

From sheltered home to special units in nursing homes

*Report from the first two years of a new initiative in
Oslo municipality*

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The memory of my father

Abstract

The background for this thesis is the establishment of a new unit for substance abusers at Stovnerskogen nursing home.

This paper looks at the process towards the new unit and how the results were after the first two years.

The results are measured both with patient data taken from existing statistics and through the level of satisfaction among the staff, with data from a specially designed questionnaire.

After two years the patients' health has improved, as well as the satisfaction and the competence among the staff.

Key words: Substance abuse, nursing home, Stovnerskogen, Oslo municipality.

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1 INTRODUCTION – How “burned-out alcoholics” and other care needing clients with substance abuse have been handled since 1950

Alcohol is mostly mentioned as ethanol, ethyl alcohol or spirits. The simplest compound of alcohol has chemical formula C_2H_5OH , and is an ethanol agent. Intake of alcohol may elicit pleasure sense, caused by alcohol's significant anesthetic effect on the brain. Moderate amounts of alcohol induce a feeling of well-being, reduces inhibitions and make it easier to have contact with other people (Store norske leksikon, 2005-2007). But the effect of alcohol also depends on the situation; on the drinker's culture and expectations.

According to the World Health Organization (WHO), an alcohol dependence syndrome exists when a person is so dependent on alcohol that it threatens his physical or mental health. In the “International Statistical Classification of Diseases and Related Health Problems” the diagnosis of alcoholism is described in section ICD-10, under mental and behavioral disorders due to psychoactive substances (ICD-10 data, 2013). In the US “Diagnostic and Statistical Manual of Mental Disorders”, DSM-IV, there is more emphasis on the social consequences of alcohol and drug use (AllPsych Online, 2011).

If the dependence has been long lasting, we may have an exhausted, “burned-out” alcoholic.

Before 1950, the care for “burned-out” alcoholics was regulated through “Løsgjengerloven” (1900) and “Fattigloven” (1845) (Reisegg & Hovind, s.a.). The objective of “Fattigloven” was to help children, elderly and women who had difficult living conditions, such as problems with paying for food, doctor's appointments, medications, midwife, obstetric and funerals. The law also allowed for care in hospitals, asylums or detention centers. Support was mainly financial, but poor people could be placed in the rooms for poor, workhouses or perform work supplied by the poverty board in the community (Universitet i Bergen, 2000).

“Løsgjengerloven” aimed at persons with low working motivation, especially vagrants and alcohol abusers. The law could sentence both to prison and forced labor. Vagrants could spend most of their life in prison because they struggled with alcohol abuse and had no place to stay (Velferdsetaten, Oslo Kommune, 2009).

1.1 Coerced labor institutions

Through “Løsgjengerloven” the most "unworthy" poor were separated from vagrants. Those who were employable and had several previous convictions for the same conditions, were sentenced to forced labor in state detention centers. According to Store norske leksikon (Store norske leksikon, s.a.) these detention centers were at Opstad workhouse, Eidsberg workhouse and Sem workhouse and nursing home. Opstad workhouse in Rogaland opened in 1912 and was an important institution for vagrants from the Eastern regions of Norway. Most of the inmates came from Oslo. Throughout the 1960s about 200 men were placed at Opstad. Women were placed at Bredtveit prison in Oslo (Velferdsetaten, Oslo Kommune, 2009).

In particular, the provisions for forced labor became subject to strong criticism because they seemed to discriminate against the disadvantaged in society.

“Fattigloven” of 1900 was substituted by "Social tjenesteloven" in 1964. Substance abuse care was still governed under this law.

1.2 Change in legislation

As the care for alcoholics was better-developed and voluntary organizations showed increasing activity to help alcohol abusers, the number of people placed in forced labor decreased. The provision for forced labor in the ”Løsgjengerloven” of May 31 1900 was repealed in 1970, unanimously in Parliament. Simultaneously there was a change in ”straffeloven” § 16 that made it no longer an offence to be drunk in public places.

Before the Second World War substance abuse other than alcohol, was mainly morphine given as medical treatment. In the 1960s cannabis was introduced in Norway as a new drug and from the 1970s benzodiazepine, normally prescribed for relaxation or sleeping problems, also became a frequently misused substance (Evjen, Kielland, & Øieren, 2012).

This change in focus from alcohol to other substances represented new challenges in the care of substance abusers because these groups of abusers represent quite different cultures that should be approached differently (Velferdsetaten, Oslo Kommune, 2009).

In the 1970s, there was a campaign for a clean city environment in Oslo. Part of this campaign was to get the homeless off the streets. A more humane approach led to the creation of new institutions for substance abuse care, usually in psychiatric hospitals operated by the state or by private organizations and foundations. New types of institutions emerged: detoxification centers, protection home, supervision home and sheltered home (Velferdsetaten, Oslo Kommune, 2009).

Homeless substance abusers were offered accommodation in dormitories and hostels. In the 1970s "Kroggen" had 500 places, when it closed in 1989 there were 100 places (Velferdsetaten, Oslo Kommune, 2009).

Substance abuse and psychiatric treatment each have their separate history and theoretical and practical approach. In the 1970s substance abuse other than alcohol was usually treated as a psychiatric problem, and based in regular and specialized psychiatric wards. The treatment comprised psycho-pharmacy, psychotherapy, group therapy, physical training and work rehabilitation. New socialpsychiatric and sociological approaches were developed. Financial status, social relationship, structures of society and political reasons were part of the new explanations of substance abuse. It was in this period rehabilitation centers started as a treatment (Evjen, Kielland, & Øieren, 2012).

1.3 Sheltered homes for alcoholics

In Oslo institutions and sleeping accommodation were established in city blocks and detached houses (Velferdsetaten, Oslo Kommune, 2009). "Kommunal helsetjenesteloven" of 1984 and "Sosialtjenesteloven" of 1991 gave inhabitants a right to health and well-being, good social conditions and a clean environment. The laws will ensure individuals right to live and reside independently, right to have a meaningful life and not to be isolated. Also the substance abuse clients have the right to stay in an institution or under residential 24-hour care when needed for reasons such as age, disability, or other. These laws have given the whole population the legal framework for proper social and nursing care.

In 1992 the new "Kommuneloven" was ratified which gave the municipality a larger degree of autonomy to organize their services according to local conditions. With this law the focus

shifted from institutional to individual. Someone who has become a social outcast should receive help and not be hidden away. Help may be rehabilitation to improve independent living, work or social skills. The main goal is to integrate everyone in society.

Before 1988 the office of rehabilitation was in charge of the institutions. Then came the Oslo municipality reform in 1988 (Regjeringen, Kommunal- og Regionaldep., s.a.). This division of responsibility made changes in the treatment of substance abusers where the different districts of Oslo became responsible for the institutions within their district. This change proved to be a poor solution because Oslo had functioned both as a municipality and a county. Because of this function Oslo had built a number of different types of institutions, which took care of both treatment and social living skills. When the different districts took over the administration, the patients with substance abuse lost many of their services offered before.

In 1994 Rusmiddeletaten was established to improve the substance abuse care in Oslo (Velferdsetaten, Oslo Kommune, 2009).

1.4 Rusreform I og II

Before 2002 the county and municipality were responsible for rehabilitation and treatment of substance abusers. After the hospital reform in 2002, substance abusers got patient status. Circular I-8/2002 also called “Rusreform 1”. “Rusreform - patient rights and changes in specialist healthcare law” instructed that treatment and other services for helping patients with substance abuse should ordinarily be performed by the social services within the municipality and the general practitioners. If the need for services were higher than what the municipality could handle, social- and health services could refer the patients to regional health enterprises for evaluation, assessment and treatment. Thus the regional health enterprises are now responsible for specialist healthcare for patients with substance abuse problems, as they are with all other patients (Reinås, 2004).

What remained was the county's responsibility for the establishment and operation of institutions for specialized services for care and treatment for substance abusers. These are measures which belong to specialized social services, that is:

"... socio-educational, psycho-social or other environmental therapeutic methods, where the objective is social and vocational rehabilitation. These are methods that focus on activities of daily living and take part in different procedures, standards and to be trained to participate in the community through activities, education and employment " (Regjeringen, 2003).

Municipal inpatient institutions should offer regular daily care such as food, clothing, warmth, shelter and someone to talk to. It was a wish from the Government that the same institution offered personal care in one phase and specialized social services in another (Regjeringen, 2003).

Rusreformen II, which came in 2004, was the answer. The responsibility for institutions is shifted from the county to the government through local and regional health enterprises. This allows in principle the same solution as before the hospital reform, that the responsibility of institutional services is again allocated at one level (the state), and the responsibility for all other services remain in another (the municipality). The vast majority of institutions, both public and private, wanted such a solution (Regjeringen, 2003).

Simultaneously with the "Rusreform II", the Government proposes to legislate the right to an individual plan in the Social Services Act, as a means to contribute to a comprehensive, coordinated and individualized services to patients and users of social and health services. The aim is to facilitate the individual substance abuser to get a better treatment, and that the society's overall resources in the field are utilized in a more appropriate manner (Regjeringen, 2003).

"Rusreformen" 2004 has provided substance abuse patients with the same right as all other citizens in Norway, and allocated the responsibility between municipality and specialist services in a new way.

With the reform, the function of Rusmiddeletaten is changed to rehabilitation, care and housing for low-threshold addicts. By January 01 2012 "Velferdsetaten" has combined many services from many sections, including Rusmiddeletaten. Substance abuse in Oslo today comprises approx. 600 inpatient beds. There are 21 public and 11 private institutions (Velferdsetaten, Oslo Kommune, 2009).

1.5 The need for care among chronic drug users

Drug abuse causes major health, social and economic problems both for the individual and for the society. History of substance abuse treatment has shown much change to meet different needs for help, but the need for care among chronic drug users will only increase.

“Samhandlingsreformen” from 2012, - Right care – at the right place - at the right time, shall ensure all patients the best treatment even when different bodies are responsible for different parts of the treatment. Substance abuse patients are included, and have the same rights as everyone else (Lovdata, 2013).

Parallell with “Samhandlingsreformen” the new "Lov om kommunal helse- og omsorgstjenester 2012” came, to clarify who, what and how in the municipality and the responsibility for its services to residents, including substance abusers (Lovdata, 2013).

"It includes all patient and consumer groups, including persons with somatic or mental illness, injury or disease, substance abuse problems, social problems or disabilities.... Municipality health care services include public care and health services that do not sort under the state or regional authorities... may be provided by the municipality itself or that the municipality enters into an agreement with other public or private service providers. The contracts are not assignable” (Lovdata, 2013).

In order to strengthen the care for substance abusers, " Opptappingsplan for rusfeltet " (2007-2012) was launched in 2007. The users´ perspective and their families are essential in this plan. One should ensure proper and comprehensive treatment and rehabilitation. The project goals had five points, and mention 147 interventions outside prevention, rehabilitation and treatment. According to the project it is necessary with broad cooperation between several sectors (Helse og omsorgsdepartementet, 2012).

It looks like all kinds of rehabilitation and housing measures have been tried and used, but the services were not always adequate for today's needs.

This is shown in the report “Forskning på rusmiddelfeltet” § 9.4.1:

"Many people who have abused substances for several years and who can not quit their addiction through treatment or by themselves, will nevertheless require different types of help and care programs. It can be a bed to sleep in, a place to stay during the day, receive nutritious food, taking care of their own hygiene, washing clothes etc..... Many municipalities have various forms of long-term living and care for so-called "heavy" substance users who can not or are not able to handle daily living situations. Treatment centers are largely run by private organizations and financed through public funds. The same applies to various types of day care, cafes and the like" (Regjeringen, 2003).

Substance abusers have become older and with more complex health problems, and they have shorter life expectancy than the general population (Helse og omsorgsdepartementet, 2012).

1.6 The "experiment" at Stovnerskogen

What is it about drug addicts that make them need extensive help with daily care that can not be provided at home or in other types of housing facilities in Oslo?

Stovnerskogen, unit for patients with substance abuse may be the answer to this question and address this need.

Until sykehjemsetaten was created in 2007, this patient group had varied services, where the districts of Oslo had to react to what the town thought was best for the patient, adjusted to their local economy. Emphasis was given on more homecare, a place in a private institution, or a place in a nursing home in Oslo.

1.6.1 The administration form in Oslo

Oslo has had parliamentary governance since 1986. The City Council is the supreme governing body. The city government makes its recommendation to the City Council, and is responsible for implementing the decisions of the City Council. The city government consists of seven departments. Department of seniors and social services has overall responsibility for municipal work of caring for the elderly and the disabled, as well as municipal health clinics

and health in schools. The department is also responsible for child welfare, eligibility, social services, services for substance abusers and housing services (Oslo Kommune, 2011).

1.6.2 **The road to Sykehjemsetatensetaten**

Here, the process of how and why Sykehjemsetaten was created will be described, as a background for the later creation of the unit for patients with substance abuse problems.

From 2002 until 2006, before the establishment of Sykehjemsetaten had been agreed on, the road had been rocky. Oslo City Council decided during budget negotiations in 2002 to change the nursing homes into municipal corporations. Council case 377/03 "Real freedom-principles for conversion of municipal-owned hospitals to municipal enterprises" had decided that nursing homes were converted to 3-municipal corporations, and these were operated from 01.01.2005. The resolution was submitted to the district committees, trade unions, charitable organizations and other interested parties for consultation. Common for consultative statements were that this was not prepared thoroughly enough, and questions from the districts about why the hearing was conducted after the resolution and not before. The Health and Social committee (now Department of seniors and social services) in turn claimed that conversion to municipal corporations would not solve today's challenges and could change the focus from quality to emphasis on economy and efficiency.

The matter was treated by the City Council in May 2004, with new proposals for alternative organizational models. In August 2004 they started the project, "Improved quality and real freedom of choice", and in May 2005, the report "Challenges for the nursing home sector in Oslo, alternative organizational models for services" was published. The final conclusion was that the nursing home sector was best served by establishing an agency model to protect the freedom of choice and the quality of services (Melvold, 2010).

In the City Council case 79/06 Sykehjemsetaten was established with effect from 01.01.2007. The aim was a more functional distribution of nursing home places in Oslo, greater choice for users and greater opportunity for a common platform for increasing competence and quality.

“It was clear to the council that there was a strong need for greater control of the coordination of the city's nursing home capacity. The main argument was based on operational efficiency as well as co-ordination and promotion of the freedom of choice among the users of the service " (Melvold, 2010).

The task force in the project establishing Sykehjemsetaten thinks it is an advantage to establish multiple departments with expertise to meet the current needs of the population, and improving the chance of recruiting professionals. Some of the special needs that the project wanted to cover were a unit for people with drug substance dependency, a palliative care unit, and a unit for the hearing impaired and neurological patients.

1.6.3 Unit for patients with substance abuse

The report 18/2009 "Sykehjemsetaten - status etter to års drift" was sent for consultation in June 2009, with a final report in August 2009. Under item 4.2.2 b) Sykehjemsetaten, allocation letters for 2009 gave guidelines to Sykehjemsetaten to continue the survey of the need to establish places for substance abusers in 2009. The task force proposal recommended the establishment of 8 places for older substance abusers in an institution that is not too close to the city center, starting in autumn 2010 (Oslo kommunerevisjonen, 2009).

The Task force consisted of people from Sykehjemsetaten, Rusmiddeletaten and two of Oslo's districts. They looked at the need for separate units for patients with substance abuse in nursing homes, before concluding with a recommendation to establish a unit for patients with substance abuse (Sørli, 2011).

In the City Council case 147/10 decisions were made to establish eight places for the elderly substance abusers in one of the nursing homes in Oslo in 2010. In Sykehjemsetaten, the main challenge was to choose a suitable location, and acquire the necessary expertise that had not been used in Sykehjemsetaten earlier (Sørli, 2011).

1.7 Experience with nursing homes for substance abusers

1.7.1 Copenhagen, unit for Patients with substance abuse

In Copenhagen there is a service for drug users. " Plejehjemmet E- huset " is a home for the weakest alcoholics, who will "Die with a bayer in their hand." Here the nursing personnel assist patients so they can drink alcohol (Venæs, 2008).

Another institution is "Spesialinstitusjonen Forchhammersvej", with "Plejekollektivet" as one of the subdivisions. In this institution there are treatment, accommodation for the homeless as well as a care and residential facility for substance abusers with particular health problems.

"Plejekollektivet" was a health service for substance abusers with complex health problems that began in 2003. Work with establishment of the unit started in 2001, when Copenhagen Municipality received additional funds. At start-up 12 patients were granted a place within 30 days (Forchhammersvej, s.a.).

The directive to the new department stated:

"The task is to establish an inpatient facility for 12 ill substance abusers with complex health problems for the rest of their lives. The patients at "Plejekollektivet" should be unable to manage on their own in their own homes or in shared housing, regardless of the extent of support from home nursing care etc" (Forchhammersvej, s.a.).

1.7.2 Stavanger, unit for substance abusers

Norway has a similar unit in Stavanger. The unit for substance abusers at Stokka nursing home was established in 2006 for seniors with substance dependence, in need of much help and care. The unit began with 8 rooms, which was half of a regular unit, but was soon expanded to an entire unit with 17 rooms. It looks like the unit for substance abusers at Stokka nursing home offers the highest level of care referred to in "NOU 2003:4". Substance abusers in need of care at this department would get more transparent living conditions that

aim to provide the best possible quality of life for patients with drug problems. This unit has been considered a success with the most satisfied patients and personnel.”

”I have tried Evangeliesenteret, Frelsesarmeen and Dag- og nattsenteret. Here is the best. It could not have been better. We have tremendous freedom. We can drink both inside and outside, says resident Ove Hagen” (Almendingen, 2011).

“Those who work in a substance abuse unit must have a high threshold for trouble, tobacco and alcohol. Nevertheless, the sick absenteeism is only 1.7 percent. Employees come to work even though they should have been at home, smiles department leader Tran” (Almendingen, 2011).

Aftenbladet Februar 21 2008, reported on the visit of Sylvi Listhaug (FrP), Commissioner by the then Department of seniors and social services in Oslo, at unit for substance abusers at Stokka. The visit was in conjunction with the proposed new services in Oslo’s municipal substance abuse care. The Commissioner was inspired by the Stokka model and with a political decision about the specialization of nursing home services in Oslo in 2010 (Oslo kommunerevisjonen, 2009), the unit for substance abusers at Stovnerskogen was established in May 2011. The target group is the same as for ”Pleiekollektiv at Forchhammersvej” and unit for substance abuse at Stokka nursing home (Sørli, 2011).

2 MY BACKGROUND

2.1 Cultural background

I came to Norway in early 1986. My father and two brothers came here first as boat refugees, afterwards came the rest of the family through family reunification. At that time it was difficult and tiresome to get family reunification. It took four years before all the papers were in order so that the rest of the family could come to Norway. I was a student at a university in Vietnam for two years, but had to quit because the Vietnamese authorities knew about my reunification application to Norway. Dropping out of college was difficult, partly because I liked the education I was doing, partly because I was so old that I felt attached to my friends and the university community. But in my culture it is always the family's wish, which weighs the heaviest. Since it was my father's wish that I should quit school and move to Norway, I had no choice.

2.2 Formal education

With an unfinished degree in Education from Vietnam, I got a job at the office of Council for the elderly Oslo in 1987. It started as a summer job, but turned out to be a lifelong career. To be certain that I had enough basic knowledge, I went to high school again, before qualifying as a nurse in 2001. I remember my little sister asked me if college had a special class for me since I got admitted at the age of 38 years. It is not common for Asian women to go to school when they are "so old."

Then I continued with one-year postgraduate education for mental health workers, three-year degree in health management, health economics at bachelor's level, and finally a two-year master's degree in "Health Management, Policy and Economics." This master's degree should have been completed by spring 2010, but the writing of the thesis had to be postponed, first because of a death in the family, and then as a result of a new and exciting job at Stovnerskogen.

2.3 Experience with patients and clients

My first job as a care worker was in a downtown area, frequented by many with substance dependence. Every day I encountered old, tired alcoholics who lived at home, under inhumane conditions or in small rooms in shelters. In social housing, I met many heavy psychiatric clients who had few or no services that were adapted to them, which meant follow-up not suited to their needs. This was also partly due to the fact that the agencies responsible for giving help to these clients, lacked personnel with sufficient competence. My experience was that at the beginning of the 1990s, substance abusers were a group that was pushed aside from health care. Many of the psychiatric patients I met were not getting the follow-up they needed.

My first job was in a nursing home in a somatic department, in connection with practice for exams. When the qualifying exam was passed, I got a job at a closed psychiatric unit at one of Oslo's nursing homes. In my assessment, patients in the unit had complex psychiatric and physical disorders, but the personnel did not have sufficient expertise to take care of this patient group. This made me want to increase my knowledge in the field.

In the psychiatric practice as a nurse student, I accidentally ended up at Rusmiddeletaten, the "outreach section". There I had the opportunity to get to know almost all types of drug addict patients in different situations: out in the streets, in their homes and at detoxification institutions. The help they received was e.g. to be saved from a drug overdose, have a therapeutic conversation, to be transported to a detoxification station, or to contact the social services. At the same time, I had the opportunity to have point-practices around Oslo: detoxification institution, field nurse, dormitories, food stations. It was a little scary to get so close to a patient population. It was scary to consult them in different places of refuge, as under bridges, at the port area with copious amounts of containers, in abandoned houses and the like. But this was a unique experience that has motivated me to continue my training in substance abuse care and mental discipline.

After having served as department nurse for two years, I spent a year on postgraduate education in mental health. During that year the so-called "Rusreform II" came. In addition to my educational background, I had practice in specialist health services at a detoxification

institution and at a DPS (district psychiatric center) associated to Akershus university hospital.

2.4 Why did I get the job?

Having finished my psychiatric postgraduate education, I applied for some jobs in this field. At least on one occasion I knew my skills were not assessed, because the job was given to someone who did not have the formal skills required in the announcement. One wonders what was the reason? Does being an ethnic Norwegian play a role in job selection? I noticed that I was the only one with a foreign background in a mental health care class of 30 students.

As I had also reached the bachelor level in Health Management and Health Economics, I additionally applied for a couple of jobs in health management. One of them was at an ordering office, requiring knowledge of laws and regulations in health care, which was one of the compulsory subjects in management education. There was one interview, but no job. The interview gave me the impression that they spent one and a half hour searching for what I could not do in relation to the job. And of course I could not write perfect Norwegian. My twenty years of experience of home care and my formal qualifications did not weigh enough for the job, which was to assess patients' need for assistance and to find the right level of care for each individual.

I was very disappointed and I quit one of my two times 50% positions in the district. I had to ensure a minimal income for a living. I felt I had to give up the district I worked in, my long-term work in home care, and my strong desire to contribute my expertise in primary care. Eventually I took extra shifts here and there, to look for other opportunities on the job market. An opportunity arose when Stovnerskogen proclaimed a position in a newly created department.

The position that was advertised required a qualified nurse with special education in substance abuse and mental health, and education in management and economics, with relevant experience with the substance abuse / mental health / somatic / municipal health services. Quite frankly, I felt like all my education and all the experience I had gained, had been in preparation for this job.

3 THE PROCESS OF BUILDING A NEW UNIT

“Stoltenbergutvalget” talked about the challenges of substance abuse treatment as follows: "Drug addiction is associated with many emotions: shame and guilt, self-loathing and degradation. Many live in poverty, under inhumane conditions and suffer from mental and physical ailments in addition to the addiction” (Helse og omsorgsdepartementet, 2012).

When the provision of the location of a substance abuse unit was taken, they set up a task force with representatives from sykehjemsetaten, rusmiddeletaten, doctors, institution manager and labor unions to plan the practical preparation before the establishment (Sørli, 2011).

The institution manager hired the staff in the unit. All the employees met the first time at Gardermoen for a study trip to Stokka nursing home in Stavanger, to learn from their experience and get practical information. The staff also had two days’ training at Stovnerskogen to learn about illness and injury caused by substance abuse, and a practical tour of the nursing home.

3.1 Positive and negative support – anxious neighbors

The unit at Stovnerskogen started from May 01 2011, but the official opening took place on the June 22 2011 (Brynildsen, 2011). The creation of the substance abuse unit put Oslo's politics in a new light, because it was an offensive action the city council took in order to enhance their key priorities within elderly care. Aud Kvalbein, Commissioner for the elderly, said "We aim to facilitate a diverse and differentiated service for all our different audiences" (Tobiassen, Vil bygge sykehjem på Ellingsrud, 2012).

Sykehjemsetaten was in turn satisfied, for all research and planning gave answers to problems where they previously had no solution.

"Currently, the Sykehjemsetaten has services for patients with substance dependence and mental illness at Akerselva, Grunerløkka nursing homes, Lindeberg care center and Vinderen treatment center" (Oslo kommunerevisjonen, 2009).

Finally, patients with the same issues can be together somewhere, where there is an offer of stability, predictability and dignity, by the help of personnel with great dedication and the right skills in the field. In the field of substance abuse, this was an excellent idea. This was seen as an opportunity to prevent that drug dependent persons only get older and sicker. Some do not have enough physical and mental health to make use of services in other substance abuse institutions. Astrid Renland has written an article "Sykehjem for rusavhengige" The Journal "Rus & Samfunn", where she speaks positively about the new unit (Rus & Samfunn Tidsskrifter, 2011).

Information about this unique offer was given to districts in advance of the establishment, around February 2011, but it seems like the message was either not received or ended up with the wrong people. Employees at the nursing home received the same information, and were questioned whether anyone was willing to work in the new unit. Information about this was on the information board in the wardrobe when I got there as a new employee on May 2011. The response from staff was not as positive as expected. None of the staff at the nursing home wanted to work at the new unit.

Prior to my job interview I had researched and read the information I could find about the new unit and found newspaper articles with concern from family and community (Tobiassen, Pårørende skeptiske til avdeling for eldre rusavhengige, 2011).

In the start-up phase, the staff in the new unit met a hold-distance attitude from the rest of the staff at the nursing home. It was not welcomed when substance abuse patients moved outside their own unit. In some cases, personnel were summoned to retrieve a substance abuse patient who had a smoke with old acquaintances in other units' smoking room. Once without any known reason I was yelled at by a relative in the cafeteria, because I worked at the substance abuse unit.

The unit was established in May. Many of our patients liked to sit out on the porch to get fresh air, have a cigarette and a cup of coffee. This caused a lot of problems. There were complaints about absolutely everything that the patients did: talked or coughed too loud. Personnel were instructed to stop patients coughing, talking loudly or shouting because this disturbed the neighborhood tranquility. On one occasion, a neighbor called and complained about the substance abuse patients who just walked about in the area.

3.2 Necessary choices

Until now there had not been any unit for people with nursing and care needs that were substance abusers in Oslo. This group of patients may have undesirable behavior and are difficult to place in other nursing home units. It is also important how the staff deal with patients. In addition, fellow patients must be taken care of and not exposed to unnecessary embarrassment.

Stokka substance abuse unit had provided Sykehjemsetaten and the institution manager with some guidance as to how to develop routines for police contact, guidelines for patients and rules for employees. At the time there was a set of rules that would apply to the unit.

3.2.1 Rules in the unit

It was difficult to make all the rules before admitting the first patient. Most patients who were moved to the unit has been in protracted care and had experienced difficulty staying in other nursing homes. Some came from municipal housing, with extensive help from home care. Others came from units in other nursing homes, without any expertise to deal with the substance abuse needs of the patient, or from a substance abuse institution that does not have enough somatic knowledge to take care of the diseases and the failing of the patient's health. Where and how the patient had lived before coming to the substance abuse unit affected the rules "sykehjemsetaten" and the nursing home introduced.

Substance abuse patients are known to have poor upbringing, broken relationships with family, little social interaction and can not afford anything other than intoxication (Kristelig

Folkeparti, 2013). Being in a place where patients had other people around them 24-hours a day, with food and other things they needed available, was not just easy. A sense of others' attention, care and nursing were unfamiliar to many of our patients. The need for help was often unconditional and unlimited.

It is a challenge to be able to give comprehensive care to patients with customized individual needs, giving patients space for their own actions while having a safe framework to deal with. Staff should be there when patients need help, while it is expected that patients take responsibility for their own actions.

The practical part was done in cooperation and agreement between the patients, the institution manager and the staff. Institution manager, head nurse, staff and patients had meetings to address problems and resolve them in the community. Specific proposals for change of rules came from the patients themselves. Individual contracts were written to address the patient's financial irregularities from previous periods.

Part of the original rules has been changed to balance between respect for patient self-regulation and respect for fellow patients both in the unit and in the nursing home. Consideration for the nursing home as a whole was an important priority for the institutional manager and myself. The line between what could be called appropriate boundaries and what is considered a "necessity" is flexible.

Adjustments had to be considered both judicially and practically. The legal advisor at Sykehjemsetaten and Oslo police department took care of the judicial part.

3.2.2 Rules in the house

Substance abuse patients have as much right as other patients to move about in the nursing home. But entering other patients' rooms is trespassing, unless the other patients give permission.

This privilege created major challenges because there were alcoholic liquids in almost every room. When the staff realized this, we needed to enforce the rules. Patients continued to keep

alcohol in other units until finally a major campaign was launched for surveillance of all the rooms. Information about the problem was given to the head nurse, who subsequently informed all staff. But this was not easy for the staff outside our unit to understand. And until today, the new procedures are still not fully implemented. Whenever our patients move into other units and staff there request to have them removed, our staff has to go there and fetch them back.

Overall, the measures in the unit nearest to ours were more challenging than in other units. Uncertainty, little understanding of the substance abuse patients' actions, as well as the "hold-distance attitude" to the operation of the unit created more opposition than cooperation. Rules and regulations were some of the measures needed in order to create a good framework for cooperation.

3.2.3 Neighbors

When informed about the new establishment, neighbors and relatives were worried. The district supervisory committee and the district council were contacted, and the health and social committee should be briefed on the matter (Tobiassen, Pårørende skeptiske til avdeling for eldre rusavhengige, 2011) (Tobiassen, Ønsker orientering om ny sykehjemsavdeling, 2011).

When the unit had started, there were many calls from neighbors, with many rude and unfair accusations against substance abuse patients. A neighbor called in because a patient was drinking a beer outside the nursing home. Staff saw a patient sitting in the courtyard with a light beer. This yard is well protected with buildings and rocks. So how could neighbors see this when the nearest house is over 100 meters away? The neighbor replied that it was easy to see with binoculars.

I chose to inform about patients' rights, patient autonomy and patient dignity. I advised neighbors to complain to the appropriate authorities and reminded neighbors that everyone has the right to sit outside, enjoy the sun and fresh air. These phones demonstrate how some of the neighbors assessed and treated people with substance abuse disorders.

The District supervisory committee has the task of ensuring that the health services for the needy in the district are given according to laws and regulations. Stovner supervisory committee was there in December of 2012 on an unannounced visit regarding the City Government's plan for expansion of substance abuse unit. The committee's comment was:

"It's some concern, especially among families, for the expansion of the substance abuse unit. Complaints from neighbors and residents seem greatly exaggerated, staff have introduced strict rules and consequences in case of trouble. The economy related to the expansion is satisfactory, and nurses who have the appropriate competence must be employed " (Stovner bydel, 2012).

3.3 Systems for registration and documentation

3.3.1 IPLOS- Gerica

Municipal health services in Oslo had a gradual introduction of various IT registration systems from the beginning of the 1990s. In connection with “bydelsreformen” in 2004, which was in a consultative and planning phase, Oslo municipality had chosen Gerica as their sector system in nursing and care services (Kommunerevisjonen, 2006). Gerica is an electronic medical record (EMR) and patient administrative system, which contains all essential functions for case management, patient management and administrative overview of the health organizations (D-IKT, 2011). Data registration has been common for the whole municipality of Oslo since 2008, and includes approximately 35,000 users with one or more active service registered by January 2012 (UIO, 2012). Head of Department at UiO, Helsam, Jeanette Magnus, found it exciting with such a municipal database. She said that:

"We must recognize that health is affected by decisions and work in all sectors. How we plan roads and build new homes impacts our health. We must therefore coordinate electronic data across sectors in the municipality" (UIO-Helsam, s.a.).

The aim of the common electronic registration system is increased continuity and improved quality in both services and legal documentation. The system has been in use, and is becoming more standardized and improved.

Within Sykehjemsetaten there is limited access for staff to other functions than what is direct patient oriented. These are features that constitute a relevant plan of measures, IPLOS (individual-based care and nursing statistics), and any message exchange with other services regarding assessment and treatment of the patient. Gerica include a scanning function, function for messaging, a booking module for nursing home places, a separate module for electronic messaging (e-Link through the Norwegian Health Network) and reporting of IPLOS (D-IKT, 2011).

IPLOS registration is a key pseudonym health registry of standardized data on information relevant to the assessment of assistance and service needs. This is pursuant to the Act of May 18 2001 No. 24 relating to health records and processing of health information (Health Register Act). Regulation No. 204 of 17 February 2006 is in addition, when all municipalities were required to provide IPLOS data to the Health Directorate for processing. Registration is part of a nationwide statistics on all statutory health and social care units so that the health authorities may have the necessary information for planning and development of services in their region (Helsedirektoratet, 2011).

The Gerica system in a nursing home is the gateway to record the patient's health condition in IPLOS. Most common is ADL "Activities of Daily Life" review, where both instrumental and primary ADL are measured at any time. High scores indicate that the patient is more dependent on assistance to perform basic daily activities.

These data provide a basis for research, monitoring, quality assurance, planning, development and overall management of health and social services and social and health administration. Data submitted to the Health Directorate of the municipality's IT-based professional system / journals after further established procedures each year (Helsedirektoratet, 2011).

3.3.2 Archivation of paper medical records

The development of electronic medical records has come far, but some paper information is still needed. Each patient has his file folder, which contains information from other interdisciplinary collaborations entities. There is limited Gerica access to other parties without direct patient contact (treatment). The patient's paper records are more relevant for

patients in a substance abuse unit, because substance abuse institutions and other private drug rehabilitation organizations do not have access to Oslo's common electronic health record system. At the same time, drug addiction patients have frequent contact with social workers and ordering consultant in the districts where they belong. These papers are archived in a locked cabinet in the unit.

3.3.3 **Stokka, status after 3 years of operation**

The doctor at the Stokka unit for substance abusers did a survey of the residents and evaluated the use of health and social services in the period prior to admission to the nursing home. The project has been carried out in the period 2009-2011, for the purpose of describing the department's objectives, working methods and user group. By means of the survey the author can see what resources are available for this group, and assess use of resources (Vossius, The Stavanger Wet House, 2012).

Some data from Stokka nursing home between 2006-2009 and from the mapping began:

- 8 beds in 2006 16 beds in 2009
- 31 patients - 5 women and 26 men
- 46-77 year old, mean age 62.2
- 9 died (11 days - 3.8 years) = mean of 1.4 years
- Five patient out after a couple of weeks
- Comorbidity: alcohol toxic encephalopathy, alcohol toxic ataxia and polyneuropathy, alcohol toxic liver, anxiety / depression, patient infection - Hepatitis C, cerebral insult
- Morbidity: liver disease, prostate cancer, lung cancer, COPD, cardiac arrest, declining general health condition, cause of death unknown
- High use of services six months before admitted
- No services aimed at detoxification
- Poor correlation between functional status and service offerings (Vossius, The Stavanger Wet House, 2012) (Vossius, Testad, Berge, & Nesvåg, 2011).

4 THE FIRST TWO YEARS

The report NOU 2003:4 "Forskning på rusmiddelfeltet "specifies that:

" The international knowledge summary contains nothing about the importance of housing and care measures, or the extent to which housing and care interventions work satisfactory in relation to the objectives of the measure. There are no national studies on the effect of such measures" (Regjeringen, 2003).

The Stavanger wet house is a wet house per definition. It is aimed more towards the burned-out alcoholics than other types of substance abusers. If this is the case, it is a local measure, showing positive effect (Vossius, The Stavanger Wet House, 2012).

Stovnerskogen is also a local substance abuse services centre, serving the city of Oslo. It has been operative for nearly two years with many challenges as well as changing needs along the way.

The change of the patients' health status, staff competence and attitudes during those two first years are the focus of this report.

4.1 Method

4.1.1 Patient data

Patient data are taken from existing paper records and Gerica - electronic medical records. Different doctors in different contexts have submitted this information. Some patients have little or no paper records or electronic records before admission. Diagnosis and assessment are therefore in some cases limited to the time the patient has been in the department.

Body weight is obtained from Gerica, registered at the time the patient was admitted to the unit, and up to the present. The patient's weight is usually recorded once a month, sometimes

even with shorter intervals if deemed medically necessary. Change in body weight is seen as a reliable indirect indicator of the patient's health status.

Individual-based care and nursing statistics, IPLOS / Activities of Daily Life ADL - Records are printed out. Each sheet is marked with three intervals: before the patient arrived, when patient was admitted and present. This is regarded an objective measure of the patient's state of health at that particular time. The objective of the data collection is to identify changes and to assess the benefits of staying at the unit.

4.1.2 The questionnaire to the unit staff and other staff at the nursing home

To see whether personal assessment of their skills had changed, I designed a questionnaire to be replied to anonymously and handed out randomly to eight personnel who worked a particular week, seven women and one man. Five staff have been at the unit since start-up, two began about half a year later and one about one year after start-up. Two have formal training in psychiatry; the others have more or less experience with addiction, mostly alcoholism.

Each question has two categories, "before" and "now". Before signifies at the time when the employee started working at the unit, and now is at present. Within each category, the possible score ranges from 1 (to a very little extent) to 6 (to a very large extent).

I also prepared a questionnaire to the staff at the eight other units at the nursing home. This was also replied to anonymously. Six of them are patient units with direct nursing care, two are services units. Sixteen questionnaires were given to randomly selected staff in the eight units. The intention originally was to interview some candidates, but this proved difficult to implement. Some said openly that they did not wish to comment in person, others blamed time pressure at work.

The collection of the questionnaires was not easy, because the questionnaires were given to the departments for staff to distribute in their respective department. The challenge was first to find out who had received the form, sometimes the person was not on duty when collection

took place. Other promised to fill it out and give it back, but did not do so, others forgot it at home. Overall, I ended up having 13 completed of the 16 distributed forms.

The respondents were two men and eleven women. Ten had worked from before 2008, and three were employed after 2008. One person was newly hired, and she only answered in the category “now”. In her case I listed the same score for both “before” and “now”.

The questionnaire has the same number of categories and questions as the questionnaire given to employees in my unit. The questions are somewhat different, because I am not looking for their assessment of skills. I want to see the change in attitude after two years of substance abuse patients in the nursing home.

Hopefully it can extract the staffs´ basic notion of persons with drug addiction and side effects related to substance abuse.

Results from the "Bedrekommune.no" municipal surveys in the past two years, are also brought in to compare with the results from my questionnaire.

That survey is a tool to measure quality of services as well as user- and staff satisfaction. The survey is carried out once a year, direct online or in printed version. The answers are registered and sorted through a program distributing the respondents´ answers on a scale from 1.0 to 6.0. The program results allow comparison on municipality, institution and unit level. Leaders have access to results from the units she/he is responsible for (Kommuneforlaget, s.a.).

4.1.3 Assessment of my role in this thesis

As a divisional nurse for the substance abuse unit as well as the leader of and a researcher in the same unit, I find myself in a mixed role. As a scientist, I want to be neutral and objective in evaluation. As a manager, I have some idea of how the operation works. This may create a more subjective assessment.

My position at the nursing home can affect survey responses because of my personal qualities and my powers as a leader. In order to balance findings, I have taken the annual survey of the

municipality, and supplied it with my own results. The annual municipal survey tends to take place right after summer vacation on the website “Bedrekommune.no”. It is anonymous and nationwide for all relevant staff in the public sector.

In order to get a good assessment after two years of operation, economic, administrative and management factors also play an important role. However, I choose to exclude these factors in order to limit the scope. This applies to both vertical and horizontal management lines, including myself.

4.2 Patients

4.2.1 Status at admission

In the first few weeks in the new unit there was a mix of patients with diagnosis of substance abuse and elderly patients with somatic diagnosis.

The patients came from other nursing homes, from their own apartments or from hospitals. The patients that came from other nursing homes were patients with complicated substance abuse, differens somatic diagnosis and several psychiatric symptoms. The other nursing home had problems taking care of them. Three out of the four first patients were on psychiatric medication, but there was no information about their psychiatric diagnosis. Other patients were clearly affected by psychiatric disorders, but without any specific diagnosis. Many of the patients had a long history of medication and not necessarily in accordance with diagnosis or symptoms.

When the unit was established, everything was new for both patients and staff. This led to uncertainty, and made the first phase of trust-building harder. The patients were to some degree restless, had problems adapting to the new environment and to building good relations with the staff.

Some patients acted out verbally and physically towards personnel and each other. Some looked for alcoholic fluids inside or outside the unit.

Other patients were comfortable and happy for the food and staff availability. They demanded food all the time and everywhere, and "urgent help " when they needed help.

However, after a few weeks, the patients had found their place and a better relationship with the staff was established.

The patients and staff experienced and still recognize these challenges when new patients arrive at the unit.

One of the main challenges was the different social and economical problem the patients had when they arrived. The staff knew how to handle patients and their health-related problems, but poor economy or lack of relatives was not so much within their competence. These patients had a lot of unpaid bills. Five of the patients had settled such problems by May 2011, by May 2013 the number is eight.

Another aspect that is unusual for nursing homes was the lack of next of kin. Most other patients have a next of kin that can visit and help buying clothes, personal items and other things that the patients need. This new group of patients had no one to do this, and the staff needed to find solutions.

4.2.2 Status by time

Out of the nine patients who arrived at the start there are seven remaining by May 2013. One died after a year and another moved back to his own apartment after a year.

Many patients have a home for the first time, and an address they can provide when asked.

Most patients see one of the doctors at the nursing home within a week after admission, and are referred to a specialist for diagnosis and assessment of treatment if necessary. All medication will be reassessed, and the dosage will be adjusted to the appropriate amount. The doctor and staff get to know patients over time, which makes it easier to prevent acute medical problems. The patients usually become more stable both mentally and physically within some weeks. The patients even have better control over nicotine and drug intake, and develop a more normal daily routine with regular meals and other activities.

Substance abuse patients are known for poor dental status (Regjeringen, 2003). This is taken care of by dentists at the nursing home, and when necessary they are referred to dental specialists. Ulcer treatment has also been a success in the unit.

The table below shows the weight and IPLOS values. Increased weight is not necessarily positive since a weight gain may also be due to less mobility and activities, but it is an indication of improvement. Change (+) in IPLOS is certainly a positive development; lower numeric values in the table means less need of help for the patient.

Table 1: The patient weight and IPLOS status.

Admitted to the unit	Weight on admission	Weight Present	Change	IPLOS on admission	IPLOS present	change
P 1- september 2012	71.5	76.0	+	3.52	2.58	+
P 2- july 2012	54.5	55.7	+	2.77	2.25	+
P 3- may 2011	65.0	61.0	-	3.45	2.47	+
P 4- may 2011	101.5	112.0	+	1.93	1.88	+
P 5- may 2011	50.5	53.0	+	4.83	3.03	+
P 6- may 2011	86.0	89.0	+	3.90	3.80	+
P 7- may 2011	61.0	54.5	-	1.48	2.48	-
P 8- may 2011	94.5	92.0	-	2.29	2.60	-
P 9- may 2011	93.0	94.0	+	3.31	2.64	+
P 10- march 2013	73.4	75.1	+	4.21	3.09	+
P11- march 2013	--	87.7		2.78	2.38	+
P12- april 2013	--	--		--	--	

Almost all substance abuse patients have lived a hard life with a long career of substance abuse. Economical insight is lacking for our patients. These patients were under management and they agreed to have an account at the nursing home. This made it possible for the staff to get an overview and to help them gain financial control. All patients can get help to repay old debts and pay incurred utility bills. In addition, they have a agreement with regular cash advances so they can buy cigarettes and alcohol (Sykehjemsetaten, 2013). Patients can get help when they need to make purchases. Patients may also plan to participate in shopping with a primary contact.

The relationship with their family has been given a new direction for some patients as well. Some manage to resume contact with their family, while others fail. But one thing is quite certain, the relationship between patients and family is better than ever. The patients feel that

¹ Table shows the patient's weight and IPLOS registration until April 2013.

their dignity is valued, and their families feel that patient safety and predictability are preserved in their new home.

4.2.3 Patients' current features

The unit had 9 rooms at start-up in 2011, and has 16 rooms today. Overall, there have been three women and thirteen men in the unit. The youngest is 49, the oldest is 79, with an average age of 62 years.

Of the patients who live in the unit, four patients had heroin as their main drug. All these patients have been on substitution treatment (LAR). All patients abuse more than one drug. Patients often combine illegal and legal drugs with alcohol and marijuana. Almost all patients are heavy smokers.

Some of the additional diagnosis are: alcohol toxic encephalopathy, alcohol toxic ataxia, polyneuropathy and polyneuritis, alcohol toxic liver damage (cirrhosis, fatty liver), alcohol-related dementia, cognitive degeneration, bipolar disease, aggressive and violent behavior, period psychotic, schizophrenia, posttraumatic stress disorder, depression and anxiety, hepatitis A and C, cerebral insults, stroke, COPD, cancer, diabetes, atrial fibrillation, delirium, epilepsy, spasm, infection and fractures.

4.1 The staff

The unit started with staff of three different professions, two social educators (vernepleiere), four nurses and nine nurse assistants. There were also one 25% doctor position and one 25% physiotherapist position connected to the unit. Even though the social educators and the nurse had the same job description, there were differences in how these two professions viewed how the assignments should be carried out. The thought behind hiring staff of both professions was to create a team with broad competence.

Initially the patients had more somatic diagnosis than expected. The social educator had less experience and competence related to somatic illnesses, some had little experience with

substance abuse patients. In addition the social educator had not expected to work so much with older clients.

The nurses and nurse assistants shared an understanding of normal aging and negative consequences of long standing substance abuse, but did not focus on the therapeutic environment at the time. The professional guidelines did not fit together, so it came as no surprise when the social educators resigned their jobs.

These first weeks represented a steep learning curve for all the staff. Everyone had to get to know each other, the patients, daily routines, and how the system worked.

4.1.1 Questionnaire, the unit

An organization is formed, to work towards a specific goal. Organizations must also have resources, social structure and participants to acquaint themselves with the society (Engelstad, 2010).

When the substance abuse unit was established, Sykehjemsetaten provided advice and coordination, Rusmiddelsetaten provided guidance, and Stovnerskogen provided buildings. Participation of all interested bodies has materialized into a common goal where Sykehjemsetaten had no previous experience: a new service to help needy substance abusers. (Oslo kommunerevisjonen, 2009).

The institution manager at Stovnerskogen was given the task of hiring staff and he has stated:

"The main expertise is still motivation and personal characteristics, persistence and commitment. The staff has prepared a common position on how to handle periods of substance abuse, and as a team they will create clear boundaries where needed " (Tobiassen, Pårørende skeptiske til avdeling for eldre rusavhengige, 2011).

Personnel who came to the unit from May 2011 and personnel who were employed later rated their expertise, influence, autonomy and meaningfulness as shown in Table 2.

Table 2: The staff's own assessment of their competence

Nr.	Questionnaire and mean score on a scale from 1 (to a very little extent) to 6 (to a very large extent)	Before	Present
1	Are you are familiar with the targets of the unit?	4.3	5.6
2	Do you get adequate information to do a good job?	4.8	5.1
3	Are you satisfied with the way your work is organized in the unit?	4.3	4.5
4	Do you have many challenges in your job?	5.5	4.6
5	Do you feel that you can work independently?	5.0	5.5
6	Do you think the staff work well as a team?	5.0	5.0
7	Do you feel that you master your job in accordance with your expectations?	4.6	5.3
8	To what extent do you feel you have the right competence to do your job?	4.3	5.1
9	To what extent do you feel that you learn through your job?	5.3	4.9
10	Do you feel that you have the possibility for further development in your job?	4.3	4.0
11	Do you feel that you have a good professional insight?	3.9	4.6
12	How satisfied you are after a working day?	4.9	4.8

2

The results in the table show a high score for engagement, and positive developments in almost all areas.

² Survey is conducted in the unit, April 2013, with 8/8 answers

The three first questions on targets, enough information to carry out a good job, and whether or not staff are satisfied with the organization in the unit, show significant improvement. The score rises from 4.3 to 5.6, 4.8 to 5.1, and 4.3 to 4.5 respectively. The results indicate a good basis for continued personal development and follow up.

The score creates a feeling of success, increased competence and enthusiasm. It enhances the interest in taking initiatives and encourages autonomy in the working place.

Question 4 on challenges in the working place shows a change in score from 5.5 to 4.6. This may be a natural result of high feeling of mastering the tasks at hand both as an individual and as a team.

Question 5 on being able to work independently and question 6 in team-work show little change except increased score from 5.0 to 5.5 for more independency at work. Both scores indicate high job satisfaction, which may be the result of unity, mutual trust and psychological harmony of team members (Kuvaas, 2011).

Question 7 on mastering the job/ expectations towards the job and question 8 on whether staff feel that their competence has increased, show increased score for 4.6 to 5.3 and from 4.3 to 5.1 respectively. This indicates increased job satisfaction and increased feeling of autonomy. It is tempting to deduct from these scores that staffs' job motivation has increased.

Question 9 on whether staff learns in their work situation, show score decrease from 5.3 to 4.9. Question 10 on development in the work situation results with score from 4.3 to 4.0. This may also be explained by the fact that the staff feels that they master their job, and there might not be so much more to learn as in the beginning.

Question 11 on professional insight shows a significant increase from 3.9 to 4.6. This score is a very positive sign that staff feels they have obtained more competence.

Question 12 on how satisfied staff feels after their working day is over shows little change in score, 4.9 to 4.8. This is a bit surprising as the many positive score changes in the table would lead to think staff feel more satisfied. However, work at this unit is in general demanding, so a score near 5.0 is still to be regarded as a high score.

4.1.2 Municipal employee surveys

Table 3: “Bedrekommune.no” staff’s survey on substance abuse unit

Nr.	Questionnaire and mean score on a scale from 1 (to a very little extent) to 6 (to a very large extent)	2011	2012
1	Organization of the work	4.3	4.8
2	Content in the job	5.0	5.1
3	Physical working conditions	4.2	4.1
4	Cooperation and job satisfaction among colleagues	5.0	5.6
5	Bullying, discrimination and notification	5.0	5.2
6	Immediate superior	4.7	5.4
7	Performance appraisals	5.0	5.1
8	Superior leadership	3.8	4.3
9	Professional and personal development	4.1	4.6
10	Wages and working hour schemes	3.4	3.5
11	Pride in their own work place	4.2	4.7
12	Overall evaluation	4.2	4.8
13	The management (new point 2012)	--	4.5
14	Values and ethics (new point 2012)	--	4.8

Table 3 comprised a comprehensive assessment related to personnel in the workplace and has more focus on job satisfaction than what table 2 has.

The purpose of using table 3 is to show that personnel have the same perception of professional development and competence necessary to perform a good job. The table shows significant change from 2011 to 2012, from question 1 through 12. Regarding 13 and 14, comparison is not possible.

Organization of the work changes from 4.3 to 4.8, showing positive change. And content in the job had high score with 5.0 in 2011 and obtained almost the same score in 2012.

Cooperation and job satisfaction among colleagues had high score with 5.0 in 2011, and 5.6 in 2012, showing positive change.

Professional and personal development scored 4.1 in 2011 and increased to 4.6 in 2012. This is a question one may say summarises regarding competence and professional development.

Changes in scores from 2011 to 2012 have in general shown that the personnel are now more satisfied to work in the unit. Some questions like; organization of the work, satisfaction among colleagues, immediate superior and overall evaluation shows a significantly increased score of more than 0.6 points of the scale. Regarding other remaining questions, the score increase is less than 0.5.

4.1.3 The questionnaire - the staff in house

The majority of staff at the nursing home has been in the process of creating the unit. However, there is no concrete information on how the staff received the messages. I wanted to explore whether there has been any change in staff attitude and what the staff thinks about the substance abuse patient group.

³ Survey was conducted in the unit, October 2011, with 8/10 answer, og October 2012, with 10/10 answer.

Table 4: The staffs' attitude towards substance abuse patients

Nr.	Questionnaire and mean score on a scale from 1 (to a very little extent) to 6 (to a very large extent)	Before	Now
1	To what extent do you think that the substance abuse is only the user's fault?	4.1	4.2
2	To what extent do you consider that the substance abuse is a disease / disorder?	4.2	4.2
3	To what extent do you consider that substance abuse patients have disorders in addition?	4.5	4.8
4	To what degree do you think substance abuse is related to crime?	4.3	4.2
5	To what extent do you think substance abuse is related to violent behaviour?	4.0	4.0
6	To what extent are you afraid to meet a substance abuse patient in the institutions entrance?	1.6	1.4
7	To what extent are you afraid to meet substance abuse patient in the canteen?	1.5	1.3
8	To what extent are you afraid to meet a substance abuse patient in your unit?	1.5	1.3
9	To what extent are you afraid to meet a substance abuse patient in the elevator?	1.6	1.4
10	To what extent are you afraid to meet substance abuse patients in their unit?	1.5	1.4
11	Do you think there ought to be a substance abuse unit in the Stovnerskogen nursing home?	3.2	3.3
12	How satisfied are you after a working day?	4.7	4.5

Table 4 shows no significant change in employee perceptions of substance abuse patients between start-up and present.

⁴ Survey is counted at Stovnerskogen, April 2013, with 13/16 answer. Total personnel is approx. 200

All employees who are covered by the survey, largely agree that substance abuse is a disease and that they have a mental illness and have violent behavior. Crime and substance abuse is only the user's fault. Score for this question is from 3.9 to 4.7. All staff involved in the research say they are seldom afraid to meet these patients elsewhere in the nursing home. Score is from 1.3 to 1.6

When asked if the employees feel that it is right to have a substance abuse unit at Stovnerskogen, the score is 3.2 and 3.3. With a share of more than half of the personnel, I consider it is right to have substance abuse unit here. Some other employees express in a way that they are unhappy with the arrangement. One comment: "I do not work in a substance abuse unit." "They do not belong here." "They should have a special place." "They should have services elsewhere, like in a private institution."

Stølen has mentioned that the attitude, the subjective norms and perceived control action will affect the option to satisfy our needs (Stølen, s.a.). It is our need for security and predictability, there are deeper underlying values that influence employees' attitude towards patients. Some other comments:

"They make use of all benefits and take over areas such as the smoking room from other patients. In addition, they leave a lot of trash and beer bottles in the rooms they use. That annoys other residents. "

"This patient group certainly needs such a facility, but I do not think it is ideal to have it at a regular nursing home. Some other patient report that substance abuse patients may be noisy or violent. But they also express an understanding for not gathering too many such patients at one earmarked institution. "

4.2 Counterparts

Establishing a substance abuse unit has led to many instances of need for cooperation. Rusmiddelsetaten offered its expertise in the field of training of new employees and is still involved in guidance to employees in the new unit. Private institutions for substance abusers have also been in contact and come to visit Stovnerskogen. Cooperation has been sporadic,

but useful because private institutions tend to have patients with heavy substance abuse. Now patients with additional somatic diseases move to Stovnerskogen when private substance abuse institutions do not have the expertise to take care of their somatic diseases.

The districts ordering office has been an important agency to work with. This is where the needs of the patients are recorded, and assessed. They allocate place at the right care level. The ordering office usually has much collaboration with the unit when we receive a patient from the district. Patients need help to arrange transfer, financial arrangements, etc.

The unit also has contact with hospitals and psychiatric wards when there is a need for this.

Nursing homes and other departments in Sykehjemsetaten have also contacted the substance abuse unit. Some make phone contact with questions regarding substance abuse, previous substance abuse patients, and the criteria for transfer of someone to the substance abuse unit at Stovnerskogen.

The unit is available to visitors. During the two years of operation there have been visits from other municipalities, private institutions of substance abuse, the substance abuse network project and a student.

5 DISCUSSION

First a look at Sykehjemsetaten's organization and their employees' internal motivation before discuss the facts advocating the substance abuse unit at Stovnerskogen.

5.1 Minzberg's organizational theory

When the nursing homes in Oslo were under district administration, the City Council had delegated the care of the elderly in institutions to the districts. This is what Minzberg calls a divisionalized structure form, which:

"...employs limited vertical decentralization. Decision-making is decentralized at the divisional level. There is little coordination among the separate divisions. Corporate-level personnel provide some coordination. Thus, each division itself is relatively centralized and tends to resemble a machine bureaucracy" (Lunenburg, 2012).

The districts have been given the responsibility for their area of Oslo, after the City Council has delegated the decision-making authority and the responsibility to the city commissioner and the districts. Each district functions as an independent organization and has the freedom to manage itself, including the district administration. The District administration has the political element, with the borough council and subordinate committees. The administration section has its own staff and operating board, including the borough president.

The District committee is composed of politicians and has 13 members reflecting the political representation in the local. The District committee is responsible for prioritization within its field of responsibilities.

The statutory services in "kommunalloven" must of course be covered, but to what extent depends on the district committee's priorities. Minzberg thinks that a divisionalized organizational model has advantages in terms of efficiency as well as financially. However, when responsibilities and power are delegated to the district, higher levels of administration, including the city council, lose some control as well. This may create tension. This means

that the head office at higher level wants more control, while the division managers try to avoid this control. In some cases the headquarters lose track of the operation. Higher levels may experience that a divisionalised unit can be quite cumbersome. The district nursing homes may work that way (Melvold, 2010).

The City Council has detected that the system of free choice of nursing home is not followed up. E.g. there may be available beds in one district while there is a waiting list in others. Districts should communicate and cooperate to meet the total need in Oslo, but this is not possible with the current organization. The total coverage of places for Oslo's elderly is considered sufficient, while nursing home coverage in some districts is not. Therefore the City Council decided on an organizational change (Melvold, 2010).

The idea of change and the model to be used has been through a long process. Many reports and a lot of consultations have taken place between the city council and districts. Referring to Mintzberg's divisional model, the City Council wants more power by organizing nursing homes as separate central agencies, with the power to control capacity, to handle coordination and to allow for more specialization. Sykehjemsetaten is not included in the central city council, but will operate as a division, as a link between districts and the city council related to the elderly. This is enhancing the City Council's vision of freedom of choice, quality and efficiency. Sykehjemsetaten works as a machine bureaucracy, where all decisions are taken centrally. Characteristics of machine bureaucracy are centralization, standardization, authority and formality (Lunenburg, 2012).

There are many elements involved in an organization; one of them is human resources, understood as employees in the company. It may be difficult to fully motivate and thereby utilize the human resources in a distinctly centralized structure.

5.2 Motivation

Motivation is described as a targeted behavior driven by human urges and various internal needs (Kuvaas, 2011). Here there are two theories of motivation: the needs theory and the cognitive theory.

According to Maslow, there are five requirements that are referred to as basic needs. These are physiological needs, safety, belonging, esteem and self-actualization. Maslow believed that humans strive for self-realization and saw the human motivation to seek recognition, any time through their presentations (Learning-theory, 2007-2013).

Cognitive theory is based on a different psychological orientation, with the assumption that humans are thinking, rational beings who can influence their choice to meet their basic needs. The choice is in line with the expectations one would obtain by completing the job (Lossius, 2012).

Kuvaas writes that in a survey on what employees regarded as the highest values in a work context, internal motivation like dedication and enthusiasm was emphasized. This is linked to the statement:

"Good employees do not think about their own or someone else's wallet while on the job, they think of the service, product, customer, client or user!... They feel, however, as owners and as part of the family and really wants to give "a little extra" for the organization to achieve its goals" (Kuvaas, 2011).

5.3 From sheltered home to nursing home

In the history of drug treatment (Fekjær, 2008), it is related how "burned-out" alcoholics have been imprisoned or sent to workhouse, to protect both society and the alcoholic's personal health.

Until about 1960, society has developed in a more than humane direction. Imprisonment or workhouse was not used anymore in place of treatment. From then on, Oslo municipality has established different institutional forms of housing and treatment for alcoholic patients. And they have established psychiatric institutional treatment for other substance abusers.

Whether to include treatment in the housing institution has been a long discussion between the involved actors in society. There has also been a lengthy discussion going on regarding how to share or divide responsibilities between central and local government.

With the Oslo district reform in 1988, it was decided to keep responsibility for housing separated from treatment. In 1994, Rusmiddeletaten was established as an organization responsible for housing as well as therapeutic treatment. However, a substance abuser in need of 24-hour nursing care has increasingly become a headache for the municipality.

Institutions with competence within substance abuse do not have competence on somatic diseases, and nursing home does not have special competence on drug abuse. There has been a long discussion on the political level about which institution is best suited to take care of elderly, exhausted substance abuse patients in need of care.

By choosing to establish an institution for drug abuse, Rusmiddeletaten expands its responsibility from treatment of drug abusers to the somatic field. An advantage is that the substance abusers will get life-long treatment and care in the same place. A disadvantage is that Rusmiddeletaten does not have enough space/ beds to house all substance abuse patients. They would have to expand their facilities considerably.

By choosing a nursing home, substance abuse treatment and care is covered in the same way as for all other inhabitants in the municipality. A nursing home is well organized and equipped with resources and competence to care for the elderly. However, the nursing home sector does not presently have special competence within addiction substance abuse and psychiatry.

While discussing what is ideally the best solution, economic constraints should be kept in mind. It is also a question of which solution is the most cost-efficient.

Oslo's politicians have made their decision when Stovnerskogen's substance abuse unit was established in 2011. With the decision, the most needy substance abuse users were given an offer in one unit. While at the same time, other elderly in the same nursing home, may have to live with a feeling of less personal security during their last years. Nothing dramatic has happened so far, but unwanted things may happen in the future.

Substance abuse patients at Stovnerskogen are a mixed group comprising users of alcohol, heroin and tablets.

The challenge, which lies in streamlining rules and routines, may easily develop into a problem. Drawing limits for the individual, different diseases and damage control as a precaution causes quite uneven exploitation of resources at different times in the unit. It should be understood that having substance abuse patients in a specialized unit, but in an ordinary nursing home, is demanding with regards to staff resources. Patients' movements inside and outside the unit as well as outside the institution have to be monitored.

These resources might have been put to better use directly in patients' treatment and care if drug abuse patients are treated in a separate institution or at least more separated structurally, even if localized together with other nursing home patients.

It would be interesting to explore models for the care of our patient group e.g. at Frochhammersvej in Copenhagen, to learn from challenges they experience.

It would also be interesting for other municipalities in Norway to try out the Frochhammersvej model or other models. This would be a way to explore and compare what model is more suited in the care of substance abuse patients in Norway. But whichever form of housing is chosen, the attitude towards and respect for the patient is of vital importance for successful treatment and care.

6 CONCLUSION

All facts in this report point to the fact that Stovnerskogen unit for substance abuse patients has been successfully established and operated during its two first years. The staff in the unit experience success in their job and seem to thrive.

Operating such a special unit in an ordinary nursing home has proved to be a bigger challenge than expected beforehand.

The proportion between resources available and resources needed is a dilemma in this kind of unit. A contingency of extra, available money on the budget to be used e.g. if needed to ensure other patients' security would ease the operation of the unit. Having such a contingency would be better than having all staff position 100% filled at all times.

Establishment and operation of a unit localized at nursing home but structurally separated, e.g. is an annex, with separate entrance etc, has not been tried in Oslo before. This might be worth trying when a new nursing home is being built. It would ensure that all staff resources used with full focus on the patient and in direct follow-up of the patient.

Stovnerskogen unit is an important step towards better care for substance abuse patients. Further research and working on adjustment of the model is a natural follow-up of the experience acquired.

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8 APPENDICES

Informasjonskriv

Til Sykehjemetaten og
alle ansatte på Stovnerskogen sykehjem

Jeg jobber som avdelingssykepleier i avdeling 2 C, Stovnerskogen sykehjem. Jeg holder på med en utdanning "Health Economics, Policy, and Management" ved Universitet i Oslo som jeg startet på i 2008. I forbindelse med min avsluttende oppgave, ønsker jeg å svare på påstanden: "Bør kommuner utvikle spesielle tilbud til eldre med rusavhengighet på et ordinær sykehjem?"

I den sammenheng trenger jeg å intervju 6-8 ansatte på Stovnerskogen sykehjem. Hvert intervju tar ca. 1 time, og det vil bli delt ut ett spørreskjema i forkant av intervjuet. Det vil også bli gitt ut 6-8 spørreskjemaer til ansatte i 2 C før påske, blant disse vil det ikke bli gjennomført noe intervju.

Oppgavens tittel:

Effekter av botilbud til eldre rusmisbrukerne på Oslo sykehjem - status etter to års drift.

Forskningsområde:

1. Effekter på pasientenes helse
Metode: analyse av data fra tilgjengelig dokumentasjon (IPLOS, Geric, ...)
2. Effekter på personalets kompetanse og faglige utvikling
Metode: analyse data i spørreskjema fra personal i 2 C
3. Holdningsendringer blant personalet på Stovnerskogen sykehjem
Metode: analyse data fra skjema og intervjuer med personal i huset.

Formålet med datainnsamlingen er å bevise at SYE har tatt en riktig/uriktig beslutning ved å etablere spesiell avdeling for rusmisbruk i et vanlig sykehjem. På grunn av min rolle i avdeling, blir ikke økonomi og administrering vurdert i denne oppgaven. Stovnerskogen er det eneste sykehjemmet med dette tilbud i Oslo området, pasienter og personal kan bli gjenkjent som gruppe, men ikke som enkelt person. Anonymitet og personvern vil bli ivaretatt etter lovens bestemmelse.

Takk for hjelpen.

Anna Cao
Avd. Sykepleier 2 C
Tlf. 918 25 834

Spørreskjema for ansatte i 2C

Strek under det alternativet som passer best

Bakgrunnsspørsmål:

- Kjønn:
mann kvinner
- Alder:
under 30 30-49 over 50
- Utdanning:
Hj.pl Hj.pl m/etterutdanning
Spl. Spl. m/etterutdanning
- Når begynte du på avdelingen:
Mai 2011-des 2011
Jan 2012-juni 2012
Juli 2012-des 2012
Jan 2013-nå

På en skala fra 1 (svært liten grad) til 6 (svært stor grad), sett ring rundt det alternativet som passer best

1. *I hvor stor grad er du kjent med målene på avdeling?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

2. *I hvor stor grad får du tilstrekkelig informasjon for å gjøre en god jobb?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

3. *I hvor stor grad er du fornøyd med hvordan jobben din er tilrettelagt i avdelingen?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

4. *Hvor mye utfordringer har du i jobben din?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

5. *I hvor stor grad føler du at du kan jobbe selvstendig?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

6. *I hvor stor grad du føler at du må jobbe i team?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

7. *I hvor stor grad føler du at du mestrer de arbeidsoppgaver du har, ut fra dine forventninger?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

8. *Hvordan føler du at du har kompetanse i forhold til arbeidsoppgavene dine?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

9. *I hvor stor grad føler du at du lærer noe gjennom jobben?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

10. *I hvor stor grad føler du at du har mulighet for videreutvikling i jobben?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

11. *I hvor stor grad føler du at du har god faglig innsikt?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

12. *Hvor fornøyd er du etter en arbeidsdag?*

I begynnelsen: 1 2 3 4 5 6
Nå: 1 2 3 4 5 6

13. *Er det noe mer du ønsker å kommentere angående kompetanse og faglig utvikling i avdelingen?*

Jeg samtykker at min kommentar kan benyttes i offentlig rapport og/eller internt utviklingsarbeid.

Takk for hjelpen Ja Nei

Spørreskjema, Stovnerskogen

Sett strekk under det alternativet som passer best

Bakgrunnsspørsmål:

- Kjønn: mann kvinne
- Alder: under 30 30-49 over 50
- Når begynte du i Stovnerskogen sykehjem eller Stovnerhjemmet:

Før august 2008	(jobbet på Stovnerhjemmet)
Fra august 2008	(Stovnerskogen er i drift)
Fra jan 2011	(rus-avd i etablering fasen)
Fra mai 2011	(rus-avd er i drift)
Etter mai 2011	(rus-avd har vært i drift)

På en skala fra 1 (svært liten grad) til 6 (svært stor grad), sett ring rundt det alternativet som stemmer best

1. *I hvor stor grad mener du rusmisbruk kun er ens egen skyld?*

Før mai 2011:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

2. *I hvor stor grad mener du at rusmisbruk er en sykdom/lidelse?*

Før mai 2011:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

3. *I hvor stor grad tror du at rusmisbruker har psykiske lidelser i tillegg?*

Før mai 2011:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

4. *I hvor stor grad forbinder du rusmisbruk med kriminalitet?*

Før mai 2011:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

5. *I hvor stor grad forbinder du rusmisbruk med voldelig atferd?*

Før mai 2011:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

6. *I hvor stor grad er du redd for å møte en rus-pasient i inngangspartiet?*

Før:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

7. *I hvor stor grad er du redd for å møte en rus-pasient i kantinen?*

Før:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

8. *I hvor stor grad er du redd for å møte en rus-pasient på din avdeling?*

Før:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

9. *I hvor stor grad er du redd for å møte en rus-pasient i heisen?*

Før:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

10. *I hvor stor grad er du redd for å møte en rus-pasient i rus-avdeling?*

Før:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

11. *Synes du det er riktig å ha rus-avdeling i Stovnerskogen sykehjem?*

Før:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

12. *Hvor fornøyd du er etter en arbeidsdag?*

Før:	1	2	3	4	5	6
Nå:	1	2	3	4	5	6

13. *Er det noe du ønsker å kommentere om rus-pasienter på Stovnerskogen sykehjem?*

Jeg samtykker at min kommentar kan benyttes i offentlig rapport og/eller intern utviklingsarbeid.

Ja Nei

Takk for hjelpen