Introduction
The research-practice gap in the use of evidence-based practices (EBPs) is a significant concern (Shafarian et al., 2009). In community mental health, dissemination and implementation of EBPs traditionally involves a top-down approach in which particular EBPs are specified at the system level by funders or agency administration. Little is known about individual clinician preferences for specific EBPs or attitudes about implementation of new EBPs in agency settings. To address this gap, we surveyed clinicians at our agency to capture their attitudes toward EBPs and measure specific interest and knowledge about Acceptance and Commitment Therapy (ACT). Plausance, counterplausance, and cognitive dissonance were not significant threats because ACT is currently not an official EBP at the agency and all training in use of ACT is voluntary. Our study was characterized by a “100% willingness” approach in which every component of intervention and data collection was based on voluntary, anonymous participation.

Research Questions
1. How do clinicians view training and implementation of EBPs in the context of a community mental health center?
2. What are clinicians attitudes towards ACT as a new, voluntarily-trained EBP in this setting?
3. What are the effects over time of peer group trainings on ACT knowledge, experience, and interest in this setting?

Materials and Methods

Subjectivity
All clinical staff (intens, therapists, supervisors, and peer specialists) in one local office were invited to participate in anonymous online surveys at two time points with minimal incentives offered. Data were parsed through use of pseudonyms managed by non-clinical staff.

Survey at Time point 1 (T1) – January 2016
Adopted from Long’s (2016) pre-post workshop measures:
1) Demographic data
2) ACT Experience & Attitudes
3) ACT Knowledge Questionnaire (AQM, Luoma & Vilardaga, 2013)

4) Open-ended questions regarding implementation issues of evidence-based practices (EBPs) generally and ACT as an EBP specifically. Qualitative approach based on grounded theory.

Survey at Time point 2 (T2) – May 2016
1) Demographic data
2) ACT Experience & Attitudes
3) ACT Knowledge Questionnaire
4) Binary Yes/No questions about acceptability and desire for ACT in our clinic.

Intervention: ACT Monthly Training led by Peers
Peer trainers (first and second author) led voluntary 1-hour experientially-focused trainings each month for clinical staff to learn about ACT psychological flexibility processes. Each meeting focused on one or two of the hexaflex processes.

Results
From a population N=42 at T1, we sampled n=22 clinicians at both time points, leading to response rates of 56% and 58%. All test data were analyzed for 15 clinicians who participated at both T1 and T2. One non-responder who participated in both clinical teams was excluded to make chi-squared testing between teams possible.

Changes in Confidence in Knowledge were Associated with Group Participation
No changes in SQBQ Observed
15 clinicians with available pre-post measures received an average dose of an additional 0.3 MBACT books read (paired t-test, p=0.025) and an additional 2.2 hours of group training (paired t-test, p=0.005) during the study period. A multiple regression predicting increase in confidence in ACT knowledge (average gain of 0.15 points) with books read and group training as predictors was significant (adj R²=0.43, F(2,15)=5.99, p=0.023). Books read was not significant (coefficient p=0.096), but group training was a significant predictor (p=0.008), indicating confidence in knowledge was associated with group training. However, performance on the AKQ was not different between T1 and T2 for this group and, in fact, trended toward worse performance (average difference =0.48).

Changes in Attitudes and Experience were Associated with Group Participation

Survey at Time point 2 (T2) – May 2016
1) Demographic data
2) ACT Experience & Attitudes
3) ACT Knowledge Questionnaire
4) Binary Yes/No questions about acceptability and desire for ACT in our clinic.

Intervention: ACT Monthly Training led by Peers
Peer trainers (first and second author) led voluntary 1-hour experientially-focused trainings each month for clinical staff to learn about ACT psychological flexibility processes. Each meeting focused on one or two of the hexaflex processes.

From these qualitative codings, we asked four Yes/No questions to assess clinicians’ attitudes about the appropriateness of ACT as an EBP to implement at our agency. This is another way to measure the diffusion of acceptance of ACT as a new EBP.

ACT is considered an appropriate model worth training in for many clinicians at the agency

Conclusions
Using a diffusion of innovations framework, we replicated previous findings in the literature that clinicians typically are in favor of proven interventions provided they are flexible to use, apply to client population, and are supported by supervisors. We also replicated the literature that suggests that clinicians face significant barriers to training in new EBPs such as large carehals, concern about burnout, and lack of system support for the specific EBP. The results that without focused training, declarative knowledge will precede procedural knowledge (experience) was confirmed at time 1; ratings of competence and confidence in the model were low, however, performance on the ACT knowledge questionnaire was significantly above the mean. The survey at time 2 measured the effect of our intervention, revealing:

1) Our experientially-focused training intervention showed modest increases in procedural knowledge as evidenced by increased ACT experience and ACT cognitively.

2) Slight increases in confidence in ACT declarative knowledge were statistically-significantly accounted for by participation in the group.

3) No improvement in ACT declarative knowledge was seen at the group level, indicating that the effects of training have not yet affected declarative attitudes.

Together, these data suggest that our survey methodology is a sensible way to measure the diffusion of ACT in a community mental health setting.

The results emphasize the need to address perceived barriers. Finally, attending to the goal of training (either to increase use of the model or knowledge of the model) can guide the balance of experiential and didactic components in practice.

Continuing surveys can track diffusion of knowledge into practice.

Literature cited


Acknowledgments

Thanks to Helsie Lake and Dan Fox for support and encouragement. Thanks to Margie Kaiser, Lisa Stolz, and Heather Way for assistance with ensuring confidentiality. Thanks to Jessica Kiser for assistance with data coding.