“Deplyfttet”
Design and outcome of a programme to implement the Swedish National Guidelines for Depression (2010) in child and adolescent psychiatry

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The gap from bench to bedside is huge

There is a 15-20 year gap from best evidence in research to clinical practice

Boren BE (2000) Yearbook of Medical informatics: Managing clinical knowledge health care improvement

Mental health is probably in an even worse condition and a only minority of patients receive care that meets minimal standards.

Grol 2001; Kazdin 2017

In Sweden, treatment in child psychiatry is generally based on therapist preferences but not on diagnosis and evidence.

National Board of Health and Welfare, 2009
Transforming the National guidelines to a clinical guideline and a manual

National guideline (NBHW)
- To managers
- For Prioritizing among interventions

Clinical guideline (SFBUP)
- To practitioners
- For bedside use
- Stepwise care, evaluation & treatment
- Algorithms
- Check lists

Manual for basic care (Deplyftet)
- Evaluation
- Treatment planning
- Treatment modules
- Evaluation
- Suicide assess
How do we make the leap from the guideline to the patient?

Implementation research…”the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices …to improve the quality of health care.

Studies on implementation in psychiatry are scarce and very far behind health care in general

Eccles et al 2009

Powell 2014
Implementation strategies

- **Discrete**
  - =do little
  - Just one single intervention
  - Ex. workshops, send out manuals

- **Multifaceted**
  - =do better
  - Combining <1 discrete interventions
  - Ex. training+audit

- **Comprehensive**
  - =do best
  - Multiple strategies
  - Implementation package
  - Ex. rehearsal, facilitate, feedback

Powell 2012
Meta-analysis of teacher training

Joyce & Showers, 2002
Taking the manual to the office

- **Pocket size outlines**
  - To aid adherence

- **Work sheets**
  - To aid in task performance

- **Videoclips**
  - Role play w feedback
  - To demonstrate a session

- **Sit ins**
  - To give feed back and advice
How to design effective implementation?

Fixsen et al model and our adaptations

How to design effective implementation?

Grol & Wensing (2013) model

Make a plan for change
Analysis baseline + setting
Develop strategies
Action
Integration
Evaluation and modification
Determinants to outcome of implementation

Intervention | Clinician | Patient | Inner setting | Outer setting | Implementation

Consolidated Framework of Implementation Research (CFIR)

Pilot study

Study sample
Site 1-2-3-4
Deplyftetsyrets national outreach

Study sites = pilot clinics
First wave
Second wave
“Home” clinics för Deplyftet
Method: Evaluating "Deplyftet" through the RE-AIM framework

<table>
<thead>
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<th>Qualitative Q</th>
<th>Quantitative data</th>
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<td>Dep identified?</td>
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<td>Recruit patients?</td>
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Forman 2017
Method: Qualitative interview

Research psychologist, team phone interviews with RE-AIM Q

Site 1, leader+clinician, 47 min
Site 2, leader+trainer+clinician, 68 min
Site 3, leader+trainer+clinician, 50 min
Site 4, leader+trainer+clinician, 80 min
Deplyftet team, educator +leader, 88 min

Verbatim transcribed, qualitative content analysis with a deductive approach (HJ) of barriers & facilitators in the RE-AIM dimensions. Co-assessor (IL).

Hsieh & Shannon 2005
Results by RE-AIM dimensions

Green text = Facilitators
Red text = Barriers

In boxes = our adjustments
1. Reach: Share of depressions to subunit

Summary of sub-unit share of depressions
- Site 3+4 did well but fell last ½ year
- Site 1+2 never established a stable sub-unit
1. Reach - qualitative analysis

- **Reach**
  - **Intervention Diagnostic tool**
  - **Clinician**
  - **Patient**
  - **Inner**
    - **Intake tool**
      - Leader support
      - **Staff turnover**
      - L non-support
    - **Overload & pressure from demands**
  - **Outer**
    - Implementation
      - Inexplicit info on resources needed and on leadership
  - Improved info + more trainers are recruited

Green text = Facilitators
Red text = Barriers
2. Effectiveness - qualitative analysis

Effectiveness

Intervention
- Clear manual
- Clear core theme
- Parental involvement

Implementation

Outer
- CAP overloaded

Inner

Clinician
- Unfocused
- Not able to sell model

Patient
- Supportive environment
- Poor parenting/school
- Comorbidities, trauma and long duration

Standards clarified to be a trainer/clinician

Green text = Facilitators
Red text = Barriers
3. Adoption: number of trainers/clinicians included and approved.
3. Adoption - qualitative analysis

Implementation
- Pedagogic method, program clarity, feedback
  No info on requirements to pass,
  Sit-in by unfamiliar person

Intervention
- Clear manual & time line

Clinician
- Unsuitable person chosen

Patient
- Too complex patients

Inner
- Supportive leaders+ colleagues+ team
  Staff turnover, leaders passiv, change of leadership, poor triageing

Outer
- Standards clarified
  Sit-in only by known teachers

Number of Trainers increased

Green text = Facilitators
Red text = Barriers
4. Implementation: Quality indicators in records - anhedonia

Summary anhedonia
- Low quality before start
- Good quality during Deplyftet without change over time
4. Implementation: Quality indicators in records - mania

Site 1-2-3-4
Before start (2014)

All sites during implementation

Summary mania
• Extremely low quality before start
• Slow improvement during Deplyftet with acceptable quality at the end
4. Implementation: Quality indicators in records - suicide attempts

Summary suicide attempts
- Low-acceptable quality before start
- Good quality during Deplyftet and improvement over time
4. Implementation: Patient/Parent feedback forms collected

- Site 1: 10
- Site 2: 20
- Site 3: 30
- Site 4: 30

Legend:
- site 1
- site 2
- site 3
- site 4
4. Implementation - qualitative analysis

**Intervention**
- Manual clear & flexible,
- Useful modules on parents, activation & sleep
- Too short and time restricted

**Implementation**
- Sit ins & pedagogic model
- Locally too short education & a site without sit-ins

**Clinician**
- Prefers "deep" talks

**Patient**
- Preference for meds or individual sessions only.
- Complex patients & high levels of conflict.

**Outer**

**Inner**

**Expanded cascade**
+1 day
Sit-ins mandatory + increased to 4

Green text = Facilitators
Red text = Barriers
5. Maintenance: number of trainers/clinicians active
5. Maintenance - qualitative analysis

- **Intervention**
  - Clear & generic model that fits in all CAP evaluations and suicide assessments, work sheets and hands on material

- **Implementation**
  - Training methods, data feedback & local project team

- **Clinician**
  - Depressions can be too heavy on the clinician

- **Patient**

- **Outer**
  - Overload and too many ADHD referrals

- **Inner**
  - Leadership drives, recruits resources & take model into education and meetings
  - Staff turnover and low priority from leadership

**Continuous dialogues with leaders over the 3 years added**

**Green text = Facilitators**
**Red text = Barriers**
Conclusions

• A **manualised model** for assessment and treatment in CAP was feasible and ecologically well suited.

• A **comprehensive implementation with hands-on training and leadership engagement** was perceived as very supportive. The cascade format seemed to work.

• The mode of implementation needed continuous adaptations, problem solving and dedication.

• **Staff turnover and external stress and overload** on clinics was a major challenge and threat to implementation, which was in jeopardy at the final stages.

• Sites with a **clear focus from the leadership** did better. The site that secured resources in spite of other demands clearly did best in maintaining the model.