Implementation of ACT in Sweden

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A study commissioned by the Swedish Board of Health and Welfare

- To investigate the implementation of the national guidelines for psychosocial interventions
- The diversity of interventions in the guidelines gives methodological challenges
- Surveys of county councils and municipalities are unreliable
- For practical reasons few interventions were studied

ACT and IPS were choosen

- **Internationally established and evidence based interventions**
- **Highest priority in guidelines**
- **There is a need for activities from both social service, social insurance, health care and work agencies to establish the services**

Aim

- **The overall aim was to investigate to what extent the interventions could be implemented into the Swedish welfare context and:**
- **identify factors of importance for the process**
- **describe the outcomes for services and clients**

Fields to investigate

- Strategies on a national level
- Factors of importance on a local organizational level
- Factors of importance for providers
- Strategies for continuous support
- Achievements in program fidelity
- Outcomes among clients

ACT in Sweden

- **Mapping of CM-services showed that different kinds of clinical CM exist but only one service had preconditions to establish ACT with program fidelity**

- **Single case study of one team**

Context for the team

- **The city of Malmö – 304 000 inhabitants**
- **With surroundings – 664 000 inhabitants**
- **Twenty minutes by train to Copenhagen**
- **Largest proportion of persons with migrant background in Sweden(41%)**
- **Low median income (place 281 out of 290 among Swedish municipalities)**

Background for ACT

- **The city has about 800 homeless people and among them 25% suffer from severe mental illness with or without drug abuse**
- **High pressure on social service and psychiatric emergency wards**
- **Fragmented service system with different authorities for health care and social service – different laws, traditions and knowledge**

Implementation

- **Planning group with members from the psychiatric department at the University hospital, municipality social service/local psychiatric service and Lund University**
- **Planning 2010 – 2011**
- **Very high ambitions to create a team**
- **Team leader recruited during autumn 2011**
- **The team started 2012 and accepted to participate in the study**

Method

- **Prospective mixed-methods-design**

- **Qualitative interviews with key-persons**
- **Structured assessments of program fidelity (TMACT)**
- **Register data, and qualitative interviews (ACT)**

Analysis of the implementation process

- **Assessments based on literature review:**
- **Factors at the system level (7 domains)**
- **Factors at the local organizational level (12 domains)**
- **Factors at the provider level (7 domains)**
- **Strategies for continuous support (5 domains)**
- ***Assessments 1=not at all, 2=to some extent, 3=to a large extent***

(Damschroder et al 2009, Durlac & DuPre 2008, Fixen et al 2009, Meyers et al 2012)

ACT at the system level

- **Strong evidence base and high priority in guidelines**
- **Consensus in national policy documents for integrated interventions**
- **Legislation on agreements between social service and health care for individuals in need**
- **The concept of integrated care well established but uncertainty about the possibilities for implementation**

ACT at the local organizational level (I)

- A distinct need for ACT (3)
- Some experience of outreach (3)
- The model supported both by health care and social service (3)
- Experience of program development (3)
- Experience of cooperation between authorities (3)
- Strong and independent steering committee (3)

ACT at the local organizational level (II)

- Access to expertise (3)
- Strategy for sustainability based on political decisions (3)
- Accurate recruitment of team members (3)
- Support from authorities involved (3)
- Misfit between ACT and the organization (2)

Misfit between ACT and the organization?

- **Social workers are not authorized to make decisions**
- **Different trade unions, different agreements**
- **Problems with documentation of confidential information**
- **Team members with different superiors**
- **Team leader without formal leader position**
- **Several town district committees**
- ***Things work because of good will among managers***

Factors on the provider level

- Staff with adequate competence (3)
- Team leader dedicated to ACT (3)
- Creation of awareness of ACT (3)
- Education and training in ACT (3)
- Cooperation with stake holders (2)
- Feed back to financiers and decision makers (2)
- Continuity (2)

Cooperation for facilitation

- **Positive development of the cooperation with psychiatric units, especially inpatient care**
- **No regular contacts with social service around individuals in care**

- **Difficulties finding ways to work with people in sheltered housing**

Continuous support

- **Supervision (3)**
- **Repeated fidelity assessments (3)**
- **Time for reflection (3)**
- **Technical and administrative support (2)**
- **Reaching the right target group (3)**

The implementation process, summary

- **Total score = 69 (max 75), in comparison, the best units for IPS reached 65,5**
- **Most ingredients for successful implementation were in place**
- **The organizational preconditions were especially favorable**

Program fidelity (TMACT)

- Operations & Structure, 11 domains
- Core Team, 7 domains
- Specialist Team, 8 domains
- Core Practices, 8 domains
- Evidence-Based Practices, 8 domains
- Person-Centered Planning & Practices, 4 domains

Program fidelity at 6,18, 24 months after start >4 = high pf

	6 months	18 months	24 months
Operations & Structure	3,9	4,2	4,6
Core Team	3,3	4,4	4,0
Specialist Team	2,6	4,2	4,9
Core Practices	3,6	4,0	4,0
Evidence-Based Practices	3,6	4,1	4,4
Person-Centered Planning & Practices	2,2	3,2	4,2
Index	3,2	4,02	4,35

Explanations for the development of program fidelity

- Improved team work, more shared case load
- Stable psychiatrist function
- Staff taken on identity and responsibility as specialists
- Individual planning improved to a large extent
- Administrative resource in place

Not achieved in program fidelity

- **Insufficient responsibility for crisis service**
- **Limited possibilities to intervene in housing and other interventions connected to social service**
- **Insufficient administrative resource**

Client evaluation

- **In-patient care before and during ACT**
- **Objective social outcomes index (SIX), (work, housing, family, friends)**
- **Qualitative interviews with participants (n=11)**

Patients during the study period (n)

- **Assessed = 100**
- **Excluded = 26**

Motivation – not suitable = 4, no need = 11

not reaching criteria = 11

Admitted = 74

Discharged = 17, reasons: never met = 2, transferred to other care = 6, refused contact <9 months = 8, deceased = 1

In treatment = 57

Patient follow up (n=34)

- **Demography:**
- **Men: 28, women: 6**
- **Age: median 45 year (m 43,7, 24 – 68)**
- **Diagnosis: Schizophrenia-spectrum disorders**

Changes in in-patient care (n=34)

One year fp	Mean	Total	Cost (euro)
n = 14	-32,6	-456,4	-232 383
Two year fp			
n = 20	-19,5	-390	-198 574
Sum		-846,4	-430 957

Changes in in-patient care (n=32, outliers excluded.)

One year fp	Mean	Total	Cost (euro)
n = 13	-41,9	-544,4	-277 210
Two year fp			
n = 19	-26,9	-511	-260 234
summa		-1055,4	-537 444

Contacts with social service

- **18 out 34 were known by social service**

- **Few persons consumed the majority of resources**

Objective social outcomes index (SIX)

- **Work: unchanged, no work before or after**
- **Housing: a small worsening situation but homelessness and sheltered living are rated as equal in the scale**
- **Family situation: unchanged**
- **Friends: Small insignificant improvement**

Results show a stable low functioning, no significant changes

Result from the qualitative interviews

- Practical support in daily living most important for establishing contact
- Perceptions of being treated in a kind manner
- The availability to the team resources were surprising and appreciated
- Gratefulness for being taken seriously

Conclusion

It is possible to implement ACT in the Swedish welfare system

Factors of importance:

- **A well prepared planning of the implementation with high competence in the steering committee and a strategy for sustainability**
- **Careful recruitment of staff and a strive for program fidelity**
- **Major obstacles were the administrative borders between authorities**

Thank You for Listening

BS, UM, MB, UB