

Health Promotion for Adults with Intellectual Disabilities: A Multi-Component Intervention in Community Residences Sweden

Title in original language:

Hälsöfrämjande gruppbostad

Short description of the intervention:

The risk of ill-health is increased in people with intellectual disabilities (ID), partly due to physical inactivity and an unbalanced diet. Caregivers at community residences face a dilemma when trying to support healthy behaviours without violating autonomy. The intervention aimed to promote healthy behaviours i.e. promote physical activity and healthy diet among people with mild to moderate ID living in community residences in Stockholm County. The intervention was based on Social Cognitive Theory and involved activities both to strengthen the individual and to influence the social and physical context, through three components: 1) Appointment of a health ambassador in each residence and network meetings; 2) a 10 session study circle for caregivers; and 3) a 10 session health course for residents. The programme took 12 to 16 months to complete and was designed to be compatible with ordinary work routines in community residences. The intervention started with an information meeting explaining the programme intended for to all caregivers and managers of the residences. A health ambassador was appointed in each residence who attended network meetings to improve health promotion competence. The role of the ambassadors was to inspire colleagues. The study circle for the caregivers intended to increase knowledge in nutrition, physical activity and health. During each 90 minute session the staff discussed a theme related to health and how to change work routines. Adults with mild to moderate ID living in community residences were eligible for inclusion and were included if at least three individuals in each residence agreed to participate. Recruitment took place between May 2009 and February 2010.

To which type of interventions does your example of good practice belong to?

Individual Intervention targeting both residents and staff.

How is this example of good practice funded?

Regional government and public health research

What is/was the level of implementation of your example of good practice?

Regional, the intervention was conducted in several municipalities in Stockholm County.

What are the main aim and the main objectives of your example of good practice?

Improve dietary habits and physical activity for adults with mild to moderate intellectual disability as well as staff work routines by targeting both residents and staff.

Please give a description of the problem the good practice example want to tackle (nature, size, spread and possible consequences of the problem):

The prevalence of ID globally is around 1 %, and the prevalence is higher among men and in low-income countries. In 2012 approximately 64 000 Swedish residents, or 0.7 % of the Swedish population, received support according to the LSS law , The Act concerning Support and Services for Persons with Certain Functional Impairments. People with intellectual disabilities have higher risk of poor health and self-rated health is 10 times more likely to be low compared to the general population. This can partly be explained by the disability per se, but one third of ill-health is attributed to level of education, lacking cash margins, sedentary leisure time, obesity, discrimination, and social participation. Thus, in theory health could be improved by targeting these factors. Increased vulnerability to poor health, behavioural risk factors and limited health literacy identifies the need for specific health interventions for people with ID.

Is your example of good practice embedded in a broader national/regional/ local policy or action plan?

People with ID are a vulnerable group and are prioritized both in the national public health policy and in various regional policies in Stockholm County e.g. the action plan against overweight and obesity.

Implementation of your example of good practice is/was:

Periodic. A manual and an evaluation plan have been made freely available, and several municipalities in Sweden have started to implement the programme.

Who implements/implemented the intervention?

The intervention was developed and evaluated by researchers at Karolinska Institutet and the Centre for Epidemiology and Community Medicine (CES) in Stockholm County Council. It is designed to be implemented by local staff in residences and in the municipality, based on a manual.

What core activities are/have been?

- An introductory information meeting explaining the intervention and preparing the staff and managers.
- Development of educational materials on nutrition, physical activity and health for health ambassadors.
- Coaching of health ambassadors by the research team during the intervention period by telephone and e-mail.
- Newsletters sent by mail.
- Four network meetings for the health ambassadors.
- One day training of leaders of the health course for residents.
- Study circle developed for the caregivers (without presence of the research team), including a booklet containing easy-to-read information on 10 health topics, suggested discussion questions for each topic, and guidance how to agree on new work routines.
- A 10 session study circle for residents including several aspects of health developed by an adult education organisation (Studieförbundet Vuxenskolan), who's employees also acted as course leaders.

Who did the evaluation?

Internal and external parties

What has been measured / evaluated?

Process evaluation: Qualitative data were collected to identify barriers and facilitators of the implantation of the health course for residents by 1) education notes from course leaders; 2) observation during course sessions; and

3) group discussions with course leaders. To study the implementation process of the whole programme, interviews were conducted with managers and health ambassadors after the intervention period.

Evaluation of the impacts/effects/outcome: The intervention was evaluated in a cluster-randomised controlled trial including 30 residences (16 intervention, 14 controls) and 130 individuals. Measurements took place at baseline, after 12-16 months and 1 year after completion of the study. Outcome variables were measured at baseline, at completion (after 12-16 months) and at 1 year follow-up. Individual outcomes were physical activity (pedometry); dietary quality (photography of meals); BMI and waist circumference was measured, resident satisfaction with life by questionnaire. Work routines were studied through questionnaire including 26 items within three domains; 1) general health-promoting work; 2) food and meals; and 3) physical activity. The items covered work routines as well as aspects related to knowledge among staff, role modelling, food supply and opportunities for physical activity.

Intervention fidelity was assessed by participation of residents and caregivers in core activities such as: 1) network meetings for health ambassadors; 2) the study circle for caregivers; and 3) the health course for residents.

What are the main results/conclusions/recommendations from the evaluation?

A significant intervention effect was found for physical activity, with an average increase of 1608 steps per day among participants in the intervention group compared to control. No other significant effects were found for other individual measures, but a desirable trend was observed for BMI and waist circumference. Satisfaction with life did not change. Work routines improved significantly in the intervention group.

The qualitative studies found that it is important to support motivation for change among managers and caregivers throughout the implementation process, and to support the residents during the health course, and in their social and physical environment.

Higher effectiveness could probably be obtained by improving implementation strategies to increase fidelity. Further studies are needed to improve diet of residents and meal work routines.

Is the evaluation report available, preferably in English or at least an English summary?

Report in Swedish: http://dok.siso.sll.se/CES/FHG/Jamlik_halsa/Rapporter/halsofarmande-gruppbestad-slutrapport.2013_5.2013.pdf; Doctoral thesis: <https://openarchive.ki.se/xmlui/handle/10616/42084>

Was there a follow-up or is any follow-up evaluation planned in the future?

8 out of 14 intervention residences participated at the 1 year follow-up. The significant effects found for work routines were sustained at follow-up. However, no significant effects on individual level persisted.

What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

There is both an objective and perceived (by staff in residences) need for health promotion among this target group, resulting in a positive attitude by local authorities. The intervention had a flexible and participatory approach and was designed to fit existing work routines. Easy-to-read materials

What are the main lessons to be learned?

This health promoting intervention has shown that the programme was well received probably due to the high degree of participation of staff in development and implementation. Work routines and physical activity can be improved and this has implication for health among persons with intellectual disabilities. It seems to be more difficult to improve dietary habits and also more difficult to evaluate.

Web page related to the intervention

In Swedish <http://folkhalsoguiden.se/gruppbestad/>

References to the most important articles or reports on the intervention

[Barriers and facilitators in health education for adults with intellectual disabilities--a qualitative study](#)
Bergstrom H, Elinder LS, Wihlman U; *Health education research* 2014;29(2):259-71

[A multi-component universal intervention to improve diet and physical activity among adults with intellectual disabilities in community residences: a cluster randomised controlled trial](#); Bergstrom H, Hagstromer M, Hagberg J, Elinder LS; *Research in developmental disabilities* 2013;34(11):3847-57

[Psychometric evaluation of a scale to assess satisfaction with life among people with intellectual disabilities living in community residences](#); Bergstrom H, Hochwalder J, Kottorp A, Elinder LSQ; *Journal of intellectual disability research : JIDR* 2013;57(3):250-6

[Validation of personal digital photography to assess dietary quality among people with intellectual disabilities](#)
Elinder LS, Brunosson A, Bergstrom H, Hagstromer M, Patterson E; *Journal of intellectual disability research : JIDR* 2012;56(2):221-6

[The role of staff in health promotion in community residences for people with intellectual disabilities: variation in views among managers and caregivers](#); Bergstrom H, Wihlman U; *Journal of intellectual disabilities : JOID* 2011;15(3):167-76

[Promoting a healthy diet and physical activity in adults with intellectual disabilities living in community residences: design and evaluation of a cluster-randomized intervention](#); Elinder LS, Bergstrom H, Hagberg J, Wihlman U, Hagstromer M; *BMC public health* 2010;10():761-

Other relevant documents:

In Swedish <http://folkhalsoguiden.se/gruppbostad/>

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