RECOVERY FOR ALL IN THE COMMUNITY

LEARNING FROM EACH OTHER

SITE VISIT Andalusia-Oslo

Report of a EUCOMS exchange

Andalusia (Spain) visiting Oslo (Norway)

25 and 26 of March, 2019

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INTRODUCTION

Mental Health Care Organizations have expressed their wish to learn from each other in the context of EUCOMS and implementing community mental health care. One way of doing this is by visiting each other and talk to colleagues from institutions in different countries and visit their services.

The purpose of these site-visits are to learn from different services about how they think, act and work in order to bring in practice the principles of good community mental health care as described in the 'Consensus Paper on Fundamental Principles and Key Elements of Community Based Mental Health Care'.

The aim of this manual is to facilitate these mutual visits by providing some topics/questions to address with practical suggestions which can be used for preparation and during the visit.

Importantly, the visits will be non-judgemental and explicitly aim for a respectful and mutual exchange on an equal level. The visits will yield a *qualitative* impression about the way the principles of the Consensus Paper are used.

PEOPLE INVOLVED IN THE VISIT

There are two groups involved in the site-visits, each from a different country and mental health service, who will play the role of the host and the visitor. To get a complete picture it is suggested to include a mix of people in each group involved in the site-visits such as people with lived experience, peer experts, significant others, professionals, directors and managers, policy makers and researchers. The group composition may vary per topic addressed during the visit. For example: when the topic of peer expertise is discussed it is important that a person with lived experience or when the topic of community network of care is highlighted it might be interesting to involve a police officer.

PREPARATION AND DURATION OF THE VISIT

After choosing your visiting partner organisation, appointments have to made about dates, (number of) visiting persons and financial aspects. Usually, a visit will take two days, during which meetings can be held and attended, and programs can be visited.

Before the visit takes place, information is provided by the host-organisation about the mental health service including the:

- Vision and mission
- History
- Organisational structure and size
- Target groups and departments
- Catchment area
- Number of professionals per discipline
- Total budget

In addition, the host organisation provides a short (max 1 A4) ''self-reflection'' about how they are dealing with the topics in the Consensus Paper. This information can be filled in the attached 'workbook'.

FINANCIAL ASPECTS

Ideally, the host-organisation does not charge for the site visit. The visiting organisation itself will pay for their own travel and accommodation costs. When the participating organisation has no financial measures to pay for the visit contact can be sought with the EUCOMS Network to explore other funding possibilities.

THE PROGRAM OF THE VISIT

The exact program of the 2-day visit can be tailor-made, based on the organizational structure of the host-service and the wishes of the exchanging partners. The host-organisation prepares a concept-program, which can be finalized together with the visiting organisation.

Ideally, at the end of the 2-day visit, the exchange group (both the hosting as well as the visiting organisation) will have a good impression about the way the principles of the Consensus Paper have been implemented.

FOCUS DURING THE VISIT

The Consensus Paper will be used as a guiding document in which the principles of community based mental health care have been formulated. The focus of attention includes the six dimensions of the Consensus Paper (ethics, public health, recovery, effectiveness of interventions, community network of care and peer expertise) which will be addressed during the visit, mostly based on presentations and tours organized by the host-organization. Notes about the findings during the visit can be summarized in the attached 'workbook'.

Questions which can be answered during the meetings and/or through observations:

1. Ethics

- In what way does the host-organization address ethical aspects, including human rights according to the convention of rights for per persons with disabilities (CRPD) and/or the WHO Quality Rights Toolkit?
- Are service users provided with an adequate standard of living, including adequate food, clothing, clean water, devices and other assistance for disabilities?
- Is there a policy in place to minimize or reduce coercion, ineffective or harmful treatments?
- Is there a policy in place to address comorbid and general health problems among the service users?
- Are service users put central in the decisions that affect them including decisions about treatment, where they live and their personal and financial matters? How is this demonstrated?
- Is there a policy in place that protects people against and prevent all forms of exploitation, violence and abuse?
- Is there a policy in place to promote the full inclusion and participation of service users in society including access to a range of housing options, education, employment and to participation in political, public and cultural life and in recreation, leisure and sport?
- Is there an intervention in place to reflect on moral considerations?
- Does the organisation think that the human rights of people in is properly addressed when looking at the above points? What could be improved?

2. Public health

- How is the public health perspective taken into account in daily practice by the organisation?
- What are the activities and collaborations with other organizations in the region of interest, in terms of prevention and promotion of good mental health?
- Is there information available about the mental health status of the population of interest, and how does this translate into practices of the service?
- Are crisis services in place?
- Is there Assertive Outreach available to engage difficult-to-engage clients?
- To what extend does the service contribute to de-stigmatization according to the TLC 3 model (Targeted, Local, Contact, Credible and Continuous – see Consensus Paper for more detail)?
- Are you satisfied about the way your organisation addresses the public health perspective? What could be improved?

3. Recovery

- How is recovery addressed in daily practice, what do clients and significant others think about this?
- To what extend is recovery the grounded vison of the whole service
- How are the 10 ways to support recovery addressed (see Consensus Paper for more detail)?
- What activities are in place to facilitate recovery (there may be overlap with the previous point)?
- Does the organisation think recovery is addressed appropriately? What could be improved?

4. Effectiveness of interventions

- How does the organization choose the interventions provided to clients?
- How is specialized care organised and is it equally accessible to all clients?
- Does the organization use guidelines and/or professional standards?
- How are pharmacological interventions used and evaluated?
- What about the implementation of psychological interventions?
- Are interventions for social inclusion in place (e.g. IPS and Housing First)?
- Does the organisations have interventions in place to prevent crisis-situations and admissions?
- Is somatic care addressed?
- To what degree is e-mental health or m-mental health in place?
- Is there a system assessing the effects of the interventions?
- What are barriers for implementation of good quality interventions?
- Is the organisation satisfied about the availability and use of effective interventions? Which improvement are necessary?

5. Community network of care

- Are ACT, FACT, CMHT or similar organisation models available and equally accessible to all clients?
- Could you describe the network of care for your organisation?
- How do ambulatory teams collaborate with psychiatric hospital teams?
- How is treatment of addiction integrated with the treatment of other mental health issues
- How do the mental health teams collaborate with primary care professionals?
- To what extend is a whole team approach and an interdisciplinary way of working implemented?
- Are social services involved in the care process? How?
- Are there strong linkages with the policy and schools in the community and how are they involved in the care process?

- Which other organisations are involved and how are the linkages maintained?
- What do these networks mean for clients and significant others in daily practice?
- Is the organisation satisfied about collaboration with social services and other networks? What could be improved?

6. Peer expertise

- To what extent is lived experience (including among the professionals) recognized as a valuable form of expertise to shape the organisation of the services and the treatment? How is this reflected?
- Do peer experts work in the organisation, paid or voluntary?
- Is there a training program to become peer expert?
- At what levels are peer experts involved in the organisation (client level, team level, management and/or board level)?
- Is there a recovery college run by peer experts (or something similar) in place?
- Are you satisfied about peer expertise in your organisation? What could be improved?

The aim is that the end of the 2-day program these aspects have been addressed and there is some mutual understanding about the way the Consensus Document has been implemented.

REPORT OF THE VISIT

The filled in 'workbook' can be summarized into a short report and presentation about your most important eye openers and lessons learned. At the end of the report you can highlight which opportunity for improvement you choose to work on the coming years. The outcomes will be presented together with the host/visiting group at the international EUCOMS meeting. In the run up to the presentation in you will be in contact with Niels Mulder about the presentation format.

CLM 22-4-2018

INFORMATION ON THE HOSTING ORGANISATION

To fill in by the hosting party.

Hosting party Oslo. Norway

- **Tor Helge Tjelta**. Leader, Chair, Project Manager (master in collaboration management in health and social sector). City of Oslo (District Gamle Oslo). Norwegian Association for Mental Health. FACT Gamle. Oslo.
- **Torbjørn Mohn-Haugen**. Peer specialist, Chair City of Oslo (District Gamle Oslo). Erfaringssentrum (new national network for peer specialists in Norway). Oslo.
- **Anne Helene Tveit.** Section chief (psychology specialist). Lovisenberg Diaconal Hospital, District Psyciatric Center. Addiction outpatient services. Oslo.
- **Møyfrid Kjønsdal.** Academic Advisor (psychology specialist). Norwegian resource center for community mental health (NAPHA). Trondheim.
- **Stig Hermann Nygård**. Senior Advisor. County Governor. Oslo.

Basic information

Vision and mission

- Norway: Together for mastery (Mental Health)
- City of Oslo: The vision for Oslo is to make it a smarter, greener, more inclusive and creative city for all citizens – a smart city that innovates with the citizens' interest and well-being at the core.
- Lovisebenberg Diaconal Hospital: Charity and quality.

Brief History

There has been an Escalation Plan for Mental Health (1999-2008) and for Addiction (2016-2020).

Lovisenberg Diaconal Hospital is a local hospital providing medical services for the inhabitants of four City Districts in Oslo: Sagene, Gamle Oslo, Grünerløkka, and St. Hanshaugen including Sentrum, about 25 percent of the city's population. In addition psychiatric services are offered to several other city boroughs and our hospice offers palliative care. Our departments have a wide range of specialists, and the health care we offer is managed in close co-operation with the other hospitals and health service providers in Oslo.

The hospital is owned by the private deaconess foundations Diakonissehuset Lovisenberg and Menighetssøsterhjemmet (Parish Sisters Home). It operates within the framework of Public Health, with a long term contract with South-Eastern Norway Regional Health Authority.

With a staff of approximately 1300 person/years, the hospital has 228 beds, and an extensive out-patient facility. The hospital has a modern x-ray department, a clinical laboratory, and a pharmacy. There is an interpretation service for patients with other mother tongues than Norwegian that will be ordered on request.

The hospital was founded in 1868 by the pioneer Cathinka Guldberg - the first trained nurse in Norwegian medical history. The word: "deacon" comes from a Greek verb, meaning "to be at someone's service", "to take care of". The mission of each individual employee and our organisation as a whole is to offer treatment and service of high quality to all our patients, with equality and respect.

Organisational structure and size

The Mental Health services are provided by primary and secondary health care.

- Norway: 5, 3 mill. inhabitants
- Big Oslo: 1 mill. inhabitants. City of Oslo: 681 000 inhabitants. There are 15 districts in Oslo. They are being served by four different hospitals.
- Lovisenberg DH: 25 % = 170 250 inhabitants.
- District Gamle Oslo: 53 000 inhabitants

Target groups and departments

In Norway the patients are divided in three different groups:

1) Mild and short problems (primary health)
2) Short severe problems/illness and long mild problems/illness (primary and secondary health)
3) Severe long term problems/illness (secondary health (and some primary health)

Catchment area

The catchment area of Lovisenberg hospital and the three districts: Gamle Oslo, Grunerløkka and St. Hanshaugen is 150,000 inhabitants.

Number of professionals per discipline

The TOTAL number of professionals for Norway is 39 884 FTEs

1)Municipalities (primary health and welfare services) in Norway

- In 2018 there was 15 894 FTEs in mental health and addiction services in the municipalities.
- 3 331 FTEs in child & adolescents. 12 563 FTEs in adult.
- In addiction comes the GPs, where we reckon that 20 % of 4 600 FTEs - 960 FTEs goes to this work.
- The TOTAL number in the Municipality is: 16 814 FTEs.

2) Specialized services in Norway

- In 2018 there was 15 510 FTEs in psychiatry for adults https://www.ssb.no/statbank/table/09551/tableViewLayout1/
- In child & adolescent psychiatry there was 3 528 FTEs https://www.ssb.no/statbank/table/09550/tableViewLayout1/
- In addiction there are 4 035 FTEs https://www.ssb.no/statbank/table/09547/tableViewLayout1
- The TOTAL number in the specialized services is: 23 070 FTEs.

Total budget

- The District Psychiatric Centre (DPS, adults). The budget there in 2019 is 15 252 200 Euro.
- The budget in the Municipality, City of Oslo, Mental Health (adults) is 5 748 618 Euro (one of three districts in Lovisenberg).

Brief reflection on how is dealt with the six principles of food community mental health care as outlined in the consensus paper

Ethics/Human rights: It depends on who you ask. Some argue that there is too much use of coercion, and others argue that Norway is quite good on this point. The Government has started a project on drug free treatment several places in Norway. (GDPRS)

Public Health: We now have a goal with Mental Health In All Policies (MHIAP). We have a new Program for Public health in the municipalities. The program is focusing on providing knowledge on what works in mental health promotion at the local levels, and how to work across sectors to improve mental health among children and young people. Drug prevention is also an important part of the program. The ABC-model are suggested to be tried out in Norway https://www.actbelongcommit.org.au/

Recovery: Hopeful, but some window dressing. Some places in Norway it's quite good. It differs which service you look at also. The City of Oslo has decided that the services should be recovery orientated, but that is quite recently. District Gamle Oslo has many peer specialists, and some services are good at supporting the patient/service user personal recovery. It's also supported by research and monitoring (fidelity measurement) – FACT, Integrated services and addiction services. They are starting a Recovery College in two different places in Norway. In Oslo we have some recovery groups (starting in FACT Gamle Oslo in 2019). We use different tools and programmes based on the recovery perspective like IMR – Illness Management and Recovery; FIT – Feedback informed systems and INSPIRE (also translated to Spanish) https://www.researchintorecovery.com/inspire

Effectiveness of intervention: Hopeful, but we can do better on monitoring both in the municipalities and in the hospitals. The Government has started many Clinical pathways now, also for mental health and addiction. We have many different journal systems that do not collaborate.

Community network of care: We can be better on using the network and other services. The services are (a bit) fragmented. Many services and levels.

Peer expertise: Hopeful. But it differs. There are more peer experts in the municipalities than in the hospitals. There is a training program in Bergen (west coast), and we have started a training program in Oslo last year. There is a new organization for peer specialist in Norway: Erfaringssentrum ('Centre for experience') www.erfaringssentrum.no In Oslo there are a network for young peer specialist.

WORKBOOK

To fill in by the visiting party.

Visiting party Andalusia. Spain.

- **Álvaro Doña Diaz**. Psychiatrist. Virgen de la Victoria Hospital. Andalusian Health Service. Malaga.
- **José Damian Gonzalez**. Psychologist. Public foundation for social integration of people with mental health disorders - FAISEM. Malaga.
- **Evelyn Huizing**. Mental Health Nurse Specialist. Policy Adviser Regional Mental Health Coordination. Andalusian Health Service. Seville.

1. Ethics

In what way does the host-organization address ethical aspects, including human rights according to the convention of rights for per persons with disabilities (CRPD) and/or the WHO Quality Rights Toolkit?

They started to work on this. At a Government level there is a lot of knowledge of the CPRD, and laws were changed, although there has been hardly any changes over the last 10 years. But there are no specific training and awareness programs for the professionals.
There are peer experts working in the services, and there are training programs for peer supporters, based on a 4-6 month of training in Oslo, and 1 year in Bergen.

Are service users provided with an adequate standard of living, including adequate food, clothing, clean water, devices and other assistance for disabilities?

In general, in Norway there are a lot of resources because it´s a wealthy country. There is a National Insurance Scheme (NAV). Nevertheless there is a problem with housing, mainly because of the lack of payable housing, but also due to stigma.

Is there a policy in place to minimize or reduce coercion, ineffective or harmful treatments?

At the inpatient units of Lovisenberg DH, they work on prevention and reduction of coercive measures like mechanical restraint. Regarding involuntary treatment, this exists both in inpatient and in outpatient settings (involuntary ambulatory treatment). The Government has made plans for reduction of involuntary treatment, but they have not succeeded in bringing it down until now. Forced medication can be used in this context. Norway has a Mental Health Act

As said in the “hosting partner information”, the government has started a project on medication free treatment in several places in Norway, so that patients can choose treatment without medication.
The Prime Minister and the Minister of Health of Norway are very aware of the importance of the protection of human rights in mental health, supporting and giving voice to the service users.

Is there a policy in place to address comorbid and general health problems among the service users?

There are a lot of challenges in this area. They are struggling with coordination between general health services and specialized MH services. There are no multidisciplinary primary health centers, and the General Practitioners work from their own practice, most of the time from their home, whereas the community nurses depends on the municipality. At the same time, all patients have to pay every year a mandatory minimum of risk sum, which provokes care avoidance in some service users.

The nurses within the FACT team are more specialized in psychiatric nursing, and not so much in somatic nursing so that the coordination with primary healthcare is very key for good care delivering. In this sense, the coordination between the FACT team and the primary health care in general is quite good, as they have been working on this aspect specifically.

Are service users put central in the decisions that affect them including decisions about treatment, where they live and their personal and financial matters? How is this demonstrated?

They work on shared decision making, empowerment of service users, peer expertise, recovery schools etc. They use measurements like INSPIRE and FIT – Feedback Informed Treatment, designed to assess a service user's experiences of the support they receive from a mental health worker for their recovery. And also programs like Illness Management and Recovery, focused on making informed decisions.

Is there a policy in place that protects people against and prevent all forms of exploitation, violence and abuse?

The laws related to the CPRD and the Mental Health Act. The latter with the following characteristics: Legal protection; Protection of autonomy, human rights, non-discrimination; Patient's right to make decisions regarding their own health; Emphasis on patient's ("user's") perspective and Capacity to consent (including to decline treatment).

There exist compulsory admission and treatment for people with serious mental disorders and lack of capacity to consent, with the additional criteria of the «possibility of cure or considerably improvement will be lost», or if the patient represents a considerable danger to himself or to others.

Compulsory measures are only used when deemed strictly necessary, to prevent danger to the patient or to others and there is always a written special resolution.

The legal protection regarding compulsory mental health care and coercion can be appealed to.

There is an independent supervising commission that talks with all newly admitted patients once a week, and that monitors all the resolutions. There is a commission meeting every fortnight (court of appeal) and there is access to a free lawyer.

Is there a policy in place to promote the full inclusion and participation of service users in society including access to a range of housing options, education, and employment and to participation in political, public and cultural life and in recreation, leisure and sport?

Again, the laws elaborated in the context of the CPRD try to guarantee this full inclusion and participation. In general there is coordination between different organizations and administrations and there are sufficient financial resources, but the challenge is the coordination between the so called "silos" (health, education, social services, housing, etc.) The bureaucratization is a weak point in this sense, especially when the person with mental health issues is a care avoider.

The housing is a problem though, as said before.

Is there an intervention in place to reflect on moral considerations?

Yes, the recovery perspective and the CPRD and human rights focus makes that the professionals reflect on their interventions in a critical way. The power of the service user's movement is important in order to put issues on the table and reflect on current practices.

Does the organisation think that the human rights of people in is properly addressed when looking at the above points? What could be improved?

As the hosting partner states, it probably depends on who you ask. Some argue that there is too much use of coercion, and others argue that Norway is quite good on this point.

Probably it depends as well on where (FACT, inpatient unit, social services…). The idea of working from a recovery perspective straight from the first contact with the patient, and in whatever intervention, is more present in the FACT team than in the clinical inpatient units, where no peer experts work and no special focus on recovery is used.

Ethics

Overall opportunities for improvement:

- Hardly any changes over the last 10 years regarding CPRD legislation.
- No specific training and awareness programs for the professionals on the CPRD.
- The housing problem for people with mental issues.
- Involuntary ambulatory treatment can be very coercive. There is a policy in place to review this, but they haven´t succeeded in reducing it.
- Challenges in addressing comorbid and general health problems.
- The coordination between the so called "silos". The bureaucratization is a weak point in this sense, especially when the person with mental health issues is a care avoider.
- They should work more from a recovery perspective at the acute inpatient units.

Overall positive points to take home:

- At a Government level (macro level) there is a lot of knowledge of the CPRD.
- Peer experts working in the services.
- Training programs for peer supporters, based on a 4-6 month to 1 year training.
- Programs on prevention and reduction of coercive measures at inpatient units like Lovisenberg.
- The medication free treatment units in several places in Norway.
- They work on shared decision making, empowerment of service users, peer expertise, recovery schools etc. with recognized tools.
- The Mental Health Act in Norway and the development of measures related to this Act.
- The power of the service user's movement is important in order to put issues on the table and reflect on current practices.
- They recognize that coercion is a critical point and that there are quite different opinions on this among the professionals.

Overall lessons learned:

- The Prime Minister and the Minister of Health of Norway are very aware of the importance of the protection of human rights in mental health, supporting and giving voice to the service users, which makes a difference.
- They are aware of the importance of good community mental health services and take into account all the current perspectives and principles.

2. Public Health

How is the public health perspective taken into account in daily practice by the organisation?
There is a clear public health perspective. The mental health services are responsible for all the citizens in of their catchment area, including existing clients, clients who need care but are hard to engage and potential future clients.

What are the activities and collaborations with other organizations in the region of interest, in terms of prevention and promotion of good mental health?
There is a coordination with other departments like education, social affairs and other organizations in the community. Although the coordination and cooperation is a challenge because of the complexity of a very organized society ("silos").
Projects like Young Arena are good examples of prevention and promotion, as they work with youngsters.
Young Arena (inspired by the Australian model headspace www.headspace.org.au) is a free low threshold service for young people in the age group 12 - 25 in need of support and practical help. It is a new model for developing and offer services to young service users (model development project). A Young Arena Center offers easily available and comprehensive help on young people's own terms. The main aims of the project are to make it easy for young people to get help they need when they need it, and give the right help to those at risk for substance abuse and mental health problems early on before the problems develop, and to increase the cooperation between different welfare services in the municipality of Oslo.

Is there information available about the mental health status of the population of interest, and how does this translate into practices of the service?
Yes, there is information available. Information about the catchment area of Lovisenberg hospital and the three districts: Gamle Oslo, Grunerløkka and St Hanshaugen: Alltogether, 150,000 people in the catchment area and 100,000 consultations per year.

Are crisis services in place?
Yes, there are crisis services. Both the City of Oslo, FACT and the Hospital deliver crisis interventions.

Is there Assertive Outreach available to engage difficult-to-engage clients?
They work with the FACT model. For example, in the catchment area of Lovisenberg Diaconal hospital (150.000 inh.) there are 3 FACT teams, and they are starting to pilots with FACT Youth now.

To what extend does the service contribute to de-stigmatization according to the TLC 3 model (Targeted, Local, Contact, Credible and Continuous – see Consensus Paper for more detail)?
Their work on erasing stigma is not that structured and in general it´s more focused on common mental disorders (depression, anxiety…), mainly targeted on the general population. They also work on suicide and stigma. The 10th of October is celebrated every year.

Are you satisfied about the way your organisation addresses the public health perspective? What could be improved?
They are satisfied, but it could be better. The Mental Health and Addiction services but the coordination with the general practitioners could be improved. They work too much in "silos", even between Mental Health and Addiction. For this, the attention to people with dual diagnosis should be improved. They also have forensic units integrated in the mental health services. And there are middle and long stay units, but we didn't visit these units. These middle and long stay units for people with severe mental disorders are somehow disconnected from the community network.
They are very proud of the Young Arena project, as an example of good practice in promotion and prevention.

Public Health

Overall opportunities for improvement:

- The coordination and cooperation is a challenge because of the complexity of a very organized society ("silos").
- Their work on erasing stigma is not that structured and in general it´s more focused on common mental disorders (depression, anxiety…).
- The Mental Health and Addiction services could improve the coordination with general practitioners.
- The middle and long stay units for people with severe mental disorders are somehow disconnected from the community network.

Overall positive points to take home:

- There is a clear public health perspective.
- Projects like Young Arena are good examples of prevention and promotion.
- There is information available about the mental health status of the population of interest
- There are crisis services in place.

Overall lessons learned:

- There is a clear public health perspective and they are aware of their challenges in a complex, bureaucratic, welfare state like Norway.
- Young Arena is s good practice, although they recognize the challenge of improving the evaluation of this project in order to keep it sustainable.

3. Recovery

How is recovery addressed in daily practice, what do clients and significant others think about this?
Within the services, the focus is still much on the "patient", on the illness. For this, patients are not used to approach their lives from this perspective either (empowerment, recovery etc.) including the youngsters. It´s important to promote the change of the *mantra* from "what´s wrong" to "what´s important"

To what extend is recovery the grounded vision of the whole service?
There is an important difference between the inpatient units and the FACT teams regarding this. In the inpatient units they don´t work that much from a recovery perspective as perceiving this more as a community perspective. There are no peer support workers in the inpatient unit. They only work in outpatient settings. But the FACT team does work with the recovery model.

How are the 10 ways to support recovery addressed (see Consensus Paper for more detail)?
Again, there is a marked difference between FACT and inpatient units, being the FACT much more recovery orientated. But overall, the challenges are related to Way 8: Acknowledge the service user's right to take risks and Way 9: Collaborate with the family and network as a resource and partner. Regarding the risk taking (8), this is easier in the FACT team than in the hospital, as the team takes the responsibility as a whole. And regarding the work with families (9), they recognize that they´re struggling with this. The family should be more involved and being seen as a resource and a partner in care.

What activities are in place to facilitate recovery (there may be overlap with the previous point)?
In the FACT team, they work where the patient wants to succeed. They work with tools from the recovery model, like IPS and peer specialists working within the community services. And they strive for multidisciplinary teams with a wide range of specialists, adapted to the needs of the patients in care.

Does the organisation think recovery is addressed appropriately? What could be improved?
Yes, but in the inpatient settings (hospital) the recovery perspective should be more a part of the vision and mission.

Recovery

Overall opportunities for improvement:

- Within the services, the focus is still much on the "patient", on the illness.
- There is an important difference between the inpatient units and the FACT teams regarding working from the recovery perspective.
- The family should be more involved and being seen as a resource and a partner in care.

Overall positive points to take home:

- In the FACT team, they work where the patient wants to succeed.

Overall lessons learned:

- They struggle with the same things as in other countries regarding the real use of the recovery perspective. They recognize the risk of window dressing, in spite of the development and use of peer expertise in the outpatient services.

4. Effectiveness of interventions

How does the organization choose the interventions provided to clients?
They use Clinical Guidelines, and key indicators. In the Improvement Plans of the organizations, objectives related to the clinical interventions are included.

How is specialized care organised and is it equally accessible to all clients?
They have a lot of different programs within the ambulatory/outpatient units, including FACT, depot team, acute teams and transcultural teams. The illegal immigrants however are at risk to not be attended in an adequate way.

Does the organization use guidelines and/or professional standards?
Yes they do. They provide psychiatric assessments and clinical evaluations, and regarding their management of psychiatric disorders they use different interventions: Psychopharmacology, Electroconvulsive Therapy, Psychological interventions and Social interventions.

How are pharmacological interventions used and evaluated?
There is a strict evaluation on this within the organizations. In the FACT team the nurses have specific competences in this area.

What about the implementation of psychological interventions?
There are psychological interventions in place. Both within the mental health and the addiction services. They work mostly cognitive behavioral therapy based, but also supportive psychotherapy and psychoeducation.

Are interventions for social inclusion in place (e.g. IPS and Housing First)?
Yes, IPS and other models of employment and social inclusion. There is no special program like "Housing First" in Oslo and somehow the housing issue is a problem that has to be tackled. Regarding middle and long stay resources, there are units which don't belong to organizations we visited. These are units outside the city, in the countryside, that are not that much integrated in the community.

Does the organisations have interventions in place to prevent crisis-situations and admissions?
The FACT team works on prevention of crisis, as being part of their working philosophy. The Lovisenberg hospital has a special acute team in their ambulatory section, and the acute hospital admissions are done by them. They have a Psychiatric emergency unit (6 beds) and 6 locked psychiatric wards with 10 beds each. The acute team in LDH work only daytime, but the City of Oslo and the hospitals have a 24/7 acute service (they also have an ambulatory team there).

Regarding prevention, from the Lovisenberg hospital they work constantly on building bridges to the community, on how to liaise with Gp´s and in close collaboration with FACT on when to discharge. They also highligt the importance of working form a multidisciplinary approach.

Is somatic care addressed?
Yes, but as said before, there is a challenge here. (see part 1: Ethics)

To what degree is e-mental health or m-mental health in place?
They are starting to work on this. There is some e-therapy in place for common mental disorders, but also for bipolar disorders. In the Young Arena project the "social media" like Twitter, FB, Snapchat, Instagram, etc. is a very important tool.
The journal system is fragmented which is quite problematic as there is no good communication between the different systems.

Is there a system assessing the effects of the interventions?
There is a general evaluation on number of patients attended, episodes, length of stay etc. It´s a transparent system, with information for the population on the website of the hospitals.

What are barriers for implementation of good quality interventions?
The fragmentation ("silos") is a very important barrier. And there is too much a focus on the inpatient units, on the hospital. They also recognize the lack of strong leadership. Norway is a wealthy country, but they are not so good at optimizing the resources. There is not enough serious evaluation and monitoring of the effect of services.

Is the organisation satisfied about the availability and use of effective interventions? Which improvement are necessary?
In general they are satisfied, but they need to tackle the main challenges: improve the communication between the different organizations, in order to make more effective all the interventions, better evaluation and leadership and more focus on community (outpatient) interventions.

Effectiveness of interventions

Overall opportunities for improvement:

- There is a challenge on delivering good somatic care.
- The journal system is fragmented which hinders a good communication between the different systems.
- They should work on barriers like fragmentation, excessive focus on inpatient units, and optimization of resources.
- The illegal immigrants are at risk to not be attended in an adequate way.

Overall positive points to take home:

- The use Clinical Guidelines, and key indicators.
- There is a strict evaluation of pharmacological interventions.
- There are a lot of psychological interventions in place.
- There are interventions for social inclusion in place, although with variable development.
- In general they are satisfied, about the availability and use of effective interventions.

Overall lessons learned:

- They have in general enough human resources and accomplish with the standards of good care.
- Their interventions have a multidisciplinary and holistic focus.
- The FACT team reaches the most vulnerable persons in an effective way.
- In spite of a very reasonable amount of resources in Norway, they face similar problems as other countries and regions with less resources.
- "More resources" is not the answer to all the problems.

5. Community network of care

Are ACT, FACT, CMHT or similar organisation models available and equally accessible to all clients?
Yes, there is a complete network of mental health care.

Could you describe the network of care for your organisation?
Regarding the mental health services, there are two parts: an inpatient and an outpatient (ambulatory) organization, with two different clinical leaders. They comprehend both mental health (psychiatry) and addiction care.
The FACT team depends on the ambulatory organization but there is a good coordination with the acute wards.

How do ambulatory teams collaborate with psychiatric hospital teams?
As said in part 4 (Effectiveness of interventions), the hospital team develop management plans and strive for building bridges to the community and liaison with primary care. There is a close collaboration with the FACT team and they plan the discharge together.

How is treatment of addiction integrated with the treatment of other mental health issues?
This is integrated in the same organization, although not at all levels. At municipality level the care is more fragmented, but in the inpatient units it´s integrated.

How do the mental health teams collaborate with primary care professionals?
They do, but as said before, there are challenges in this area. There are no multidisciplinary primary health centers, and the General Practitioners s work form their own practice, most of the time from their home, and the community nurses work at municipality level.

To what extend is a whole team approach and an interdisciplinary way of working implemented?
This is better developed regarding common mental disorders. But in severe mental disorders it is more complex. There are treated both in the policlinic and in the FACT team. At municipality level, the addiction services are not integrated in mental health.

Are social services involved in the care process? How?
Yes, there is a wide development of social services, because of the welfare state in Norway (National Insurance Scheme - NAV). There is coordination and cooperation at community level between services, but also with some challenges like the housing problem. There are activity centers for people with mental issues.

Are there strong linkages with the policy and schools in the community and how are they involved in the care process?
There is coordination with school nurses and school psychologists. Health promotion is done within schools. This is important because schools provoke stress and there is a lot of dropout from school. The services in general are youth friendly.

Which other organisations are involved and how are the linkages maintained?
Around the person with severe mental disorder there are a lot of organizations involved: General Practitioners, School nurses, Emergency services, Social services, Acute mental health teams, Depot teams, Club House (Fountain House), Activity centers, the FACT Team…
The FACT team has a very important role in the maintenance of contact, supporting the patient with severe mental disorder, as using the case management model.

What do these networks mean for clients and significant others in daily practice?
With the FACT team everything is better coordinated. It´s less complex for the patient to get his or her needs met. It´s a more holistic approach because of the case management model.

Is the organisation satisfied about collaboration with social services and other networks? What could be improved?
They identify 3 groups, as said in the information of the hosting partners:

1) Mild and short problems (primary health)
2) Short severe problems/illness and long mild problems/illness (primary and secondary health)
3) Severe long term problems/illness (secondary health and some primary health)

In general they are good at group 1 and 3, because the care is better organized, although they need more financial resources for group 1.
But the care of group 2 is not that good organized, there are a lot of challenges here. It´s a group that is at risk of falling between the cracks.

Community network of care

Overall opportunities for improvement:

- There are no multidisciplinary primary health centers, which hinders the coordination with the primary health care and need a special attention from both care levels.
- The group of people with “short severe problems/illness and long mild problems/illness” need more attention and a better organisation of care.

Overall positive points to take home:

- The mental health (psychiatry) and addiction care are integrated, although it is more fragmented at municipality level.
- The FACT team has a good coordination with the acute mental health wards.
- The hospital strives for building bridges to the community and liaison with primary care.
- The social services are involved in the care process for people with mental health problems
- The services in general are youth friendly.
- Around the person with severe mental disorder there are a lot of organizations involved: and the FACT Team has a very important role in the maintenance of contact.

Overall lessons learned:

- The FACT team model guarantees a good patient centered coordination.
- The good coordination that exists between the inpatient unit and the FACT team is key for people with severe mental problems.
- A good “Community network of care” needs a constant commitment and proactive attitude of all the parts involved.

6. Peer expertise

To what extent is lived experience (including among the professionals) recognized as a valuable form of expertise to shape the organisation of the services and the treatment? How is this reflected?

This is recognized as a valuable form of expertise. Peer experts work in the health system, both in de services and at management level. They are well integrated. There are over 300 peer experts working in Norway. But the exact number is uncertain, as the information oscillates in a range of 300-500.

Do peer experts work in the organisation, paid or voluntary?

They are for the most part being paid, and a few are volunteers.

Is there a training program to become peer expert?

Yes, there is a school for peer experts, with a training program of 4-6 month in Oslo (1 year in Bergen)

At what levels are peer experts involved in the organisation (client level, team level, management and/or board level)?

They are engaged at all levels, but much more in the community services. For example not in the Lovisenberg Diaconal hospital.

In Bergen there are several peer support specialists connected to the local Hospitals there. Oslo have not gotten that far. There are also Peer support specialists connected to Hospitals in Tromsø and Telemark.

Is there a recovery college run by peer experts (or something similar) in place?
There isn´t a "Recovery college" in the strict sense of the word in Oslo. They look into Day Schools (as in Denmark). And offer training as said above.
But they are currently starting a Recovery College in two different places in Norway, but not in Oslo.

Are you satisfied about peer expertise in your organisation? What could be improved?
They are satisfied and are evaluating the services, by asking both de peer experts and the services. It´s very interesting that they work at all levels: client level, team level, management and/or board level. They would like to work more on the integration of peer workers in the hospitals.
They are looking at that now and want to learn from the Swedish model.

There is a new organization for peer specialist in Norway (Erfaringssentrum www.erfaringssentrum.no) and In Oslo there is a network for young peer specialist.

Peer expertise

Overall opportunities for improvement:

- The peer experts should be more engaged at hospital level.

Overall positive points to take home:

- Peer expertise is recognized as a valuable form of expertise and they work in the health system, both in de services and at management level. They are well integrated.
- Peer experts are being paid for their work, and a few are volunteers
- There is a school of peer experts and they started with recovery colleges in different parts of Norway.
- They are evaluating the services of the peer experts, by asking both de peer experts and the services.

Overall lessons learned:

- It´s very interesting that the peer experts work at all levels: client level, team level, management and/or board level.
- The peer experts are valued as important for delivering a good quality of mental health services.
- Peer experts have a good training program and are being paid for their work, and a few are volunteers.

Summary

Overall opportunities for improvement:

- Hardly any changes over the last 10 years regarding CPRD legislation.
- No specific training and awareness programs for the professionals on the CPRD
- The housing problem for people with mental issues.
- Involuntary ambulatory treatment can be very coercive. There is a policy in place to review this, but they haven´t succeeded in reducing it until now.
- Challenges in addressing comorbid and general health problems.

- The coordination between the so called “silos”. The bureaucratization is a weak point in this sense, especially when the person with mental health issues is a care avoider.
- They should work more from a recovery perspective at the acute inpatient units
- The coordination and cooperation is a challenge because of the complexity of a very organized society (“silos”).
- Their work on erasing stigma is not that structured and in general it´s more focused on common mental disorders (depression, anxiety…).
- The Mental Health and Addiction services could improve the coordination with general practitioners.
- The middle and long stay units for people with severe mental disorders are somehow disconnected from the community network
- Within the services, the focus is still much on the “patient”, on the illness
- There is an important difference between the inpatient units and the FACT teams regarding working from the recovery perspective
- The family should be more involved and being seen as a resource and a partner in care.
- There is a challenge on delivering good somatic care.
- The journal system is fragmented which hinders a good communication between the different systems.
- They should work on barriers like fragmentation, excessive focus on inpatient units, and optimization of resources.
- The illegal immigrants are at risk to not be attended in an adequate way.
- There are no multidisciplinary primary health centers, which hinders the coordination with the primary health care and need a special attention from both care levels.
- The group of people with “short severe problems/illness and long mild problems/illness” need more attention and a better organisation of care.
- The peer experts should be more engaged at hospital level.

Overall positive points to take home:

- At the Government level (macro level) there is a lot of knowledge of the CPRD.
- Peer experts working in the services.
- Training programs for peer supporters, based on a 4-6 month to 1 year of training.
- Programs on prevention and reduction of coercive measures at inpatient units like Lovisenberg.
- The medication free treatment units in several places in Norway
- They work on shared decision making, empowerment of service users, peer expertise, recovery schools etc., with recognized tools.
- The Mental Health Act in Norway and the development of measures related to this Act.
- The power of the service user’s movement is important in order to put issues on the table and reflect on current practices.
- They recognize that coercion is a critical point and that there are quite different opinions on this among the professionals.
- There is a clear public health perspective.
- Projects like Young Arena are good examples of prevention and promotion.
- There is information available about the mental health status of the population of interest.
- There are crisis services in place.
- In the FACT team, they work where the patient wants to succeed.
- The use Clinical Guidelines, and key indicators.
- There is a strict evaluation of pharmacological interventions.
- There are a lot of psychological interventions in place.
- There are interventions for social inclusion in place, although with variable development.

- In general they are satisfied about the availability and use of effective interventions.
- The mental health (psychiatry) and addiction care are integrated, although it is more fragmented at municipality level.
- The FACT team has a good coordination with the acute mental health wards.
- The hospital strives for building bridges to the community and liaison with primary care.
- The social services are involved in the care process for people with mental health problems.
- The services in general are youth friendly.
- Around the person with severe mental disorder there are a lot of organizations involved: and the FACT Team has a very important role in the maintenance of contact.
- Peer expertise is recognized as a valuable form of expertise and they work in the health system, both in de services and at management level. They are well integrated.
- Peer experts are being paid for their work.
- There is a school of peer experts and they started with recovery colleges in different parts of Norway.
- They are evaluating the services of the peer experts, by asking both de peer experts and the services.

Overall lessons learned:

- The Prime Minister of Norway and Minister of Health are very aware of the importance of the protection of human rights in mental health, supporting and giving voice to the service users, which makes a difference.
- They are aware of the importance of good community mental health services and take into account all the current perspectives and principles.
- There is a clear public health perspective and they are aware of their challenges in a complex, bureaucratic, welfare state like Norway.
- Young Arena is s good practice, although they recognize the challenge of improving the evaluation of this project in order to keep it sustainable.
- They struggle with the same things as in other countries regarding the real use of the recovery perspective. They recognize the risk of window dressing, in spite of the development and use of peer expertise in the outpatient services.
- They have in general enough human resources and accomplish with the standards of good care.
- Their interventions have a multidisciplinary and holistic focus.
- The FACT team reaches the most vulnerable persons in an effective way.
- In spite of a very reasonable amount of resources in Norway, they face similar problems as other countries and regions with less resources.
- “More resources” is not the answer to all the problems.
- The FACT team model guarantees a good patient centered coordination.
- The good coordination that exists between the inpatient unit and the FACT team is key for people with severe mental problems.
- A good “Community network of care” needs a constant commitment and proactive attitude of all the parts involved.
- It´s very interesting that the peer experts work at all levels: client level, team level, management and/or board level.
- The peer experts are valued as important for delivering a good quality of mental health services.
- Peer experts have a good training program and are being paid for their work.