SPECIAL PAPER

# How we do it in Norway: a golden middle way for quality development of in-patient services as applied to acute adolescent psychiatry

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*Keywords.* Quality improvement; in-patient treatment; psychiatric nursing; service users; clinical governance.

First received 19 Jun 2020
Final revision 21 Dec 2020
Accepted 26 Jan 2021

doi:10.1192/bji.2021.7



**In-patient treatment is a complex system of recursively interacting components. Patient characteristics interact with caregiver characteristics, home context and ward factors. Quality improvement requires primary focus on the interacting factors over which the ward itself potentially has influence. Ward practice has to integrate the demands of the hospital owner, the legal framework for treatment and what we know facilitates effective treatment plans. We describe how we have implemented a quality improvement system that addresses these interplaying influences in acute adolescent psychiatry in Norway. The process involved with this system (developed in the UK for child and adolescent psychiatric units) is independent of the organisational structure of the department and which alternative resources it has to rely on. It is independent of the characteristics of the patient population, although specific standards can be developed for local requirements.**

## From QNIC to KvIP

The challenge for quality development concerns how to unite the perspective of the hospital owner with budgets to meet and politicians who determine those budgets with clinical expertise and patient and caregiver perspectives. In Norway there are clear political demands that there be reduced use of coercion, increased patient safety and more patient involvement – ideally costing less. With our focus on the running of acute units, our aim is safe, effective in-patient treatment. The issues are nevertheless the same for other types of unit, and there exists a model for out-patient treatment along similar lines to that described here, where the processes established for self-learning networks are the same.[1]

We first became involved with the model we describe here over 10 years ago. The Royal College of Psychiatrists in the UK developed the Quality Network for Inpatient CAMHS (QNIC).[2] Joining QNIC enabled us to become aware of alternative ways to resolve the challenges of in-patient treatment through three members of staff visiting different units each year. Participating units from the UK, Ireland, Iceland and Turkey sent staff to visit us, and we learned from their reflections on our way of doing things.

The QNIC approach is based on a process of mutually informed reflection on practice, in relation to an agreed set of standards (Box 1). The aim is the creation of a self-learning network of peers. Six years ago one of us established a quality network of in-patient psychiatric units for children and adolescents, known in Norway as KvIP (Quality in In-patient Treatment in Mental Health Care).[3] Establishing KvIP depended on the support of the network for acute psychiatric provision in Norway. Their prime focus is acute admissions, so KvIP limited itself to the adolescent psychiatric acute units, although it would have been just as appropriate to develop a system for all in-patient units. In 2015 four units came together to try out the model for applicability and import for the development of practice. Since then, the network has expanded to encompass 13 units, and none have dropped out. The UK standards were adapted to Norwegian laws and conditions. It is of interest that we found very few to be culturally bound to UK practice and values. The original set of standards came out of the Children and Young Persons Inpatient Evaluation Study (CHYPIE) project.[4]

## The quality assurance process

The guiding principle is a network of peers who evaluate themselves according to a set of standards acknowledged by all as parameters of good practice in that culture. Every year the standards are evaluated and updated if needed. Often this has required a more precise wording so that all agree on what is required. Last year we completed the

**Box 1.** Standard groupings (Norwegian version 2019 (updated 2021 version available at https://www.akuttnettverket.no/prosjekter/kvip-barn-og-unge/materiell-for-deltakere))

- Relevant facilities (49 standards)
- Staffing and training (61 standards)
- Admission and discharge (23 standards)
- Treatment and care (25 standards)
- Information, consent and confidentiality (21 standards)
- Rights and legal framework (15 standards)
- Clinical governance (50 standards)


https://doi.org/10.1192/bji.2021.7 Published online by Cambridge University Press

work to link all standards to our legal framework and the guidelines for interpreting these laws, or to other bureaucratic demands. This implied a series of changes after the introduction of a system for ensuring a standard treatment package across levels of service for specific patient populations and conditions. In setting these new standards, top-down demands and bottom-up clinical experience were resolved and integrated into new objective standards. This process we believe is the essence of the process we now share, as it proves easily adaptable from the UK's National Health Service (NHS) to ours in Norway.

Having agreed standards is of no use unless there is a process within the network to enable their application. The network process is the necessary lubrication to gear up the unit for continual development and is the element that can be adopted in any country, albeit with differences in the standards. Each unit plans for a day visit from a visiting team, consisting of one or two representatives from patient associations (in Norway this might involve one from an association for parents of patients, and another for patients), a medical consultant, a clinical psychologist, a milieu therapist (such as a nurse, a social educator or a therapist with background similar to a residential social worker) and one person with a leadership role from a comparable unit. The participants come from different units. The principle is sharing experience of how challenges in meeting standards can be solved with representatives from major disciplines, together with user representation.

KvIP attempts to create a radically different process compared with an inspection from a quality assurance institution accountable to the owners of the hospital. There is no Norwegian equivalent of the UK's Care Quality Commission. KvIP is a meeting of equals supporting each other through comprehensive continual development. The process starts with the unit going through the 244 standards from seven areas (Box 1). They score themselves according to whether the standard is met, partially met, not met, irrelevant or difficult to answer. Comments to explain the challenges with the standard can be added to help the visiting team. They fill in their achievements for the year and their vision of where they aim to be next year for each area. Each standard is categorised at one of three levels: level 1, absolutely essential to meet, such as a legal requirement; level 2, which any competent unit would be expected to meet; or level 3, which are standards that either the unit itself does not have control over, such as easy access by public transport, or that an ideal unit would be expected to meet. The form is filled out with participation of as many as possible from the unit, including the health and safety representative and representatives of involved unions, before distribution to the visiting team.

The team prepares for the visit on the basis of the self-evaluation and the report from the previous year's site visit, which includes what the unit was aiming to improve prior to the present visit. The evening before the visit the team gathers with a handful of seniors from the unit for an informal meal. Often this meal has proved useful for everyone to get to know each other and for the representatives from the patient organisations to become integrated as equals in the team. It sets the tone for the visit the following day, where all are equal in helping to find solutions to the challenges facing the unit in meeting the standards.

The visit starts with an orientation from team members and the unit to their respective practices and challenges. The team is shown around the unit, ideally by a patient. The team inspects for potential hazards, with the advantage of avoiding the taken-for-granted perspective of the home unit. Then, the team meets the leader group from the unit; the rector from the attached school may be involved. We go through the standards that are not being met, identifying barriers to meeting them and discussing potential solutions given the team's experience. At a first site visit all standards are reviewed, but at subsequent visits two areas for greater in-depth discussion can be singled out. However, the meeting structure can be adapted according to the particular needs of the ward, or to the need for social distancing as in the current pandemic, when we have had virtual site visits.

Half-way through this session one of the patient representatives leaves with another member of the team. In a parallel session they interview a group of volunteer parents/caregivers and record responses to a semi-structured interview guide. The guide can easily be developed to suit local needs. In our situation we asked user organisations to refine our initial guide.

After lunch there are again two parallel sessions. In one of these the other patient representative, and another team member, interview a group of volunteer patients. Another semi-structured interview guide is used. While that is going on, the remainder of the team are interviewing a group of front-line staff. In this group there will be no seniors or supervisors attending, but milieu therapists, psychologists, junior doctors and teachers.

The next part is the most demanding part of the process. Within 40 min the team summarises their feedback for the unit. Feedback is given to those at the unit who can attend, on the unit's strengths, challenges and the team's tips for improvement. After a closing debrief the team head home.

A report written by the team is available for the unit within 20 days. The unit leader provides an introduction to the report and explains the local context for the readers. There is a chance for the unit leader to check facts and clarify misunderstandings before the final version is sent out. The unit leader makes the report available internally to superiors and quality-control leaders at the hospital.

## A final thought

The different components of running a ward are in dynamic interaction with each other in recursive fashion. The array of standards enables the


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interacting moments to be addressed. Challenging blind spots in the building may require a higher staffing ratio. High staff turnover makes demands on the routines for preparing new employees for their duties. Improving quality requires involving both those who receive and provide complex interventions, combining both a top-down and bottom-up perspective. The KvIP process makes this possible.

Do not be put off by the large number of standards. They function, but not on their own. They are embedded in a process to facilitate development over time. We believe that the routines in place with KvIP enable units to be safer places of work, with secure patient contact, in healthy environments which have integrated the current demands from both political committees and the owners of the institutions with good clinical practice.

The annual report from KvIP summarises the overall findings.[5]

## Author contributions

S.R.W. took the lead in writing the manuscript, with input and support from K.E.A.L. Both authors provided critical feedback and contributed to the final version.


## Funding

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.


## Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at https://doi.org/10.1192/bji.2021.7.

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COUNTRY PROFILE

# Towards community care: Qatar's rapidly evolving mental health landscape


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*Keywords.* Psychiatry and law; community care; mental health; Qatar; mental health strategy.

First received 3 Nov 2020
Final revision 17 Jan 2021
Accepted 16 Feb 2021

doi:10.1192/bji.2021.21





**An undercurrent of change is occurring in Qatar's approach towards mental healthcare. In the past 5 years, significant attention has been given to community care initiatives. There is much progress to be made, but the provision of psychiatric support outside of hospitals, the launch of several community services and the tackling of the associated social stigma represent a marked step away from the norm that has usually pervaded in the region. This article analyses these changes and identifies the challenges that remain.**


In recent years, several authors have contributed to a burgeoning body of publications on mental health in Qatar.[1–5] This article builds on this expanding literature by assessing Qatar's progress towards community care as a method for dealing with mental health concerns in the country. This assessment is particularly important at this stage. Healthcare leaders have been determined to enhance community mental healthcare by moving away from institution-based care requiring hospital admission. Although the availability of mental health services remains limited in Qatar, the intention is to move towards a more robust offering of community-based services around the country.[6] Several factors underlie a greater focus on implementing, integrating and utilising mental health services. These include the National Mental Health Strategy (NMHS), Law No. 16 of 2016 on Mental Health, and community-based initiatives. This paper outlines these developments and identifies the remaining challenges. The intention is to establish a comparative anchor for future assessments following the expiry of the current NMHS in 2022. This work was undertaken in Qatar.

## A strategy for community care

The first goal of the National Health Strategy (NHS) is to have a comprehensive world-class healthcare system, with mental health an integral



https://doi.org/10.1192/bji.2021.7 Published online by Cambridge University Press