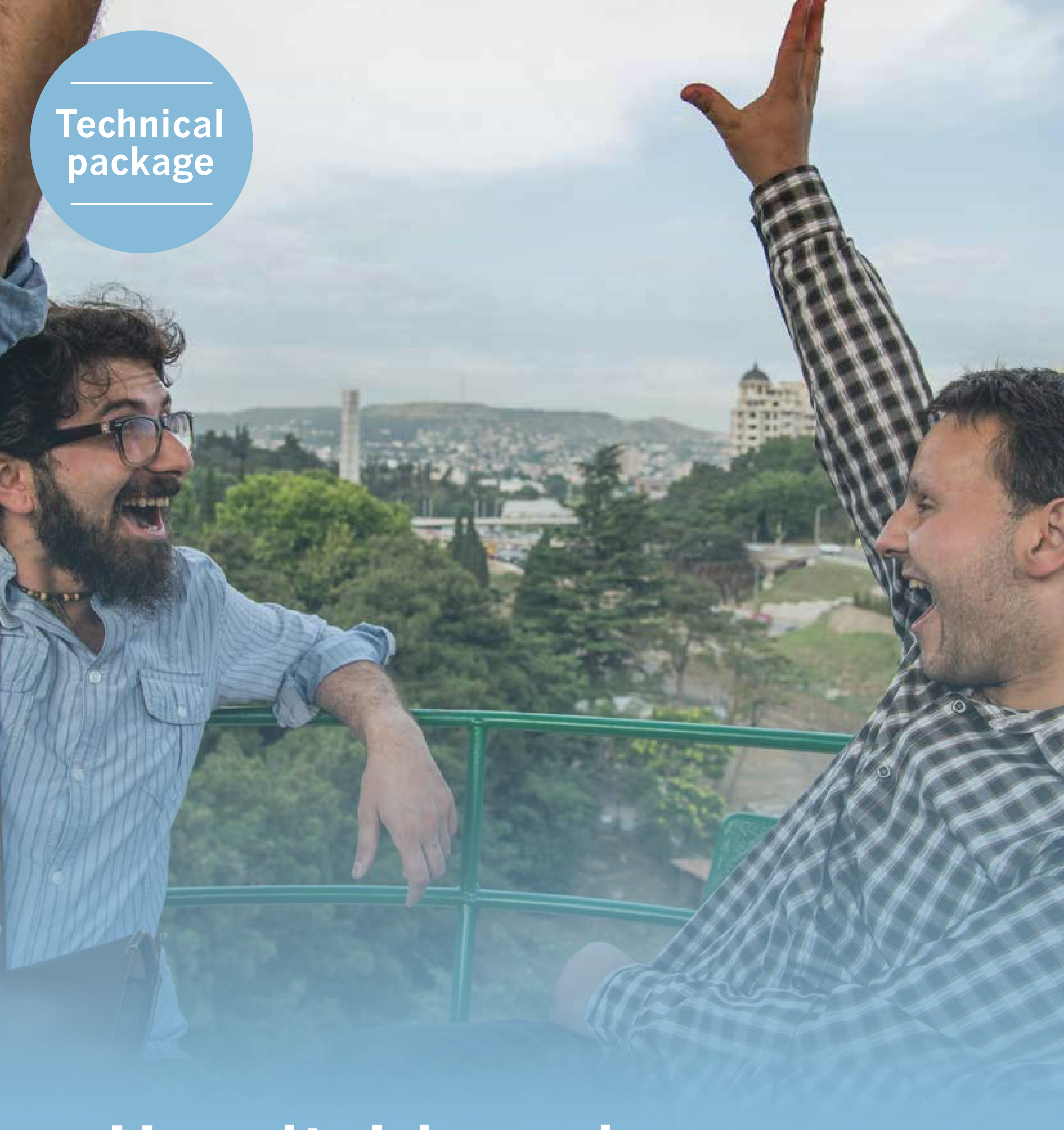
Technical package



# Hospital-based mental health services

## Promoting person-centred and rights-based approaches

World Health Organization

Technical package

# Hospital-based mental health services

## Promoting person-centred and rights-based approaches

World Health Organization

QualityRights

Hospital-based mental health services: promoting person-centred and rights-based approaches

(Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches)

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The accompanying guidance document and technical packages are available here

# Contents

# Foreword

Around the world, mental health services are striving to provide quality care and support for people with mental health conditions or psychosocial disabilities. But in many countries, people still lack access to quality services that respond to their needs and respect their rights and dignity. Even today, people are subject to wide-ranging violations and discrimination in mental health care settings, including the use of coercive practices, poor and inhuman living conditions, neglect, and in some cases, abuse.

The Convention on the Rights of Persons with Disabilities (CRPD), signed in 2006, recognizes the imperative to undertake major reforms to protect and promote human rights in mental health. This is echoed in the Sustainable Development Goals (SDGs) which call for the promotion of mental health and wellbeing, with human rights at its core, and in the United Nations Political Declaration on universal health coverage.

The last two decades have witnessed a growing awareness of the need to improve mental health services, however, in all countries, whether low-, medium- or high-income, the collective response has been constrained by outdated legal and policy frameworks, and lack of resources.

The COVID-19 pandemic has further highlighted the inadequate and outdated nature of mental health systems and services worldwide. It has brought to light the damaging effects of institutions, lack of cohesive social networks, the isolation and marginalization of many individuals with mental health conditions, along with the insufficient and fragmented nature of community mental health services.

Everywhere, countries need mental health services that reject coercive practices, that support people to make their own decisions about their treatment and care, and that promote participation and community inclusion by addressing all important areas of a person's life – including relationships, work, family, housing and education – rather than focusing only on symptom reduction.

The WHO Comprehensive Mental Health Action Plan 2020–2030 provides inspiration and a framework to help countries prioritize and operationalize a person-centred, rights-based, recovery approach in mental health. By showcasing good practice mental health services from around the world this guidance supports countries to develop and reform community-based services and responses from a human rights perspective, promoting key rights such as equality, non-discrimination, legal capacity, informed consent and community inclusion. It offers a roadmap towards ending institutionalization and involuntary hospitalization and treatment and provides specific action steps for building mental health services that respect every person's inherent dignity.

Everyone has a role to play in bringing mental health services in line with international human rights standards – policy makers, service providers, civil society, and people with lived experience of mental health conditions and psychosocial disabilities.

This guidance is intended to bring urgency and clarity to policy makers around the globe and to encourage investment in community-based mental health services in alignment with international human rights standards. It provides a vision of mental health care with the highest standards of respect for human rights and gives hope for a better life to millions of people with mental health conditions and psychosocial disabilities, and their families, worldwide.

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# Executive summary

Mental health has received increased attention over the last decade from governments, nongovernmental organizations (NGOs) and multilateral organizations including the United Nations (UN) and the World Bank. With increased awareness of the importance of providing person-centred, human rights-based and recovery-oriented care and services, mental health services worldwide are striving to provide quality care and support.

Yet often services face substantial resource restrictions, operate within outdated legal and regulatory frameworks and an entrenched overreliance on the biomedical model in which the predominant focus of care is on diagnosis, medication and symptom reduction while the full range of social determinants that impact people's mental health are overlooked, all of which hinder progress toward full realization of a human rights-based approach. As a result, many people with mental health conditions and psychosocial disabilities worldwide are subject to violations of their human rights – including in care services where adequate care and support are lacking.

To support countries in their efforts to align mental health systems and services delivery with international human rights standards, including the Convention on the Rights of Persons with Disabilities (CRPD), the WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches calls for a focus on scaling up community-based mental health services that promote person-centred, recovery- oriented and rights-based health services. It provides real-world examples of good practices in mental health services in diverse contexts worldwide and describes the linkages needed with housing, education, employment and social protection sectors, to ensure that people with mental health conditions are included in the community and are able to lead full and meaningful lives. The guidance also presents examples of comprehensive, integrated, regional and national networks of community-based mental health services and supports. Finally, specific recommendations and action steps are presented for countries and regions to develop community mental health services that are respectful of peoples' human rights and focused on recovery.

This comprehensive guidance document is accompanied by a set of seven supporting technical packages which contain detailed descriptions of the showcased mental health services

1. **Mental health crisis services**
2. **Hospital-based mental health services**
3. **Community mental health centres**
4. **Peer support mental health services**
5. **Community outreach mental health services**
6. **Supported living for mental health**
7. **Comprehensive mental health service networks**

## Key messages of this guidance

- **Many people with mental health conditions and psychosocial disabilities face poor-quality care and violations of their human rights, which demands profound changes in mental health systems and service delivery.**
- **In many parts of the world examples exist of good practice, community-based mental health services that are person-centred, recovery-oriented and adhere to human rights standards.**
- **In many cases these good practice, community-based mental health services show lower costs of service provision than comparable mainstream services.**
- **Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities.**
- **It is essential to scale up networks of integrated, community-based mental health services to accomplish the changes required by the CRPD.**
- **The recommendations and concrete action steps in this guidance provide a clear roadmap for countries to achieve these aims.**

## Introduction

Reports from around the world highlight the need to address discrimination and promote human rights in mental health care settings. This includes eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion[a] and tackling the power imbalances that exist between health staff and people using the services. Sector-wide solutions are required not only in low-income countries, but also in middle- and high-income countries.

The CRPD recognizes these challenges and requires major reforms and promotion of human rights, a need strongly reinforced by the Sustainable Development Goals (SDGs). It establishes the need for a fundamental paradigm shift within the mental health field, which includes rethinking policies, laws, systems, services and practices across the different sectors which negatively impact people with mental health conditions and psychosocial disabilities.

Since the adoption of the CRPD in 2006, an increasing number of countries are seeking to reform their laws and policies in order to promote the rights to community inclusion, dignity, autonomy, empowerment and recovery. However, to date, few countries have established the policy and legislative frameworks necessary to meet the far-reaching changes required by the international human rights framework. In many cases, existing policies and laws perpetuate institutional-based care, isolation as well as coercive – and harmful – treatment practices.

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[a] Strategies to end seclusion and restraint. WHO QualityRights Specialized training. Course guide. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/329605/9789241516754-eng.pdf).

Providing community-based mental health services that adhere to the human rights principles outlined in the CRPD – including the fundamental rights to equality, non-discrimination, full and effective participation and inclusion in society, and respect for people's inherent dignity and individual autonomy – will require considerable changes in practice for all countries. Implementing such changes can be challenging in contexts where insufficient human and financial resources are being invested in mental health.

This guidance presents diverse options for countries to consider and adopt as appropriate to improve their mental health systems and services. It presents a menu of good practice options anchored in community-based health systems and reveals a pathway for improving mental health care services that are innovative and rights-based. There are many challenges to realizing this approach within the constraints that many services face. However, despite these limitations, the mental health service examples showcased in this guidance show concretely – it can be done.

## Examples of good practice community mental health services

In many countries, community mental health services are providing a range of services including crisis services, community outreach, peer support, hospital-based services, supported living services and community mental health centres. The examples presented in this guidance span diverse contexts from, for example, the community mental health outreach service, Atmiyata, in India, to the Aung Clinic community mental health service in Myanmar and the Friendship Bench in Zimbabwe, all of which make use of community health care workers and primary health care systems. Other examples include hospital-based services such as the BET unit in Norway, which is strongly focused on recovery, and crisis services such as Tupu Ake in New Zealand. This guidance also showcases established supported living services such as the KeyRing Living Support Networks in the United Kingdom and peer-support services such as the Users and Survivors of Psychiatry groups in Kenya and the Hearing Voices Groups worldwide.

While each of these services is unique, what is most important is that they are all promoting a person-centred, rights-based, recovery approach to mental health systems and services. None is perfect, but these examples provide inspiration and hope as those who have established them have taken concrete steps in a positive direction towards alignment with the CRPD.

Each mental health service description presents the core principles underlying the service including their commitment to respect for legal capacity, non-coercive practices, community inclusion, participation and the recovery approach. Importantly, each service presented has a method of service evaluation, which is critical for the ongoing assessment of quality, performance and cost-effectiveness. In each case, service costs are presented as well as cost comparisons with regional or national comparable services.

These examples of good practice mental health services will be useful to those who wish to establish a new mental health service or reconfigure existing services. The detailed service descriptions in the technical packages contain practical insights into challenges faced by these services as they evolved, and the solutions developed in response. These strategies or approaches can be replicated, transferred or scaled up when developing services in other contexts. The guidance presents practical steps and recommendations for setting up or transforming good practice mental health services that can work successfully within a wide range of legal frameworks while still protecting human rights, avoiding coercion and promoting legal capacity.

## Significant social sector changes are also required

In the broader context, critical social determinants that impact people's mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, and lack of access to housing, social safety nets, and health services, are factors often overlooked or excluded from mental health discourse and practice. In reality, people living with mental health conditions and psychosocial disabilities often face disproportionate barriers to accessing education, employment, housing and social benefits – fundamental human rights – on the basis of their disability. As a result, significant numbers are living in poverty.

For this reason, it is important to develop mental health services that engage with these important life issues and ensure that the services available to the general population are also accessible to people with mental health conditions and psychosocial disabilities.

No matter how well mental health services are provided though, alone they are insufficient to support the needs of all people, particularly those who are living in poverty, or those without housing, education or a means to generate an income. For this reason, it is essential to ensure that mental health services and social sector services engage and collaborate in a very practical and meaningful way to provide holistic support.

In many countries, great progress is already being made to diversify and integrate mental health services within the wider community. This approach requires active engagement and coordination with diverse services and community actors including welfare, health and judiciary institutions, regional and city authorities, along with cultural, sports and other initiatives. To permit such collaboration, significant strategy, policy and system changes are required not only in the health sector but also in the social sector.

## Scaling up mental health service networks

This guidance demonstrates that scaling up networks of mental health services that interface with social sector services is critical to provide a holistic approach that covers the full range of mental health services and functions.

In several places around the world, individual countries, regions or cities have developed mental health service networks which address the above social determinants of health and the associated challenges that people with mental health and psychosocial conditions face daily.

Some of the showcased examples are well-established, structured and evaluated networks that have profoundly reshaped and reorganized the mental health system; others are networks in transition, which have reached significant milestones.

The well-established networks have exemplified a strong and sustained political commitment to reforming the mental health care system over decades, so as to adopt a human rights and recovery-based approach. The foundation of their success is an embrace of new policies and laws, along with an increase in the allocation of resources towards community-based services. For instance, Brazil's community-based mental health networks offer an example of how a country can implement services at large scale, anchored in human rights and recovery principles. The French network of East Lille further demonstrates that a shift from inpatient care to diversified, community-based interventions can be achieved with an investment comparable to that of more conventional mental health services.

Finally, the Trieste, Italy network of community mental health services is also founded upon on a human rights-based approach to care and support, and strongly emphasizes de-institutionalization. These networks reflect the development of community-based mental health services that are strongly integrated and connected with multiple community actors from diverse sectors including the social, health, employment, judiciary and others.

More recently, countries such as Bosnia and Herzegovina, Lebanon, Peru, and others, are making concerted efforts to rapidly expand emerging networks, and to offer community-based, rights-oriented and recovery-focused services and supports at scale. A key aspect of many of these emerging networks is the aim of bringing mental health services out of psychiatric hospitals and into local settings, so as to ensure the full participation and inclusion of individuals with mental health conditions and psychosocial disabilities in the community. While more time and sustained effort is required, important changes are already materializing. These networks provide inspiring examples of what can be achieved with political will, determination and a strong human rights perspective underpinning actions in mental health.

## Key recommendations

Health systems around the world in low-, middle- and high-income countries increasingly understand the need to provide high quality, person-centred, recovery-oriented mental health services that protect and promote people's human rights. Governments, health and social care professionals, NGOs, organizations of persons with disabilities (OPDs) and other civil society actors and stakeholders can make significant strides towards improving the health and well-being of their populations by taking decisive action to introduce and scale up good practice services and supports for mental health into broader social systems while protecting and promoting human rights.

This guidance presents key recommendations for countries and organizations, showing specific actions and changes required in mental health policy and strategy, law reform, service delivery, financing, workforce development, psychosocial and psychological interventions, psychotropic drugs, information systems, civil society and community involvement, and research.

Crucially, significant effort is needed by countries to align legal frameworks with the requirements of the CRPD. Meaningful changes are also required for policy, strategy and system issues. Through the creation of joint policy and with strong collaboration between health and social sectors, countries will be better able to address the key determinants of mental health. Many countries have successfully used shifts in financing, policy and law as a powerful lever for mental health system reform. Placing human rights and recovery approaches at the forefront of these system reforms has the potential to bring substantial social, economic and political gains to governments and communities.

In order to successfully integrate a person-centred, recovery-oriented and rights-based approach in mental health, countries must change and broaden mindsets, address stigmatizing attitudes and eliminate coercive practices. As such, it is critical that mental health systems and services widen their focus beyond the biomedical model to also include a more holistic approach that considers all aspects of a person's life. Current practice in all parts of the world, however, places psychotropic drugs at the centre of treatment responses whereas psychosocial interventions, psychological interventions and peer support should also be explored and offered in the context of a person-centred, recovery and rights-based approach. These changes will require significant shifts in the knowledge, competencies and skills of the health and social services workforce.

More broadly, efforts are also required to create inclusive societies and communities where diversity is accepted, and the human rights of all people are respected and promoted. Changing negative attitudes and discriminatory practices is essential not just within health and social care settings, but also within the community as a whole. Campaigns raising awareness of the rights of people with lived experience are critical in this respect, and civil society groups can play a key strategic role in advocacy.

Further, as mental health research has been dominated by the biomedical paradigm in recent decades, there is a paucity of research examining human rights-based approaches in mental health. A significant increase in investment is needed worldwide in studies examining rights-based approaches, assessing comparative costs of service provision and evaluating their recovery outcomes in comparison to biomedical-based approaches. Such a reorientation of research priorities will create a solid foundation for a truly rights-based approach to mental health and social protection systems and services.

Finally, development of a human rights agenda and recovery approach cannot be attained without the active participation of individuals with mental health conditions and psychosocial disabilities. People with lived experience are experts and necessary partners to advocate for the respect of their rights, but also for the development of services and opportunities that are most responsive to their actual needs.

Countries with a strong and sustained political commitment to continuous development of community-based mental health services that respect human rights and adopt a recovery approach will vastly improve not only the lives of people with mental health conditions and psychosocial disabilities, but also their families, communities and societies as a whole.

# What is the WHO QualityRights initiative?

WHO QualityRights is an initiative which aims to improve the quality of care and support in mental health and social services and to promote the human rights of people with psychosocial, intellectual or cognitive disabilities throughout the world. QualityRights uses a participatory approach to achieve the following objectives:

1. **Build capacity to combat stigma and discrimination, and to promote human rights and recovery.**
   - WHO QualityRights face to face training modules
   - WHO QualityRights e-training on mental health and disability: Eliminating stigma and promoting human rights
2. **Improve the quality of care and human rights conditions in mental health and social services.**
   - WHO QualityRights assessment toolkit
   - WHO QualityRights module on transforming services & promoting rights
3. **Create community-based and recovery-oriented services that respect and promote human rights.**
   - WHO guidance and technical packages on community mental health services: Promoting person-centred and rights-based approaches
   - WHO QualityRights guidance module one-to-one peer support by and for people with lived experience
   - WHO QualityRights guidance module on peer support groups by and for people with lived experience
   - WHO QualityRights person-centred recovery planning for mental health and well-being self-help tool
4. **Support the development of a civil society movement to conduct advocacy and influence policy-making.**
   - WHO QualityRights guidance module on advocacy for mental health, disability and human rights
   - WHO QualityRights guidance module on civil society organizations to promote human rights in mental health and related areas
5. **Reform national policies and legislation in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards.**
   - WHO guidance currently under development

**For more information visit the WHO QualityRights website**

# About the WHO Guidance and technical packages on community mental health services

The purpose of these documents is to provide information and guidance to all stakeholders who wish to develop or transform their mental health system and services. The guidance provides in-depth information on the elements that contribute towards the development of good practice services that meet international human rights standards and that promote a person-centred, recovery approach. This approach refers to mental health services that operate without coercion, that are responsive to people's needs, support recovery and promote autonomy and inclusion, and that involve people with lived experience in the development, delivery and monitoring of services.

There are many services in countries around the world that operate within a recovery framework and have human rights principles at their core – but they remain at the margins and many stakeholders including policy makers, health professionals, people using services and others, are not aware of them.

The services featured in these documents are not being endorsed by WHO but have been selected because they provide concrete examples of what has been achieved in very different contexts across the world. They are not the only ones that are working within a recovery and human rights agenda but have been selected also because they have been evaluated, and illustrate the wide range of services that can be implemented.

Showing that innovative types of services exist and that they are effective is key to supporting policy makers and other key actors to develop new services or transform existing services in compliance with human rights standards, making them an integral part of Universal Health Coverage (UHC).

This document also aims to highlight the fact that an individual mental health service on its own, even if it produces good outcomes, is not sufficient to meet all the support needs of the many people with mental conditions and psychosocial disabilities. For this, it is essential that different types of community-based mental health services work together to provide for all the different needs people may have including crisis support, ongoing treatment and care, community living and inclusion.

In addition, mental health services need to interface with other sectors including social protection, housing, employment and education to ensure that the people they support have the right to full community inclusion.

The WHO guidance and technical packages comprise a set of documents including:

- ***Guidance on community mental health services: Promoting person-centred and rights-based approaches –*** This comprehensive document contains a detailed description of person-centred, recovery and human rights-based approaches in mental health. It provides summary examples of good practice services around the world that promote human rights and recovery, and it describes the steps needed to move towards holistic service provision, taking into account housing, education, employment and social benefits. The document also contains examples of comprehensive, integrated networks of services and support, and provides guidance and action steps to introduce, integrate and scale up good practice mental health services within health and social care systems in countries to promote UHC and protect and promote human rights.

- ***Seven supporting technical packages on community mental health services: Promoting person-centred and rights-based approaches*** **–** The technical packages each focus on a specific category of mental health service and are linked to the overall guidance document. The different types of services addressed include: mental health crisis services, hospital-based mental health services, community mental health centres, peer support mental health services, community outreach mental health services, supported living services for mental health, and networks of mental health services. Each package features detailed examples of corresponding good practice services which are described in depth to provide a comprehensive understanding of the service, how it operates and how it adheres to human rights standards. Each service description also identifies challenges faced by the service, solutions that have been found and key considerations for implementation in different contexts. Finally, at the end of each technical package, all the information and learning from the showcased services is transformed into practical guidance and a series of action steps to move forward from concept to the implementation of a good practice pilot or demonstration service.

Specifically, the technical packages:

- showcase, in detail, a number of mental health services from different countries that provide services and support in line with international human rights standards and recovery principles;
- outline in detail how the good practice services operate in order to respect international human rights standards of legal capacity, non-coercive practices, community inclusion, participation and the recovery approach;
- outline the positive outcomes that can be achieved for people using good practice mental health services;
- show cost comparisons of the good practice mental health services in contrast with comparable mainstream services;
- discuss the challenges encountered with the establishment and operation of the services and the solutions put in place to overcome those challenges; and
- present a series of action steps towards the development of a good practice service that is person-centred and respects and promotes human rights and recovery, and that is relevant to the local social and economic context.

It is important to acknowledge that no service fits perfectly and uniquely under one category, since they undertake a multitude of functions that touch upon one or more of the other categories. This is reflected in categorizations given at the beginning of each mental health service description.

These documents specifically focus on services for adults with mental health conditions and psychosocial disabilities. They do not include services specifically for people with cognitive or physical disabilities, neurological conditions or substance misuse, nor do they cover highly specialized services, for example, those that address eating disorders. Other areas not covered include e-interventions, telephone services (such as hotlines), prevention, promotion and early intervention programmes, tool-specific services (for example, advance planning), training and advocacy. These guidance documents also do not focus on services delivered in non-specialized health settings, although many of the lessons learned from the services in this document also apply to these settings.

## How to use the documents

*Guidance on community mental health services: Promoting person-centred and rights-based approaches* is the main reference document for all stakeholders. Readers interested in a particular category of mental health service may refer to the corresponding technical package which provides more detail and specific guidance for setting up a new service within the local context. However, each technical package should be read in conjunction with the broader Guidance on community mental health services document, which provides the detail required to also integrate services into the health and social sector systems of a country.

## These documents are designed for:

- relevant ministries (including health and social protection) and policymakers;
- managers of general health, mental health and social services;
- mental health and other health and community practitioners such as doctors, nurses, psychiatrists psychologists, peer supporters, occupational therapists, social workers, community support workers, personal assistants, or traditional and faith based healers;
- people with mental health conditions and psychosocial disabilities;
- people who are using or who have previously used mental health and social services;
- nongovernmental organizations (NGOs), and others working in the areas of mental health, human rights or other relevant areas such as organizations of persons with disabilities, organizations of users/survivors of psychiatry, advocacy organizations, and associations of traditional and faith-based healers;
- families, support persons and other care partners; and
- other relevant organizations and stakeholders such as advocates, lawyers and legal aid organizations, academics, university students, community and spiritual leaders.

## A note on terminology

The terms “persons with mental health conditions and psychosocial disabilities” as well “persons using mental health services” or “service users” are used throughout this guidance and accompanying technical packages.

We acknowledge that language and terminology reflects the evolving conceptualization of disability and that different terms will be used by different people across different contexts over time. People must be able to decide on the vocabulary, idioms and descriptions of their experience, situation or distress. For example, in relation to the field of mental health, some people use terms such as “people with a psychiatric diagnosis”, “people with mental disorders” or “mental illnesses”, “people with mental health conditions”, “consumers”, “service users” or “psychiatric survivors”. Others find some or all these terms stigmatizing or use different expressions to refer to their emotions, experiences or distress.

The term “psychosocial disability” has been adopted to include people who have received a mental health-related diagnosis or who self-identify with this term. The use of the term “disability” is important in this context because it highlights the significant barriers that hinder the full and effective participation in society of people with actual or perceived impairments and the fact that they are protected under the CRPD.

The term “mental health condition” is used in a similar way as the term physical health condition.  A person with a mental health condition may or may not have received a formal diagnosis but nevertheless identifies as experiencing or having experienced mental health issues or challenges. The term has been adopted in this guidance to ensure that health, mental health, social care and other professionals working in mental health services, who may not be familiar with the term ‘psychosocial disability’, nevertheless understand that the values, rights and principles outlined in the documents apply to the people that they encounter and serve.

Not all people who self-identify with the above terms face stigma, discrimination or human rights violations. a user of mental health services may not have a mental health condition and some persons with mental health conditions may face no restrictions or barriers to their full participation in society.

The terminology adopted in this guidance has been selected for the sake of inclusiveness. It is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere. Above all, a diagnosis or disability should never define a person. We are all individuals, with a unique social context, personality, autonomy, dreams, goals and aspirations and relationships with others.

# 1.

# Introduction

General hospital-based mental health services provide treatment and care through mental health inpatient units, outpatient services and community outreach services. Historically, hospital-based services for mental health in many countries have comprised psychiatric hospitals or social care institutions that resemble prisons and are isolated from the rest of the community. People often reside in these settings for weeks, months and even years. These settings are often associated with extensive coercive practices and human rights violations including violence, abuse and neglect, as well as involuntary admission and treatment, seclusion and physical, mechanical and chemical restraints, as well as inhuman and degrading living conditions *(1-3)* .

The services presented in this technical package depart from this model and instead provide hospital-based care in general hospital settings that are integrated within the general health system and the rest of the community. Indeed, these services are organized so that people spend a minimum amount of time in inpatient care and remain connected to their support networks throughout their stay. The services strive to connect people to other community-based services and supports beyond those provided in the hospital setting, to facilitate peoples' return to their lives and community.

Moreover, all of the services showcased have processes in place to end the use of coercive practices. These services also strive to respect people's right to informed consent and to make decisions for themselves about treatment and other matters. For example, they may be encouraged to draft advance directives or crisis plans, or participate in other initiatives to promote decision-making and autonomy.

Phasing out stand-alone psychiatric hospitals and social care institutions in favour of community-based alternatives is critical. Ensuring people receive care and support that is responsive to their needs and respects their human rights is paramount. Mental health services provided in general hospital settings can be helpful in achieving these goals, when provided as part of a range of community-based services and support. Such services, delivered in a non-coercive way, can respect a person's will, preferences and autonomy and support them through their recovery journey. The examples provided in this technical package show that it is possible to have quality mental health care and support in general hospital settings, and is an option for people who believe they would benefit from hospital-based services.

The services described in this technical package were chosen following an extensive search and screening of services identified through literature reviews, a comprehensive internet search, an e-consultation and with input from existing WHO networks and collaborators. A detailed description of the methodology is provided in the annex of the *Guidance on community mental health services: Promoting person-centred and rights-based approaches* The selection process was based on the five human rights and recovery criteria, namely: respect for legal capacity, non-coercive practices, participation, community inclusion, and the recovery approach. Services from low-income contexts and under-represented geographical regions were prioritized where possible and/or appropriate, as well as services with evaluation data. One of the key challenges identified in reviewing the services was the lack of robust evaluation data. This challenge was encountered across all service categories. The need for greater investment in evaluating services is one of the recommendations made in the section on guidance and action steps in *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. The services described in this technical package are not intended to be interpreted as best practice, but rather to illustrate what can be done and to demonstrate the wider potential of community-based mental health services that promote a person-centred, rights-based, recovery approach.

Providing community-based mental health services that adhere to human rights principles represents considerable shifts in practice for all countries and sets very high standards in contexts where insufficient human and financial resources are being invested in mental health. Some low-income countries may assume that the examples from high-income countries are not appropriate or useful, and equally, for high-income countries looking at the examples showcased from low-income countries. New types of services and practices may also generate a range of questions, challenges, and concerns from different stakeholders, be it policy makers, professionals, families and carers or individuals who use mental health services. The intention of this guidance is not to suggest that these services be replicated in their entirety, but rather to take and learn from those principles and practices that are relevant and transferrable to one’s own context in providing community-based mental health services that are person-centred and promote human rights and recovery.

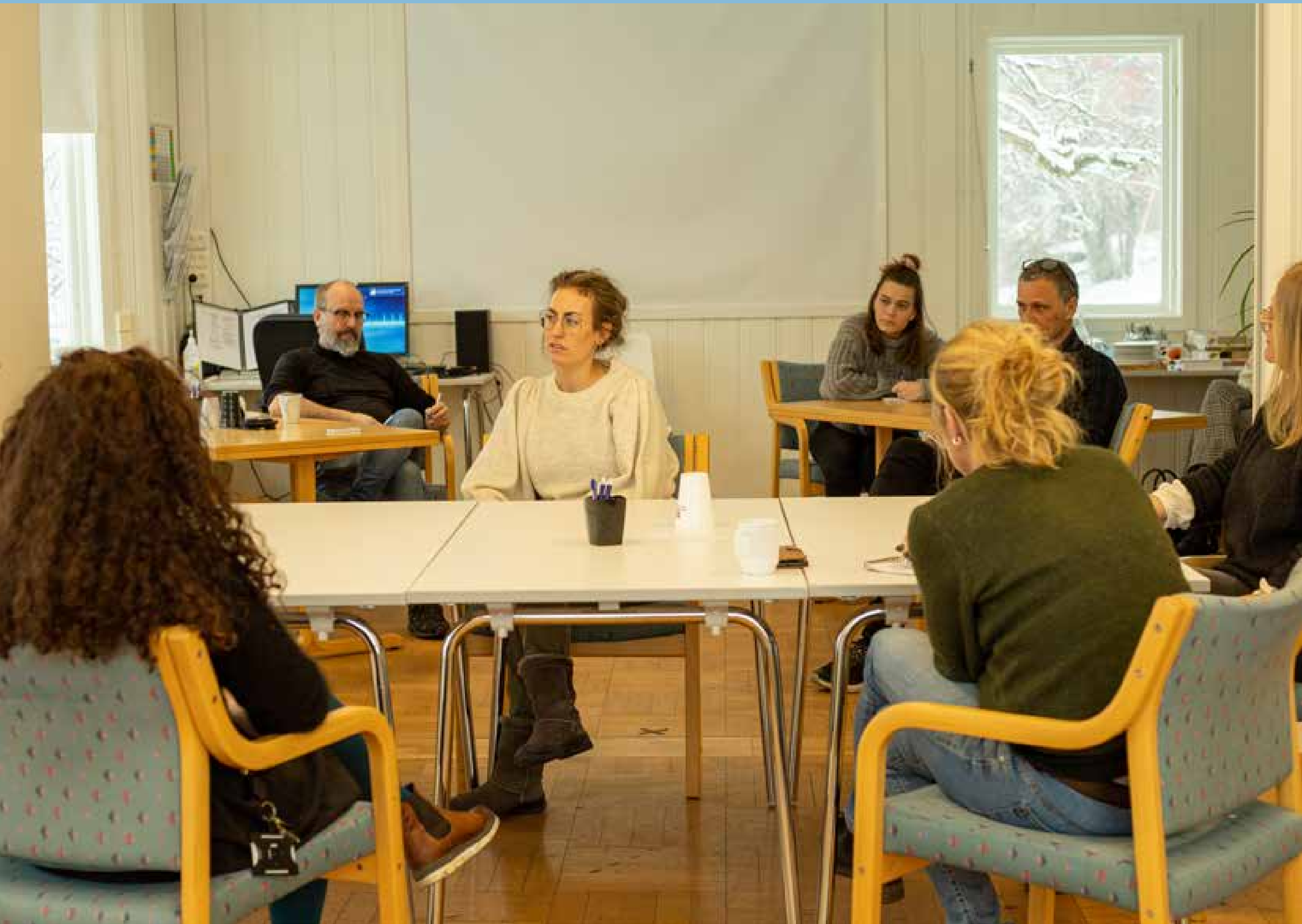
# 2.

# Hospital-based mental health services – description and analysis

## 2.1

# BET Unit, Blakstad Hospital, Vestre Viken Hospital Trust

Viken, Norway



**Primary classification: Hospital-based service**

**Other classifications:**

☐ Community mental health centre
☐ Community outreach
☐ Peer support
☐ Crisis service
☐ Hospital-based service
☐ Supported living service

**Availability in different locations:**

☑ Yes
☐ No

**Evidence:**

☑ Published literature
☑ Grey literature
☐ None

**Financing:**

☑ State health sector
☐ State social sector
☐ Health insurance
☐ Donor funding
☐ Out-of-pocket payment

## Context

The Basal Exposure Therapy (BET) Unit is located at Blakstad Hospital near Asker, 30 km south of Oslo in Norway. Blakstad Hospital is part of the Vestre Viken Hospital Trust, within the South-East Health Care Region — the largest of four health care regions in Norway. Since its creation in 2000, the BET Unit has offered services to people with mental health conditions and psychosocial disabilities who have found other forms of mental health care and support neither beneficial nor effective. Previously part of the locked psychosis unit at Blakstad Hospital, in 2018 the BET Unit became an independent open-door service available 24 hours a day, seven days a week. Since then, the approach used by the unit has also been more widely incorporated throughout the Trust and is currently available as a treatment alternative at several outpatient clinics. The BET services receive referrals from all over Norway.

The BET Unit at Blakstad has been involved in establishing BET facilities elsewhere in Norway. It helped Northern Norway Hospital Trust implement the BET approach at a treatment facility for youth (UPS) in 2017; Vestfold Hospital District Psychiatric Centre was helped to establish a BET Unit in 2019 and the following year, established a specialized BET team at its outpatient clinic. The Blakstad Unit is currently involved in planning a BET Unit at the Southern Norway Hospital Trust in 2021 and is applying for Norwegian National Advisory Unit status. The mandate for such a national unit is to disseminate knowledge about BET and support the implementation of this treatment modality by additional health care trusts in Norway.

## Description of the service

The BET Unit was developed as a service for people with complex, long-term mental health conditions. The open unit is equipped with six beds and provides round-the-clock residential treatment and support for an average of 6–10 people per month. The service strives to meet individuals on their own terms, providing a holistic model of care and moving beyond the traditional biomedical model of diagnosis and treatment. Users of the service include individuals diagnosed with or who identify has having diagnoses such as those on the schizophrenia spectrum and other psychoses, post-traumatic stress disorder (PTSD), complex trauma and dissociative conditions, as well as various mental health conditions affecting mood and personality. Many of the service users also struggle with the harmful use of substances.

The BET Unit is located on the Blakstad Hospital campus. It is housed in a two-storey building with individual bedrooms and three shared bathrooms for users of the service. The building was recently renovated and adapted for BET treatment; the interior is relatively minimalistic, but comfortable. Offices and therapy rooms are in a separate building located nearby. The unit has a total of 19.5 full-time employees, including a psychiatrist, two psychologists and administrative personnel *(4)*. Other professionals include psychiatric nurses, social workers and learning disability nurses, known as social educators (*vernepleiere*). All team members at the BET Unit receive the same therapeutic training in the BET model. Regardless of their formal qualifications, they are all referred to as therapists and directly involved in the intensive psychotherapeutic processes in the unit, where they operate as a multi-disciplinary team.

Individuals referred to the BET Unit have generally experienced numerous and lengthy admissions to mental health facilities. Most have repeatedly tried to harm themselves, attempted suicide or have been subject to excessive coercive and restraining interventions by other mental health services. Many have used multiple psychotropic drugs for prolonged periods of time *(5, 6)*. All individuals admitted to the BET Unit have severe and complex mental health conditions and challenges involving severely impaired psychosocial functioning. Despite several prior attempts at long-term or intensive treatments, these individuals have not reported significant improvements in terms of quality of life, and some have deteriorated over time *(5)*.

The BET Unit does not provide services to people with intellectual disabilities or mental health conditions characterized by extensive harmful use of substances combined with persistent hostility and a history of frequent episodes of severe violent behaviour *(6)*. The harmful use of substances is not an exclusion criterion per se. However, if it has an adverse impact on the individual's chances to profit from treatment, it is addressed as an avoidance strategy and therefore as a part of the problem.

Individuals with multiple severe mental health challenges are referred to the BET Unit by their GPs, outpatient clinics and other inpatient wards in the Vestre Viken Hospital Trust and other hospital trusts in Norway. When admitting referrals to the BET Unit, the clinical practitioners — psychiatrists or specialists in clinical psychology — assess whether:

- the person fulfils the statutory criteria laid down by Norwegian health authorities for a mental health service of this nature;
- the person requires round-the-clock residential treatment or could instead benefit from outpatient services or other evidence-based care that is less costly; or
- care at the BET Unit is a cost-effective option compared with other services.

The decision to offer 24-hour BET care and support is based on information provided in the referral, interviews with the person in question and psychometric assessments. A decision to refuse a referral to the BET Unit will usually be made after meeting the person in question and completing assessments. In 2020, the waiting list for admission to the BET Unit was 8 – 12 months long. While waiting, individuals will continue to receive treatment services from their local district psychiatric service.

It is highly unusual for the BET team to ask a user of the service to leave the unit. However, such a request may be necessary in response to the ongoing harmful use of substances or active opposition to care and support especially when this has an adverse impact on other service users. Individuals are free to stop their care and leave the service at any time. They can also suspend their care temporarily if the challenges of life outside the unit make excessive demands on their time and energy.

### *The psychotherapeutic model used by the BET Unit*

Basal exposure therapy addresses symptoms of severe, complex mental health challenges that can originate from a pervasive fear response — sometimes called phobic fear or "existential catastrophe anxiety" *(5, 6)* — which the person is unable to address using effective, functional coping strategies. People with lived experience using this service, refer to this as a fear of being engulfed by a total void, or of being trapped forever in eternal pain. For example, a service user may feel that they are going to explode, if they fail to do whatever they can to prevent an increase in affective arousal. As a result, service users go to great lengths to avoid triggers and experiences associated with this fear. In doing so, however, they often perpetuate and exacerbate their mental health conditions. Examples of avoidance strategies include direct and indirect self-harm, inactivity and hyperactivity, starvation and overeating, dissociation, and the excessive use of legal and illegal drugs *(7)*.

At the BET unit, individuals are offered the opportunity to expose themselves to their innermost fears — both thoughts and feelings — in a safe and secure environment. Within this context, repeated exposure enables individuals to gradually recognize that there is actually nothing to fear, even though it may feel like danger is present *(8)*. Eventually, avoidance loses its function, since it is no longer the only way to cope with fears. Consequently, people learn to relate to and accept pain or difficult experiences rather than using all their energy to avoid them.

One of the aims of this therapeutic process is for individuals to start to manage emotional stress by exposing themselves to their fears when they are on their own and not just with the support of a therapist. This autonomous coping is validated, followed up and supported by therapists through solution-focused interventions. This method reinforces the person's successful efforts to try new functional coping skills. Thus, these interventions empower the person and promote self-efficacy *(4)*.

Solution-focused interventions may also be used to support and reinforce the process of developing routine coping skills and making functional choices, such as setting an alarm to be on time for appointments and asking for help before a situation becomes critical. Such actions are highlighted, validated and attributed to the individual's willingness and effort to cope with and manage challenges. In this way, functional choices made by the individual are reinforced, increasing the probability that these positive coping strategies will be repeated under other challenging circumstances.

The BET Unit considers medications secondary to the psychotherapeutic approach. In addition, the use of certain medications may be contraindicated, such as the regular use of high-dose benzodiazepines. The rationale for avoiding certain medications at this unit is that they can prevent the person from accessing their innermost experiences, phobias and fears, as part of exposure therapy *(6)*. During the weeks or months prior to admission, the BET team often initiates a dialogue on tapering medications with the informed consent of the service user. While tapering drugs is not mandatory at BET, most people with polypharmacy taper their medications with support because of negative health impacts and in order to achieve maximum benefit from the therapeutic process.

The service user and the BET psychiatrist work together to draft a plan for drug discontinuation or reduction. This dialogue focuses on the person's own values, which are key to promoting ownership of the process *(6)*. Together, they work out a schedule, taking into account the person's motivation, previous experiences with medication, types of medication, dosage, severity of side-effects, drug interactions, and mental health challenges. To ensure a holistic approach to care and support throughout the entire inpatient stay, the psychiatrist and multi-disciplinary BET team review and adjust the service user's medication lists on a weekly basis.

### *Complementary External Regulation*

Complementary External Regulation (CER) is an approach initiated as soon as the person enters the BET service. CER aims to promote positive functional choices and actions, and to eliminate coercive measures from the care process *(7)*. The successful application of the CER strategy both secures and strengthens the person's autonomy, ensuring that the inpatient stay can be used to address mental health challenges rather than dealing with acute crises *(4)*.

CER's primary strategy is called under-regulation. Here, therapists interact with service users in a non-hierarchical manner, treating them as equals who are fully responsible for their own choices and actions. For example, while individuals in the BET Unit are free to leave the unit whenever they want, they are held accountable for being on time for appointments *(4)*. They are never reminded or told to take medication or eat meals. Instead, there is constant acknowledgment and recognition that they are capable of making their own decisions. They are, however, encouraged to notify staff members when they leave the unit and to be transparent about any plans they may have to leave.

If a service user self-harms while on the ward, the BET team will not take legal steps. Instead, follow-up focuses exclusively on providing the medical attention the person requires after the self-harm event (for example, stitches for wounds). After addressing the person's medical needs, the under-regulated approach is continued.

In situations where a service user's actions present an acute threat to life or health, staff members intervene in a purely medical and procedural manner. If such actions recur, the service team, together with the service user, may agree on a strategy to introduce what is termed an "over-regulation" phase. Over-regulation is a coordinated approach in which care and attention provided by staff is intensified, but exposure to stimuli in the environment is reduced. Everything is slowed down, for example, and therapists will speak slowly and pause for longer than usual before responding. Over-regulation is carried out in a compassionate, cautious and respectful manner and in collaboration with the person concerned *(7, 9)*.

Importantly, over-regulation has been used no more than four or five occasions since 2005. In each case, the service user's life and health were at risk in acute situations, and the BET team felt obliged to take control and prevent the person from taking their own life or inflicting severe, irreversible physical injury. Well-coordinated under-regulation is the primary means by which the service addresses suicidal and self-harming actions. Suicide risk assessments are performed regularly, but not by questioning the service user directly. The team makes round-the-clock observations, with each shift reporting to the next if there are indications of heightened suicide risk. The psychiatrist or clinical psychologist on the BET team documents risk factors on a weekly basis and makes recommendations related to safety for the coming week.

### Intervention-validating communication

Validating communication is an ongoing strategy used in BET. Service users are always included in an accepting relationship with members of the BET team. The experiences that service users share are always respected; any feeling is considered true and real, no matter who or what has evoked it. Acknowledging and speaking freely about emotions enhances service users' self-awareness and ability to engage in functional self-regulation *(7)*.

### A treatment context that resembles normal working life

The BET Unit provides a highly structured environment that is organized like a full-time workday for the people using the service. The day is scheduled from 09:00– 16:30. Activities from Monday to Friday include group and individual sessions, physical activities and treatment planning, as well as process meetings with individuals who are active participants in the programme.

### Morning meeting and psychoeducation

To coordinate and inform service users, each day starts with a group meeting to share information about appointments and activities. Psychoeducation groups are held with a visitor, often a former user of the service or a therapist. Service users can request specific topics be discussed. They are expected to participate, although doing so is not mandatory.

### Individual therapy and support sessions

Each service user has at least one daily individual therapy session with a therapist. However, a service user does not have just one designated therapist. The therapists on the BET team alternate and team members are to some degree involved in all therapeutic processes within the unit. Alternating therapists helps to widen the range and scope of perspectives available to the service user. This may stimulate psychological flexibility, as well as promote the adaptation of the treatment to the individual, thus making exposure therapy more effective. The frequency of alternation may differ from person to person, however. While it may be optimal for some service users to meet a different therapist every day, others find it more worthwhile to work with the same therapist for two or three days in a row.

The BET unit also provides psychosocial support, interactions not based on individual therapy sessions. Support may take place during everyday activities such as before or after a meal or a walk; the therapist may invite the service user to sit down together and work towards the acceptance of intrusive painful thoughts. These therapy interactions are coordinated in reflective team sessions among staff.

### Care planning

Service users have regular individual process meetings with the BET team. These sessions usually last for half an hour, addressing care planning in terms of what the service user wants to process or reflect upon with staff members. For instance, a service user may ask for a group discussion regarding their need for community services after being discharged from BET. The concerned service user is actively engaged in formulating and specifying the meeting agenda for such team meetings, as well as for follow-up work to revise and update their care plan. A service user can also call on the team to provide feedback on the therapeutic process itself. They are routinely invited and encouraged to do so at the end of their BET treatment.

### Focus sessions

Focus sessions in the morning and afternoon respectively, are used to help service users identify and zoom in on a specific challenge during each day, and to think about what they have experienced and learned by addressing this challenge. Focus sessions are narrowed down to 10–15 minutes and feature parameters that are more formal. The wider goal is to facilitate and prepare the service user for exposure therapy, and then work with the therapists systematically to replace avoidance strategies with acceptance and mindfulness.

### Physician appointments

BET aims to separate therapy from somatic health issues. Together with the physician at the BET Unit, service users make plans to adjust and adapt their use of medication to the psychotherapeutic process, which will usually involve a step-by-step withdrawal from polypharmacy. Individuals have weekly opportunities for appointments to discuss any somatic health problems they may be experiencing.

### General monthly meetings

Service users meet with the administrative BET staff members once a month to address practical issues. For example, they may wish to discuss the quality of food services, cleaning, and ways to improve the practical organization of the care programme and their workdays. The BET staff can also take advantage of this forum to inform service users about relevant practical issues and hospital procedures.

### Physical activity

Physical activity is included in the BET programme on a daily basis, with a 30-minute walk after the morning meeting as the mandatory minimum. Any additional physical activity can be initiated and organized by the individual service user.

### The weekend

As part of the programme, the working week is normalized and distinguished from leisure time. Individuals spend weekends at home, where they can practice what they have learned and gain new experiences that can be the focus of therapy sessions in the coming week. Service users who live too far away have the option of spending weekends in the unit, but are required to take weekend leave at least once a month. This is a well-coordinated practice, so the unit is staffed during three out of every four weekends. For service users who spend their weekends in the unit, there is a minimum programme consisting of a daily focus session, supplemented by a 20 or 30-minute therapy session that may be oriented to more practical issues than the regular exposure sessions during the working week.

### Coordination of services and clinical training

Different strategies are employed to enhance multi-disciplinary coordination and ensure that staff members maintain a consistent course of treatment even in the face of difficult situations. Team members participate in feedback-based supervision, which consists of skills training with role-play and feedback from other team members. In the collective supervision sessions, therapists are trained to make functional decisions about when and how to intervene, while remaining cognizant of the therapeutic purpose for interacting with the service user. Situations experienced in the therapy room and everyday situations in the unit will be used later for both role-plays and feedback.

Feedback-based supervision takes place six times a week in 30-minute sessions. The purpose of such frequent and comprehensive skills training is to empower team members and enhance their abilities to manage and put into practice a clinical practice that deliberately reflects the principles and guidelines of BET.

As part of the BET team's morning meeting, employees also participate in their own reflective team meetings on top of more structured, feedback-based supervision. The purpose of these meetings is to establish a common focus and sense of coherence for all team members with a view to supporting and coaching individual service users. By using a reflective team, the BET therapists work together to transfer BET principles and values into everyday clinical practice. Reflective team meetings are also used in the ongoing efforts to improve BET's service in terms of administration, clinical services and the provision of supervisory and educational services to other units in the hospital trust.

### The team coordinator as the service user's personal assistant

A key role within the BET Unit is that of team coordinator. Here, a member of the BET team, usually one of the nurses or social workers, serves as a personal assistant or secretary to service users. The individual using the service is in charge, but the team coordinator supports the person in a variety of ways; helping to contact the family or community services, preparing care plans and making an agenda for the next meeting with the BET team. Regular meetings between the service user and the team coordinator serve as a means to establish mutual understanding. The individual can convey what is important to them, and the team coordinator explains the core principles of BET treatment. Later, in feedback-based supervision and reflective team sessions, the team coordinator is able to seek guidance from other BET team members.

When preparing to be discharged from the BET Unit, service users can ask for help from their team coordinator and the BET team. Assistance will usually include meetings with close relatives, guidance on the use of community services, scheduling appointments, and facilitating follow-up meetings between the service user and the BET Unit.

## Core principles and values

### *Respect for legal capacity*

Treatment at the BET unit, and the therapeutic process is never forced on an individual. It is always based on the service user's choices *(7)*. In principle, a service user can choose not to expose themselves at all. In such cases, the BET team and the service user discuss what to do next. If the service user refuses any treatment aimed at self-efficacy and autonomy, the next step will be to prepare for discharge. This has very rarely been required. However, when it has occurred, the BET team has been supportive so that the person involved was able to find mental health care more suitable to their needs.

The BET service is based on the principle that before recovery can take place, it is imperative that service users take responsibility for their own choices and lives *(10)*. Indeed, service users are considered the main actors in decisions about their own care and support throughout the process. For instance, they can decide the frequency and intensity of exposure in the therapeutic sessions with the therapists, and they are involved in drafting their own psychotropic drug withdrawal plan. All therapeutic steps are discussed with the service user. This is a practice that promotes ownership of and responsibility for therapeutic success *(11)*. Informed consent is secured through structured interviews, process-oriented meetings with the team coordinator and the BET team. The service user is also involved in decisions, which are usually made at the end of discussions they have with the team. This practice reflects BET's ethos, that service users are considered to have legal capacity on an equal basis with others. Those who struggle with unusual experiences, such as hearing voices, are also considered accountable for their own choices and actions, meaning they are also capable of participating in making decisions about their own treatment.

Furthermore, the Complementary External Regulation approach invites people who experience mental health challenges to take full responsibility for their actions. Health care workers at BET refrain from interventions that could feed into ideas service users may have about being saved or taken care of by others. Instead, the very context of the BET service encourages service users to make functional choices in order to regulate their own behaviour *(12)*. Indeed, in under-regulation, service users are held fully accountable for all their decisions and actions (for example whether to eat, to go out or withdraw from social interaction, and whether to be passive or active in meetings).

Though rare, service users may sometimes harm themselves repeatedly. In such cases, over-regulation offers an environment that provides an incentive for the person to initiate a dialogue about how to regain full freedom to decide for themselves a course of action. Once they are back on track, the steps to recovery are attributed exclusively to their own choices and actions. This total credit for progressive change and treatment success is empowering and reinforces the service user's capacity and motivation to cope with mental health challenges *(7)*.

Sometimes situations arise that require acute medical attention and, therefore, independent intervention in accordance with provisions set out in Norway's existing legislation on legal capacity and emergency care. Yet, despite such legal provisions, the unit tries to solve such dilemmas by referring to the service user's will and preferences in a crisis situation. To save a life or prevent serious physical harm, medical attention is provided on the assumption that the service user would have wanted treatment — based on earlier discussions with the service user. By design, this action is rooted in a supportive decision-making model rather than a best-interest approach. BET has compiled procedures and detailed descriptions that include when and how to intervene, when not to intervene, as well as how episodes and interventions should be documented in the service user's hospital record.

Training and institutional guidance are also provided to ensure that staff members respect the values and choices of the people using the service, even when they choose not to cooperate *(9)*. BET training focuses on the language used during an intervention; specifically how questions are formulated, the tone of voice, and the kind of responses that are appropriate for a specific type of behaviour. The goal is to facilitate autonomy in every interaction. Service users are interviewed before and during the therapeutic process so that they can explain their treatment goals and express their wishes in advance. The process also involves mapping users' networks, including who they would like to involve in their care and who will support their autonomy and the right to make decisions. The BET Unit strives to put a therapeutic focus on promoting a service user's ability to make functional, considered choices, not least under difficult or challenging circumstances. This reduces reliance on advance planning for managing a potential crisis.

### *Non-coercive practices*

The clear stance of the BET Unit is not to use force. In the past two years, no coercive measures have been used by BET. The safety and well-being of other service users and therapists was threatened at the BET Unit just once. The success of the therapy is contingent upon a strong working alliance between staff and service users. When difficulties arise, the focus is placed on "the context that precipitated the situation" *(4)*. Almost without exception, a modest adjustment and enhanced coordination of the under-regulation approach will effectively address the crisis and re-establish cooperation between the service user and the BET team.

Tools such as reflective practices and feedback-based supervision, exist in the BET service to promote a coordinated approach to care that does not include the use of coercion. Exercises include envisaging a particular situation and reflecting on how staff should react under those circumstances. Staff members are also trained in conflict management and prevention, and staff are debriefed after crises *(9)*.

Through their affiliation with Blakstad Hospital, team members at the BET Unit are committed to participating in a training programme entitled Management of Aggression Problems (MAP). This course promotes good practice for cooperation among health professionals within and between units. Health care workers are trained to identify early signs of aggression and practice de-escalation techniques, as well as techniques that can reduce the risk of physical harm. All members of staff participate in 45-minute MAP training sessions every Monday.

In challenging situations, service users are always treated as having the capacity to be responsible for their own actions. Good communication and verbal de-escalation are used to secure the situation, and the person may be asked to leave the unit or to consider referral to another unit. At the BET Unit, service users are invited to take ownership of their problems as the starting point for a dialogue with BET therapists on how to address the challenges they face.

On occasion, hospital administrators have requested (or required) the BET Unit to take responsibility for a person committed for involuntary treatment. In such cases, one explicit goal is to establish an alliance with the person as quickly as possible to diminish the need for hospital treatment against their will. In the period from 2018–2020, one service user spent a few weeks at the BET service while hospitalized on an involuntary basis. When discharged, the service user stated that if in need of hospitalization in the future, they would like to be transferred to the BET Unit.

### *Participation*

People using the service participate actively in planning their own care in the weekly psychoeducation groups. Once a month, these groups are led by an individual with lived experience and a previous BET programme service user. Here, they discuss their perspectives and experiences *(4)*.

The BET unit routinely collects feedback from service users to improve the quality of provision. People are asked to identify the most and least useful aspects of the service as well as concrete suggestions for improving it. Towards the end of their stay, service users are asked to reflect on their own experience of the therapeutic process and stay at the unit. On discharge people receive a questionnaire (co-developed with previous service users). Feedback collected is used to make decisions on how to improve the service.

A formalized group of people with lived experience is involved in high-level decision-making at Vestre Viken Hospital Trust. It meets once a month as part of a wider reference group meeting and is involved in funding and budget allocation, service development and implementation, auditing, and organizational restructuring. Currently the BET unit is working towards employing people with lived experience as full-time staff members.

### *Community inclusion*

All service users at the BET unit are struggling with challenges related to social functioning. The service works closely with people to identify and discuss these challenges and understand how it can best support people within their wider community network. Team members, often the team coordinator, can take an active role to initiate processes that help people find housing, return to work or school, and connect with peer networks or similar services in the community. This focus on community inclusion is central to the service´s holistic understanding of recovery. Although not explicitly addressed in the BET model, each person's religious orientation and spirituality is respected and encouraged.

The BET programme actively encourages the involvement of each person's family and social network in their care; this supports people to maintain continued involvement with their community. Importantly, people are also encouraged to go home at weekends to maintain community ties during the period they receive treatment at the BET unit. The hospital site is easily accessible and well connected by a direct bus link to Asker town centre and central Oslo.

### *Recovery approach*

In its overall design and practice, the BET service promotes a holistic approach to health and treatment. In a study describing how CER could contribute to reducing coercion in treatment, Hammer et al concluded that, "an important component could be [...] the introduction of a holistic treatment philosophy that emphasizes voluntarism, cooperation and autonomy" *(9)*.

Empowerment is a central component of treatment offered at the BET Unit. Rather than focusing simply on symptom reduction, a core therapeutic goal is accepting, self-regulating and coping with existential anxiety *(12)*. All BET interventions available on the unit aim to help service users regain control over their life situations, demonstrating that they are the main decision-makers in their own lives. Furthermore, care offered by the service is centred on the individual service user; each person follows a specific drug withdrawal plan and exposure schedule specifically designed to accommodate their individual wishes and needs throughout the treatment period. Service users' own goals and values — which may vary widely from individual to individual — are identified and incorporated into a treatment plan. Depending how they define full recovery, some aim to be symptom-free, while others want to cut back on medications or no longer want to require inpatient admission when in crisis. The BET Unit strives to determine how all service users can attain these specific goals in accordance with their individual values.

## Service evaluation

A growing body of evidence demonstrates that the BET model and CER strategy helps to improve the mental health condition of individuals who have not previously responded to repeated treatment efforts in mental health care. Evaluations of the BET service indicate that the use of coercion in treatment can be drastically reduced, and quality of life and psychological and psychosocial functioning can be significantly improved among service users *(7, 9)*.

First, using a prospective evaluation framework, service users exhibit a significant reduction in mental health symptoms from admission to BET and over the course of the treatment period. Concurrently, a significant improvement is seen in service users' level of functioning. These benefits correlate directly with the service users' degree of success in completing their exposure work *(9)*.

A 2017 retrospective study showed individuals who used the service had fewer subsequent admissions to psychiatric and general hospital inpatient units 12 months following discharge from BET, compared with the 12 months prior to admission *(12)*. This reduction is consistent with the individuals' improved mental health and correlates directly with their decreased levels of experiential avoidance. These results indicate that, for some people, BET may be a feasible alternative to treatments that focus on symptom reduction.

Another interesting aspect of research related to BET is that it highlights and supports the possibility of reducing and discontinuing drug treatment, even for people who have been taking drugs for a long time. According to a 2016 study, the reduction in medication seems to contribute to positive treatment effects. At long-term follow-up (5.3 years after BET treatment, on average), service users who decided to reduce their psychotropic drug use, ultimately becoming drug free, exhibited significantly better psychosocial functioning than those who continued taking psychotropic drugs *(9)*.

Additionally, findings suggest that the implementation of CER results in drastic reductions in the use of force and coercion. In a study that included 101 female service users, researchers compared the number of coercive interventions at the BET Unit from the period before CER was implemented (2006–2008) to the period after CER was in place (2009–2014) *(9)*. Results showed a 97% reduction in the number of coercive interventions (including physical and mechanical restraints, seclusion and forced medication) after implementation of CER. Importantly, the average number of coercive interventions per service user was reduced from 23.5 before CER to 0.3 in 2012–2014, when CER was well established. The authors concluded that CER is a promising intervention for reducing coercive measures in long-term psychosis wards. It should be noted that only a small percentage of the subjects who participated in this study received BET as a psychotherapeutic treatment. This study focused merely on CER, and at least half of the participants received other forms of psychosocial treatment combined with psychotropic medication.

A qualitative study of service users at the BET Unit examined the effect of the treatment on recovery, most notably the effect of assigning responsibility to individuals for their own lives. The authors concluded that, "after BET, [study participants] gained a life that was better than they had dared to hope [for]. They were less afflicted by symptoms and described significant improvement in their level of functioning. Several had re-established connections with their families, some had started their own families, and most of them, at some level, were engaged in either education or work. Some had stopped using medication altogether" *(9, 10)*. These findings indicate that both empowerment and assigning responsibility for change to the individual in treatment can play a huge part in recovery.

In addition to a report following a visit by the United Nations Special Rapporteur on the Rights of Persons with Disabilities in 2019 stated that BET was an example that proves it is possible to provide intensive care and support without the use of force and coercion.

Several users have participated in qualitative studies, given interviews, or have written about their experiences of being in treatment at the BET Unit. Here are some excerpts:

"Something happens to you when you go through BET. You realize that you actually can be free and feel free, and that you don't have to spend all your time fighting. Accommodating and accepting emotional experiences and being able to let any feeling stay with me, means that I can live a normal life without producing symptoms. What is more, I'm no longer continuously tired from fighting something that I hadn't previously understood or known what it was all about."*(7)*

"There is a huge difference [...] I was in the hospital for two years before I came to the BET Unit. During those two years, I believed what they said: 'You have a serious mental disorder that can't be cured. You have to rely on medicine for the rest of your life.' Then I went to the BET Unit, and was discharged without any diagnosis, without medication, without anything."*(13)*

"I used to feel worthless, having been in psychiatry for so long and being tossed back and forth from one hospital ward to another. [...] [Now, I am] able to stand on my own two feet and somehow cope with things. In other words, this is as big a change as it is possible to get, really. I have a life. I haven't had that before."*(13)*

"Through BET, I took my life back. Hard work with the therapists made a huge difference. Being seen and heard and having someone who was willing to be there with me during that painful and difficult time meant a lot. I am no longer afraid of my feelings, and I can accept that things are just the way they are. Instead of fighting against my thoughts and feelings, I can now go with the flow and accept what is happening. Pain is now a natural part of life, a life I can finally live. "*(14)*

### Costs and cost comparisons

In Norway's public health care system, all treatment is funded by the Norwegian State and made available to service users free of charge. All treatments offered must be reasonable and recognized by the academic community.

The approximate cost for the BET Unit per person per day is roughly 8,800 Norwegian kroner (about US$ 1,042[b]). Benchmarked against the average costs for other treatment units in the Vestre Viken Hospital Trust, three shifts (day, evening, and night) at Blakstad's BET service are 30-40% lower. Lower costs are partly attributable to lower staffing costs due to the normalized model of interaction between staff and service users. A lack of coercion reduces the need for staff-intensive interventions, such as 1:1 observations, and other regulating measures. Additionally, lower medication costs compared with other round-the-clock Vestre Viken residential units are seen. A lower sick leave rate benefits the BET unit too, with staff consistently reporting high levels of job satisfaction.

## Challenges and solutions

### *Overcoming scepticism*

The idea of the service was initially met with scepticism and mixed views from some therapists and administrative staff. Many misunderstood what the service involved and some staff members even protested against it. Misleading accounts of the population targeted by the service were circulated.

Scepticism was gradually overcome by demonstrating positive outcomes. Through the collection of data to measure effectiveness from the start, the team could prove that there was less coercion, less medication, and (for some service users) a full recovery or major positive changes to their quality of

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[b] Conversion rate as of March 2021.

life. Positive feedback from people who had used the service also helped to promote this way of working among colleagues and management. The service also held public meetings involving those who used the service, relatives, professionals and other interested people.

### *Building a positive working culture*

There were substantial differences and conflicts between the proposed form of treatment and some existing procedures and rules. Initially, the service was delivered on a ward where "treatment as usual" was predominant and it was difficult to influence how staff (from clinical to maintenance and kitchen staff) interacted with people using the service.

One of the solutions was the gradual separation of the service from the ward on which it was started; it became an independent unit with its own staff and administration. Establishing and maintaining a core set of the values for the service through all interactions and actions over the long term was also critical. The service gained the support of clinical and administrative staff and succeeded in influencing non-professional staff such as cleaning and kitchen staff. Educational activities have been at the fore of the team's efforts too. This has helped to answer questions raised by others and to explain the logic of the intervention.

### *Promoting understanding of the BET approach within the wider mental health system*

A major challenge has been that the service was regarded as existing outside the ordinary treatment system. Additionally, the team often received referrals from other parts of the mental health service, and therefore were not involved in early treatments – often based on traditional methods – offered to people.

One solution has been to make the BET system more widely known and used throughout the mental health system in Norway. Clinicians from other mental health services are encouraged to visit the BET unit and learn first-hand about its principles, values and practices. Blakstad also set up a national 2-year BET education programme in 2014 with teachers from the BET Unit or peer-approved BET therapists from other units in the Vestre Viken Hospital Trust. Importantly, learners included health professionals from mental health care units for children and adolescent around Norway, outpatient clinics, and closed and open hospital units for adults. Several course participants have since worked as unit leaders and team leaders. A parallel BET education programme is planned in Tromsø, in cooperation with the Northern Norway Hospital Trust.

## Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- being patient, taking a long-term outlook and maintaining the values underlying the service;
- building a body of scientific evidence which contributes both to the development and improvement of the treatment programme and to the dissemination of the service approach;
- being open to feedback and undertaking qualitative research to explore the experiences of people using the service;

- collecting quantitative data systematically on various aspects of the intervention including outcomes and publishing this in peer-reviewed journals to enhance the credibility and sustainability of the service; and
- promoting a culture of self-reflection; continuously asking whether the service is on track in meeting the needs of people who use it.

## Additional information and resources:

**Website:**
https://vestreviken.no/avdelinger/klinikk-for-psykisk-helse-og-rus/psykiatrisk-avdeling-blakstad/bet-seksjon-blakstad

**Videos:**
Didrik Heggdal: What is Basal Exposure Therapy?
https://www.youtube.com/watch?v=PXrdwOMznvs&t=10s

Didrik Heggdal: Basal Exposure Therapy (BET): Alternative to coercion and control in suicide prevention.
https://youtu.be/fsfdrFoEhfQ

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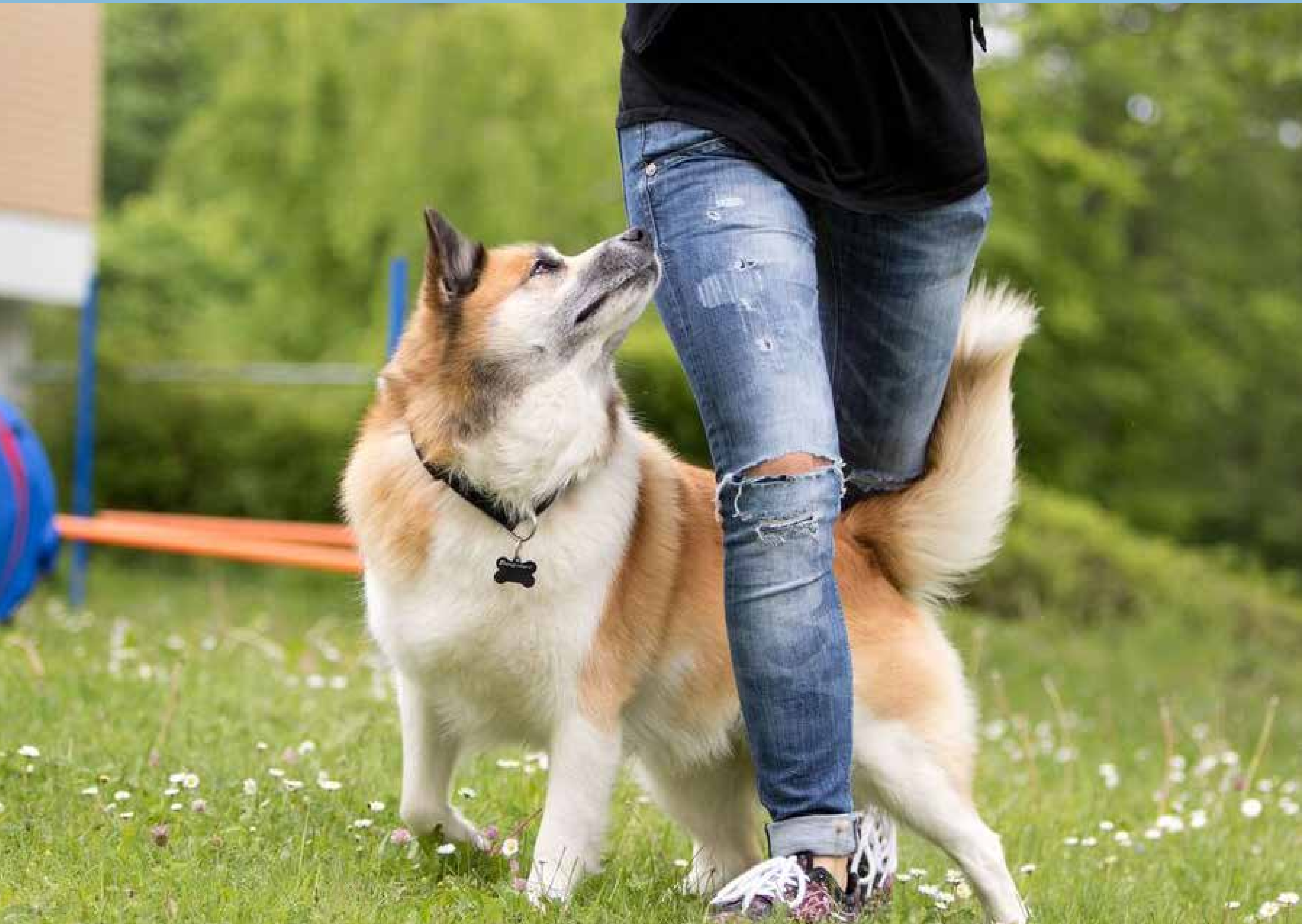
## 2.2

# Kliniken Landkreis Heidenheim gGmbH

## Germany



## Primary classification: : Hospital-based service

**Other classifications:**

☐ Community mental health centre ☑ Community outreach ☑ Peer support

☑ Crisis service ☐ Hospital-based service ☐ Supported living service

**Availability in different locations:**

☐ Yes ☑ No

**Evidence:**

☑ Published literature ☑ Grey literature ☐ None

**Financing:**

☑ State health sector ☐ State social sector ☑ Health insurance

☐ Donor funding ☐ Out-of-pocket payment

## Context

Kliniken Landkreis Heidenheim is the only general hospital located in Heidenheim district, a small rural town with a population of 130 000 inhabitants located in Baden Württemberg, south west Germany. Established in 1994, the hospital operates a mental health department among other services including surgery, internal medicine, neurology, obstetrics and gynaecology. The mental health service, officially known as the Department of Psychiatry, Psychotherapy, and Psychosomatic Medicine, serves the district population but also admits people from neighbouring districts. The department is obliged to admit people according to German public and civil mental health law. There are no mental health services for children and adolescents nor forensic mental health provision. Because the Department is an integral part of the general hospital there is considerable liaison with the medical wards and medical and nursing staff rotate between medical and psychiatric wards.

In 2017, Heidenheim became a model region for mental health according to Section 64b of Germany's social code (SGB V), allowing for full flexibility of mental health services with an agreed yearly budget *(15, 16)*. The regulations for model regions remove the incentives for hospitals to admit as many inpatients as possible to increase hospital revenues. On the contrary, if the hospital provides care and support for the same number of people in both outpatient and community settings, the budget remains the same. Wages increase incrementally to retain medical, nursing and therapeutic staff.

Hospital mental health services are an integral part of general health care for the district population and are well accepted in the community *(17)*. They are part of the wider network of comprehensive community mental health services (*Gemeindepsychiatrischer Verbund*), coordinated by the district council *(17)*. District resources include counselling services for people with alcohol and drug use problems, support services for homeless people, supported housing schemes for those with psychosocial disabilities, including residential facilities in small group homes for people with more complex needs, located across Heidenheim town and district. There are eight residential facilities; one has 16 places, another has 12 and six have 4–8 places each. There are office-based psychotherapists offering cognitive behavioural or psychodynamic psychotherapies, both for people with public and private health insurance. Heidenheim Hospital is owned by Heidenheim District with strong support from the district council and the population, even at times when public finances are strained *(18)*.

## Description of the service

The Heidenheim hospital-based mental health service aims to provide comprehensive mental health services according to the needs of the whole of Heidenheim District. A 24-hour service that operates day and night, 365 days per year, it supports people with more severe mental health conditions and forms an essential part of the network of psychosocial services provided district-wide.

The hospital mental health service provides inpatient services, day clinics, home treatment and support as well as outpatient services. Admissions to services are possible without delay or waiting lists and people can change from inpatient to home-based treatment, or to day-based hospital care at any time. The will and preferences of service users form the basis of such changes and are discussed between the clinical team, service users, their families and support networks. Since the different services are closely aligned — run by the same teams —a consistent recovery plan is followed even if a person moves between services. There is no fixed duration for the inpatient, day-clinic or home-treatment settings.

The service consists of four distinct teams; three inpatient unit teams, and one day-clinic team. To allow for a smooth transition between treatment settings, a person remains with one team throughout their time at Heidenheim. The service does not operate a separate home-based treatment team, as all four teams provide their own home-based treatment options, either following from an inpatient or day-clinic treatment or starting home treatment in the community with the option to change to inpatient or day-clinic sessions, should the need arise.

### *Inpatient units*

There are three inpatient units for adults. No diagnostic exclusions apply at the service. With 79 beds, the average length of stay is 21 days. All three units are open wards from 08:00–20:00, however the doors are locked at night. While 98% of service users are free to leave when they want, day or night, for 2%, restrictions on movement apply as they have been placed under involuntary treatment orders by a district court for a certain period of time, typically between 2–6 weeks. Service users who are free to go are often granted escorted leave or leave with certain restrictions, for example to avoid visiting home when domestic violence has taken place.

Two of the three units provide inpatient admission, day-based hospital treatment and home treatment for 53 people including those who have received diagnoses for depression, psychosis, dementia, personality disorders, and trauma-related disorders. Therapeutic interventions include group and individual psychotherapy, social assistance, medication and occupational therapy, which consist of arts and crafts, daily living help, cognitive training programmes, support writing a CV, applying for a job or university, and to attend an interview with an employer. Music and dance therapy, peer to peer consultation and other activities are also available. The staff include six doctors, 34 nurses, two psychologists, two social workers, two occupational/art therapists, a music/dance therapist and a peer support worker.

The daily routine consists of therapeutic activities, agreed individually between service users and their therapeutic team. A typical weekly programme would include an individual session, one or two group therapy sessions, two or three sessions of occupational therapy and one or two sessions in art and/or music therapy. Peer-to-peer support is offered once a week. Service users are free to pick from the therapeutic activities on offer. Some service users have a busy week, others prefer not take part in therapeutic activities but join group activities such as cooking meals or going for walks.

The third inpatient unit provides support for 27 people with addiction problems, personality disorders, anxiety disorders, psychosomatic disorders and depression, through inpatient and day-based hospital treatment. Therapeutic interventions include group and individual psychotherapy, art therapy, occupational therapy, and dance and movement therapy. The staff includes three doctors, 13 nurses, one psychologist, a social worker, occupational/art therapist and dance/movement therapist. There is a structured programme for inpatient or day-clinic detoxification (for alcohol and drug dependency) including individual and group therapy sessions, meetings with self-help groups and occupational therapy.

For those at this third unit without addiction problems, there is a separate programme with individual and group therapy, art therapy, dance/movement therapy and occupational therapy. Unlike activities offered by the other two units, service users here are expected to take part in all or most of the scheduled activities. They can also access peer support offered in the other two units.

Once accepted into the inpatient service, individuals can choose to stay at the unit at night or attend only during the day. They may also decide to opt only for one or two therapeutic activities and be seen, instead, on a daily basis by the home service team. While some people will go to the inpatient unit for three days a week, for example to have an individual therapy session, a group therapy session and a session of art therapy, others may opt to stay for 5 –7 days per week.

### *Day clinic*

Day treatment and support can be arranged in all three units and people are free to choose the number of days a week they will participate. The programme is agreed between the service user and the treatment team. It can be intensive, with therapeutic activities every day, or intermittently.

In addition to the day-clinic support offered by the three inpatient units there is a separate day clinic, located at a different building on the hospital campus. With 14 places, there is a comprehensive therapeutic programme five days a week, consisting primarily of group sessions and individual psychotherapy, but with some social activities, cooking, leisure time and excursions. People can choose to take part in the clinic programme for the whole day, five days a week or for some part of it. The content of the individual treatment programme proposed is based on the will and preferences of the service user, alongside the clinical expertise of the treatment team. This day-clinic team (including two doctors, a psychologist, two nurses, a social worker and two occupational/art therapists) also offers outpatient and home treatment. The average length of participation in the programme is 28 days.

### *Home treatment and support*

If a person prefers to be treated at home rather than being admitted to inpatient care, home treatment and support can be arranged with any of the four teams. Home-based treatment can start at any time and involves daily home visits by a nurse and weekly home visits by a doctor. Social workers, psychologists, occupational/art/music therapists and peer-support workers will also conduct home visits on request. The average length of home treatment and support is 28 days. If daily or weekly home visits are no longer indicated or wanted by a service user, the person can still request sporadic home visits by any of the team members.

### *Outpatient services*

These can be arranged at any time and without delay because they are offered by all four teams, which can shift resources quickly from inpatient to home-treatment or outpatient services. People being seen on an outpatient basis have scheduled appointments with the service and treatment ranges from more acute care, with one or two sessions per week, to less frequent monthly appointments. As with inpatient and day-clinic care, people who opt for outpatient services can access the whole range of therapy and support, in a group or individually. Outpatient treatment may consist of individual psychotherapy, medication management, group therapy (including art, music, dance and movement) and peer support.

### *Peer support workers*

There are currently two part-time peer support workers and one volunteer who work with the hospital department, although they are not part of a particular team. Unlike nurses, doctors and therapists, they are not obliged to document interventions in service users' case notes. They hold weekly peer support sessions on the wards, with individual service users or a small group of service users, family members and support networks.

### *Therapy dogs*

Four therapy dogs are used by the service, joining their owners who are members of staff (a doctor, a social worker, an occupational therapist and a nurse), when they are working. As the hospital does not normally allow any animals, therapy dogs introduce some normality and are ice-breakers; they help to build trust and make people feel comfortable in their new environment. One therapy dog joins a nurse during home-treatment sessions. People using the service often spend time with or take the dog for a walk.

Particularly relevant for service users who have experienced detention in hospital or coercive treatment in the past, there is support to draft advance directives, power of attorney instructions and agree on joint crisis plans with the hospital team *(19)*. All resulting documents are stored permanently in hospital records; advance directives are kept for future admissions and are available and easily accessed by the accident and emergency department of the hospital. Typically, a service user will first meet the peer support worker or another member of staff to draft the crisis plan. Once details of the plan are negotiated with the hospital team and agreed, it is signed by the service user, family member or power of attorney, a hospital doctor and ward manager, and included in the individual's case notes. The service not only believes that these provisions reduce detention and coercion, but that engaging in discussions with service users has an empowering effect on individuals and staff. Both feel more competent to master future crises.

## Core principles and values underlying the service

### *Respect for legal capacity*

The Heidenheim service is obliged to provide for compulsory admission under mental health laws; in Germany; both guardianship law and regional mental health acts allow for detention in a psychiatric hospital. However, the service has built a partnership with the community, service users and families to avoid compulsory admissions and treatment as much as possible in practice. Rates of compulsory admissions are therefore much lower in Heidenheim (1.7% of all admissions in 2019 compared with the average 10.7% in Germany) *(20)* .

Supported decision-making is not anchored in German mental health law. However, the German Medical Council strongly recommends it specifically within mental health services *(21)*. In the Heidenheim service, supported decision-making based on will and preference is used and encouraged, including in situations where there has been a history of self-harm, suicidal urges, or violence against others *(22-24)*.

A variety of support options from social to medical care are presented to service users. Community support options include a choice between peer support and professional support, or a choice between supported housing, a group home setting or an adult placement scheme. Service users may choose between treatment without medication, treatment with intermittent medication or continuous long-term medication. The advantages and disadvantages of any options are explored with information from professional bodies and therapeutic guidelines, but always in the context of the individual's life situation. For example, staff members explore what has worked well for the person in a similar situation in the past and what has not. If the person would like help to make decisions, the service staff actively works with them to identify a support person they'd like to bring in.

The service's policy is to actively encourage and support people using the service, particularly those who have previously experienced detention and or coercion, to formulate joint crisis plans and advance directives that are anchored in the German Civil Code *(25)*. Some service users prefer to negotiate a joint crisis plan with the hospital team and others, an advance directive with the assistance of a peer support worker or lawyer *(19, 26)*. Joint crisis plans and advance directives form part of the service user's hospital records, so documents are readily available for those who attend to the person in an emergency crisis situation. In the Heidenheim service advance directives will always be followed as long as legally and ethically possible. Joint crisis plans and advance directives typically contain information on treatment; for example the type of medication to be taken, the dosage and how it should be administered.

Everyone, including those detained in hospital, has the right to refuse medication, and forced medication in Heidenheim hospital is rare, requiring a separate application to the court and an independent expert opinion. Acceptance of medication is not a condition to stay in the home-treatment setting. On the contrary, home-based treatment after a period of detention in hospital provides an opportunity for the treatment team to win the trust of the service user and potentially agree on a treatment plan, with or without medication. Some people may opt not just to refuse medication, but all services. The hospital team will then communicate to the person that it is still there to help, at any time, in hospital or at the person's home.

That people can choose the home treatment service over inpatient care has also contributed significantly to the low rates of coercion. For many service users and their families, home treatment is far more acceptable than hospital treatment.

Weeks or even months of engagement with service users may be needed to agree or even disagree on how to characterize the particular problems facing an individual and their family. For example a person may want to return to the place where they had been violent towards family members. Family members may interpret the violence as a symptom of an illness that needs to be treated medically, while the service user may see it as a way of defending themselves or may deny that any violence took place in the first place. Social, psychological or medical viewpoints may differ, resulting in conflicting views on the right course of action. As a result, the course of action may take a long time to resolve. Service users may raise these issues in peer support meetings or they may be picked up in Open Dialogue meetings, based on the approach developed in Finland (for more information see *Mental health crisis services technical package: Promoting person-centred and rights-based approaches*). The treatment team also holds bi-monthly supervision meetings with experienced team supervisors to reflect on contradicting viewpoints which are always documented in case notes. All service users can access their case notes at any time without restrictions *(27)*.

People compulsorily admitted to the service by order of a district or guardianship court are helped to obtain legal support to challenge detention and are offered home-based treatment as an alternative to detention in hospital. The hospital team can suggest to the court that the person be released from inpatient detention to home-based treatment on a strictly voluntary basis.

### Non-coercive practices

The service is not free of coercion, but rates of coercive interventions are low compared to the available data on psychiatric institutions in Baden-Württemberg, Germany's third largest federal state with a population of 11 million *(28)*. As German-wide data are not collected in a reliable way, that from Baden-Württemberg serves as only an approximation for the situation in the whole country. Of all people admitted to psychiatric hospitals in Baden-Württemberg, 6.7% experienced coercive measures while treated at the hospital; 5.3% experience mechanical restraint, 4.5% seclusion, and 0.6% coercive medication *(27)* . In contrast, 2.1% of people in Heidenheim in 2019 experienced coercive measures, and compulsory medication was less than 0.1% *(29)*. Indeed, between 2011– 2016 no one in the service was forced to take medication. Thereafter, one person per year experienced coercive measures, contributing to the 0.1%.

Rapid tranquilization is never used in response to someone in a crisis unless a person explicitly requests it. The service does not seclude people at all. During the day wards remain open, however, inpatient units are locked at night to meet State law requirements that people with detention orders remain in hospital. To keep wards open at night would require three additional nurses, an expense not currently covered in in the personnel budget. The service aims to extend the open-door policy to 24hrs, and increasingly, the wards now remain open until 22:00 or 23:00 and will reopen earlier in the morning.

Strategies implemented to avoid coercive practices are as follows:

## 1:1 Support for people in acute crisis

Legally detained service users are intensively supported, if necessary, with 1:1 support to engage them in the treatment programme and prevent harm *(30)*. Such a high level of support requires a member of staff (a nurse, therapist, doctor, or social worker) to remain with the person almost continuously, for several hours, a night or even several days. Essentially, 1:1 support is a trust-building exercise; the service user learns to trust that the hospital team will not cause them harm and hospital staff learn to trust that the individual will not harm themself or others. Self-harm or confusion are never reasons to use coercive interventions, but will be managed with intensive 1:1 support.

### Joint crisis plans to prevent coercion

For people who have experienced acute crises with or without coercion in the past, joint crisis plans are vital *(19)*. Based on people's will and preference, these plans indicate particular sensitivities and provide indications of how to respond to signs of distress; for example to call a particular person; be given a particular medication, or comfort room or to be left alone; to use sensory stimuli. They may ask that a physical examination not be conducted, that certain aspects of their personal history not be discussed, to receive certain visitors or request that certain visitors not be admitted. De-escalation is achieved in accordance with the Prevention, Assessment, Intervention and Reflection (PAIR) manual *(19, 31, 32)*, a training resource developed by and for acute mental health care staff to help them engage in a non-violent way during tense and stressful situations.

### A response team

For particular intense crises, there is a response team available, day and night, typically consisting of two additional nurses and a doctor. The response team provides additional personnel and advice to the treatment team on how to respond to the situation. Everyone in the response team is trained in de-escalation according to the PAIR manual *(32)*. The response team will assist the treatment team with 1:1 or 2:1 support. For example, they may take a walk with the service user, accompany the individual to collect items from home or visit a pet at the animal shelter. Response teams will also help the treatment team in deciding whether a situation is sufficiently serious to require police intervention to prevent or respond to violence.

### De-escalation and communication skills

New staff members are trained in de-escalation techniques and the prevention of aggressive incidents and coercive measures *(31, 32)* during the course of a three-day workshop which takes place as soon as possible after they start working at the hospital. After that, a refresher training (two-day workshop) is held every four years.

### Coercive measures

Mechanical restraint is only employed when there is actual harm to service users or staff and when other means of de-escalation have failed; such de-escalation options include talking, responding to basic needs, going for a walk, retreating voluntarily to a comfort room (the service does not use seclusion), speaking to a member of the family, doing some exercise, spending some time with one of the therapy dogs or 1:1 support. After a coercive measure has been used, the service user, staff, and family members and supporting network — if desired by the service user — hold a debriefing session. The aim of this session is to further explore and understand why the coercive measure was undertaken and how it can be avoided in the future, for example, by drafting a joint crisis plan and/or an advance directive.

### Receiving people brought to the hospital by the police

Under state mental health law, German police are entitled to bring a person to a psychiatric hospital if they are considered an acute danger to their own life and health or that of others, and if the officers responding to the situation believe the person is experiencing an acute mental health crisis. People most commonly brought to psychiatric hospitals are intoxicated from alcohol or drug use, experiencing psychotic symptoms or some other extreme distress *(32, 33).* In such situations, the first intervention by the hospital will be to reassure the person that coercion will not be used except in self-defence and encourage them to stay until the next day to have a clearer picture of the situation. This opens up a negotiation on the terms of a brief stay in hospital, with the police still in attendance. When there is a positive result in the negotiation, handcuffs are released, the police officers retreat and the person is offered food, drinks, an opportunity to talk, rest, or to call someone. Only if negotiations yield no results and the person is actively violent to other service users or staff, will mechanical restraint be used to maintain safety.

### Acceptance and refusal of medication

Service users in inpatient and outpatient care, day clinic and home treatment are free to refuse medication; doing so does not affect the care they receive from their hospital team. Indeed, service users can still take advantage of the whole range of therapies, supports and activities. If doctors or family members believe medication would be beneficial but the service user refuses, this will be dealt with in Open Dialogue meetings, where the aim is not primarily to resolve the differing opinions but rather to foster mutual understanding and to give all participants the opportunity to ask questions to one another.

To start medication, verbal informed consent is required, which is then recorded in the case notes for future reference. For acute situations, a general agreement to try a tranquilizer, such as lorazepam, may be sufficient to administer an initial dose. For antipsychotic medication, full and informed consent is required, after providing information on short and long-term effects. Additionally, the medication will be started on a low dose, to assess tolerability before it is adjusted a few days later.

The reduction in coercive interventions within the service has not led to an increase in use of chemical restraint or sedation, as frequently happens at other services. Indeed, the use of antipsychotic medication and benzodiazepines has not increased from the 2009 levels despite reduced rates of restraint ([Zinkler M], [Kliniken Landkreis Heidenheim gGmbH], unpublished data, [2018]). The service has not used electroconvulsive treatment (ECT) since 2010 and has publicly argued against forced ECT in Germany's most important psychiatric journals *(34, 35)*.

## *Community Inclusion*

The service has direct links with religious communities, self-help groups, support for homeless people, unemployment agencies, and charities supporting the elderly or isolated and people with addictions. The service directly supports a charity, Schritt für Schritt, facilitating leisure activities for people with mental health conditions and psychosocial disabilities. It also meets on a regular basis with the local courts, police, the local public health agency and public order authorities to discuss how to implement non-discriminatory practices and collaboration.

The service actively links with the community. With the model region designation in 2017, the provision of home treatment, as an alternative to inpatient admission, was made available to the whole of Heidenheim district and reported in the local press and national broadcasting *(36, 37)*.

The service has developed the Irre Gut school prevention project for all secondary schools in the district: classes with students of 14–16 years of age can book a small team of three people comprising a service user, a person with lived experience who is a family member, and someone working in mental health services, such as a nurse or social worker. The team visits the classroom and talks about stigma, prevention, self-help and access to services *(38)*.

### *Participation*

The service employs two part-time workers who provide peer-to-peer counselling and support *(39)*. Peer support takes place as individual sessions or in groups held weekly on the hospital wards. Current and former service users and family members are encouraged to share their experiences of the service, seek advice on subjects such as medication and diagnoses, air feelings about the hospital team, and report on discrimination in hospital or the community.

Both peer support workers have been service users in the past and are now part of the treatment team. They offer confidential advice, social support, advice on how to access services, how to file a complaint and how to prepare for therapy sessions. They have expertise and skills such as rhythmical massage therapy *(40)* and can assist service users who want to prepare their own food while in inpatient care.

One of the peer support workers and a representative of the families of service users also join the management team (the clinical director, nursing director, head of therapies, senior doctors and ward managers), to review and discuss improvements to the service. They look at policies, outcome data, complaints and the implementation of home treatment services in order to explain and implement improvements to the service.

The service does not systematically collect feedback from service users. However, there are several distinct complaints procedures in place, within the hospital, the community mental health network (or IBB), through the public health insurance system and the regional medical regulation body *(41-44)*. All complaints received by these bodies are fed back to the service management and responded to, thereby forming a constant source of learning and improvement for the service.

### *Recovery approach*

The home-treatment teams symbolize a move away from traditional ward rounds or doctors' visits and towards network meetings in the format of the Finnish Open Dialogue model in people's homes. The model has been systematically integrated into the home-treatment service. It is currently being integrated into the inpatient service too.

At these meetings, service users and family members set the agenda, and hospital staff respond to the themes raised; recovery plans are agreed which follow the wishes and preferences of the service user. Service users decide who will take part in network meetings and even if they take place at all. Hospital staff and family members support decision-making without being prescriptive about the type of support necessary. The case manager writes up a summary of the network meeting, which will become part of the case and personal notes of the service user.

In addition to these meetings, once a month an open recovery meeting, similar to psychosis seminars, takes place outside the hospital in a local community centre, where service users, family members and hospital staff meet to discuss individual paths and obstacles to recovery *(45)*. These meetings are open to the public. On a more informal level, a group of services users, family members and hospital staff meet once a month in a downtown pub to discuss all matters relating to mental health and beyond, while having food and drinks.

## Service evaluation

The service has gradually transformed from a traditional hospital department of psychiatry to a community mental health service *(46)*. While historically the 79 beds were occupied most of the time, with the advent of flexible home and day-clinic treatment, bed occupancy has reduced from 95% in 2016 to 60% in 2019 and 52% in 2020 *(47)*. Indeed fewer people are admitted to the inpatient service, more are seen in the outpatient clinic or are supported through the home outreach service.

The service continuously monitors the use of coercion and involuntary treatment. Importantly, when involuntary medication in psychiatric hospitals in Germany was outlawed for a brief period of time between 2011 and 2013, the Heidenheim hospital service did not record an increase in other forms of coercion or an increase in the use of medication overall, while other services found it more challenging to cope with this temporary ban *(29, 48)*.

The service is subject to inspections from the Baden-Württemberg Ministry of Social Affairs which monitors compliance with safeguards for service users detained under German mental health law. The latest report from July 2018 notes, "The whole team is committed to the common goal of establishing and maintaining therapeutic relationships built on trust. In summary, the commission is of the opinion, that the Heidenheim Hospital department of mental health is a lighthouse project in relation to coercive measures according to the mental health act."*(49)*

There are 18 German model regions for integrated care. Situated in various parts of Germany they provide huge potential for knowledge transfer in financing, policies, service provision and evaluation towards mainstream services. Although it remains to be seen if the evaluation results will inform health policy in the future, all model regions report similar changes towards more flexible, user-oriented and community-based care. With agreed yearly budgets, they protect public and private health insurance funds from uncontrolled increases in financial costs for mental health care *(50)*. What sets the Heidenheim service apart from the other model regions is a strong emphasis on prevention of coercion and on fostering flexible treatment according to the will and preferences of service users.

### *Costs and cost comparisons*

As a model region, the service has entered into a contract with all public and private health insurance companies which made it eligible for a yearly budget, based on the previous expenditures for inpatient, day-clinic and outpatient treatment. The budget increases annually in line with increments in wages agreed between unions and public health care providers. The contract is fixed-term for the years 2017-2023 with an option to renew for a further eight years. Public and private health insurance covers all treatment options. There are no additional costs for the service users *(47)*.

## Challenges and solutions

### *Addressing financial implications of moving to community-based services*

The first major challenge was the hospital management's concerns surrounding the financial implications of reforming the service towards community-based provision. Shifting treatment from the hospital to the community would normally incur lower remunerations from insurance providers (for example per diem outpatient treatment is around €100 (US$ 121[c]), day-hospital treatment is €190 (US$ 230) and inpatient, €300 (US$ 363). However, expenses for paying staff would remain the same.

By way of a solution, the hospital negotiated a contract with health insurance providers with an agreed yearly budget for inpatient, outpatient and home treatment services. This budget created incentives for providing treatment and support in the community rather than the hospital. Inviting clinicians from other model sites to present the financial outcomes of reformed services also helped to inform the service. The service repeated a core message to many of the stakeholders that it did not need more money, just the freedom to spend the resources more effectively. Gaining support from local and regional administrations was clearly important in this effort.

### *Overcoming staff reservations*

A major challenge was that many staff members were not motivated to conduct home visits. While some doctors and nurses were keen to venture out into the community, thereby broadening their professional perspective, others clearly preferred to continue with their daily routine in the institution. Concerns raised included personal safety when conducting home visits, contracting infectious diseases, liability issues, and the use of company cars or parking tickets.

To overcome this obstacle, the service led by example. It provided the opportunity for members of staff to shadow experienced clinicians in conducting home visits. It also clarified that home visits are not just a "nice thing to do" once inpatient duties had been completed, but a first priority in reforming the service. Importantly, the service engaged and collaborated with service users to co-create an initial plan with clinicians and then brought service managers and financial officers on board.

### *Improving recruitment*

Finding and recruiting the right staff was a challenge. Many people seeking work seemed more interested in conventional jobs, similar to those they had encountered during their training or at other workplaces. To improve the quality of applicants applying for work, therefore, the service made it clear that it was looking for the kind of staff (nurses and doctors) who wanted to join an innovative service. Another way to improve the quality of the staff recruited was to provide plenty of opportunities for future mental health professionals to learn and experience work of this kind during training. The service organized internships and placements for medical students, psychologists in postgraduate education, nurses, social workers, and peer workers.

### *Changing the dominant view of psychiatric care*

Another challenge faced, was maintaining the service's momentum in an environment where traditional service provision was popular and seen as "normal". To support a person in the community rather than in hospital therefore raised concerns about public safety or the welfare of the person.

The service overcame this problem by providing information on how the change in operations would not lead to a deterioration of services. It invited stakeholders (police, guardianship courts, and local administration officials) to discuss the issues they had with the changing service. When discussions centred around concerns for public safety and safeguarding the health and wellbeing of people using the service, the staff could explain how concerns are addressed in a more flexible community, rights-oriented manner. Many were reassured by this message.

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[c] Conversion rate as of March 2021.

### *Overcoming fears that lead to coercion*

Supporting the will and preferences of people using the service has been a major challenge in an environment where coercion in mental health services is seen as necessary and legitimate by many staff and the wider mental health community.

To solve this problem, the service embarked on a capacity-building campaign, educating its staff about human rights, the CRPD and recent case law on coercion. In addition, it tried to critically review outcomes of traditional service provision on an ongoing basis. As the service provision began to change it sought the first-hand experiences of those using the service before the reform started. Their experiences of the service were insightful when shared in training sessions with staff.

## Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- defining and monitoring service evaluation criteria that include the frequency of detention, use of restraint and other coercive interventions;
- benchmarking service evaluation against traditional services;
- publishing outcomes in the local newspaper and other media outlets as well as in scientific journals;
- actively seeking political support;
- giving up specialization (including specialist wards for psychosis, depression, and borderline personality disorders) and transforming to provide longitudinal support, based on individually-agreed recovery plans;
- ending practices that separate acute from long-term or rehabilitation care and support;
- viewing disagreements about diagnosis and appropriate treatment as an opportunity to implement a dialectic approach rather than as a justification to use coercive practice due to “non-compliance” and “lack of insight”;
- prioritizing home-treatment over inpatient care and individually-agreed recovery plans over treatment plans based on diagnostic categorizations;
- ensuring support is not conditional on the acceptance of a diagnosis or compliance with medication regimes;
- changing the funding incentives typically used for many large psychiatric hospitals whose finances heavily rely the number of beds and on centralized institutional care (vs. community-based services); and
- assessing which of the tasks being carried out by skilled professionals could be transferred to lay workers or peers.

## Additional information and resources:

**Website:**
https://kliniken-heidenheim.de/klinikum/patienten/kliniken/psychiatrie-psychotherapie-und-psychosomatik/

**Videos:**
Mildere Mittel. A film about the experience in Heidenheim, made by a service user's collective from Berlin
https://vimeo.com/521292563

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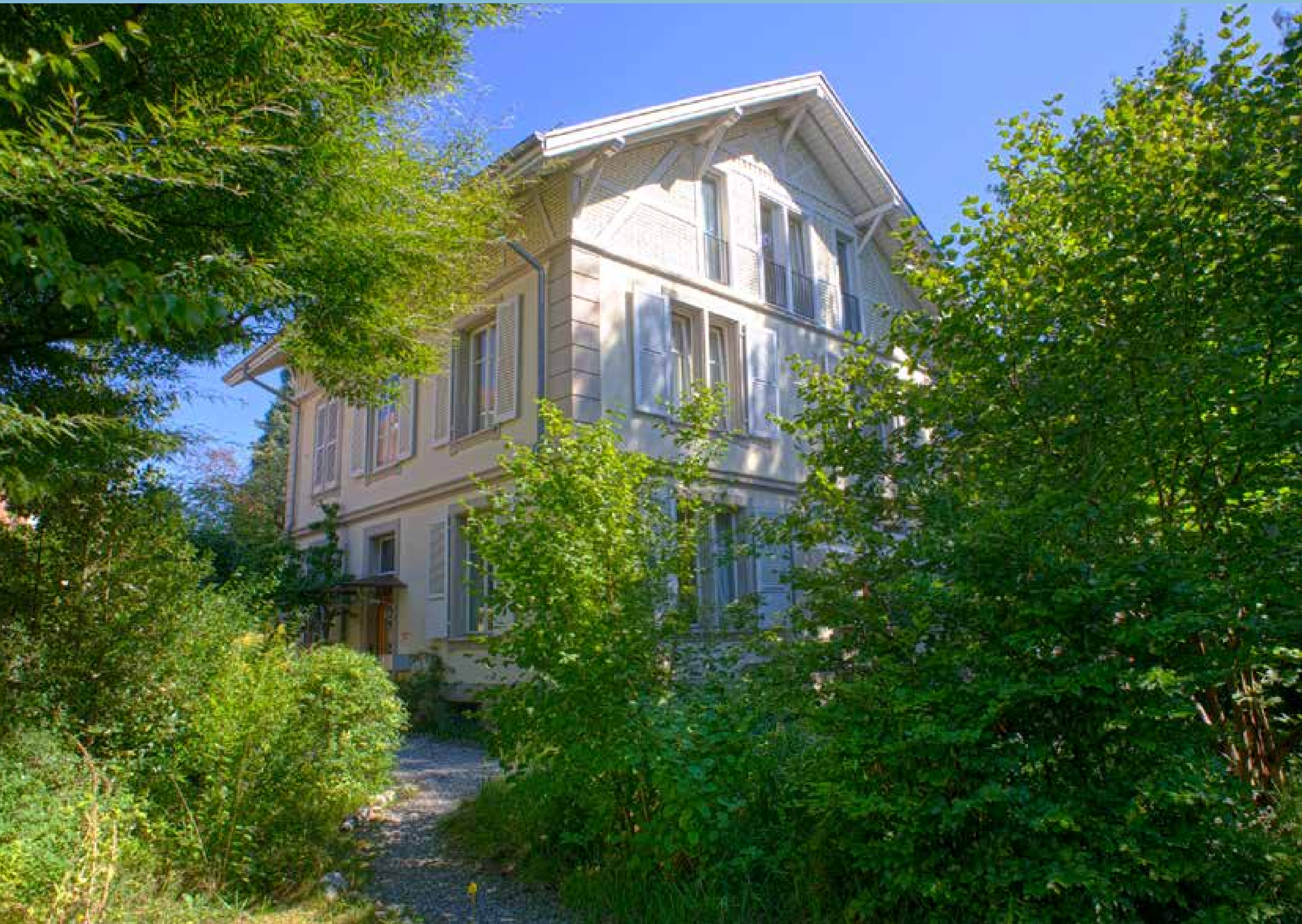
## 2.3

# Soteria

## Berne, Switzerland



## Primary classification: **: Hospital-based service**

### Other classifications:

☐ Community mental health centre
☑ Crisis service
☐ Community outreach
☐ Hospital-based service
☐ Peer support
☑ Supported living service

### Availability in different locations:

☑ Yes
☐ No

### Evidence:

☑ Published literature
☑ Grey literature
☐ None

### Financing:

☑ State health sector
☐ Donor funding
☐ State social sector
☐ Out-of-pocket payment
☑ Health insurance

## Context

Berne is a city in Switzerland with a population of 140 000. Inpatient services for people with mental health conditions and psychosocial disabilities are predominantly provided by public general hospitals, psychiatric hospitals (state and private), and residential facilities. The average length of stay in a psychiatric hospital is 35 days *(51)*. Outpatient services are provided in multiple settings, from private clinics to private practices.

The first Soteria house was founded in San Francisco, USA, in 1971. The work of this house was based on the philosophy that, "being with" or being accompanied during a crisis, particularly in a small, supportive, non-hospital and family-like environment, with low or no medication, could have similar or even better therapeutic outcomes than hospital methods *(52)*. This initiative showed such promising results *(53)* it led to the opening of many Soteria-like services internationally. Soteria Berne, modelled on the San Francisco service, opened in 1984 *(54, 55)*.

Located in the city of Berne, this residential crisis service accepts people from the Canton of Berne and the neighbouring canton *(55)*. It aims to provide an alternative, low-medication therapeutic environment for people who are experiencing so-called extreme states or have a diagnosis of psychosis or schizophrenia. The service is integrated with two other psychiatric services in Berne; the University Psychiatric Services Bern (*Universitäre Psychiatrische Dienste* (UPD) and the Social Psychiatry Interest Group Berne (*Interessengemeinschaft Sozialpsychiatrie Bern* (IGS)). IGS provides various management and financial services for Soteria. Its involvement has meant the service has been able to maintain its independence *(56)*. Soteria Berne has the legal status of a specialized public psychiatric hospital and is financed by public health insurance and the healthcare system *(57)*.

Soteria Berne collaborates closely with other mental health services and practitioners in the canton *(58)* and receives referrals from GPs, individual psychiatrists and other hospitals (both psychiatric and general medicine).

The Soteria house model has been replicated to varying degrees worldwide including sites within Berlin's Charité Clinic, in Vermont, USA, Tokyo and most recently Jerusalem *(59-64)*. So that Soteria services remain faithful to the principles and values that informed the original service, a Soteria International Working Group (IAS) was formed in Berne in 1997. While new services can make appropriate adaptations to local conditions, to be recognized by the working group, they must achieve a certain level on the IAS Soteria Fidelity Scale (SFS) *(65)*.

## Description of the Service

The service offers an integrated care approach to people living through an episode of psychosis. The guiding notion behind Soteria Berne is that hospital environments can often be counter-therapeutic for those experiencing these episodes. High levels of external stimuli, changes in staff, lack of privacy, lack of transparency related to treatment, rigid and sometimes complex rules, and a lack of flexibility can all lead to high levels of stress. Instead, an environment that produces as little stress as possible is preferable.

Soteria Berne therefore operates using the following eight principles:

- the creation of a small, relaxing, low stimulus setting: as home-like and "normal" as possible;
- continually "being with" the person experiencing psychosis in a personalized way;
- continuity of staff and the use of the same approach throughout the entire treatment period;
- continued close collaboration with family members and the person's social network;
- clear and consistent information about mental health conditions and the benefits and risks of treatments for the person concerned, their family and staff members;
- elaboration of common goals and expectations for future housing and work;
- voluntary use of low-dose neuroleptic medication, with free and informed consent; the aim being controlled self-medication; and
- after-care and relapse prevention for at least two years *(58)*.

Soteria house is based in a residential area near the centre of Berne. It has bedrooms for 10 individuals and two team members *(66)*. All admissions and discharges are decided together with the person using the service and, if they wish, with their family and friends. The house is open; people can come and go freely, even in situations where team members consider that the person is not ready to leave the house. In this situation, the person is informed that they can return should they wish. The majority of people using the service are aged between 16 and 40 years old. The average duration of stay in the Soteria house is 7–9 weeks but can be prolonged to three months, depending on the needs of the person. The decision is made by the Soteria Berne team, together with the person using the service. Over the last 10 years an average of 60 people have stayed at Soteria house annually.

## Staffing the service

Two team members are present at all times in the Soteria house, usually a male and female working together. They are responsible for therapeutic programmes and relationships with the families. Most, but not all staff are mental health professionals. At present, there are five mental health nurses, two psychologists, two educational workers and one artist.

The individuals in the team are carefully chosen by the Soteria Berne team for their degree of motivation to work in the service. Besides their specialist training and health care experience, they are expected to be many things; curious, engaged, interested, courageous, patient, emotionally empathetic, independent, intellectually bright, psychologically stable, good team workers, flexible, and creative. People with lived experience of mental health conditions are particularly encouraged to work at Soteria. To assess motivation and competencies, an interview and a day-long trial period is organized. There is intense on-the-job training because the team and people using the service interact so closely in everyday life. All staff members are offered case and family supervision once a month. Interested team members can access external training based on the Open Dialogue Approach *(67)*, Experienced Focused Counselling *(68)*, a Hearing Voices-type intervention, as well as other approaches if these are deemed to be helpful in promoting recovery from psychosis according to the Soteria framework.

Team members work in shifts of over 48 hours without interruption, following which they have a number of days off. This ensures continuity and immersion in the day-to-day life at Soteria house *(69)*. The full team also meets once a week for half a day to exchange information, discuss therapeutic plans, and participate in staff peer-support and supervision groups *(66)*.

## Accessing the service

Over 90% of people experiencing psychosis can be treated at Soteria. And, while in the past, the service admitted people with a wide range of mental health conditions, the type of low-stimulus environment that Soteria offers is now considered best suited to people going through psychosis *(70)* and today, Soteria Berne focuses exclusively on people with this diagnosis.

People can be admitted into Soteria Berne either by planned entry or emergency admission. For planned entry, people are interviewed by a member of the Soteria team and one of the two part-time psychiatrists with the service. In this interview, the current situation and the type of stay at Soteria is discussed, be it inpatient, day-patient, or outpatient treatment *(71)*.

Emergency admission is possible at any time of the day or night. Whether a bed is available and admission appropriate is decided by the psychiatrist in collaboration with team members on duty. Soteria doctors or psychiatric emergency services are available 24 hours a day and seven days a week. The team decides if the person can be admitted safely within the framework of Soteria Berne and if they are going through an episode of psychosis *(70)*. The person does not always require a referral from a doctor or hospital. Individuals, relatives or therapists, may contact Soteria directly to seek admission. A transfer from any other psychiatric hospital in Switzerland to Soteria Berne is also possible if the treating psychiatrist or therapist requests this. In the event of a recurring crisis, it is possible for people to directly access the day-care or the outpatient programmes even while using other outpatient services *(72)*. However, efforts are made to avoid a person receiving treatment from multiple sources, as this can cause confusion.

## Treatment and support

Support at Soteria house is subdivided into three phases with different therapeutic objectives and characteristics:

- a first phase of support is about anxiety resolution and finding emotional relaxation when experiencing acute psychosis. During this phase, a team member is always present with the individual (24 hours a day, seven days a week) in a low stimulus, calm and comfortable place called the soft room. Everything is done in the house to ensure a calm therapeutic atmosphere, free from anxiety and pressure. Not every person needs the soft room upon admission. It is available throughout the course of a person's stay. It is not used as a form of seclusion;
- secondly, when the crisis has lessened, the individual is gradually integrated into normal everyday activities within the therapeutic community. This part of the treatment is called, "activation and realism adjustment". The residents participate in everyday household activities such as cooking, cleaning, and planning; and
- thirdly, when the individual feels ready, they can receive support to gradually reinsert themselves into the external world, with preparation for social and professional integration and planning for 'relapse prevention'. In their own time, the person can then move on to receive ongoing support in the community, either through day-care or as a full outpatient *(66)*.

Two psychiatrists and a psychologist work part-time in the house and offer integrated psychotherapeutic input on a regular basis to each person for a minimum of one session a week. Psychotherapy for a wide range of issues is therefore embedded in the therapeutic practice at the house. According to the emotional state of the person, psychotherapy starts slowly, exploring common ground the therapist and individual can use to work together. Elements of Cognitive Behavioural Therapy (CBT) are often used to identify problems and initiate problem-solving. Sometimes a more psychodynamic approach is used. All aspects of daily life in and around the house are organized by service users and team members together to establish a relationship which focuses on the experience of a mutually shared reality, not solely on mental health issues.

In 2018, the Open Dialogue approach was introduced into the service; several team members followed a structured two-year training course in the technique. During a weekly treatment conference, the person reflects on the past week and then discusses next steps or aims of treatment with two Soteria team members and the psychiatrist or psychologist responsible for their treatment. An additional 2–4 team members listen to the discussion and add their reflections at the end. The person receives a written description of the treatment conference, which they can approve, on the same day. Each resident also has individual sessions with a psychologist or a psychiatrist trained in psychotherapy.

Family and other relevant persons are involved in the treatment process from the beginning, with the full agreement of the service user, and there is also a monthly meeting offered by team members to address their specific needs and concerns, and to promote communication *(66)*. Meetings with families take place without the person using the service, because the focus is on the needs of relatives and relevant others. The meetings can only take place with the full agreement of the person using the service.

Visits are allowed at any time of the day and night *(57)*. At times, babies have stayed at Soteria with their mothers. On discharge, some people are referred to other psychiatrists who work with a similar philosophy to Soteria. The service provides a form of home support for people after discharge but this is not available at weekends or in the evening.

Soteria house also offers a supervised apartment, named Wohnen & Co, in the city centre to support people transitioning to independent living *(73)*. The apartment is shared by 2– 3 residents. During their stay they are supported by Soteria's outpatient aftercare service which makes weekly visits *(74)*. Residents can stay up to two years in the apartment, but they are encouraged to find their own accommodation and are assisted with this.

As well as an outpatient aftercare service for former Soteria service users *(74)*, there is a specific group for people experiencing psychosis who are dependent on cannabis, called the Cannabis & Psychosis group, and a recovery group. Both meet on a weekly basis and are moderated by a psychologist and a team member with lived experience of psychosis *(75)*. A group of former residents and a peer support group also meet every month.

In 2014, a day centre was established 600 m away from Soteria house, which people can attend full-time or on days convenient to them. Although open to people between 16–40 years old; most attendees are between 17–29 years old. The day centre offers the same therapeutic approach as that offered within Soteria house to young people experiencing any form of psychosis (with or without cannabis use). People may come after discharge from a psychiatric hospital or from the Soteria house, or they may use the day centre to avoid an inpatient stay at a hospital.

## Core principles and values underlying the service

### *Respect for Legal capacity*

Preservation of personal power is a key element of the Soteria approach, reflecting an alignment with the protection and promotion of the individual's legal capacity. Informed consent is always obtained when people enter the service and in relation to treatment offered by the service. Any forms that require a signature, are fully and carefully explained in plain language by the team members.

Since the establishment of the treatment conference using the Open Dialogue model, discussions are held with the service user as well as their family or other relevant persons as appropriate. However, it is the person using the service who takes the lead concerning all treatment and life decisions during and after Soteria. The professionals may comment, add further ideas, and even express their doubts and concerns, but it is the person's own preferences which prevail. Team members and the therapeutic programme aim to work with, and empower, the person to develop a programme for their life after Soteria *(76)*. In the Soteria Fidelity Scale item number eight refers to co-determination during treatment *(65)*. This means that decisions about therapeutic goals are actively developed by the person themselves, in conjunction with the team. No treatment is given without explicit agreement. A process of discussion and exchange takes place before treatment objectives are set.

Supported decision-making is facilitated at Soteria because of the, "being with" philosophy, which means that much emphasis is placed on spending time with the person until they are comfortable making a decision themselves. This philosophy permeates activities at all times; such as choices about meals; how to find rest at night; how to deal with different experiences; coping with the effects of medication; when and how to leave the house to organize work or rehabilitation; and how to access financial support and housing.

Service users' opinions and decisions are respected even if team members do not share them. Staff will always explain their opinions and promote a discussion as equals. Rather than there being single acts of supported decision-making, the overall approach is one involving support and respect for the choices of the person.

Service users are asked to complete several questionnaires. The first questionnaire, examining vulnerability to symptoms of psychosis, is used to introduce the bio-psychosocial model and forms the basis for a discussion aimed at enabling the person to develop their own explanatory model of why they developed psychosis and what life experiences might have to contributed to it. Discussing individual vulnerability gives users the chance to integrate their experience of psychosis into their own biography in a meaningful way. The second questionnaire, Relapse Prevention, is essentially an advance directive in which people identify their early warning symptoms ahead of crisis. It details: how service users or other trusted persons can address early warning symptoms for example; strategies (not only medication) that are helpful and those which are not; which hospital they prefer to go to; and who should bring them there.

Many of the elements that usually create power differentials between staff and service users are erased at Soteria. With a home-like environment, it tries to avoid the restrictive features of a hospital setting: there are no uniforms, staff members sleep at the house, and everyone participates in the daily life of the house without distinction. Power differentials, while not eliminated, are therefore reduced and consequently residents are facilitated to voice their questions, concerns, and opinions.

### *Non-coercive practices*

Soteria Berne is a voluntary service, which means that it only admits people willing to enter the service. A core principle of the Soteria house is that, "all psychotropic medications [are] being taken by choice and without coercion"*(77)*. If someone does not want to take their prescribed medication, the staff carefully explain — as often as appropriate — the possible benefits and side-effects of medication. They try to understand, from the service user's point of view, what might make it difficult to accept medication, and may inform and involve the family if the person agrees to this. Staff will also discuss the possible risks of not taking medication. Ultimately, however, they accept and respect the decision taken by the service user. The service stresses that many people do recover without the use of medication.

All team members are aware of the need to avoid aggressive speech or gestures and to avoid highly expressed emotion, to create an atmosphere of trust. However, staff are not specifically trained in non-coercive techniques.

There are no isolation rooms in Soteria, and restraint and force are never used. When a person is experiencing acute psychosis, the team members focus on de-escalating the crisis by providing the person with a secure environment where they can feel safe and rest. The soft room used for this purpose is the equivalent of a comfort room sometimes found in mental health facilities. It is a sanctuary from stress that is furnished with items that are physically comfortable and pleasing to the senses. The idea is the person in crisis can experience soothing visual, auditory, olfactory, and tactile stimuli. A team member will remain with the person around the clock if they so wish and will provide them with care and support during the crisis *(78)*.

The staff also work to develop individualized written plans for some service users to help them identify and better respond to sensitivities and signs of distress they may experience. This will always be done in line with the person's wishes.

If no working alliance can be established, or when treatment cannot continue for any reason, a person can make alternative arrangements for themselves, or be referred by the Soteria team to one of the local psychiatric hospitals *(79)*. This is rare and happens only 2–3 times a year. Furthermore, if a service user is severely aggressive, staff report this to the police. This scenario is also reported to be extremely rare.

### *Community inclusion*

As the service is based on the idea that performing everyday activities and recovering in a "normal" environment is therapeutic for a person experiencing psychosis, all tasks performed are relevant to living independently in the community – such as cleaning and cooking. Practicing these skills in a therapeutic setting within the Soteria house can have empowering effects on residents. Phases two and three of treatment, and later outpatient support, are designed specifically to allow people to create links with the community. Because family and friends have constant access to the house, and residents are free to come and go, there is no barrier or feeling of isolation from the community.

Additionally, team members at Soteria take time with each resident to discuss their future projects, such as employment or living independently. Soteria team members can therefore facilitate connections with community services and organizations. They also assist residents to build positive relationships in the community. For example, a former resident of Soteria reported in an interview, that team members coordinated discussions with the company he worked for before his crisis and set up working arrangements so that he could keep his job. He said, "It was taking a lot of pressure away from me in this difficult situation" *(74)*.

### *Participation*

Soteria house connects current residents with former residents of Soteria through group meetings. These so-called former resident meetings are organized by the members themselves and take the form of peer support. Soteria house also helps former users of the service to establish peer support groups where there is an interest to do so.

Soteria House systematically collects feedback from service users and uses this to improve the delivery of the service. Each service user completes a questionnaire about satisfaction with the service before discharge, organized by the National Association for Quality Development in Hospitals and Clinics (ANQ) *(80)*. Questions address subjects including the quality of Soteria's professionals, information provided For example about medication), preparation of discharge and whether service users have ample opportunity to ask questions and are satisfied with the answers provided. The feedback rate is close to 100% and forms are completed anonymously. Service users are asked more informally about ideas for improving the service.

In the Soteria house, a person with lived experience works part-time — at 30% — as an art therapist, has individual talks with service users about recovery, and co-moderates the Cannabis & Psychosis and recovery groups *(81)*. This person also links those using the service to peer networks in the community. Peer workers have received "experienced involvement" - or ex-in - education, provided by the Ex-In Switzerland Association, which trains people with lived experience to become peer workers. Other training comes from the Recovery College in Berne, organized by UPD *(82)*. The peer support worker has the same rights and respect as other team-members. There are also plans to enable people with lived experience to participate in high-level decision-making in Soteria Berne.

### *Recovery Approach*

The recovery approach is explicitly stated as one of Soteria Berne's core eight principles *(75)* and is an integral part of practices and underlying philosophy. It acknowledges trauma or negative social experiences associated with psychosis using a phenomenological relational style. The idea is to give meaning to the person's subjective experience of psychosis by developing an understanding of it through "being with" and, "doing with" the person *(83)*. Taking the view that there is meaning to be found in a crisis normalizes feelings as well as how the person acts and thinks in the acute phases of psychosis.

People are supported to develop individual recovery plans regarding health, housing, work, finances, leisure and more. The questionnaires used by the service systematically capture the person's hopes, worries, goals, and strategies for dealing with difficult situations and staying well.

Other elements, such as non-medical staffing, preserving the resident's personal power, involvement of social networks, and communal responsibilities are all aligned with the recovery model.

## Service evaluation

Since 2012, it has been mandatory for psychiatric hospitals to report data on key quality indicators for inpatient care to the Swiss Association for Quality Assurance in Hospitals (ANQ) on an annual basis *(84)*. Service user satisfaction data in 2018 and 2019 ranks Soteria House Berne above average on all assessed criteria, including perceived quality of care, participation and informed consent, compared to other participating hospitals *(85)*. Furthermore, internal evaluations of Soteria House Berne from 2015–2017 demonstrate high levels of service user satisfaction regarding treatment success, staff interactions, support received and inclusion of external support networks *(86)*.

Results from studies also suggest the Soteria Berne approach uses far less medication compared to conventional approaches. A 1992 study compared outcomes for people staying in Soteria with people treated in conventional settings — two traditional Swiss psychiatric hospitals, one acute crisis ward in Switzerland, and one German hospital — on a matched pairs basis *(87)*. The outcomes measured were: psychiatric symptoms, work and housing situation, and relapse rates of participants immediately following discharge and after two years. Results after two years showed no significant differences on major outcomes between people who stayed at Soteria and those who stayed in the four conventional settings. Importantly however, these results were achieved with significantly lower daily and total doses of neuroleptics at Soteria over two years. Given the side effects of these drugs, this is a positive outcome.

A systematic review *(83)* summarized the findings from controlled trials which, "assessed the efficacy of the Soteria paradigm for the treatment of people diagnosed with schizophrenia spectrum disorders." The authors found three controlled trials involving a total of 223 participants diagnosed with first or second-episode schizophrenia spectrum disorders, including the controlled study at Soteria Bern discussed above, and two studies from the original US Soteria house. Again, although there were no significant differences in measured outcomes between the people using Soteria and those treated in conventional settings, they suggested that, "[Soteria] seemed to be at least as effective as traditional hospital-based treatment, this being achieved without the use of antipsychotic medication as the primary treatment”*(88)*.

Moreover, seriously dangerous incidents were rare during the three decades analyzed. There were approximately three life-threatening situations, and five suicides (four occurred outside Soteria), out of a total 50–70 treated cases per year on average, or approximately 2000 cases in total *(66)*. Careful assessment prior to acceptance for admission may be the reason for such low levels. However, the service said strong sustained relationships built between staff and the people using the service may also be responsible.

It is important to note that there are many direct advantages of the Soteria approach besides the fact that it uses less medication. The paradigm underpinning Soteria is respect for the rights and dignity of each service user, and in the acknowledgement of the uniqueness of their experience with psychosis; this creates a more pleasant environment in which to receive treatment *(66)*.

One recent service user explained: “When I was in the psychiatric hospital, I mostly felt left alone. There have been talks with the doctors, but in contrast to Soteria, I missed out on a personal meeting, encounter or talk with a person who was there for me. When you are very psychotic, you need rest, tranquility and people who are talking to you in a normal manner […] In the hospital they always said to me: ‘You are now here and you must wait […]’ They also offered activities during the day, but I missed somebody motivating and supporting me […] After a psychotic episode, the world looks quite grim and gloomy and it really helps a lot, when you get hope and confidence from the outside, which was my experience in Soteria.” ([Gekle W], [Soteria Berne], personal communication, [2020]).

A family member of a person who stayed at Soteria explained, “When we were here the first time, we were welcomed by the smell of the house, we were offered a seat, had a tea […] [It is] simply a house, with people who live there and keep up a normal life in this crazy situation” *(88)*. There is also value for people going through a psychotic episode to be able to stay in a relaxing, normalizing and safe environment with peers, in which no force, seclusion or restraint is practiced.

### *Costs and cost comparisons*

Soteria Berne has the legal status of a public psychiatric hospital which is financed by the health insurance and healthcare system *(57)*. Soteria is allocated 673 Swiss francs per day (US$ 751.50[d]) for each person using the service; this rate is covered by the Bernese government (55%) and health insurance companies (45%).

Costs at Soteria Berne in 2020 were consistently 6-8% lower than comparable psychiatric hospitals in Berne that also care for people going through episodes of psychosis *(89)*. This is in keeping with findings from the US Soteria house. According to Ciompi et al, costs are lowered, “by the fact that all housework (cooking, shopping, cleaning, gardening) is part of the therapeutic programme and done by the members of the therapeutic community themselves” *(75)*. Additionally, people used to stay at Soteria for about 90 days on average but this has gradually reduced, due to the development of the other parts of the service, described above. This, in turn, has reduced costs.

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[d] Conversion rate as of February 2021.

## Challenges and solutions

### *Securing financial support*

A major challenge was the limited finances associated with developing Soteria house. Therefore, the service used education, targeted at politicians and service commissioners, to help them understand the cost-effective nature of the service. These stakeholders were persuaded by the fact that the service is preferred to more mainstream services by many who have used both.

### *Changing negative perceptions*

Soteria Berne faced significant challenges in terms of mistrust and resistance from other mental health professionals. There was also a significant lack of confidence in the service itself, with doubts as to what could be achieved. Providing input into the education of trainee psychiatrists twice a year has proved to be one solution. The service also undertakes a yearly presentation to other psychiatrists, alongside people who have used the service.

### *Integrating within the mental health system*

A major challenge was managing the transition from being a project to becoming a fully-fledged hospital with all the rules, regulations and compromises that entailed. Active collaboration and networking with other services helped garner the support and learning the service needed to help manage the transition.

### *Targeting individuals who need the service most*

Initially, as a small service with only 10 places, Soteria required an occupancy rate of 85% to cover costs. This was a major challenge because it put pressure on the service to accept people who were not the true targets of the service. In addition, those going through a psychosis-related crisis were not always referred to Soteria. Active efforts were therefore made to communicate and present the service and its advantages so that correct referrals were made. The service had to mount what was in effect, a public relations campaign. Additionally, Soteria medical staff began to participate in the local on-call psychiatry service. This helped to ensure that appropriate referrals are made to the service.

## Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- finding opportunities for collaboration with other mental health services without compromising the core principles of the service;
- making significant efforts to get the support of independent foundations;
- trying to find agreement with others that there are alternative, but equally effective, pathways to recovery;
- encouraging staff and people using the service to be actively involved in evaluation;
- nurturing critical reflection in the team and not always assuming that they are always right;
- being prepared to adapt the way of working to real life challenges;
- considering how to overcome resistance from the local community to having a mental health service in their midst; and
- making positive contact with the health departments, private practitioners and good public relations.

## Additional Information and resources:

**Website:**
Soteria, Berne, Switzerland www.soteria.ch
The international Soteria network, https://soteria-netzwerk.de/

**Videos:**
Einhornfilm, Part 1 - Soteria Berne - Acute
https://www.youtube.com/watch?v=_fMoJvwMZrk

Einhornfilm, 2 Teil - Soteria Bern - Integration
https://www.youtube.com/watch?v=8iIj7BcS7XU

Einhornfilm, Part 3 - Soteria Berne - Conversation
https://www.youtube.com/watch?v=Ggvb_ObrVS8

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# 3.

# Moving forward: from concept to good practice hospital-based mental health service

The purpose of this section is to provide readers with some key practical steps and recommendations that will facilitate the process of conceptualizing, planning and piloting a good practice hospital-based mental health services that aligns with human rights standards. It is not meant as a comprehensive and complete plan for setting up the service since many context-specific factors, including socio-cultural, economic and political factors, play important roles in this process. Further detail on integrating the service into health and social sectors is provided in the guidance and action steps section in

## Action steps for setting up or transforming a good practice hospital-based service:

- **Set up a group of different stakeholders** whose expertise is crucial for setting up or transforming the service in your social, political and economic context. These stakeholders can include but are not limited to:
    - policymakers and managers from health and social sectors, people with lived experience and their organizations, general health and mental health practitioners and associated organizations, legal experts, politicians, NGOs, OPDs, academic and research representatives and community gatekeepers such as local chiefs, traditional healers, leaders of faith-based organizations, carers and family members.
- **Provide the opportunity for all stakeholders to thoroughly review and discuss the good practice services** outlined in this document to get an in-depth understanding of the respective services. This is an opportunity to identify the values, principles and features of the good practice services that you would like to see incorporated into your country's services given the social, political and economic context.
- **Establish contact with the management or providers of the service(s)** that you are interested in to get information and advice on setting up or transforming a similar service in your context and to understand the nuances of the service. Ask specific questions about how these services operate keeping in mind the local context in which the services would be developed. This can be done via a site visit to the good practice service and/or video conference.
- **Provide training and education on mental health, human rights and recovery** to the groups who will be most relevant for setting up or transforming the service using WHO QualityRights face-to-face training materials (https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools) and e-training platform. Changing the attitudes and mindsets of key stakeholders is crucial to reduce potential resistance to change and to develop attitudes and practices in line with the human rights-based approach to mental health.
- **Research the administrative and legal regulations** concerning setting up or transforming the service.

## Questions specific to setting up or transforming hospital-based mental health services:

- Are you aiming to transform an existing hospital or mental health unit or to set up a new mental health unit in a hospital?
- Are you planning to provide crisis support?
- Are you planning to have an inpatient unit?
- Are you planning to have an outpatient unit?
- Are you planning to offer home treatment and support?
- Are you planning to offer support people as they leave hospital and transition into the community?
- Who are the beneficiaries of the service: will anyone be excluded? How will the service be accessed?
- How will your service ensure coverage 24 hours a day, seven days a week to respond to people in crisis?
- What treatment/interventions are you planning to provide?
  - » assessments of support needs and diagnosis if agreed by a person
  - » trauma informed therapy
  - » person-centred recovery planning
  - » psychotherapy, e.g. Cognitive Behavioural Therapy
  - » problem solving and behavioural activation/activity scheduling
  - » individual and group based supportive counselling/therapy
  - » psychotropic and other medication (including prescribing medication, as well as support for withdrawing safely from medication)
  - » dialogue/meetings with families, friends and supporters (with the agreement of the person using the service)
  - » transitional support for people returning to their home and community
  - » crisis hotline phone-in
  - » peer support
  - » other.
- How will your service assess, provide for or refer people for any physical health conditions they may have?
- Will the service support community mental health centres, outreach services, supported living services etc., by providing specialized consultations, supervision and training?
- What human resources will be required (doctors — including psychiatrists, general practitioners and others, psychologists, nurses, social workers, peer support workers, occupational therapists, outreach workers, community/lay workers, administrative staff, etc.) and what sort of skills and training will be required for them to provide quality and evidence-based service in line with human rights?

- What will be the interrelationship between this service and other services, supports and resources in the community, including upward and downward referral systems?
- What strategies and training are you planning to put in place to realize legal capacity, non-coercive practices, participation, community inclusion and recovery orientation[e]?

## Legal capacity

- How will the service ensure that mechanisms for supported-decision making are in place so that decisions are made based on the will and preference of the person?
- How will the service approach informed consent by service users in relation to treatment decisions?
- How will the service ensure that people are:
  - able to make informed decisions and choices among different options for their treatment and care; and
  - provided with all critical information relating to medication, including its efficacy and any potential negative effects?
- What processes will the service put in place to systematically support people to develop advance plans?
- What kind of mechanisms will the service put in place to ensure that people can make a complaint if they need to?
- How will the service facilitate access to legal advice and legal representation by its users who may need this type of service (e.g. pro bono legal representation)?

## Non-coercive practices

- How will the services ensure an open-door policy and coercion-free culture to avoid both overt and subjective experiences of coercive practices?
- How will the service ensure the systematic training of all staff on non-coercive responses and de-escalation of tense and conflictual situations?
- How will the service support people to write individualized plans to explore and respond to sensitivities and signs of distress?
- How will the service create a “saying yes” and “can do” culture in your service in which every effort is made to say “yes” rather than “no” in response to a request from people who are using the services?
- How will the service establish a supportive environment?
- Will the service have a comfort room?
- Will the service have a crisis response team?

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[e] For more information see section 1.3 in *Guidance on community mental health services: Promoting person-centred and rights-based approaches.*

## Participation

- How will people with lived experience be an integral part of the service team as staff, volunteers or consultants?
- How will people with lived experience be represented in the high-level decision-making in your service?
- How will the service systematically collect feedback from service users and integrate this into your service?
- How will people using the service be linked to peer networks in the community?

## Community inclusion

- How will the service support people to find work and income generation, for example through a transitional employment programme, supported employment programme and independent employment as appropriate?
- How will the service facilitate access to housing services?
- How will the service facilitate supported education and assistance in accessing community-based education opportunities and resources to continue education?
- How will the service facilitate access to social protection benefits?
- How will the service facilitate access to social and recreational programmes

## Recovery

- How will the service ensure that persons will be considered in the context of their entire life and experiences, and that care and support will not solely focus on treatment, diagnosis and symptom reduction?
- How will the service ensure that the five dimensions of recovery: *(1)* connectedness, *(2)* hope and optimism, *(3)* identity, *(4)* meaning and purpose and *(5)* self-empowerment, are integral components of service provision?
- How will people be supported to develop recovery plans; that is, to think through and document their hopes, goals, strategies for dealing with challenging situations, managing distress, strategies for keeping well, etc.?

- **Prepare a proposal/concept note** that covers process issues, detailing the steps for setting up the service, the vision and operation of the service network based on the full range of services that will be provided, covering the following:
  - human resource, training and supervision requirements;
  - how this service relates to other local mental health and social services;
  - strategies to ensure that human rights principles of legal capacity, non-coercive practices, community inclusion, and participation will be implemented, along with a recovery approach;
  - details about the monitoring and evaluation of the service; and
  - information on costs of the service and how this compares with the previous services in place.
- **Secure the required financial resources** to set up or transform the service, exploring all options including government health and social sectors, health insurance agencies, NGOS, private donors, etc.
- **Set up and provide the service** in accordance with administrative, financial and legal requirements.
- **Monitor and evaluate the service on a continual basis and publish research** using measures of service user satisfaction, quality of life, community inclusion criteria (employment, education, income generation, housing, social protection), recovery, symptom reduction, assessment of quality and human rights conditions (for example, by using the QualityRights assessment toolkit), and rates of coercive practices (involuntary treatment, mechanical, chemical and physical restraints).
- **Establish dialogue and ongoing communication with key stakeholders and members of the public** by holding public forums and hearings with these groups to allow people to openly express their views, ideas, and concerns about the service, and to address these concerns.
- **Advocate and promote the service** with all relevant stakeholder groups (politicians, policy makers, health insurance agencies, media, people with lived experience, families, NGOs, OPDs and the community at large). This also involves actively reaching out through both traditional and social media. Having the successes of the service highlighted publicly can be a good strategy to bring people on board.
- **Put in place the strategies and systems** required to ensure the sustainability of the service.

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