Norrbotten, Sweden: Care process schizophrenia and schizophrenia-like state

Part 1: General Information

Publication on EIP on AHA Portal	Yes
Copyright	Yes
Verification of the Good Practice	No
Evaluation of the Good Practice	Yes
Type of the Good Practice	Promising practice

Part 2: Description of the Good Practice

Name of the Good Practice	Care process schizophrenia and schizophrenia-like state
Short name (Acronym)	Care Process Psychosis
URL of the Good Practice	Not available
Geographical scope	Local level
Country	Sweden
Region(s) involved	The County Council of Norrbotten, Gallivare
Status of the Good Practice	On-going
Stakeholders involved	• Hospitals • Specialised physicians • Primary care centres • General practitioners • Nurses • Home care centres
Size of population covered	100-249
Targeted audience	Irrelevant
Summary of the Good Practice The group of patients with schizophrenia and schizophrenia -like state with varying disabilities with mental and somatic illness. The patient group should be offered early intervention and professional treatment by a health care programs that support. Intervention will be symptoms and function-oriented. Provide medical treatment and psychosocial interventions. A clear and documented care plan must be drawn up jointly and evaluated.	
Key words: participation, cooperation, equal treatment	
Good practice being part of the larger programme	

Yes. Deleted from the National guidelines for schizophrenia and schizophrenia -like state .
Challenges / problems addressed by the good practice Improvement work based on the patient's needs and aims to see the whole person, not just the person's mental illness. It's a big problem with unemployment, inactivity, isolation, poor diet, high use of alcohol and tobacco among people with mental illness. This leads to increased mental and somatic illness.
Importance of the challenges / problems before starting to implement good practice It is difficult for psychosis patients to get the support they need, often they answer not on the phone, do not open mail, etc. and then usually ends caregivers to contact them. They are usually a question of resources, and these patients are at the bottom of the priority although they are a priority group with a poor quality of life and with recurrent relapses of the disease.
Environment before the good practice was implemented Vagueness of patient contributes to poor structure and division of responsibilities between health and medical care providers. The patient was referred to various parties without holistic perspective. Poor collaboration between health care providers.
Key innovative elements of the good practice and how the good practice improved situation compared to previous practice Collaboration with health care "neighbours", inpatient care, local authorities and primary care is getting better and the patient's needs are more in focus.

Part 3: Transferability of the Good Practice

Cost-effectiveness of the good practice (including all kind of costs and outcomes such as better health, quality of life or other resources)	Equal costs, improved outcomes
Resources required for the deployment of the good practice (personnel, equipment, facilities, ICT and other resources required. It requires staff training, to health neighbours such as primary care, community care, with more to gain understanding of these patients and their need for individual action. We can do it but need staff who can devote time to training to healthcare neighbours. Joint educational efforts for patients and relatives.	
Total budget of the Good Practice	Not available.
Source of funding	Local funding
The main actions that have to be done to deploy the Good Practice	

• Implementation • Training own personnel and healthcare neighbours • Get understanding what the disease does to the individual and how it affects the individual as well as the approach staff should adopt in relation to this group of people with mental illness
Issues during the implementation of the Good Practice • Poor understanding of the patient group's problems (healthcare neighbours). • Lack of follow-up meetings. Recurring relapses of the disease with inpatient hospitalization of medication interruption caused by medication interruption • Lack of social action in terms of housing, employment. • Lack of social action in terms of housing, employment.
Additional resources required to scale up Good Practice Yes. Several health care providers with adequate training and/or experience.
Basis to support sustainability of the Good Practice Consensus of all concerned health care providers.
Evidence to observe the Good Practice A home page is under construction.

Part 4: Viability assessment of the Good Practice

Time needed to deploy the Good Practice Between one year and three years. Meetings with health canters and municipalities are in progress in our catchment area, four meetings are planned with the municipalities aiming to start up a collaboration and enter it into the on going process.
Investment per citizens / patient / client in terms of financial resources No available calculation.
Evidence behind the Good Practice Apparent evidence. Evidence is based on qualitative success stories. The method is based in the Swedish national guidelines.
Maturity of the Good Practice The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.

Continuation is planned with primary care and municipalities and we have agreed with health care neighbours that integrated care gives better results for the patient .We must conduct common procedures and checklists to support patients with mental illness. An important group is young patients and how we identify those in the early stages where psychosis is present and quickly offer these persons interventions/treatments to prevent chronic conditions.
Estimated time of impact of the Good Practice Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began.
Impact observed Better quality of life (societal). Other alternatives imply: Better health (societal) Better quality of life (societal) Less isolated people (societal) Increased sense of security (societal) Better care integration (economic and societal) Less hospital re-admission (economic) Shorter stay in hospital (economic) Better health (societal) Better quality of life (societal) Less isolated people (societal) Increased sense of security (societal) Better care integration (economic and societal) Less hospital re-admission (economic) Shorter stay in hospital (economic) creation of jobs or SMES, or growth of local companies.
Transferability of the Good Practice Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Part 5: Your organisation

Name of the organisation	The County Council of Norrbotten, Gallivare
Address of the organisation	Psykiatrin Källgatan 14 982 34 Gällivare
Type of organisation	Hospitals
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