None-exploratory question to meet study aims	
	Anything else you need to run a high fidelity ACT team?	None-exploratory question to meet study aims	
	Tell me a little bit about how outside forces (your parent agency, State) helps your leadership of the team?	Concepts from literature	Swain, Whitley, McHugo, & Drake (2010); Bond, Drake, McHugo, Rapp, & Whitely, 2009
	Anything you wish was in place to help you that isn't?	None-exploratory question to meet study aims	
Q13.	**What hinders your ability to sustain high fidelity ACT?**	None-exploratory question to meet study aims	
	Can you name for me one category you received a low TMACT score on? Thinking about that item, what is a barrier to improving that individual score?	Concepts from literature	Swain et al., 2010; Carlson, Rapp, & Eichler, 2012; Bond et al., 2009; Torrey, Bond, McHugo, & Swain, 2012.
	What are the biggest threats to you in running a high fidelity team? How do you manage these threats?	Concepts from literature & exploratory question to meet study aims	Mancini et al., 2009
	Tell me a little bit about how outside forces (your parent agency, State) hinders your leadership of the team?	Concepts from literature	Swain et al., 2010
Q14.	**What challenges have you faced as a**	Exploratory	Torrey et al., 2012

	team leader?	question to meet study aims & Concepts from literature	
	For Challenge A, what did you do to overcome it?	None-exploratory question to meet study aims	
	What factored into your choices of strategies to overcome Challenge A?	None-exploratory question to meet study aims	
	For Challenge B, what did you do to overcome it?	None-exploratory question to meet study aims	
	Any specific challenges to sustaining a high fidelity ACT team? What did you do?	None-exploratory question to meet study aims	
Q15.	**Can you tell me, what contributes to your effectiveness as an ACT team leader?**	None-exploratory question to meet study aims	
	What characteristics do you have that lends to your effectiveness?	Exploratory question to meet study aims & Concepts from literature	Stogdill, 1974; Hemphill & Coons, 1957; Fiedler, 1964.
	What principles guide your work as a team leader?	None-exploratory question to meet study aims	
	What skills do you have that are important for your leadership?	None-exploratory question to meet study aims	Corrigan et al., 1998
Q16.	**Do you have well defined state standards?**	Concept from literature	Mancini et al., 2009; Magnabosco , 2006;
	How are you aware of these?	None-exploratory question to meet study aims	
	What role if any do they play with your	None-exploratory	

	knowledge of ACT and how you run your program?	question to meet study aims	
Q17.	**In regards to practice standards, what contingencies or incentives do you have for following them?** Are you certified or licensed as an ACT team? How does certification or funding link to the standards?	Concept from literature None-exploratory question to meet study aims Concept from literature	Swain et al., 2010; Mancini et al., 2009; Rapp, Bond, Becker, Carpinello, Nikkel, & Gintoli, 2005; Swain et al., 2010; Mancini et al., 2009
Q18.	**What types of funding for support for ongoing implementation of ACT do you have?** Can you describe for me what types of ongoing training or consultation you have had in regards to ACT?	Concept from literature & exploratory question to meet study aims Concepts from literature	Swain et al., 2010; Mancini et al., 2009 Swain et al., 2010
Q19.	**Who is the identified leader at the state level with responsibility and authority to provide oversight and advocate for the use of a model?** What is this person's role, if any, in helping you run a high fidelity ACT team? (Probes: build and sustain support; encourage program development and strategic planning; function as a watchdog).	Concepts from literature Concepts from literature	Rapp et al., 2010; Swain et al., 2010 Swain et al., 2010; Torrey et al., 2003
Q20.	**Can you give examples of how your agency has been willing to embrace ACT?**	Concepts from literature & exploratory question to meet study aims	Swain et al., 2010; Mancini et al., 2009
Q21.	**What outcome monitoring do you have in place for your team?** How do you know you are meeting objectives?	Concepts from literature None-exploratory question to meet study aims	Swain et al., 2010; Carlson, Rapp, & Eichler, 2012

Appendix 5: Letter of Approval from UW-Madison Institutional Review Board (IRB)

Notice of Action
University of Wisconsin–Madison
Institutional Review Board (IRB)

Principal Investigator: Colleen Mahoney, Ph.D
Department: Social Work, School of
Co-Investigator: Lynette Studer
Point of Contact: Lynette Studer
Protocol Title: The Roles and Contributions of Team Leaders to High Fidelity Assertive Community Treatment: A Collective Exemplary Case Study
Protocol Number: SE-2012-0613
IRB: Social & Behavioral Sciences IRB (Contact: 263-2320)
Committee Action: Approved on: **September 21, 2012** Expires: **September 20, 2013**

Special Notes or Instructions: This protocol was reviewed by the convened IRB and approved as submitted. Written consent is being obtained from participants. If additional sites are added, a Change of Protocol will be submitted for review and approval prior to engagement at those sites. The IRB determined that the study was minimal risk.

INVESTIGATOR RESPONSIBILITIES:

Unless this protocol is exempt, or the IRB specifically waived the use of written consent, an approved consent form that is stamped with approval and expiration dates can be found on IRB WebKit. To find the stamped consent form, go to IRB WebKit at https://rcr.gradsch.wisc.edu/irbwebkit/Login.asp. Login and open this protocol number. The link to the consent form can be found on the left side of the page. All copies of the form must be made from this original. Any changes to the consent form must be approved in advance by the IRB.

Any changes to the protocol must be approved by the IRB before they are implemented.

Any new information that would affect potential risks to subjects, any problems or adverse reactions must be reported immediately to the IRB contact listed above.

If the research will continue beyond the expiration date indicated above, a request for renewal/continuing review must be submitted to the IRB. You must obtain approval before the current expiration date. If you do not obtain approval by the expiration date noted above, you are not authorized to collect any data until the IRB re-approves your protocol.

Signed consent forms must be retained on campus for seven years following the end of the project.

If you are continuing to analyze data, even though you are no longer collecting data, you should keep this protocol active.

Appendix 6: Sample Recruitment Letter to Agencies

[DATE]

[Agency Name & Address]

Dear [AGENCY LEADERSHIP NAME]:

Hello! My name is Lynette Studer and I am a doctoral student at the University of Wisconsin-School of Social Work. I am writing to ask your assistance with a study I am conducting exploring the roles and contributions of ACT team leaders on high fidelity ACT teams. It is my understanding that [insert TEAM LEADER NAME] has already approached you and shared some information about this study; however, the intent of this letter is to provide more specific details about what participation would actually involve.

The purpose of this study is to better understand and describe the roles and contributions of ACT team leaders to the implementation and sustenance of high fidelity ACT teams. Your ACT team has been identified as an exemplary, high fidelity ACT team within the United States based on recent TMACT evaluations. Your team would be one of three ACT teams being studied. All ACT team members of your team, including the team leader and psychiatrist, would be asked to participate in the study.

The primary objectives of this study are to (1) describe ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it); (3) understand what roles they may play in promoting high fidelity to ACT, and (4) identify the challenges they have faced and/or overcome in implementing and sustaining high fidelity ACT teams.

To achieve these objectives, I would be on-site with your team for three consecutive days, likely September, October or November of this year. During that time, I will be (1) observing all activities of the team leader, including all team and treatment planning meetings; (2) conducting two in-depth interviews with the team leader; (3) conducting one 60-90 minute interview with the team psychiatrist; (4) interviewing team members once in a focus group setting (e.g., all team members together) lasting approximately 90 minutes; and, (5) reviewing team documents relevant to team leadership (excluding any client records or personnel information). I may also engage with team members in informal conversations to gain clarity about my observations. Audio taped, digital recordings will be made of all participation so that data can accurately be captured and transcribed for analysis. Additionally, during the data analysis phase of this study, team members will be asked to review preliminary findings and check them for accuracy, assuring I captured information correctly.

All data collection segments of this research project will be conducted in the location of your ACT team, with some possible follow-up phone interviews. Participation in this study is completely voluntary and you may withdraw from the study at any time.
Information shared by team members will be kept confidential in so far as the agency will not have access to individual participant responses. When the focus group data are analyzed, the analysis will combine responses from all individuals on the team, and will not be identifiable in reports published or presented. All collected data will be kept in locked file cabinets and computer files will contain unique

ID numbers rather than using the profession (i.e., nurse or vocational specialist) or name of team members as identifiers. No identified client information will be transcribed if captured on the audiotape.

However, given the nature of case study research (and that you are one of only three teams), your team and team leader will likely be identified in the write up of the results. A summary of findings will be presented to all team members to verify analysis and findings prior to publication. At that time, anything you wish to remain confidential will be omitted from final reports prior to dissemination. The results of this study will be used for my dissertation, as well as to lend to the larger literature through publications on ACT team leaders and their contributions to sustaining high fidelity ACT teams.

In honor of your time and dedication to the study, incentives are offered for participation. The agency will be offered $250.00, the team leader offered a $50 gift card, and each team member, including the team psychiatrist, will be offered a $25 gift card. If staff are unable to accept individual gift cards, the agency can choose to have a monetary donation made to an organization of their choice on behalf of the team. There is wide flexibility on how you may choose to accept these incentives, and this will be left up to your discretion.

I would be happy to answer any further questions you may have regarding this project and can be reached at the email address or phone number listed below. I would like to acknowledge that this request may be a bit out of the ordinary, but I do hope you can consider the contribution that this could make to the ACT field. All of us can improve by learning from those teams that are considered exemplary, and your agency has one such team. Ultimately, it is my hope that consumers are offered better quality ACT services based on information I would learn from your team. I look forward to your reply. Thank you for your time and consideration.

Sincerely,

Lynette M. Studer, MSSW
Ph.D Candidate
UW-Madison, School of Social Work
email: lstuder@wisc.edu
cell: 608-712-1942

cc: [insert team leader name]

Appendix 7: Consumer Agreement to Attend Treatment Planning Meeting Form

UNIVERSITY OF WISCONSIN-MADISON
Consumer Agreement to Attend Treatment Planning Meeting Form

Title of the Study: The Roles and Contributions of Team Leaders to High Fidelity Assertive Community Treatment: A Collective Exemplary Case Study

Principal Investigator: Colleen Mahoney, PhD (phone: 608-263-6356; email: camahoney@wisc.edu). **Student Researcher:** Lynette M. Studer (phone: 608-712-1942; email lstuder@wisc.edu)

DESCRIPTION OF THE RESEARCH

I am studying the roles and contributions of ACT team leaders on high fidelity ACT teams. The ACT team you work with has been identified as an exemplary, high fidelity team in the United States and has agreed to be part of the study.

The primary objectives of this study are to (1) describe ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it); (3) understand what roles they may play in promoting high fidelity to ACT, and (4) identify the challenges they have faced and/or overcome in implementing and sustaining high fidelity ACT teams.

In trying to better understand the role of [team leader name] to the ACT team, I wish to observe all of her activities while she is working. Part of that includes her role at treatment planning meetings with ACT consumers. It is important to this case study to see her in her "real world" setting to better understand and observe what the team leader does.

Your treatment planning meeting has been scheduled for the day I am on site collecting information about the team leader. With your permission, I would like to observe [team leader name] during your treatment planning meeting. During this meeting, I will be taking notes on what she says and does. At no time will I be taking notes on you, or any specific treatment information that is shared within the meeting. If you allow me to observe this meeting, I am happy to show you my notes at the conclusion of the meeting to assure you no identifiable information was documented.

Your signature indicates that you have read this form, had an opportunity to ask any questions about my research and voluntarily consent to let me attend your treatment planning meeting. If you choose to not have me attend, there will be no consequences to you and your treatment planning meeting will occur as usual.

Name of Participant (please print):_____

Signature Date

Appendix 8: Changes Made to Team Leader Interview after Pilot Phase

Observations or Suggested Changes	Modifications
Interview #1 (Questions 1 through 10)	
It was suggested that the first probe on "personal experiences" was challenging and "threw" the respondent. She stated she had never thought of that. All other questions the respondent felt were "not hard to answer". Q5: Respondent suggested using the probe "describe a typical day" to get at what a team leader does Q8: Respondent needed clarification with the question.	• Q1 probes were re-worded for clarity • Q2 probe order was changed (moved the 4th probe to #2 spot); intended to improve the flow of questions • Q3 was reworded for clarity and the probe was omitted • Q5 had two probes added (1 & 4) and all probes reordered to improve the flow. • Q6 added two prompts • Q7 fixed a punctuation error • Q8 Re-worded the question for improved clarity
Respondent did not feel that the order of questions needed to be changed	No changes
Respondent did not suggest any improvements in the overall introduction to the interview or in sub section introductions	One addition to the opening script was made, prompting the team leader to say if she/he needed a break during the interview
Respondent did not offer any suggested deletions	No changes
Respondent did not feel like there were any problems with the interview, including the length of time it took.	No changes
Total time of interview=76 minutes	No changes made as I anticipate the interview may take a bit longer as I will have examples observed during the day that I will prompt team leader to discuss.
Interview #2 (Questions 11 through 15)	
Q11: Respondent found this section on fidelity was harder to answer, but not because of confusion but related to deeper thought was necessary to answer questions. Q11: The probe asking for examples was good.	Two potential solutions to this concern. One, a prompt could be added in the opening script of this question, or two I could put Q11-Q13 in Interview #1 and then follow up with any additional information the team leader would like to add at the beginning of Interview #2. That would allow for some time for further contemplation. I modified the interview with the second option (as the first option I felt like I may be too suggestive to the team leader that this section is more "difficult" to answer). • Q11-13 will be included in the first interview. • Q11: One probe was added asking how

	the relationship with the agency is (to give answers some context for Q12 & Q13) • Q12: one probe was re-worded to improve clarity
Q13: Respondent needed some clarification on this question. She suggested that the word "barriers" or "obstacles" be used. In one of the probes, the word "threats" was used. The respondent stated that word felt odd. However in discussion, we could not find an alternate.	• A probe was added to Q13 that includes the words "barriers or obstacles" in the event the team leader needs clarification. • Kept the word "threats".
Respondent did not feel there were any redundant questions in this part of the interview. Respondent indicated the section on challenges went well and the questions were clear.	No changes
Q14: In this question, the respondent focused on examples related to client issues rather than programmatic issues. The fourth probe in Q14 seemed redundant to previous questions.	• Wording "within the program" was added to move the focus to programmatic challenges rather consumer based ones. • Omitted the fourth probe to Q14.
Q14: Respondent highlighted that she was unclear on how writer was defining the word "challenges".	• No changes made to the interview, and if this comes up, writer will ask the respondent to suggest a definition of challenges and go from the respondent's point of view.
In closing script: I found myself re-reading the study's objectives to remind and prime the respondent before asking if there was anything else she/he feels is important to his/her leadership.	• Added wording to the closing script
Total time of interview=83 minutes	No changes

Appendix 9: Informed Consent for ACT Team Leader

UNIVERSITY OF WISCONSIN-MADISON
Research Participant Information and Consent Form
ACT Team Leader

Title of the Study: The Roles and Contributions of Team Leaders to High Fidelity Assertive Community Treatment: A Collective Exemplary Case Study

Principal Investigator: Colleen Mahoney, PhD (phone: 608-263-6356; email: camahoney@wisc.edu)

Student Researcher: Lynette M. Studer (phone: 608-712-1942; email lstuder@wisc.edu)

DESCRIPTION OF THE RESEARCH

You are invited to participate in a research study exploring the roles and contributions of ACT team leaders on high fidelity ACT teams. The purpose of this collective case study is to better understand and describe the roles and contributions of ACT team leaders to the implementation and sustenance of high fidelity ACT teams. You have been asked to participate as your ACT team has been identified as an exemplary, high fidelity team in the United States. This study will include three high fidelity ACT teams as determined by recent TMACT scores and identification by state authorities. All ACT team members of the identified teams, including the team leader and psychiatrist, as well as agency leadership will be asked to participate in the study.

The primary objectives of this study are to (1) describe ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it); (3) understand what roles they may play in promoting high fidelity to ACT, and (4) identify the challenges they have faced and/or overcome in implementing and sustaining high fidelity ACT teams.

All parts of this research project will be conducted in the location of the identified ACT team, with some possible follow-up phone interviews. It is important to this case study to see you in your "real world" setting to better understand and observe what you do.

Audio taped, digital recordings will be made of your participation so that data can accurately be captured. Transcripts of your digital recordings will be professionally transcribed and stored in a locked filing cabinet. Only the research team will have access to the printed transcripts and audio recordings. Digital recordings and transcripts of observations, interactions, interviews, or focus groups will be kept for no more than five years before they are destroyed. Any information related to this study and stored on a computer (i.e., data analysis) will be password protected.

WHAT WILL MY PARTICIPATION INVOLVE?

In order to understand your roles and contributions to the ACT team, there are a variety of ways that I will be seeking to learn from you. I will be on-site with you and your team for three consecutive days and observing all your activities, including all team and treatment planning meetings. I may also engage you in informal conversations about my observations. You will

be asked to participate in two separate, approximately 2 hour long, face-to-face interviews in which you and I will discuss your experiences as an ACT team leader. Finally, during the data analysis phase of this study, you will be asked to review preliminary findings and check them for accuracy, this is a process known as "member checking" and assures I captured information correctly.

Your primary participation will last approximately 3 working days, based on a mutually agreeable time frame. During the data analysis phase of the study your participation may include up to two hours of phone follow up and reviewing the preliminary findings.

ARE THERE ANY RISKS TO ME?

I do not foresee any risks to you in participating in this study. Your participation is completely voluntary and you are free to discontinue at any time. There is no penalty if you choose to not participate in this study. If you do participate, it is possible that being continually observed may create some minimal discomfort or anxiety. However, if at any time you are uncomfortable or wish to take a break, please feel free to say so or talk more with me.

ARE THERE ANY BENEFITS TO ME?

I do not expect any direct benefits to you from participation in this study; however, the information gathered in this study may help to advance the field of Assertive Community Treatment. Potential indirect benefits to you may include the sharing of your knowledge as an exemplary ACT team in the U.S. and provide opportunity to reflect on your contributions to ACT and the consumers you serve.

WILL I BE COMPENSATED FOR MY PARTICIPATION?

Based on your preference, you will receive either $50 cash, a $50 gift card, or a $50 donation to a charitable organization of your choice made in honor of your time and dedication to this project. If you do withdraw prior to the end of the study, you will still receive full compensation for your time.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?

Although the agency is supportive of this study, they will not have access to individual participant responses. When the interview or survey data are analyzed, the analysis will combine responses from all individuals on the team, and will not be identifiable in reports published or presented. Focus groups and interview responses, along with notes from direct observations will be kept in locked file cabinets and computer files will contain unique ID numbers rather than using the profession (i.e., nurse or vocational specialist) or name of team members as identifiers.

However, given you are the only team leader and the nature of case study research, your team and you as the leader will likely be identified in the write up of the results. Additionally, if you agree to participate in this study, I would like to be able to quote you directly. If you agree to allow me to quote you in publications, please initial the statement at the bottom of this form. A summary of findings will be presented to the team and to you as the team leader to verify

analysis and findings. At that time, anything you wish to remain confidential will be omitted from final reports prior to dissemination.

WHAT IF I HAVE QUESTIONS?

You may ask any questions about the research at any time. If you have questions about the research please contact the Principal Investigator Dr. Colleen Mahoney at 608-263-6356. You may also call the student researcher, Lynette Studer at 608-712-1942 or reach her by email at lstuder@wisc.edu.

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education Research and Social & Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. If you begin participation and change your mind you may end your participation at any time without penalty.

Do you have any questions about the study before you decide whether or not to participate?

I have read the above and (check all that apply):

____ give permission for the researcher to record observations of and audiotape my work and all interactions with the ACT team
____ am willing to participate in two separate, 2 hour face-to-face interviews
____ am willing to engage in informal conversation over the three days regarding my work within the ACT team
____ am willing to have a follow-up phone call and review findings to check accuracy prior to dissemination of results

Your signature indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate. You will receive a copy of this form for your records.

Name of Participant (please print):_____

_____ _____
Signature Date

_____ I give my permission to be quoted directly in publications.

Appendix 10: Informed Consent for ACT Team Psychiatrist

UNIVERSITY OF WISCONSIN-MADISON
Research Participant Information and Consent Form
ACT Team Psychiatrist

Title of the Study: the Roles and Contributions of Team Leaders to High Fidelity Assertive Community Treatment: A Collective Exemplary Case Study

Principal Investigator: Colleen Mahoney, PhD (phone: 608-263-6356; email: camahoney@wisc.edu)

Student Researcher: Lynette M. Studer (phone: 608-712-1942; email lstuder@wisc.edu)

DESCRIPTION OF THE RESEARCH

You are invited to participate in a research study exploring the roles and contributions of ACT team leaders on high fidelity ACT teams. The purpose of this collective case study is to better understand and describe the roles and contributions of ACT team leaders to the implementation and sustenance of high fidelity ACT teams. You have been asked to participate as your ACT team has been identified as an exemplary, high fidelity team in the United States. This study will include three high fidelity ACT teams as determined by recent TMACT scores and identification by state authorities. All ACT team members of the identified teams, including the team leader and psychiatrist, as well as agency leadership will be asked to participate in the study.

The primary objectives of this study are to (1) describe ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it); (3) understand what roles they may play in promoting high fidelity to ACT, and (4) identify the challenges they have faced and/or overcome in implementing and sustaining high fidelity ACT teams.

All parts of this research project will be conducted in the location of the identified ACT team, with some possible follow-up phone interviews. It is important to this case study to see you in your "real world" setting to better understand and observe what you do.

Audio taped, digital recordings will be made of your participation so that data can accurately be captured. Transcripts of your digital recordings will be professionally transcribed and stored in a locked filing cabinet. Only the research team will have access to the printed transcripts and audio recordings. Digital recordings and transcripts of observations, interactions, interviews, or focus groups will be kept for no more than five years before they are destroyed. Any information related to this study and stored on a computer (i.e., data analysis) will be password protected.

WHAT WILL MY PARTICIPATION INVOLVE?

In order to understand the roles and contributions of your ACT team leader, there are a variety of ways that I will be seeking to learn from you. I will be on-site with you and your team for three consecutive days and observing all activities, including all team and treatment planning meetings. I may also engage you in informal conversations about my observations. You will

be asked to participate in an approximately 60-90 minutes face-to-face interview in which you and I will discuss your perceptions of the roles and contributions of your team's ACT leader. Finally, during the data analysis phase of this study, you will be asked to review preliminary findings and check them for accuracy, this is a process known as "member checking" and assures I captured information correctly.

Your primary participation will last approximately 3 working days, based on a mutually agreeable time. During the data analysis phase of the study your participation may include up to two hours of phone follow up and reviewing the preliminary findings.

ARE THERE ANY RISKS TO ME?

I do not foresee any risks to you in participating in this study. Your participation is completely voluntary and you are free to discontinue at any time. There is no penalty if you choose to not participate in this study. If you do participate, it is possible that being observed may create some minimal discomfort or anxiety. Additionally, you may experience some discomfort disclosing information about a work colleague. However, if at any time you are uncomfortable or wish to take a break, please feel free to say so or talk more with me.

ARE THERE ANY BENEFITS TO ME?

I do not expect any direct benefits to you from participation in this study; however, the information gathered through this study may help to advance the field of Assertive Community Treatment. Potential indirect benefits to you may include the sharing of your knowledge as an exemplary ACT team member in the U.S., and provide opportunity to reflect on your contributions to ACT and the consumers you serve.

WILL I BE COMPENSATED FOR MY PARTICIPATION?

Based on your preference, you will receive either $25 cash, a $25 gift card, or a $25 donation to a charitable organization of your choice made in honor of your time and dedication to this project. If you do withdraw prior to the end of the study, you will still receive full compensation for your time.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?

Although the agency is supportive of this study, they will not have access to individual participant responses. When the interview or survey data are analyzed, the analysis will combine responses from all individuals on the team, and will not be identifiable in reports published or presented. Focus groups and interview responses, along with notes from direct observations will be kept in locked file cabinets and computer files will contain unique ID numbers rather than using the profession (i.e., nurse or vocational specialist) or name of team members as identifiers.

However, given you are the only team psychiatrist and the nature of case study research, your team and you will likely be identified in the write up of the results. Additionally, if you agree to participate in this study, I would like to be able to quote you directly. If you agree to allow me to quote you in publications, please initial the statement at the bottom of this form. A summary of findings will be presented to the team and to you as the team psychiatrist to verify analysis and

findings. At that time, anything you wish to remain confidential will be omitted from final reports prior to dissemination.

WHAT IF I HAVE QUESTIONS?

You may ask any questions about the research at any time. If you have questions about the research please contact the Principal Investigator Dr. Colleen Mahoney at 608-263-6356. You may also call the student researcher, Lynette Studer at 608-712-1942 or reach her by email at lstuder@wisc.edu.

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education Research and Social & Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. If you begin participation and change your mind you may end your participation at any time without penalty.

Do you have any questions about the study before you decide whether or not to participate?

I have read the above and (check all that apply):

____ give permission for the researcher to record observations of and audiotape my work and all interactions with the ACT team
____ am willing to participate in the 60-90 minute face-to-face interview
____ am willing to engage in informal conversation over the three days regarding my work within the ACT team
____ am willing to have a follow-up phone call and review findings to check accuracy prior to dissemination of results

Your signature indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate. You will receive a copy of this form for your records.

Name of Participant (please print):_____

_____ _____
Signature Date

_____ I give my permission to be quoted directly in publications.

Appendix 11: Informed Consent for ACT Team Member

UNIVERSITY OF WISCONSIN-MADISON
Research Participant Information and Consent Form
ACT Team Member

Title of the Study: The Roles and Contributions of Team Leaders to High Fidelity Assertive Community Treatment: A Collective Exemplary Case Study

Principal Investigator: Colleen Mahoney, PhD (phone: 608-263-6356; email: camahoney@wisc.edu)

Student Researcher: Lynette M. Studer (phone: 608-712-1942; email lstuder@wisc.edu)

DESCRIPTION OF THE RESEARCH

You are invited to participate in a research study exploring the roles and contributions of ACT team leaders on high fidelity ACT teams. The purpose of this collective case study is to better understand and describe the roles and contributions of ACT team leaders to the implementation and sustenance of high fidelity ACT teams. You have been asked to participate as your ACT team has been identified as an exemplary, high fidelity team in the United States. This study will include three high fidelity ACT teams as determined by recent TMACT scores and identification by state authorities. All ACT team members of the identified teams, including the team leader and psychiatrist, as well as agency leadership will be asked to participate in the study.

The primary objectives of this study are to (1) describe ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it); (3) understand what roles they may play in promoting high fidelity to ACT, and (4) identify the challenges they have faced and/or overcome in implementing and sustaining high fidelity ACT teams.

All parts of this research project will be conducted in the location of the identified ACT team, with some possible follow-up phone interviews. It is important to this case study to see you in your "real world" setting to better understand and observe what the team leader does.

WHAT WILL MY PARTICIPATION INVOLVE?

In order to understand the roles and contributions of your ACT team leader, there are a variety of ways that I will be seeking to learn from you. I will be on-site with you and your team leader for three consecutive days and observing all activities of the team leader, including all team and treatment planning meetings. I may also engage you in informal conversations about my observations.

You will be asked to participate in an approximately 90 minute focus group with all other ACT team members (excluding the team leader and team psychiatrist). Focus group questions will explore the roles and contributions of your team's leader to ACT from your unique perspective as a team member. Additionally, during the data analysis phase of this study, you will be asked to review preliminary findings and check them for accuracy, this is a process known as "member checking" and assures I captured information correctly.

All study participants will be assigned a study ID# as they enter the study. The study ID# will be attached to all data as it is collected, and participant names will not be attached to the data. Audiotaped, digital recordings will be made of your participation so that data can accurately be captured. You may ask me to turn off the tape recorder at any point in the focus group, and you may withdraw your consent to have all interactions taped at any time. Nothing will be written on the tapes that would identify you. Transcripts of your digital recordings will be professionally transcribed and stored in a locked filing cabinet. Only the research team will have access to the printed transcripts and audio recordings. Digital recordings and transcripts of observations, interactions, interviews, or focus groups will be kept for no more than five years before they are destroyed. Any information related to this study and stored on a computer (i.e., data analysis) will be password protected.

Your primary participation will last approximately the 3 working days I am on-site. During the data analysis phase of the study your participation may include up to two hours of phone follow up and review of the preliminary findings.

ARE THERE ANY RISKS TO ME?

I do not foresee any risks to you in participating in this study. Your participation is completely voluntary and you are free to discontinue at any time. There is no penalty if you choose to not participate in this study. If you do participate, it is possible that being continually observed may create some minimal discomfort or anxiety. Additionally, you may experience some discomfort in disclosing information about your team leader. However, if at any time you are uncomfortable or wish to take a break, please feel free to say so or talk more with me. There will be no influence on your employment by a decision to not participate.

ARE THERE ANY BENEFITS TO ME?

I do not expect any direct benefits to you from participation in this study; however, the information gathered through this study may help to advance the field of Assertive Community Treatment. Potential indirect benefits to you may include the sharing of your knowledge and experience as an exemplary ACT team member in the U.S., and provide opportunity to reflect on your contributions to ACT and the consumers you serve.

WILL I BE COMPENSATED FOR MY PARTICIPATION?

Based on your preference, you will receive either $25 cash, a $25 gift card, or a $25 donation to a charitable organization of your choice made in honor of your time and dedication to this project. If you do withdraw prior to the end of the study, you will still receive full compensation.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?

Although the agency is supportive of this study, they will not have access to individual participant responses. When the focus group data are analyzed, the analysis will combine responses from all individuals on the team, and will not be identifiable in reports published or presented. Focus group responses, along with notes from direct observations, will be kept in locked file cabinets and computer files will contain unique ID numbers rather than using the profession (i.e., nurse or vocational specialist) or name of team members as identifiers.

However, given the nature of case study research, your team will likely be identified in the write up of the results. Additionally, if you agree to participate in this study, I would like to be able to quote you directly, without using your name or professional association (e.g. nurse). If you agree to allow me to quote you in publications, without identifying you, please initial the statement at the bottom of this form. A summary of findings will be presented to team members to verify analysis and findings. At that time, anything you wish to remain confidential will be omitted from final reports prior to dissemination.

WHAT IF I HAVE QUESTIONS?

You may ask any questions about the research at any time. If you have questions about the research please contact the Principal Investigator Dr. Colleen Mahoney at 608-263-6356. You may also call the student researcher, Lynette Studer at 608-712-1942 or reach her by email at lstuder@wisc.edu.

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education Research and Social & Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. If you begin participation and change your mind you may end your participation at any time without penalty.

Do you have any questions about the study before you decide whether or not to participate?

I have read the above and (check all that apply):

____ give permission for the researcher to record observations of and audiotape my work and all interactions with the ACT team leader
____ am willing to participate in the 90 minute focus group of ACT team members
____ am willing to engage in informal conversation over the three days regarding my work within the ACT team
____ am willing to have a follow-up phone call and review findings to check accuracy prior to dissemination of results

Your signature indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate. You will receive a copy of this form for your records.

Name of Participant (please print):_____

_____ _____
Signature Date

_____ I give my permission to be quoted directly in publications.

Appendix 12: Informed Consent for Agency Leader/Supervisor of ACT Team Leader

UNIVERSITY OF WISCONSIN-MADISON
Research Participant Information and Consent Form
Agency Leader/Supervisor of ACT Team Leader

Title of the Study: the Roles and Contributions of Team Leaders to High Fidelity Assertive Community Treatment: A Collective Exemplary Case Study

Principal Investigator: Colleen Mahoney, PhD (phone: 608-263-6356; email: camahoney@wisc.edu)

Student Researcher: Lynette M. Studer (phone: 608-712-1942; email lstuder@wisc.edu)

DESCRIPTION OF THE RESEARCH

You are invited to participate in a research study exploring the roles and contributions of ACT team leaders on high fidelity ACT teams. The purpose of this collective case study is to better understand and describe the roles and contributions of ACT team leaders to the implementation and sustenance of high fidelity ACT teams. You have been asked to participate as your agency's ACT team has been identified as an exemplary, high fidelity team in the United States. This study will include three high fidelity ACT teams within the U.S. as determined by recent TMACT scores and identification by state authorities. All ACT team members of the identified teams, including the team leader and psychiatrist, as well as agency leadership will be asked to participate in the study.

The primary objectives of this study are to (1) describe ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it); (3) understand what roles they may play in promoting high fidelity to ACT, and (4) identify the challenges they have faced and/or overcome in implementing and sususstaining high fidelity ACT teams.

All parts of this research project will be conducted in the location of the identified ACT team, with some possible follow-up phone interviews. It is important to this case study to see you in your "real world" setting to better understand and observe what you do.

Audio taped, digital recordings will be made of your participation so that data can accurately be captured. Transcripts of your digital recordings will be professionally transcribed and stored in a locked filing cabinet. Only the research team will have access to the printed transcripts and audio recordings. Digital recordings and transcripts of observations, interactions, interviews, or focus groups will be kept for no more than five years before they are destroyed. Any information related to this study and stored on a computer (i.e., data analysis) will be password protected.

WHAT WILL MY PARTICIPATION INVOLVE?

In order to understand the roles and contributions of your ACT team leader, there are a variety of ways that I will be seeking to learn from you. I will be on-site with your agency's team for three consecutive days and observing all activities, including all team and treatment planning meetings. You will be asked to participate in an approximately 60-90 minutes face-to-face

interview in which you and I will discuss your perceptions of the roles and contributions of your ACT's team leader. During the data analysis phase of this study, you will be asked to review preliminary findings and check them for accuracy, this is a process known as "member checking" and assures I captured information correctly.

Your primary participation will last only 90 minutes during the face to face interview. During the data analysis phase of the study your participation may include up to two hours of phone follow up and reviewing the preliminary findings.

ARE THERE ANY RISKS TO ME?

I do not foresee any risks to you in participating in this study. Your participation is completely voluntary and you are free to discontinue at any time. There is no penalty if you choose to not participate in this study. If you do participate, it is possible you may experience some discomfort disclosing information about the work of the team leader. However, if at any time you are uncomfortable or wish to take a break, please feel free to say so or talk more with me.

ARE THERE ANY BENEFITS TO ME?

I do not expect any direct benefits to you from participation in this study; however, the information gathered through this study may help to advance the field of Assertive Community Treatment. Potential indirect benefits to you may include the sharing of your knowledge as an agency leader for an exemplary ACT team in the U.S., and provide opportunity to reflect on your contributions to ACT and the consumers your agency serves.

WILL I BE COMPENSATED FOR MY PARTICIPATION?

Your agency will receive $250 to thank you for both your individual contribution as well as your agency's willingness to participate in the research and allow access to your ACT team. If you do withdraw prior to the end of the study, you will still receive full compensation for your time.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?

Although the agency is supportive of this study, they will not have access to individual participant responses. When the interview or survey data are analyzed, the analysis will combine responses from all individuals on the team, and will not be identifiable in reports published or presented. Focus groups and interview responses, along with notes from direct observations will be kept in locked file cabinets and computer files will contain unique ID numbers rather than using the profession (i.e., nurse or vocational specialist) or name of team members as identifiers.

However, given you are the only agency representative interviewed and the nature of case study research, your team and you will likely be identified in the write up of the results. Additionally, if you agree to participate in this study, I would like to be able to quote you directly. If you agree to allow me to quote you in publications, please initial the statement at the bottom of this form. A summary of findings will be presented to the team and to you as the agency leader to verify analysis and findings. At that time, anything you wish to remain confidential will be omitted from final reports prior to dissemination.

WHAT IF I HAVE QUESTIONS?

You may ask any questions about the research at any time. If you have questions about the research please contact the Principal Investigator Dr. Colleen Mahoney at 608-263-6356. You may also call the student researcher, Lynette Studer at 608-712-1942 or reach her by email at lstuder@wisc.edu.

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education Research and Social & Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. If you begin participation and change your mind you may end your participation at any time without penalty.

Do you have any questions about the study before you decide whether or not to participate?

I have read the above and (check all that apply):

____ give permission for the researcher to record observations of and audiotape my interview
____ am willing to participate in the 60-90 minute face-to-face interview
____ am willing to have a follow-up phone call and review findings to check accuracy prior to dissemination of results

Your signature indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate. You will receive a copy of this form for your records.

Name of Participant (please print):_____

_____ _____
Signature Date

_____ I give my permission to be quoted directly in publications.

Appendix 13: Questionnaire Guide for ACT Team Leader

ACT Team Leader Interview

Participant ID: _____

Date of Interview #1: _____ Date of Interview #2: _____

Introduction/Opening Script: *Again, I just want to thank you so much for agreeing to participate in this study and for the help in coordinating all the staff to participate too. For this interview, I am going to be asking you questions about your roles and contributions to the ACT team, your approach to leadership of the team, your ideas about ACT fidelity, and any challenges you have faced and/or overcome as an ACT team leader. If you do not feel comfortable answering any of these questions, please just let me know and we will move on to the next one. I also want to remind you that I am trying to understand the answers from your perspective, so there are no right or wrong answers. Please let me know if you would like/need to take a break at any time. Before we begin, do you have any questions?*

First, I would like to begin by asking you questions about "who you are" and your experiences as an ACT team leader…

1. Can you start by telling me a little bit about how you became an ACT team leader?

   Possible probes: Any professional or personal experiences that influenced you?
   Any person you were influenced by?

2. What is it like to be an ACT team leader?

   Possible probes: Can you tell me a little more about _____?
   What do you find enjoyable about your job?
   How do you prevent burnout?
   What do you find difficult as a team leader?

3. If someone was describing your leadership style, what would he/she say about you?

4. As an ACT team leader, what is important to you?

I would like to switch topics now and ask you questions about what it is that you do as an ACT team leader…

5. What do you do as an ACT team leader?

   Possible probes: Describe for me a typical day as a team leader.
   What types of tasks (clinical/administrative) do you do?

What are your responsibilities and roles?
Can you give me examples of _____?
What tasks do you find unpleasant to do? What do you do in these situations?
How do you approach hiring and training of new staff?

6. What are you trying to accomplish as a leader?

Possible probes: Describe any short term goals you have for the team.
Describe any long term goals you have for the team.

7. What is your approach to leading a multidisciplinary team?

Possible probes: What is important?

8. Describe for me, different interactions you have with team members.

Possible probes: What do your clinical supervision sessions look like with staff?
How do you know what individual staff need?
How does the team psychiatrist inhibit or promote your leadership?
What is important for you as the leader in this relationship with the MD?

9. Tell me what you take into consideration when interacting with staff?

Possible probes: What are the ways you influence staff? Motivate staff?
How do you promote team morale?
In the team meeting I saw you do ____. Can you tell me more about why you did it this way?
Tell me about the independence staff have to make decisions?

10. Can you describe how you approach handling conflict with your team? Can you give an example?

Possible probes: What was the resolution?
How do you hold staff accountable?
How do you prepare your team for changes or share news that you know the team will not like?

Next, are questions about the role you play in promoting high fidelity to ACT, including any challenges you may have experienced…

11. Can you share with me your perspective about fidelity to ACT?

    Possible probes: How did you learn about ACT fidelity?
    In what ways does fidelity factor into your daily decisions about the team? Examples?
    In a hypothetical situation, let's say your agency asks you to "adapt" the model in a certain way, what would your approach be to this?
    How would you describe your relationship with your parent agency?

12. What helps you facilitate high fidelity ACT services?

    Possible probes: Anything else you need in place to run a high fidelity ACT team?
    Tell me a little bit about how outside forces (your parent agency, state) helps your leadership of the team?
    Anything you wish was in place to help you that isn't?

13. What hinders your ability to sustain high fidelity ACT?

    Possible probes: Can you describe any barriers or obstacles that hinders your ability to sustain a high fidelity ACT team?
    Can you name for me one category you received a low TMACT score on? *If unable to think of one, pull one off the TMACT*. Thinking about that item, what is a barrier to improving that individual score?
    What are the biggest threats to you in running a high fidelity team? How do you manage these threats?
    Tell me a little bit about how outside forces (your parent agency, state) hinders your leadership of the team?

END OF INTERVIEW ONE HERE

---

14. What challenges have you faced with your program as a team leader?

    Possible probes: For Challenge A, what did you do to overcome it?
    What factored into your choices of strategies to overcome Challenge A?
    For Challenge B, what did you do to overcome it?

15. Can you tell me, what contributes to your effectiveness as an ACT team leader?

    Possible probes: What characteristics do you have that lends to your effectiveness?
    What principles guide your work as a team leader?
    What skills do you have that are important for your leadership?

16. Tell me a little about your state standards.

    Possible probes: What is your opinion on how well defined they are?
    How are you aware of these?
    What role, if any, do they play with your knowledge of ACT and how to run the program?

17. In regards to practice standards, what contingencies or incentives do you have for following them?

    Possible probes: How does certification or funding link to the standards?

18. What types of support funding for ongoing implementation for ACT do you have?

    Possible probes: Describe for me what types of ongoing training or consultation you have had in regards to ACT.

19. Who is the identified leader at the state level with responsibility and authority to provide oversight and advocate for the use of the ACT model?

    Possible probes: What is this person's role, if any, in helping you run a high fidelity ACT team (probe further for build and sustain support: encourage program development and strategic planning; function as a watchdog).

20. Can you give examples of how your agency has been willing to embrace ACT?

21. What outcome monitoring do you have in place for your team?

    Possible probes: How do you know you are meeting objectives?

As a reminder, the objectives of this study include: (1) describing ACT team leaders (i.e., who they are); (2) understanding their approach to leadership (i.e., what they do and how they do it); (3) understanding what roles they may play in promoting high fidelity to ACT, and (4) identifying the challenges they have faced and/or overcome in implementing and sustaining high fidelity ACT teams.

Based on these aims, is there anything else you feel it is important that I know about you or your leadership that I did not ask you about?

Appendix 14: Demographic Team Leader Form

Team Leader Demographic Form

Participant Number _____
Date _____

Please answer the following questions about yourself:

1. My birthday is: _____ 19 _____

2. Race/Ethnicity (check all that apply)
   - □ African American/Black
   - □ White (Non-Hispanic)
   - □ Asian/Pacific Islander
   - □ Hispanic/Latina
   - □ Native American
   - □ Other (please specify): _____

3. Gender:
   - □ Female
   - □ Male
   - □ Other (please specify): _____

4. Highest Education Level Completed:

   - □ Less than high school
   - □ Some high school
   - □ High school graduation/GED
   - □ Trade school/vocational school
   - □ Some college
   - □ BS/BA degree
   - □ Masters degree
   - □ MD/PhD/JD degree
   - □ Other (please specify): _____

5. What field is your degree in:
   - □ Social work
   - □ Nursing
   - □ Psychology
   - □ Rehabilitation Psychology
   - □ Vocational Rehabilitation
   - □ Other (please specify): _____

6. How long have you worked in the mental health field?
   ____years and _____months

7. How long have you worked in this ACT program?
____years and _____months

8. How long have you worked as this team's ACT leader?
____years and _____months

9. Have you worked in an ACT program previous to this one?

□ Yes
□ No

If yes, how many years were you in that other program?: _____
In what capacity/position? _____

10. Please describe any additional ACT trainings you have received in the past.

_____

_____

_____

11. Other comments?

_____

_____

_____

Appendix 15: Questionnaire Guide for ACT Team Psychiatrist

ACT Team Psychiatrist Interview

Participant ID: _____

Date: _____

Introduction/Opening Script: *Again, I just want to thank you so much for agreeing to participate in this study. For this interview, I am going to be asking you questions about the roles and contributions of [name of ACT team leader] to your team. Specifically, I want to learn about her who she is, her approach to leadership of the team, your ideas about the role she may/may not play in your team's fidelity, and any challenges she has faced and/or overcome as an ACT team leader. I recognize that there may be some potential awkwardness of answering some of these questions about [insert team leader name] and that given you are the only team psychiatrist, I cannot offer you complete or meaningful confidentiality. You will get to see results prior to dissemination and anything that you wish to be removed prior to dissemination will be. That said, if you do not feel comfortable answering any of these questions, please just let me know and we will move on to the next one. I also want to remind you that I am trying to understand the answers from your perspective, so there are no right or wrong answers. Before we begin, do you have any questions?*

1. To begin, can you tell me a little about your work with the ACT team?

2. Can you describe your perception of how the team functions?

   Possible probes: What do they do well?
   What could be better?

Next, I would like to ask you questions about "who [team leader name]is"...

3. Can you describe [team leader name] to me?

   Possible probes: What characteristics does she possess?
   What skills does she have?
   You mentioned [team leader name] is ____. Can you give me an example?
   Are there principles that guide her work as a team leader?

Next, I would like ask you questions about what [team leader name] does as an ACT team leader.....

4. Can you describe what does [team leader name] do on a day to day basis?

   Possible probes: What types of tasks (clinical/administrative) or responsibilities?
   How does she approach hiring and training of new staff?
   How does she manage staff?

5. In general, how would you describe her leadership style?

Possible probes: What influence does she have over team members? Can you give me an example?
How does she motivate staff?
How does she encourage staff to be independent?
How does she know what individual staff members need?

6. In what ways does [team leader name] contribute to the team?

Possible probes: How does the team show respect for her?
How does she promote the vision of the team?

7. How does [team leader name] handle conflicts in the team?

Possible probes: Can you give an example of when [team leader name] managed a conflict?
How does [team leader name] prepare the team for change?
How does she hold staff accountable?

8. As a team psychiatrist, you also have a lead role within the team clinically. Can you describe for me what your relationship with [team leader name] is like?

Possible probes: How do you two make decisions about the team?
If the two of your disagreed on something, what would happen?

Next, are questions about fidelity to ACT.

9. What role, if any, does [team leader name] play in promoting ACT fidelity?

Possible probes: Can you share some examples of how [team leader name] promotes ACT fidelity?
Does she ever have conversations with you about ACT fidelity? If yes, what gets discussed?
In a hypothetical situation, let's say your agency asks the team to "adapt" the model in a certain way, what would her approach be to this? What factors would she consider?

10. What helps [team leader name] facilitate high fidelity ACT services?

Possible probes: Tell me about how outside influences (parent agency, state) helps [team leader name]'s leadership? Examples?

11. What hinders [team leader name] ability to sustain high fidelity ACT?

Possible probes: Can you name for me one category your team received a low TMACT score on? *If unable to think of one, I will find one from TMACT and point out*. Thinking about that item, what is a barrier to improving that individual score?
What are the biggest threats to [team leader name]in running a high fidelity team?
Tell me about how outside influences (parent agency, state) hinders [team leader name]'s leadership?
How does [team leader name] manage these outside influences?

Next, I would like to ask you about any challenges your team has had.

12. What challenges has [team leader name] faced in sustaining this high fidelity ACT team?

Possible probes: For Challenge A, what did she do to overcome it?
For Challenge B, what did she do to overcome it?

Anything else you feel it is important that I know about [team leader name]and her leadership that I did not ask you about?

Lastly, I just would like to ask you some demographic questions.

a. Age
b. Ethnic affiliation
c. Identified gender
d. Degree/Any other professional sub training?
e. Years in practice
f. Years worked in ACT

Appendix 16: Interview Guide for Agency Leader/Supervisor of ACT Team Leader

Agency Leader/Supervisor of ACT Team Leader Interview

Participant ID: _____

Date: _____

Introduction/Opening Script: *Again, I just want to thank you so much for agreeing to participate in this study. For this interview, I am going to be asking you questions about the roles and contributions of [name of ACT team leader] to your agency's ACT team. Specifically, I want to learn about her who she is, her approach to leadership of the team, your ideas about the role she may/may not play in your team's fidelity, and any challenges she has faced and/or overcome as an ACT team leader. I recognize that there may be some potential awkwardness of answering some of these questions about [insert team leader name] and that given you are her supervisor, I cannot offer you complete or meaningful confidentiality. You will get to see results prior to dissemination and anything that you wish to be removed prior to dissemination will be. That said, if you do not feel comfortable answering any of these questions, please just let me know and we will move on to the next one. I also want to remind you that I am trying to understand the answers from your perspective as her supervisor, so there are no right or wrong answers. Before we begin, do you have any questions?*

1. To begin, can you tell me a little about your work with this agency?

   Possible probes: Specifically, can you tell me about your work with [team leader name].
   How long have you worked with one another?
   If you hired her, why?
   Can you describe how often you two interact and for what purpose?

2. Can you describe your perception of how the team functions?

   Possible probes: What do they do well?
   What could be better?

Next, I would like to ask you questions about "who [team leader name]is"...

3. Can you describe [team leader name] to me?

   Possible probes: What characteristics does she possess?
   What skills does she have?
   What else makes [team leader name] a good or great leader?
   You mentioned [team leader name] is ____. Can you give me an example?
   Are there principles that guide her work as a team leader?
   Any other beliefs or attitudes that describe her?

Next, I would like ask you questions about what [team leader name] does as an ACT team leader…..

4. Can you describe what does [team leader name] do on a day to day basis?

   Possible probes: What types of tasks (clinical/administrative) or responsibilities?
   What role does she have in hiring and training of new staff?
   How does she manage staff?
   What would you say takes up the most of her time?

5. In general, how would you describe her leadership style or practice?

   Possible probes: How does she help out the staff?
   What influence does she have over team members? Can you give me an example?
   How does she motivate staff?
   How does she encourage staff to be independent?
   How does she know what individual staff members need?

6. What does [team leader name] contribute to the team?

   Possible probes: How does the team show respect for her?
   How does she promote the vision of ACT for the team?
   How is she an ambassador for the team?

7. How does [team leader name] handle conflicts in the team?

   Possible probes: Can you give an example of when [team leader name] managed a conflict?
   How does [team leader name] prepare the team for change?
   How does she hold staff accountable?

8. How would you describe the working relationship between [team leader name] and the team psychiatrist?

   Possible probes: If the two disagreed on something, how would that get resolved?

9. How does she communicate with you needs she has either personally or for the team?

   Possible probes: Can you give me an example of a personal professional need she has had?
   Can you give me an example of how she communicated a need of the team to you?

Next, are questions about fidelity to ACT.

10. What role, if any, does [team leader name] play in promoting ACT fidelity?

Possible probes: Can you share some examples of how [team leader name] promotes ACT fidelity?
Does she ever have conversations with you about ACT fidelity? If yes, what gets discussed?
What are your expectations of her in regards to ACT fidelity? Certain outcomes your agency requires?
In a hypothetical situation, let's say your agency asks the team to "adapt" the model in a certain way, what would her approach be to this? What factors would she consider?

11. What helps [team leader name] facilitate high fidelity ACT services?

Possible probes: Tell me about how outside influences (parent agency, state) helps [team leader name]'s leadership? Examples?

12. What hinders [team leader name] ability to sustain high fidelity ACT?

Possible probes: Can you name for me one category your team received a low TMACT score on? *If unable to think of one, I will find one from TMACT and point out*. Thinking about that item, what is a barrier to improving that individual score?
What are the biggest threats to [team leader name]in running a high fidelity team?
Tell me about how outside influences (parent agency, state) hinders [team leader name]'s leadership?
How does [team leader name] manage these outside influences?

Next, I would like to ask you about any challenges your team has had.

13. What challenges has [team leader name] faced in sustaining this high fidelity ACT team?

Possible probes: For Challenge A, what did she do to overcome it?
For Challenge B, what did she do to overcome it?

Anything else you feel it is important that I know about [team leader name]and her leadership that I did not ask you about?

Lastly, I just would like to ask you some demographic questions.

a. Age
b. Ethnic affiliation

c. Identified gender
d. Degree/Any other professional sub training?
e. Years as her ACT supervisor
f. Years at this agency

Appendix 17: Fieldnote Recording Template

Record for On-site Observations/Fieldnotes for _____ ACT Team

Date & Time:		Accompanied audiotape? Y or N
Setting the Scene (who is present; what does the setting look like; what the is "state" of the environment)		
Study Aims: (1) describe the ACT team leaders (i.e., who they are); (2) understand their approach to leadership (i.e., what they do and how they do it) (3) understand what roles they may play in promoting high fidelity to ACT (4) identify the challenges they have faced and/or overcome in implementing and sustaining high fidelity ACT teams What acts, activities, events, or behaviors are observed? What are the interactions, relationships, and expressions of feelings or emotions?	**Descriptive Notes (Verbatim, paraphrase)**	**Reflective Notes/Summaries/Analytic Notes (Impressions, Feelings, and Concerns)**
Questions for Team Leader at end of day meeting		

Appendix 18: Focus Group Questioning Guide

Discussion Guide for ACT Team Member Focus Group

Focus Group ID#: _____ Date & Time of Interview:_____

I. **Introduction**

Who I am/Thank you for participating
Purpose: To understand and describe the role and contributions of ACT team leaders from the perspective of team members.
Audio-taping
Review of confidentiality/Informed consents
Ground rules including comfort level talking about leader
Distribute demographics sheet to complete
Introduction of focus group participants (for sake of me and recording)
- First name
- Discipline
- Number of months/years on this ACT team

II. **Discussion**

In all instances, please feel free to provide me with examples to relay what you mean if that is easier for you.

1. Can you start by just describing [team leader name] to me? What is [team leader name] like?

   Possible probes:
   - What are some of her strong points?
   - What makes her an effective team leader?
   - You mentioned [team leader name] is ____. Can you give me an example?
   - What principles does [team leader name] abide by? In other words, what does she "stand" for?
   - Any other qualities she may have that were not mentioned?

Next, I would like ask you questions about what [team leader name] does as an ACT team leader…..

2. Can you describe what does [team leader name] do on a daily basis?

   Possible probes:
   - How does your team leader support you in your job?
   - What makes your team leader great?

3. In what ways does [team leader name] influence you?

   Possible probes:
   - How does [team leader name] contribute to your job satisfaction? Does she do things specific to your role?
   - What is it like to have her as a boss/leader?
   - How does she approach clinical supervision with you?

How would you approach the team leader about a problem you were experiencing?
Suppose you have a really difficult situation with a consumer that comes up in team meeting, how would [team leader name] handle this?

4. Can you give me any examples of how [team leader name] motivated you?

   Possible probes: Can you give examples of how she attends to your personal professional needs?
   Can you give any examples of how she encourages the team to grow and/or improve?
   How does she encourage you to be better?
   How independent can you be? How does she encourage this?

5. How does [team leader name] handle conflict among team members?

   Possible probes: Let's suppose there is something that the team won't like, that [team leader name] has to tell you, how would she approach telling you this less desirable news?

6. Can you describe for me how [team leader name] and [team psychiatrist name] work together?

   Possible probes: Does one ultimately has the say?
   Can you give an example of a time when they disagreed? What happened?

Next, are questions about fidelity to ACT.

7. In what ways, does [team leader name] communicate with you about ACT fidelity?

   Possible probes: How does [team leader name] contribute to the ACT fidelity of your team?
   What and how are expectations set regarding ACT fidelity?
   Suppose I was a new staff person, what training would I get regarding ACT fidelity?
   Can you give me an example of when [team leader name] made a choice regarding fidelity?
   What would happen if a team member was not following ACT fidelity?

8. In a hypothetical situation, let's say your agency asks the team to "adapt" the model in a certain way, what would happen? What factors would she consider?

9. Tell me about how outside influences (parent agency, state) help or hinder [team leader name]'s running of the team?

   Possible probes: You said [insert outside influence name] influences [team leader name]'s leadership. Can you provide an example? If a hindrance, what was the resolution?
   What are the biggest threats to [team leader name]in running a high fidelity team?

Next, I would like to ask you about any challenges your team has had.

10. What challenges has this team had in sustaining this high fidelity ACT service?

    Possible probes: For Challenge A, what did [team leader name] do to overcome it?
    For Challenge B, what did [team leader name] do to overcome it?

Anything else you feel it is important for the description of [team leader name]and her leadership that I did not ask you about?

III. **Ending the Discussion**

1. Summary Question:
   So in listening to this conversation, this is what I am taking from it….[summarize each main area above beginning with the overarching aim]. Is this an adequate summary? Is it complete? Do you have any changes or additions? Have I missed anything?
2. Complete demographic form and return to me.
3. Distribute the End of Focus Group form and explain.
4. Describe process of member checking. Get suggestions from them on how best to handle this? Skype interview? Email?
5. Thanking them & distribution of incentives

Appendix 19: End of Focus Group Worksheet

End of Focus Group Worksheet

Focus Group ID#_____ Participant ID# _____ Date: _____

---

1. On the scale below, could you please rate how comfortable you felt sharing information on your team and team leader in the focus group.

1	2	3	4	5	6	7	8	9	10
Not at all comfortable									*Extremely comfortable*

2. Is there anything else that you would like to tell me about your team leader and her leadership that you did not feel comfortable sharing within the larger group? If so, please write below and/or on the back of this sheet.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please return this form to Lynette Studer before you leave the focus group. Thank you.

Appendix 20: Focus Group Participant Demographic Form

Focus Group Participant Demographic Form

Participant Number _____
Date _____

Please answer the following questions about yourself:

1. My birthday is: _____ 19 _____

2. Race/Ethnicity (check all that apply)
   - □ African American/Black
   - □ White (Non-Hispanic)
   - □ Asian/Pacific Islander
   - □ Hispanic/Latina
   - □ Native American
   - □ Other (please specify): _____

3. Gender:
   - □ Female
   - □ Male
   - □ Other (please specify): _____

4. Highest Education Level Completed:

   - □ Less than high school
   - □ Some high school
   - □ High school graduation/GED
   - □ Trade school/vocational school
   - □ Some college
   - □ BS/BA degree
   - □ Masters degree
   - □ MD/PhD/JD degree
   - □ Other (please specify): _____

5. What field is your degree in:
   - □ Social work
   - □ Nursing
   - □ Psychology
   - □ Rehabilitation Psychology
   - □ Vocational Rehabilitation
   - □ Other (please specify): _____

6. How long have you worked in the mental health field?
   ____years and _____months

7. How long have you worked in this ACT program?
   ____years and _____months

8. Have you worked in an ACT program previous to this one?
   □ Yes
   □ No

   If yes, how many years were you in that other program: _____

Appendix 21: Request for Feedback/Member Checking Worksheet

Request for Feedback/Member Checking
[TEAM NAME] ACT Team
[DATE]

Those of you who have participated in focus groups, or interviews and who have assisted in completing the surveys have worked really hard to contribute to an understanding of ACT Team Leaders on high fidelity ACT teams. It is critical to the integrity of this study that I ask you to review and respond to my way of organizing what I have learned from you. Seeking your reactions to the data (called "member checking") is one of the most important ways to lend trustworthiness to a qualitative study. Therefore, I would greatly appreciate your taking a few minutes to share your reactions and suggestions with me.

Instructions: Please refer to document titled "Summary Findings for [Team Name] ACT". The document is arranged according to each of the four study aims. Under each study aim, there is a summary of the findings (these categories are labeled with capital letters, e.g., "A", "B", etc.). Each category is further defined along with various codes that were grouped under the main category (these are bullet pointed). Finally, each aim section concludes with actual example quotes participants' provided during the data collection that support the creation of the category.

As you read through the findings, please complete this worksheet. Keep in mind the quotes are only examples and every listed code may not have a corresponding quote. Also, please recall that you have the personal option of striking any quote that you wish to not be published. If this occurs, please list the quote, in its entirety under answer 5.1 of this form or email me the quote you wish to have removed at lstuder@wisc.edu.

Aim 1: Describe ACT Team Leaders (i.e., who they are).

1.1 To what extent do the categories that I have developed make sense to you?

_____
_____
_____
_____
_____

1.2 To what extent do the categories accurately describe your team leader? (Please keep in mind this is not meant to give a holistic picture of your team leader, but rather indicate repeated themes that came up during data collection; a holistic description of your team leader will be included in the final write up).

_____
_____
_____
_____
_____
_____
_____
_____

1.3 To what extent do the categories under Aim #1 accurately capture who your team leader is?

_____

1.4 Please describe anything in Aim #1 that you disagree with or that I captured incorrectly?

Aim 2: Understand their approach to leadership (i.e., what they do and how they do it).

2.1 To what extent do the categories that I have developed make sense to you?

2.2 To what extent do the categories accurately describe what your team leader does and how she does it?

2.3 To what extent do the categories under Aim #2 accurately capture what and how your team leader does?

2.4 Please describe anything in Aim #2 that you disagree with or that I captured incorrectly?

Aim 3: What role does she play in promoting high fidelity to ACT?

3.1 To what extent do the categories accurately capture the roles your team leader may play in promoting high fidelity to ACT?

_____
_____
_____
_____
_____

3.2 Are there other primary roles you see her playing in promoting high fidelity to ACT that are not represented here?

_____
_____
_____
_____
_____

Aim 4: Identify the challenges the team leader has faced and/or overcome in implementing and sustaining high fidelity ACT teams

4.1 To what extent do the categories under Aim #4 accurately capture the range of challenges the team leader has encountered and/or overcome in implementing and sustaining high fidelity ACT?

_____
_____
_____
_____
_____

4.2 What challenges, barriers, or dilemmas has the team leader encountered not represented here?

_____
_____
_____
_____
_____

4.3 What strategies to addressing the challenges are not represented here?

_____
_____
_____
_____

4.4 Please describe any suggestions you might offer for enhancing the presentation of results relevant to the roles the team leader plays in promoting high fidelity to ACT or in the identification of challenges she has faced in implementing and sustaining high fidelity ACT that are not represented here.

_____
_____
_____
_____
_____

5.1 Any additional thoughts or comments on the content of any of the findings?

_____
_____
_____
_____
_____

5.2 Name(s) of participants completing this form:

_____
_____
_____
_____

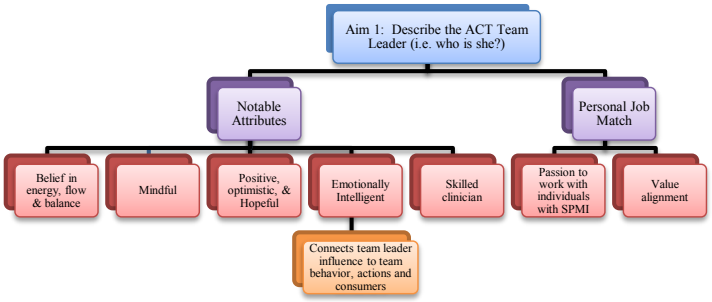
6.1 You are the first team who has member checked their findings. Based on this, are there any suggestions you could provide me as to how to make this process easier or clearer for the next two teams (e.g., less quotes, organized differently, added instruction)?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

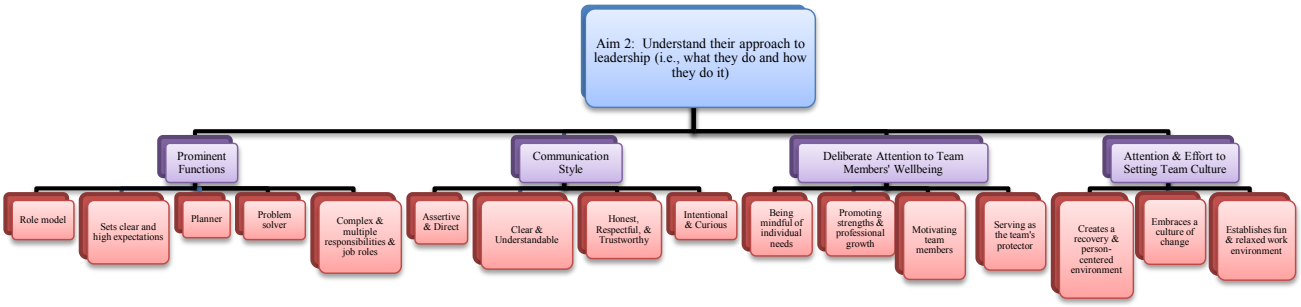
If you would like to add more information than this form allows, feel free to attach additional sheets of paper.

Please return to _____ no later than _____.
Any questions/comments/concerns, please email me at lstuder@wisc.edu
THANKS SO MUCH FOR YOUR INPUT!!

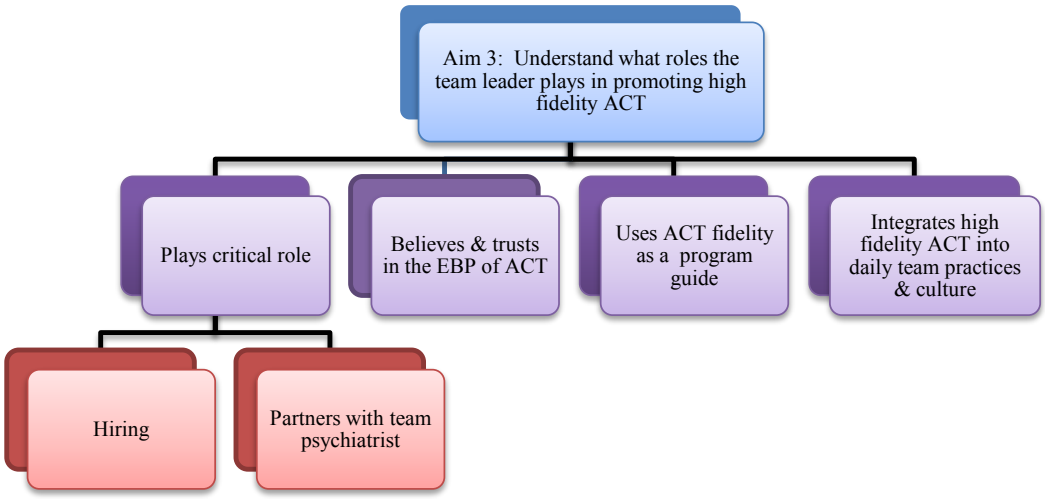
Appendix 22: Visual Representation of Findings for Ramsey County ACT Team


Aim 1: Describe the ACT Team Leader (i.e. who is she?)
Notable Attributes
Personal Job Match
Belief in energy, flow & balance
Mindful
Positive, optimistic, & Hopeful
Emotionally Intelligent
Skilled clinician
Passion to work with individuals with SPMI
Value alignment
Connects team leader influence to team behavior, actions and consumers

Aim 1

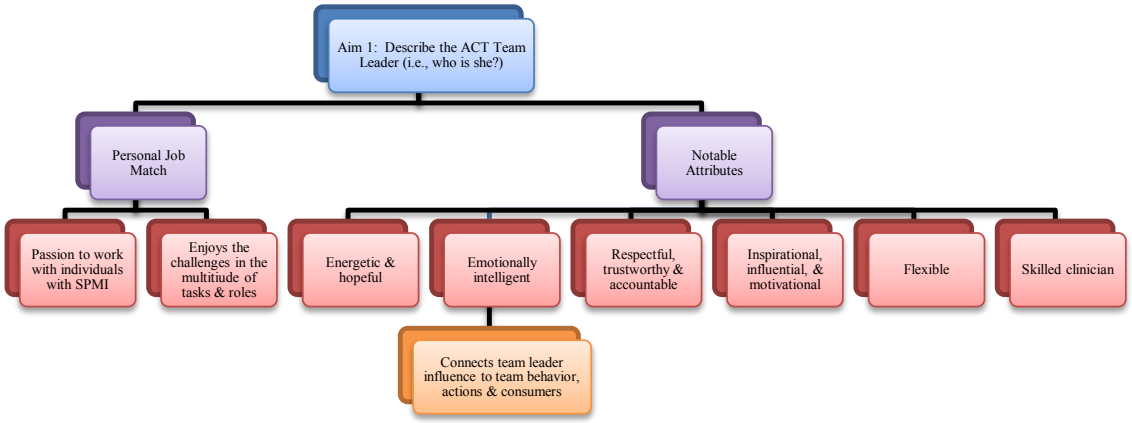

Aim 2: Understand their approach to leadership (i.e., what they do and how they do it)
Prominent Functions
Communication Style
Deliberate Attention to Team Members' Wellbeing
Attention & Effort to Setting Team Culture
Role model
Sets clear and high expectations
Planner
Problem solver
Complex & multiple responsibilities & job roles
Assertive & Direct
Clear & Understandable
Honest, Respectful, & Trustworthy
Intentional & Curious
Being mindful of individual needs
Promoting strengths & professional growth
Motivating team members
Serving as the team's protector
Creates a recovery & person-centered environment
Embraces a culture of change
Establishes fun & relaxed work environment

Aim 2

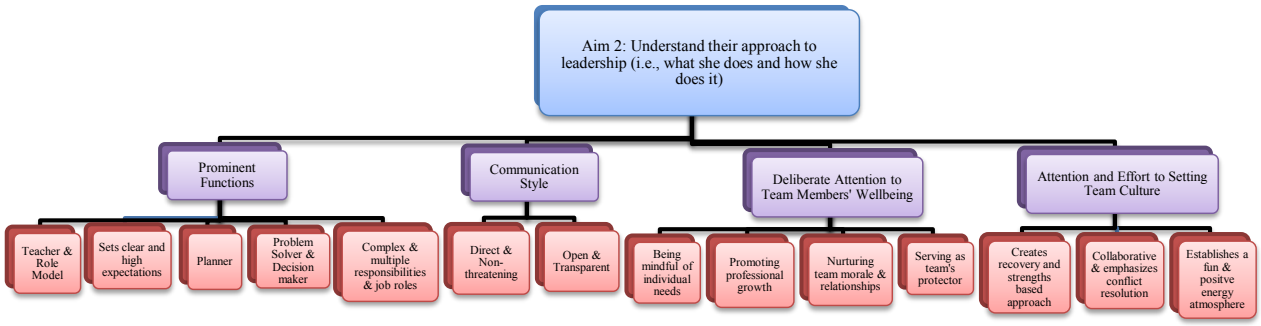

Aim 3: Understand what roles the team leader plays in promoting high fidelity ACT
Plays critical role
Believes & trusts in the EBP of ACT
Uses ACT fidelity as a program guide
Integrates high fidelity ACT into daily team practices & culture
Hiring
Partners with team psychiatrist

Aim 3

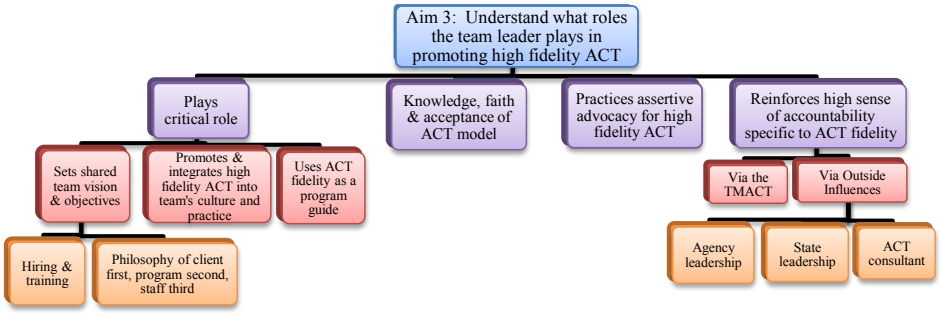
Appendix 23: Visual Representation of Findings for Lincoln PIER ACT Team


Aim 1: Describe the ACT Team Leader (i.e., who is she?)
Personal Job Match
Notable Attributes
Passion to work with individuals with SPMI
Enjoys the challenges in the multitiude of tasks & roles
Energetic & hopeful
Emotionally intelligent
Respectful, trustworthy & accountable
Inspirational, influential, & motivational
Flexible
Skilled clinician
Connects team leader influence to team behavior, actions & consumers

Aim 1


Aim 2: Understand their approach to leadership (i.e., what she does and how she does it)
Prominent Functions
Communication Style
Deliberate Attention to Team Members' Wellbeing
Attention and Effort to Setting Team Culture
Teacher & Role Model
Sets clear and high expectations
Planner
Problem Solver & Decision maker
Complex & multiple responsibilities & job roles
Direct & Non-threatening
Open & Transparent
Being mindful of individual needs
Promoting professional growth
Nurturing team morale & relationships
Serving as team's protector
Creates recovery and strengths based approach
Collaborative & emphasizes conflict resolution
Establishes a fun & positve energy atmosphere

Aim 2


Aim 3: Understand what roles the team leader plays in promoting high fidelity ACT
Plays critical role
Knowledge, faith & acceptance of ACT model
Practices assertive advocacy for high fidelity ACT
Reinforces high sense of accountability specific to ACT fidelity
Sets shared team vision & objectives
Promotes & integrates high fidelity ACT into team's culture and practice
Uses ACT fidelity as a program guide
Via the TMACT
Via Outside Influences
Hiring & training
Philosophy of client first, program second, staff third
Agency leadership
State leadership
ACT consultant

Aim 3