Adapting and implementing Acceptance and Commitment Therapy groups to support personal recovery of adults living with psychosis: A qualitative study of facilitators' experiences

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Abstract

Background: Psychosocial, evidence-based interventions (EBI) may support personal recovery from psychosis; however, little is known about their implementation.

Methods: This paper describes the adaptation, implementation, and evaluation of a psycho-social EBI, group Acceptance and Commitment Therapy (ACT), designed to support personal recovery of people living with psychosis who are accessing Australian public mental health services. We outline the process of adapting and implementing a group program, and present results of a qualitative analysis of facilitator experiences of the first 6 groups conducted involving 69 participants. Eight facilitators participated in an expert-led reflective interview developed to gather feedback in five domains.

Results: A thematic analysis of transcribed audio-recorded interviews elicited nine themes that indicated: local adaptations facilitated participant learning; targeted efforts to engage all stakeholders were successful; clinical supervision and research support by local experts enabled program implementation and evaluation; implementation offered facilitators personal rewards; and a need for further engagement of organisational support.

Discussion: This paper identifies enablers of successful adaptation and implementation of ACT groups for recovery from psychosis, an EBI in public mental health services. Study limitations include the risk of a self-serving reporting bias and the absence of lived experience expertise in group facilitation and evaluation.

Keywords*:* psychosis; Acceptance and Commitment Therapy; group therapy; public mental health services; evidence-based interventions; adaptation and implementation

Introduction

People recovering from psychosis have complex needs only partially met through case management and routine medical care (Dixon et al., 2010; NICE, 2014). Over the past two decades, *personal recovery*, or support for consumers (i.e., people who use mental health services) to live engaged, connected, and purposeful lives (Leamy et al., 2011), has been adopted as a framework for mental health service delivery worldwide (Adams et al., 2009), including Australia (Commonwealth of Australia, 2013). Public mental health services, however, face many challenges in offering a range of evidence-based interventions (EBI) supporting personal recovery from psychosis (Ince et al., 2016; van der Krieke et al., 2015). Psychological interventions, ideally offered in a variety of formats to engage consumers, can be an important component in supporting recovery (Dixon et al., 2016; NICE, 2014; Nowak et al., 2016). Group formats may be an effective, economical, and accessible option (Knapp et al., 2014), however, an emphasis on personal recovery from psychosis is missing in available evidence-based, manualised group programs for people with psychosis (Moritz et al., 2013; Owens et al., 2015).

In addition to the need for EBI group programs targeting personal recovery, there is an imperative to evaluate their implementation and sustainability in real-world settings (Aarons et al., 2017; Jolley, 2018; Shelton et al., 2018). The development of psychosocial EBIs often focuses on efficacy: effectiveness is not guaranteed when implemented in routine practice (Shelton et al., 2018). Once interventions are implemented in new contexts ongoing evaluation of their sustainability and fidelity is required (Shelton et al., 2018).

Acceptance and Commitment Therapy (ACT) is a feasible individual therapy for supporting people with psychosis (Wakefield et al., 2018). ACT encourages people to develop greater psychological flexibility when responding to their internal experiences: this is the capacity to connect with the present moment, be open to one's experiences (described

within ACT as *willingness*), and change or persist with actions based on personal values (Hayes et al., 2012). Psychological flexibility is a key determinant of wellbeing and personal effectiveness (Kashdan & Rottenberg, 2010), including for people living with psychosis (e.g., Goldstone et al., 2011). While people vary in psychological flexibility, it can be strengthened with psychosocial interventions like ACT (Gloster et al., 2020).

A group ACT protocol for people with psychosis ("ACT for Life") was developed in the United Kingdom (UK) (Butler et al., 2016; O'Donoghue et al., 2018). This program helped participants to develop mindfulness skills, connecting with personal values, and promotes willingness and curiosity toward inner experiences (Butler et al., 2016), all psychological flexibility processes. Evaluations of ACT for Life (Bloy et al., 2021; Johns et al., 2016; Jolley et al., 2020) demonstrate that people with psychosis not only engage in group ACT but also benefit from improvements in wellbeing, personal recovery, and quality of life. We adapted ACT for Life to suit an outpatient community mental health service in Australia, with a focus on promoting personal recovery ("Recovery ACT" as a program title). We describe the adaptation, implementation, and evaluation of Recovery ACT, presenting results from a qualitative evaluation of facilitator experiences of the process.

Method

Establishment and adaptation

Recovery ACT originated in 2015 following a presentation at a public sector psychologists' forum by author EM about ACT for psychosis groups. Psychologists from NorthWestern Mental Health (NWMH), a public mental health service in Melbourne, Australia recognised a local need for recovery-oriented psychosocial EBIs and resolved to adapt the group for their service. Local academicians who are experts in ACT for psychosis and research (JF, EM) were invited to participate in a steering group to support authors JG, EG and JC as key clinicians (the local term for clinical mental health staff in a case

management role) in an evaluation of group effectiveness, and to provide clinical supervision to ensure treatment fidelity. The steering group made three adaptations to the ACT for Life group (a 4-session, 2-hour group; Johns et al., 2016): shortening session duration to reduce cognitive demand, increasing number of sessions to maximise understanding and retention through greater repetition of content, revising manual to suit the local vernacular.

Program outline

Recovery ACT is an 8-session group for adults recovering from psychosis. Seven core sessions are held weekly and a booster session a month later (see supplementary Table 1). Groups of 4-12 participants in 90-minute sessions (with a 15-minute break) were each led by two facilitators who were employed by NWMH as key clinicians. Authors JG, EG, and JC were facilitators, along with additional facilitators who joined the program as it proceeded. Consistent with ACT principles (Hayes et al., 2012), group sessions involve experiential learning through exercises and metaphors.

Similar to the UK group, Recovery ACT anchors content with the "Passengers on the Bus" metaphor (Hayes et al., 2012), inviting participants to consider their experiences as similar to that of a bus driver, driving a "bus of life", who has various "passengers" (emotions, thoughts, memories, urges, voices, etc.) travel with them during their journey. Participants are encouraged to reflect on their responses to these "passengers" (such as coping by giving in to bullying passengers) and whether these efforts enable progress in personally-valued directions. The group explores whether skills of openness (acceptance) are useful for valued actions. The metaphor is reflected across exercises and language used in the group, and brought alive in an extensive role-play exercise fostering skill development in mindfulness (*noticing*), acceptance and cognitive defusion (*willingness*) , and the use of personal values to guide choices and actions. Participants are encouraged to notice their internal experiences with curiosity and self-compassion. Both participants and facilitators are

invited to share their own experiences with the group. Between-session practice of exercises is encouraged and later reviewed.

Implementation

Engaging managers and key clinicians

To maximise implementation feasibility, we prioritised garnering support from managers and clinical teams at various community mental health sites belonging to a single government-run clinical mental health service. We provided managers with information and evidence on ACT for psychosis and engaged them in discussion around the need for a recovery focused EBI. Our pitch proposed groups be run within existing service resources and promoted as a professional development opportunity for key clinicians to act as facilitators. Information sessions were held in team meetings to increase understanding of ACT principles, outline the group, and explain inclusion criteria. During these sessions, key clinicians participated in an experiential exercise drawn from the group to increase their familiarity with group processes. These sessions acted primarily to recruit group participants, but also introduced the group structure to key clinicians who might be interested in becoming facilitators.

Recruiting, selecting and engaging participants

Flyers were placed in team workspaces and then facilitators repeatedly approached key clinicians to identify consumers on their caseload. Once a consumer expressed interest, an information and engagement session was arranged with a facilitator to confirm suitability, build rapport, and address barriers to engagement. The group was described to consumers as focusing on their wellbeing and personal recovery, rather than their mental illness. Consumers were also invited to participate in a program evaluation.

Consent was sought for facilitators to contact participants between sessions. This contact served to review their group experience, identify difficulties, promote out-of-session practice

of group activities, and encourage continued attendance.

Supporting facilitators

Consistent with O'Donoghue et al. (2018), both planned group supervision and peer consultation between pairs of facilitators conducting a group, guided local adaptation and ensured fidelity with the ACT model. Group supervision sessions were held during the preparation and conduct of each group, and prioritized during the planning phase and early sessions of a group. Sessions typically including facilitators from other sites and led by the local ACT experts. Between one and four sessions were held for each group depending on facilitator and supervisor availability. Group supervision was informal, providing peer support in building facilitation skills and addressing challenges. Consistent with ACT's emphasis on active learning, role-play with active reflection was central.

Group supervision focused on delivery of key ACT concepts in everyday language along with attention to pacing of material and use of repetition. Clarifying use of self-disclosure was another focus. Self-disclosure is used within ACT to illustrate processes and show that facilitators are also affected by challenging internal experiences, promoting common humanity (Westrup, 2014). Demonstration of facilitator self-disclosure intends to normalise the experience of internal distress and active sharing of personal experiences in the group.

Building in evaluation

We selected a mixed-methods study design to address research questions by contextualizing quantitative results and further understanding of implementation (Zhang, 2014). The study aims were to inform development of Recovery ACT groups into an ongoing program, and explore the feasibility of incorporating research. The Royal Melbourne Hospital's Human Research Ethics Committee approved the project (QA2015.151). We report here the qualitative facilitator feedback; quantitative results and qualitative consumer data will be reported separately.

From October 2015 to March 2018, 69 consumers enrolled in six groups at three sites within two NWMH services. Sixty consumers enrolled in the evaluation (first-time attendees); the majority were unemployed men (60%) in their early thirties (M=32.9, SD=10.5) with a primary diagnosis of schizophrenia or schizoaffective disorder.

Participants

Of the nine facilitators, eight (3 men, 5 women) consented to participate in the study. All facilitators were psychologists ranging in experience from postgraduate trainees (n=1) to qualified clinical psychologists with up to ten years' experience. Five interview sessions were conducted (one included facilitators from two separate groups); four were in-person and one by phone. Two facilitators led more than one group and participated in additional feedback sessions.

Procedure

Following each group all facilitators were invited to participate in a semi-structured reflective group. The reflective group was structured around an interview schedule eliciting feedback in five domains: adaptation; the engagement process; supervision and support; managing the organisational context; experiencing implementation. Standard prompts within each domain were followed. Written consent was sought. Interviews were audio-recorded and transcribed.

Data analysis

We followed Braun and Clarke's (2016) six phases of thematic analysis to evaluate facilitator responses as it is compatible with essentialist and constructionist paradigms in psychology. After transcription, interviews were uploaded to the R-Qualitative Data Analysis (RQDA; http://rqda.r-forge.r-project.org/) package. Our qualitative research lead (JG) used RQDA to become familiar the interview content, reading and re-reading each before generating initial codes. A process of systematically identifying and coding as many features

of the data that appeared relevant was conducted. Transcripts were re-read to recode any missing elements, and coded elements collated into potential themes.

All authors reviewed identified themes, iteratively on multiple occasions. The authors then met to further review internal consistency and theme appropriateness.

Results

The five domains of interest included: adaptation; the engagement process; supervision and support; managing the organisational context; experiencing implementation. Across these, we identified nine themes.

Domain 1: Adaptation.

Facilitators described the importance of adapting group content to the local context, to enhance participants' learning. Further adaptations to the group were also generated.

Theme 1: Enabling learning through repetition. Facilitators noted that restructuring the group to eight sessions allowed for repeated exposure to concepts, enhancing participant learning around three key ACT processes.

> *"…repeatedly coming back to just those two or three key concepts of mindfulness, willingness and sort of a values focus… really helped to meet the needs of why [participants] were there" (P5,G1&2).*

Theme 2: Future adaptations. Facilitators also identified ways to enhance structure and presentation.

> *"…be…more structured in how much time we want to be spending on each [PowerPoint] slide or each exercise, so that we don't end up crunching things down in the second half." (P5,G6).*

This included refining the local manual.

> *"Having a manual more specific to the service would be helpful because it was a bit messy for me [to cross reference with the UK manual]… the order of things just took me a little…organizing my mind" (P3,G3).*

Facilitators noted that introducing a structured workbook (to replace individual handouts) could further enhance participant engagement and learning.

> "*The homework sheets, I think people just throw them out, or gave them back to us. Having a formal book that people could go back and reflect on, is something they can take notes on and follow along with" (P4,G1&2).*

Domain 2: The engagement process.

Engagement of both participants and key clinicians was perceived as essential in effective recruitment to the group by facilitators.

Theme 1: Investing in consumer engagement. Initial engagement meetings with prospective participants provided a space to address barriers to participation.

> *"The pre-group meetings with consumers [were] very important to gauge their level of motivation and to problem solve barriers to attending the group" (P4,G1&2).*

These meetings also allowed participants build rapport with facilitators and feel supported to attend.

> *"… [participants] to get to know us as facilitators, that it's not so daunting. I remember one participant saying, promise you're going to wait for me outside, I don't*

want to enter by myself" (P4,G1&2).

Theme 2: Investing in clinician engagement. Facilitators identified that engaging with key clinicians was also essential.

"We both worked diligently meeting key clinicians one-on-one, sitting down, and going through their case lists, …. following up with them on multiple occasions" (P5,*G6*).

Engaging key clinicians involved "showing" rather than just "telling" – a core ACT group principle (O'Donoghue et al., 2018).

*"The Passengers on the Bus thing we did in the [key clinician] meeting was a very effective tool for getting [key clinicians] thinking about getting [consumers] involved" (P7,G*1&2).

Domain 3: Supervision and support.

Development of facilitator skill and confidence through expert-led group supervision, and peer consultation was identified as key to successful implementation of the group (facilitator dyads typically comprised of an experienced Recovery ACT facilitator supporting a new facilitator). Three themes identified effective processes.

Theme 1: Accessing proximal help via peer consultation. The proximal support of co-facilitators allowed for rehearsal (pre-group) and reflection (post-group), enabling fine-tuning of skills as groups progressed.

"It was really helpful [meeting with my co-facilitator] before the groups… I … practiced things out and [I] got feedback... After the groups, we usually had a chat about reflections of the group and what we're going to do next time." (P3,G3).

Theme 2: Learning the ACT Style. Group supervision led by experts in ACT for psychosis was a core means of building familiarity with the group's style, particularly from an ACT-consistent perspective.

"Having the practice in the lead up to the groups starting, running through the group content, focusing on the language we would use, trying to be ACT-consistent. I found that very helpful" (P4,G1&2).

Theme 3: Experiencing ACT-consistent supervision. ACT-consistent group supervision led by ACT experts promoted acceptance and normalised challenges in presenting group content.

"It's helped me become a bit more natural in how I present metaphors … which is always something I felt that I struggled with" (P1,G5).

Facilitators also recognised the importance of group supervision in re-evaluating personal expectations about leading groups with managing the demands of being a key clinician in public mental health.

"I remember feeling a little bit disorganized before each group and I wasn't prepared as I could be. And the [supervisor] response to that was, 'Well yeah - you work in public mental health, no shit! You've got other things to be doing. I don't expect you to be perfectly prepared'… that was so relieving to hear" (P5,G3).

Domain 4: Managing the organisational context.

One dominant theme, *Managing the organisational context,* reflected the variable experience of working with management. Some facilitators felt a tension from management

about the addition of the group to their core roles.

"I certainly had to argue fairly strongly to be able to co-facilitate the group… Because it was seen as a detraction from my general key clinician activities." (P6,G6).

However, this was counter-balanced by others' experience, who perceived management supported new initiatives.

"I think managers are always looking for new initiatives and new ways to demonstrate the work of their team and the value of what we do, and I think having this as a new initiative, as something that has garnered attention around NWMH has been positive for our manager" (P5,G1&2).

These differing perspectives captured the ambivalence experienced by facilitators when working with management, finding that although managers were supportive of novel interventions, facilitators felt constrained by service demands to meet core clinical tasks.

Domain 5: Experiencing implementation.

Three themes were identified relating to the rewards and challenges of implementation.

Theme 1: The rewards of shared experience. Facilitators noted the process of group participation promoted shared humanity. It was rewarding to contribute (where appropriate) their own experiences, and noticing others sharing and developing.

"Most rewarding [was]…an opportunity to share experiences and see people share experiences" (P2,G4).

and,

"There [were] a lot of moments, especially early on of "Oh my god, you too"...That sort of progressed into group members providing support to each other and normalising each other's experiences and comforting each other." (P1,G5).

Further, noticing participants actively use concepts discussed in group was gratifying.

"Seeing them make changes in their lives, actually using the concepts we were teaching them and then internalizing them and using them to make changes, it was just incredible to see" (P2,G5).

Theme 2: The challenge of tuning into group dynamics. Facilitators recognised a tension between letting participants drive group discussions and assuming a more active style to encourage sharing by more reluctant participants. This meant being aware of participants' varied needs, and the interplay between group members.

"The importance of, from the get-go, being aware of who's more likely to be sharing and giving them space to, but also being a little bit more proactive in… providing the space for others to participate, so it doesn't become so imbalanced" (P5,G6).

Theme 3: Accepting gradual and variable change. At times, facilitators found it difficult to adjust their expectations of change and recognise each participant came with their own challenges, and for some, just turning up to sessions was meaningful. Sitting with moments when there appears to be little change was important, rather than intervening.

"Accepting that what might look like no progress to us, might be very significant progress to them, keeping in mind how significant it is just being willing to be in a group space, and for them to be sharing" (P5,G3).

Discussion

This study describes implementation of a group-based ACT program designed to support the personal recovery of people living with psychosis and reports a thematic analysis of facilitator reflections on the process. Our grassroots, clinician-led effort resulted in nine facilitators over a 2.5-year period conducting six groups. Analysis of reflective facilitator interviews indicated that: local adaptations promoted participant learning and a multi-faceted engagement process with all stakeholders nurtured implementation. A key enabler of program implementation and evaluation was engagement of local experts in research and ACT. A need for continued organisational support for program implementation was identified. This evaluation adds to evidence that recovery-focused ACT groups for people living with psychosis are acceptable and feasible to implement (Johns et al, 2016), as well as literature on implementation of EBIs in public mental health settings.

Adaptation

Facilitator feedback highlighted the benefit of adaptations to an existing program to suit consumer needs. In particular, adding sessions was perceived to enhance participant learning of concepts through increased repetition. These observations are consistent with a review of EBI implementation that found strict intervention fidelity may be at odds with effective implementation in real-world settings (Aarons et al., 2017). Although such change arguably reduces fidelity, we contend that this process sensibly utilises professional judgements and is best understood within dynamic models of EBI sustainability in public health care (Shelton et al., 2018), where ongoing adaptation in response to changing contextual influences is considered central to implementation success.

Implementation

Intentional engagement of all stakeholder groups—experts, managers, facilitators, key clinicians, consumers—appears central to the successful program implementation.

Access to research and clinical expertise particularly enabled implementation. Availability of an in-house Academic Unit and recruitment of research experts overcame barriers to clinician-led research (Sahs et al., 2017). This support reduced the time demand on facilitators and increased credibility, likely boosting managers' willingness to approve the group and its evaluation.

Another finding reinforces earlier observations that implementing and formally evaluating new interventions is most successful when the clinicians involved play a significant role in planning and execution (Sahs et al., 2017). Regular meetings between facilitators and experts drew upon one another's knowledge and experiences, highlighting the value of reciprocal learning. Program implementation into a real-world context necessitated research guidance, organisational knowledge, and familiarity with the consumer population. While research experts facilitated study design, clinician/facilitators informed local adaptation and implementation strategies. Such collaboration can minimize implementation delays and maximise uptake, as local realities and opportunities are considered from the beginning (Sahs et al., 2017).

Access to expert-led group supervision promoted facilitator engagement. Supervision prior to and during implementation led to timely perceived competence and fidelity in our facilitators' provision of Recovery ACT, effectively addressing the common barrier of low practitioner confidence, even after training (Ince et al., 2016). More broadly, the collaboration between facilitators and experts stimulated interest from key clinicians to become facilitators and utilise the embedded opportunities for practice-relevant clinician development, and involvement in formal evaluation (Sahs et al., 2017; Shelton et al., 2018).

In the local service system, key clinicians function as "gatekeepers" for supports and interventions. Therefore, addressing the potential barrier of clinician "buy-in" (Sahs et al., 2017) was seen as essential to consumers becoming aware of, attending and remaining

engaged with the group. Meeting presentations which involved clinicians participating in a brief experiential role-play brought alive the nature and potential of the group, while time invested with key clinicians one-on-one to discuss group content and consider potential participants prompted referrals. Both engagement strategies seemed effective. Having a multi-faceted strategy for engagement of consumers also contributed to successful implementation, most notably, the pre-group individual engagement session and between-session contacts.

Jolley (2018) and Ince et al. (2016) emphasise the need for organisational support is vital as without sufficient time, staffing and training, implementation of EBIs is poor. Although management were supportive of new initiatives generally, this did not extend to additional financial investment or a reduction of caseloads, an unexpected observation. However, we found that an intervention perceived to be stimulating and rewarding for facilitators overcame these hurdles. Our interviews show facilitators were rewarded by witnessing the learning and development amongst participants, and in themselves as facilitators, through the experience of noticing their "shared humanity". Moreover, we argue that facilitators' experiences reflect several therapeutic group factors described by Yalom and Leszcz (2005): universality, installation of hope, interpersonal learning, group cohesiveness, and altruism.

Limitations and future directions

The clinician-led nature of this evaluation means that the data reporting and interpretation were done by those who were also central players in the processes being studied, bringing with it a risk of self-serving bias. Furthermore, the facilitator feedback interviews were not individual and anonymous, but occurred in a peer group setting, potentially constraining the sharing of difficult matters by those who consented to participate. Nonetheless, mitigating factors are likely to have been the structured processes of thematic

analysis, the familiarity of peer reflection settings to all facilitator-participants, and the enabling presence of research experts who led the feedback interviews, and oversaw the study.

The absence of perspectives from key clinicians and management, the former who serve as gatekeepers to consumers and the latter to organisational resources, limits our understanding of these processes and possible solutions. Including these perspectives in future evaluations may strengthen sustainable implementation of Recovery ACT.

Although consumer perspectives of the group experience were collected (and will be reported elsewhere), only brief feedback related to group development, implementation and sustainability was sought and another method of data collection used (not audio-recorded). Involvement of consumers or other experts-by-experience in future development and evaluation of the group is recommended. Additional future directions include training other experts-by-experience as co-facilitators, and promoting Recovery ACT directly to consumers to bypass misguided gatekeeping.

Conclusion

Group ACT for recovery from psychosis is an EBI that was successfully adapted and implemented in an Australian public mental health service. A qualitative analysis of facilitators' experiences identified that local adaptations improved participant learning, and successful program implementation hinged on a multi-faceted engagement strategy, particularly collaboration with local experts for supervision and research support. Future sustainability of Recovery ACT groups in these public mental health settings should prioritise further engagement of management and organisational support, and involvement of other experts-by-experience in further adaptation and facilitation.

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