Implementation of ACT in Sweden

Bengt Svensson, Lund University
Urban Markström, Umeå University
Magnus Bergmark, Umeå University
Ulrika Bejerholm, Lund University
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*

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

- 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

<table>
<thead>
<tr>
<th></th>
<th>6 months</th>
<th>18 months</th>
<th>24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations &amp; Structure</td>
<td>3,9</td>
<td>4,2</td>
<td>4,6</td>
</tr>
<tr>
<td>Core Team</td>
<td>3,3</td>
<td>4,4</td>
<td>4,0</td>
</tr>
<tr>
<td>Specialist Team</td>
<td>2,6</td>
<td>4,2</td>
<td>4,9</td>
</tr>
<tr>
<td>Core Practices</td>
<td>3,6</td>
<td>4,0</td>
<td>4,0</td>
</tr>
<tr>
<td>Evidence-Based Practices</td>
<td>3,6</td>
<td>4,1</td>
<td>4,4</td>
</tr>
<tr>
<td>Person-Centered Planning &amp; Practices</td>
<td>2,2</td>
<td>3,2</td>
<td>4,2</td>
</tr>
<tr>
<td>Index</td>
<td>3,2</td>
<td>4,02</td>
<td>4,35</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th></th>
<th>One year fp</th>
<th>Mean</th>
<th>Total</th>
<th>Cost (euro)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 14</td>
<td></td>
<td>-32,6</td>
<td>-456,4</td>
<td>-232 383</td>
</tr>
<tr>
<td>Two year fp</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 20</td>
<td></td>
<td>-19,5</td>
<td>-390</td>
<td>-198 574</td>
</tr>
<tr>
<td>Sum</td>
<td></td>
<td></td>
<td>-846,4</td>
<td>-430 957</td>
</tr>
</tbody>
</table>
## Changes in in-patient care (n=32, outliers excluded.)

<table>
<thead>
<tr>
<th></th>
<th>One year fp</th>
<th>Two yearfp</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n = 13</strong></td>
<td>-41.9</td>
<td>-26.9</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-544.4</td>
<td>-511</td>
</tr>
<tr>
<td><strong>Cost (euro)</strong></td>
<td>-277,210</td>
<td>-260,234</td>
</tr>
<tr>
<td><strong>Summa</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cost (euro)</strong></td>
<td></td>
<td>-537,444</td>
</tr>
</tbody>
</table>
Contacts with social service

- 18 out of 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