The in between

A design exploration of youth´s transition from child to adult oriented public services

Masters project, spring 2021
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The Oslo School of Architecture and Design

Summary

Around the age of 18, youth with long term follow-up by several health, care and welfare services transition from child oriented to adult oriented parts of the public sector. This diploma project is an exploration of the gap between these two "sides" and how to start bridging it.

During the transition to adulthood, youth are in between dependence and independence, childrens rights and adults rights. Parallel to this, they are transferred from services for children and youth to services for adults. The risk is that they fall in between the two sides, as the services struggle to collaborate, share responsibilty and see the transition as a longer, fragile process. Youth and their next of kin need flexible and predictable services adapted to their needs. Investing in facilitating a proper transition into an inclusive and independent adult life could equal qualitaitive and quantitative benefits in the long run, for both the families and the public sector.

To approach these complex structures I used a combination of a service and systems oriented design. I mainly explored the transition through the lens of healthcare, where continutiy in the follow-up is especially important. While exploring, however, it became evident that the transition is about so much more than just health and care services. Eduaction, housing, social work and labor are examples of other relevant sectors.

The gap between the "sides" can be bridged in different ways, with small steps and long term, systemic change. Several long standing structures like organizational and financial differences have to be uprooted. In addition to pointing at some of these structures, presenting a future vision and associated principles, I propose interventions - mainly from low hanging fruits. As a stepping stone for further development I created a low threshold tool for adapting information about the transition to each youth´s needs. Another intervention is a set of cards presenting leverage points to stimulate dialogue and reflection across services on each side of a transfer.

Taking small steps towards more flexible and adaptive services should be done parallel to challenging the more systemic, structural barriers for collaboration. Additionally, there is potential in shifting mindsets through stimulating dialogue. This project exemplifies how the complexity can be approached from these angles.

Title
The in between

Field
Service and systems oriented design

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Theme
Transitions, collaboration and implementation in the Norwegian public sector

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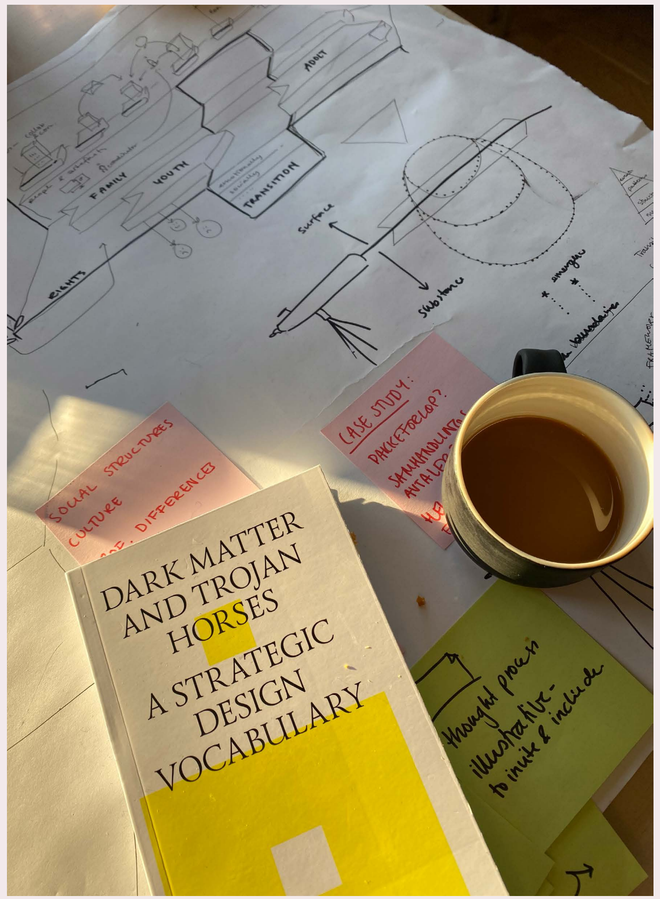
This project follows NSD guidelines. Names and information of interviewees have been anonymized accordingly.

The report is written in English, but the design interventions are in Norwegian given the context.

If nothing else is specified, the illustrations and photos are my own.

Introduction

Motivation



As a designer, it motivates me to contribute to a relevant initiative; creating cohesive public services, now prioritized by several stakeholders, including the Norwegian government. Design is one of several competencies that can contribute, and I believe in the value of this interdisciplinarity.

I have been involved with a StimuLab-project, (service design-led project) connected to the Digital Strategy throughout my diploma semester. Still, I was clear from the beginning that I wanted to be a counterweight and point to parts of the system that can supplement or complement digital solutions. I am not necessarily motivated by the digital, but rather by the human and structural aspects that surround and relate to it.

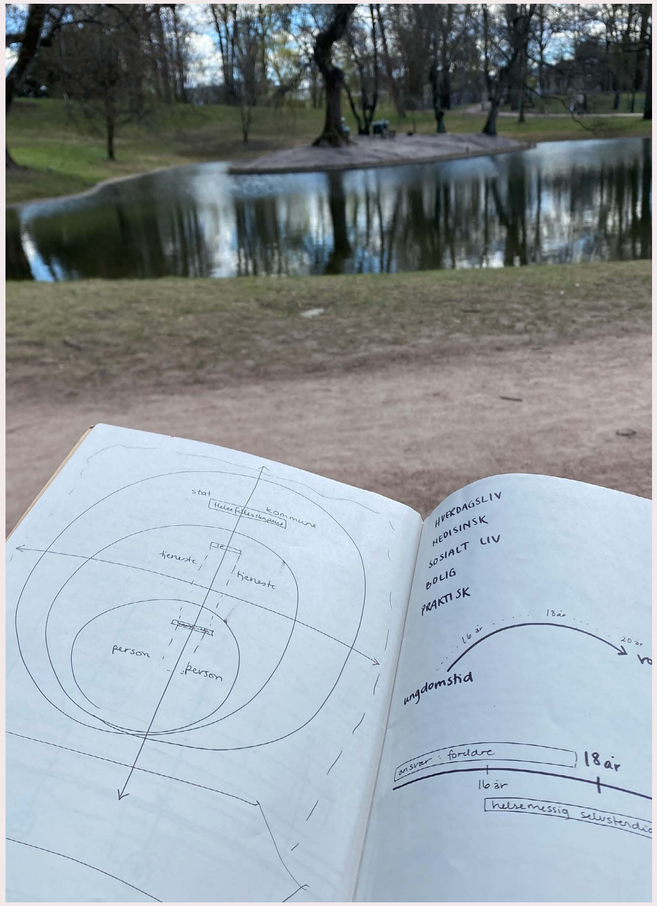
The idea of bringing value to actual services and people motivates me. From an early point I knew that I wanted to create something that can have an impact today, and something to spark engagement and awareness. My goal has been to uncover structures that affect how youth transition into adulthood while followed up by multiple public services of different shapes and sizes, and see wether I could come up with specific interventions that contribute to make the services more cohesive.

Introduction

Perspective

From my perspective, my role as a designer in the public sector has been to understand, compile, communicate and design for parts of its complexity. Being a student allows for a broader perspective, and seeing the structures from the outside has helped in challenging traditions, silos and mindsets.

This highly complex problem field can be detangled from several angles and leverage points. I believe in the power of telling this story in a human centered way, and shedding light on some of the aspects that complicate the path towards more seamless service experiences.



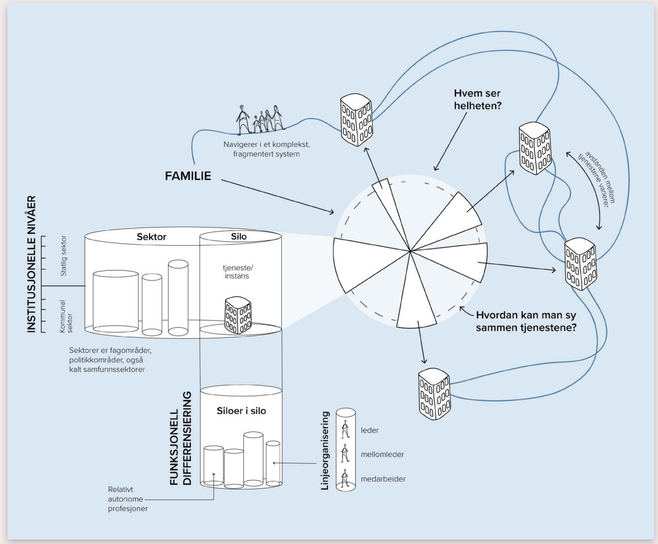
Introduction

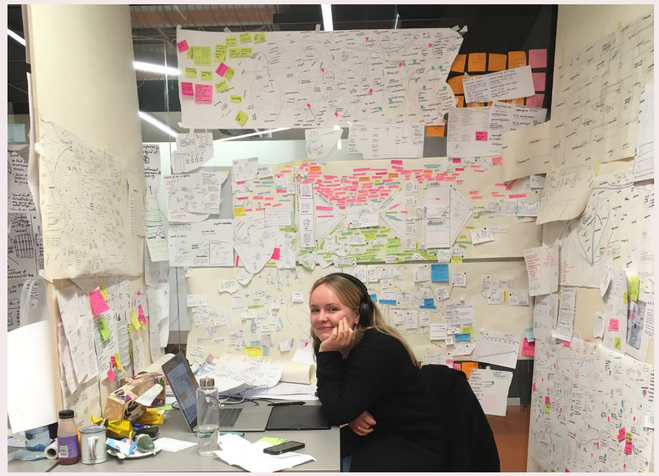
Approach

This diploma marks the end of my educational specialization in designing with and for the public sector, which I have done for the past three years. In both school and part time work I have explored designing within these frames, with the public sector´s structures and preconditions as the design material.

The topic of collaboration has been a red thread, and this has highly affected the way I entered this diploma. Having already internalized several mental models, as in the examples to the right, I did not feel the need to do in-depth mapping in the same way for this project. For me, systems oriented design has been more of an approach than specific tools and methods.

My experience has guided my priorities and considerations, as well as my perspectives on what constitues an impactful design delievery in this context. My understanding of the public sector led me to want to be creative within the frames of today´s system, keeping the threshold for implementation relatively low. Implementing new solutions can be tiring work, and I believe in small steps that does not simultaneously uproot several long standing structures that take time to reshape.





Abstract

Transitions to new life stages can be challenging for most people. Youth with complex needs and their families are no exception. For them, several public services are involved simultaneously and in succession. The transition from youth to adulthood consists of several shifts, both personally, socially and within public services. Among the major shifts is the change of services, mainly replacing services for children and youth with services for adults - for instance from child psychiatry to adult psychiatry. The families experience this as unpredictable and stressful, and in the adult side there is less frequent and holistic follow-up. Improving this shift requires collaboration across levels and silos.

Being transferred from the child oriented to the adult oriented part of the public sector, you are in between cultural, philosophical, organizational, financial and legal structures that differenciate the "child side" and the "adult side". Relations between the two "sides" affect the experience due to difficulties in coordination, communication, sharing of information and transfers of responsibility across them.

Transitions like this are acknowledged challenges in the public sector, both in Norway and internationally. There are guidelines and early movers, but today's intitiatives are mainly oriented towards hospitals, with some links to primary health services. Healthcare is therefore a natural place to start learning about transitions - but the overall transition is about so much more than health. Living, economy, education and work are some of the important pieces of the puzzle. Together, these aspects of life affect the level of inclusion and quality of life as well as the shift towards an independent, adult life.

This complex backdrop leads me to ask: What could change, why and how: **How might the public services facilitate a good transition between adolescence and adulthood, for youth with long term, complex needs?**

This report takes you through my process of diagnosis, exploration and making design interventions. First I contextualize the project and take you through the approach, research and findings, beofre presenting the design interventions in detail.

Definitions

Transition

”The process or a period of changing from one state or condition to another” (Definition from Oxford Languages). In this context transition generally refers to the process of changing from youth to adulthood, and the related changes socially, legally and in the service network. It also refers to a longer process before, during and after a transfer from one service to another.

Transfer

”An act of moving something or someone to another place, organization, team, etc.” (Definition from Oxford Languages). In this context, generally from the ”child side” to the ”adult side” of public services. In this case I would say several smaller transfers, or handovers, between services are incorporated in the overall transition.

Public service

In this project the term "public service" is used relatively broadly, and includes both municipal and state services in different sectors. It mainly refers to health, care or other welfare services.

Content list

1: The background and context

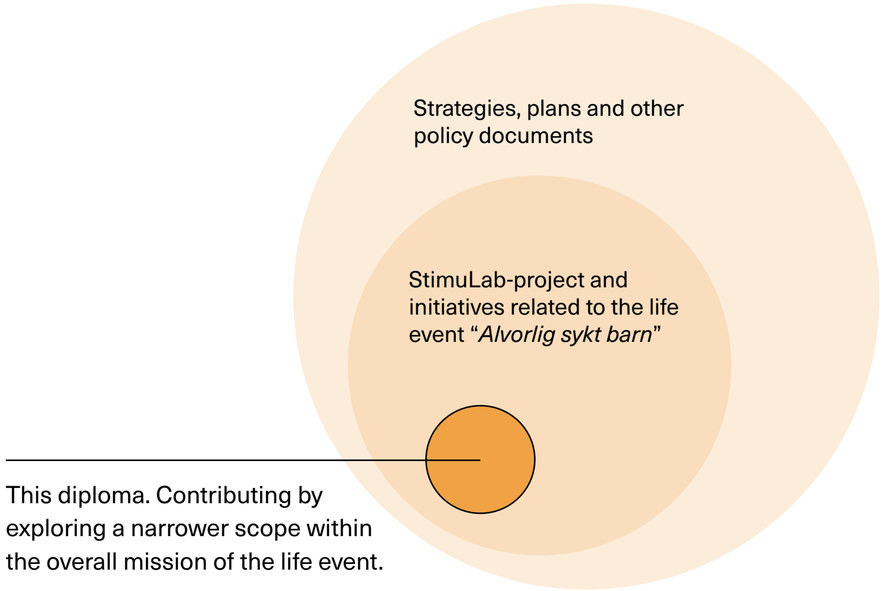
Chapter one

An introduction to the background, context and relevance told through the main thematics of this project.

The project in a larger context / In between youth and adulthood / Youth and young adults / Transitions / Collaboration / Implementation / Long term value

The project in a larger context

I am following and contributing to a StimuLab-project with a broarder focus, Life event Seriously ill child (Livshendelsen Alvorlig sykt barn). This project is part of the bigger prioritized work with life events from the Digital Strategy for Public Sector 2019 - 2025. The strategy says, among other things, that *"important situations and life events for the users are chosen as a starting point for the development of cohesive services."* (The Ministry of Local Government and Modernisation, 2019.)



Life events in the digital strategy

Seven life events were presented in the Digital Strategy for the Public Sector 2019–2025, One Digital Public Sector. Examples are "Having a child" and "Lose and find a job". These will be prioritised in the digitalisation of the public sector in the years to come. There is a special focus on developing coherent services connected to these life events, as they are complex and difficult to solve in traditional, siloed approaches.

StimuLab-project

The Norwegian Directorate for Health is now responsible for the life event "Seriously ill child", and they have rephrased it "Seriously ill child, children and youth with complex needs". Together with relevant directorates, The Norwegian Association of Local and Regional Authorities (KS) and Flekkefjord municipality, they are embarking on the challenging and complex mission to *"(...) uncover the needs of children and youths with complex needs, how they meet different services and sectors and where it is most important to implement measures."* (DOGA, 2020)

"The goal of the project is to provide children and young people with complex needs and their parents, a seamlessly personalized and predictable offer."

StimuLab-project Livshendelsen Alvorlig sykt barn, 2020

In between youth and adulthood

Traditionally, youth and young adults have been in between the two main categories of children and adults. They are somewhat recongnized in what is often referred to as "the child and youth side", but not as clearly on "the adult side". Youth medicine is a quite recent focus, and through conversations with youth and front line workers it is apparent that it can be difficult for the services to remember that youth might have different needs from both children and adults. They are somewhere in between, developing at different paces.

"I think a lot of adult wards "forget" that they have youths/young adults. Everything is just adult in the adult ward."

- Health care personnel, hospital

A complex transition

Shifting between life stages is difficult in itself. A lot is changing both personally and externally, in relations and in society. On a human level, the overall transition is about practicing and learning to be more in control and responsible. You develop from being a child, to being a youth, to being a young adult - a vulnerable period of finding your identity and way of life. Put health issues, other challenges or changes in the network of services around you on top of that, and you have a complex transition. In several cases it might be a transition into social exclusion, falling out of school or into young disability (ung uførhet) (The Norwegian Directorate of Health, 2019).

New rights, services and expectations

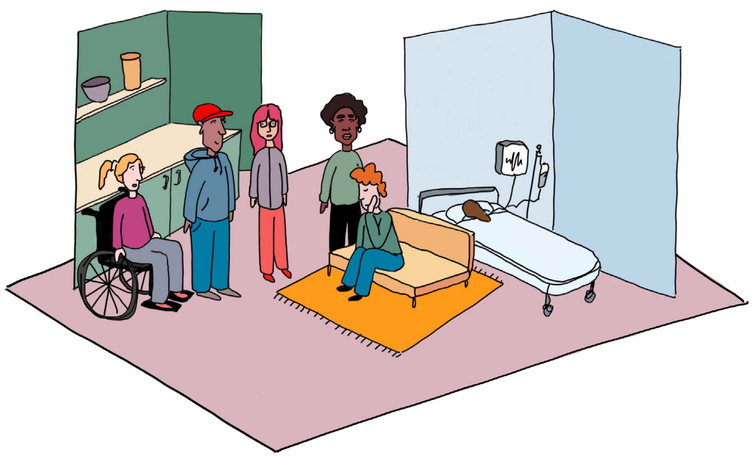
Certain ages, in the same way as a diagnosis, come with changes in several rights. At 18, for instance, you are no longer entitled to the services you have had for years, but have to meet new people and routines in different services. Studying this means looking more closely at the experience of the transition for youth, young adults and next of kin, but also studying the services and structures affecting the transition. What happens before, during and after this transition?

Youth and young adults

About the user group

Youth with long term, complex needs that are followed-up by several services during the transition to adulthood. The transition stretches from 12-25/26 years of age, according to guidelines by Oslo University Hospital and The Norwegian Society of Pediatricians.

I have focused on the youth that are moving towards a relatively independent adult life, rather than the most serious conditions that require extensive health and care services at all hours of the day. An example of the type of user are youth with complex diagnoses like diabetes with accompanying conditions like anxiety, anger management issues and celiac disease, meaning you need continuous follow-up and support from health care service and NAV, among others.

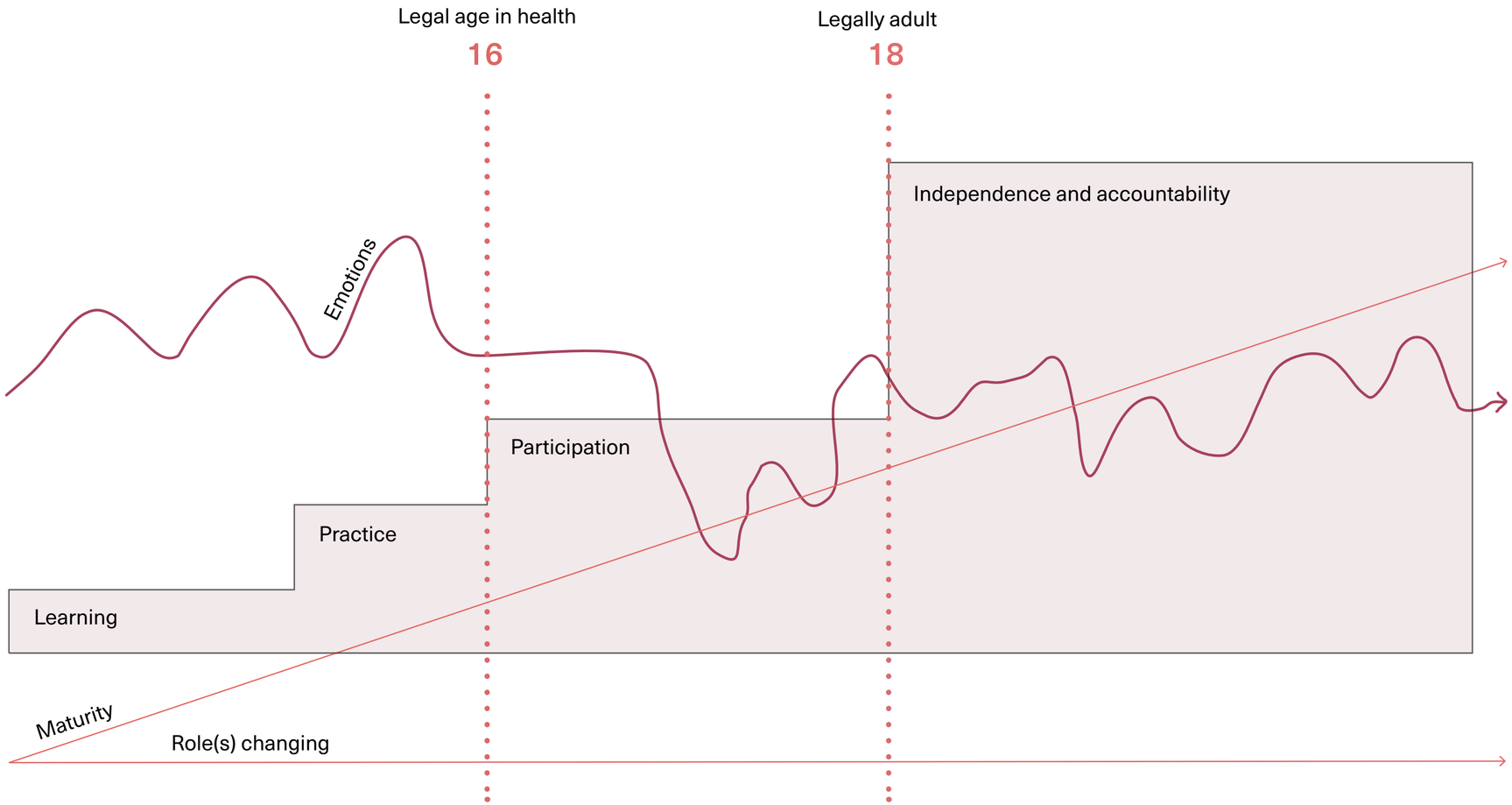


Transitioning into adult life does not necessarily have everything to do with diagnosis or level of functionality. It definitely affects the level of independence and how involved next of kin and caretakers have to be, but zooming out, there are several common needs regardless of diagnosis. I want to challenge the tendency in public services to emphazise diagnoses and rather focus on the common, human aspects of the transition.

Not focusing on diagnosis means that my project encompasses a multitude of conditions, life situations, needs and levels of complexity. Still, a specific diagnosis or need would need to be taken into account at a later stage, through various professional and individual adjustments.

Next of kin

While I focused mainly on the youth themselves, next of kin are important resources. Even though you are of legal age in healthcare at 16, parents have a certain right to information due to their role as caregivers until 18. Several youth will possibly also want and need this support after 18.



This sketch exemplify some of the general aspects of moving through youth and gradually becoming an independent, adult "user" - exagerated to communicate the abrupt and somewhat brutal shift from participation to independence and accountability.

Transitions

Transitions are recognized as a problem in general, and emphazised by youth coucils at several hospitals. They imply change, new surroundings, faces, routines and expectations. Transitions are especially interesting in healthcare because it can be important not to break the chain of quality treatment, with people and systems you know and trust, to be able to handle and be in control of your health.

”I was prepared for it to be different, everyone knows it somehow, and transitions are scary because it changes the way you are treated and medication, at least in my case. Several things changed.”

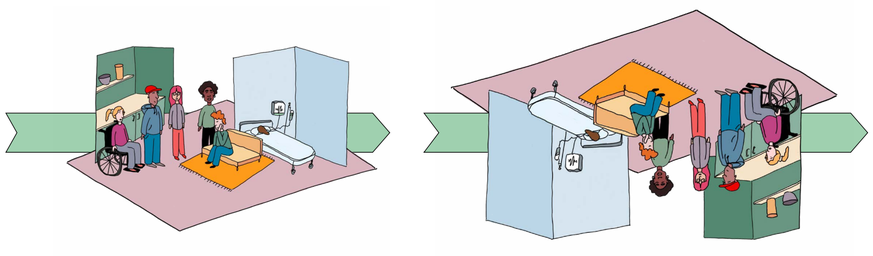
- Young adult 2

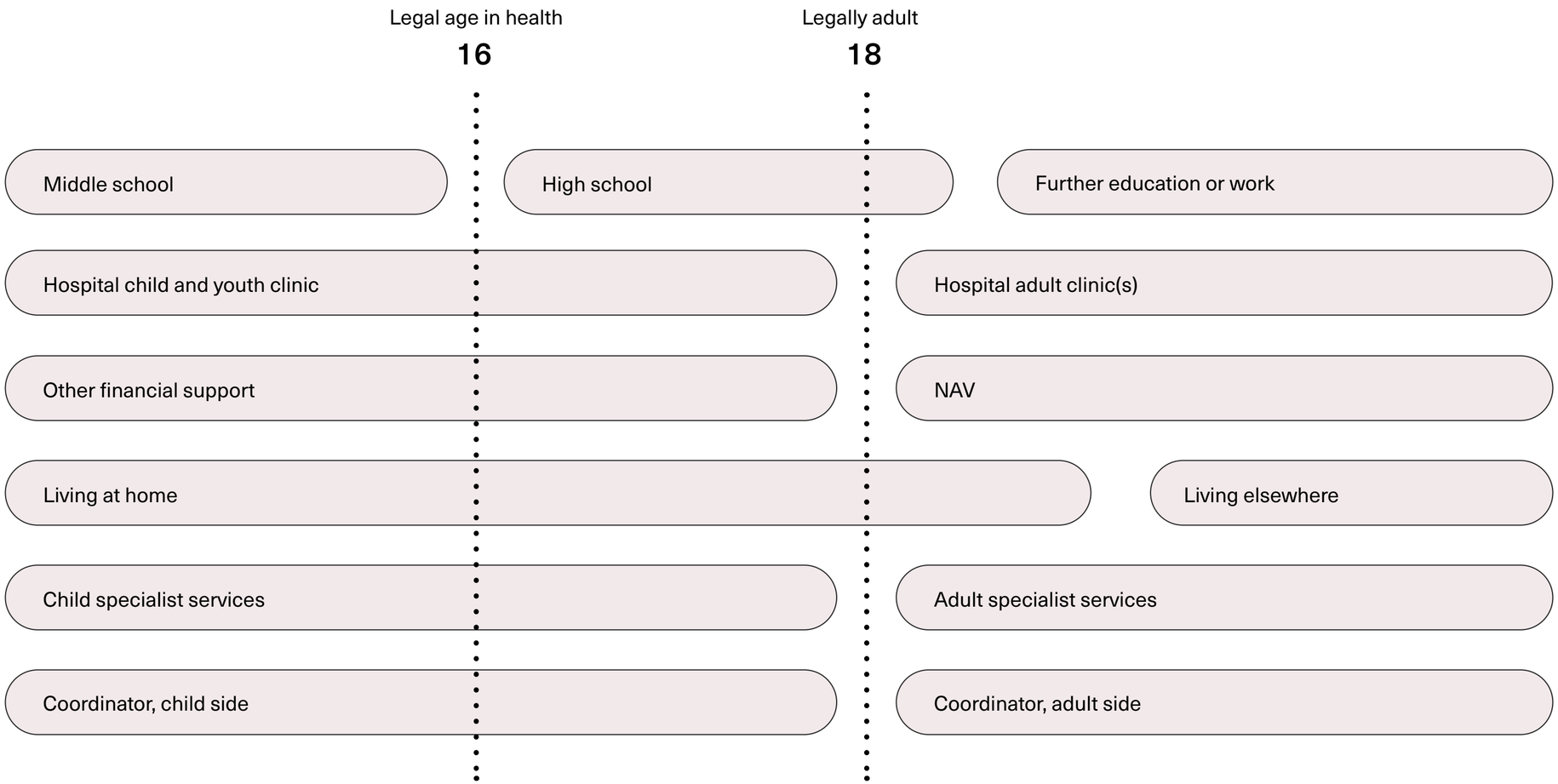
The transfers within the transition

A number of transfers potentially occur simultaneously during the transtion due to the way public services are structured and the way competences are organized. The transfers basically means transferring responsibility and information from one service, or role, to another. Clarifying and following through on this is a challenge, given the distance between stakeholders, the digital, siloed legacy systems and other barriers for a seamless shift of responsibility.

“There is a risk of falling out of treatment in these abrupt transitions.”

- Coordinator child protective services/psychiatry, municipality

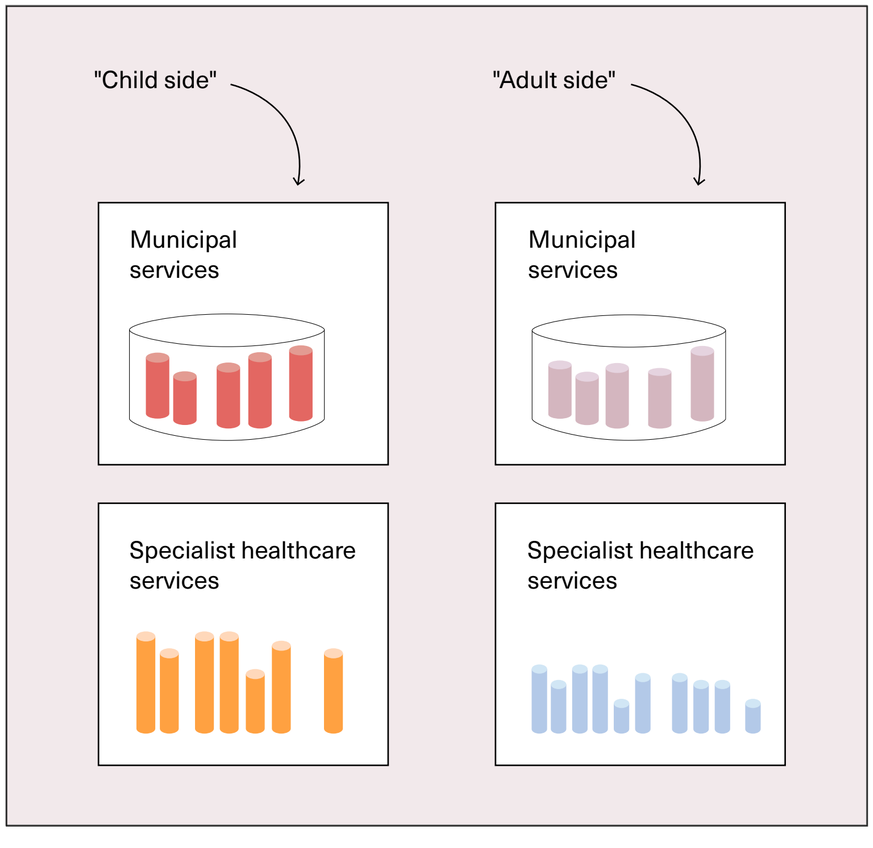




This is an example of the transition youth might have, depending of the complexity of their needs, rights and willingness to receive services from the public sector. Most shifts are connected to age, which means several transfers occure simultaneously.

Collaboration

Creating good transitions and transfers inevitably means that different professionals need to collaborate - across levels, sectors and services. The way I see it, these are four of the most relevant parts of the public sector that cross paths in the overall transition;



These four parts are different in several ways - culturally, organisationally, financially and legally. They have different philosophies and perspectives on youth and young adults, on treatment, are different in shape and size and have varying capacity. Generalists and specialists meet, and the state and municipalities meet. Not knowing each other, as well as physical distance, complicate the day to day communication and collaboration.

Scope: Specialist healthcare and municipal services

I started by focusing on health, and have used health services as a case and lens through which to learn about the system and transfers. Based on this I draw parallels to transfers in general, because there seem to be several similarities.

Through interviews it became apparent that focusing only on health is too narrow if you want to explore the transition from youth to adulthood. To my understanding municipalities are more concerned with the totality, and their services span across most sectors which means they have a broader view on every day life and needs. This was a fresh breath compared to the highly health centric focus in existing transition guidelines and projects.

Implementation

A month and a half into this diploma I came to the realisation that several of the findings and ideas brought forth in interviews and workshops coincided with what is stated in existing guidelines. An example is the idea of having proper transfer meetings, for instance, between the old and the receiving service. This is also recommened in a guideline and a national *veileder.* Realising this, I started digging into implementation, with the hypothesis that even if these guidelines and ideals exist, there are barriers to realizing them.

Innovation in the healthcare sector

I once heard that it takes 17 years to make large and lasting changes stick in the healthcare sector. I have no way of validating this, but it says something about the pace of the processes, the resistance in the system, the resources and so on. Incremental changes can have an impact tomorrow, and even affect user experience before more radical shifts in the system are made.

Barriers to implementation

Sometimes these guidelines are seen more as “the golden standard”, and you do not necessarily have the capacity, resources or competence to actually implement it. The implementation work is fragile, and transitions are generally not prioritized because there is a lack of clear benefits. The benefits are potentially qualitative, hard to measure in traditional manners and also might be more long term than in other cases. Disagreements, time and an overload of guidelines to implement are other examples of barriers to implementation. A healthcare worker in a hospital said ”there was a woman who quit, and then it all collapsed”.

“It is easier to create the guidelines than to implement them. It requires time, facilitation and commitment from you various professionals.”

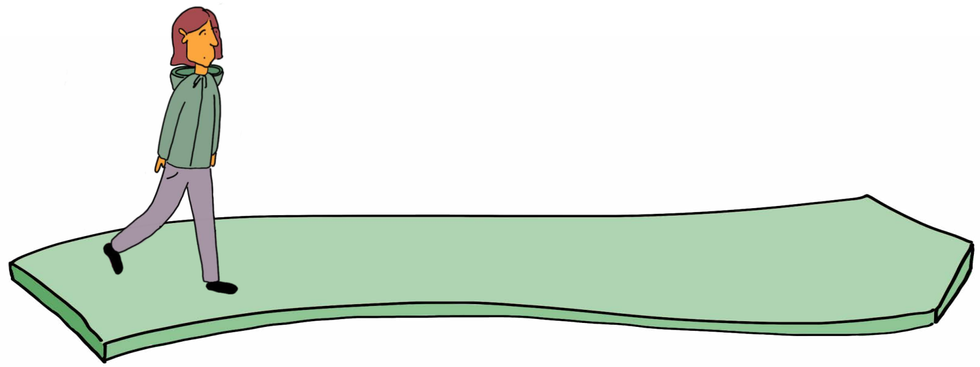
- Health care personnel hospital

Long term value

This quote summarizes the value of good transitions in healthcare. I believe it could translate to other sectors as well (like education, finance, labor etc.), if you replace "patient" with "youth" and "treatment" will a broader "follow-up":

"(...) Knowing that the patient understands and can succeed, and that there is better agreement, the patient follows up the treatment better, one needs fewer controls, and perhaps the GP (fastlege) can be given greater responsibility. In the long run, you can also have fewer negative effects of your disease. For example, by managing your diabetes, there is less risk of negative effects later. It stresses the health system less in the long run, but you have to invest to reap these benefits."

- Child and youth psychiatrist, hospital



2: The designerly approach

Chapter two

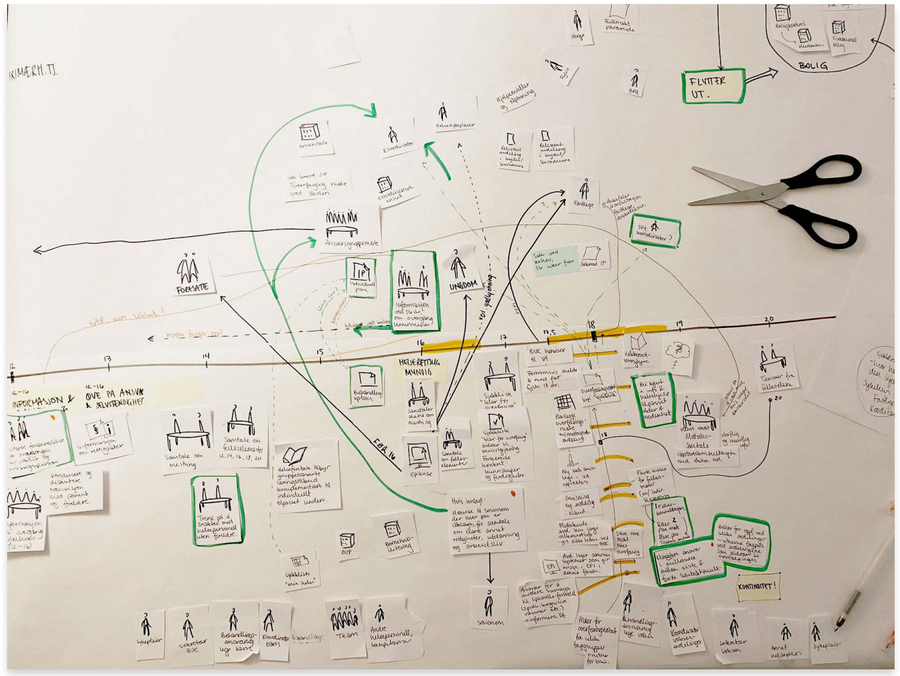
This chapter covers my overall approach, methods and process. What have I done and why?

Overall approach / Process / Involved people / Key methods

Overall approach

I approached this problem field using a combination of systems oriented and service design methods and tools. Mixing two contrasting yet complementary design fields allows for a deeper understanding of the complex field, as I tried to balance the fidelity of the human centered approach with the broader, systemic lens. I have attempted to always see the challenges from several perspectives - the user, the services and the overall relations and processes.

I kept a tight relation to existing structures to not remove myself from the context and thereby complicate the implementation of my interventions. I wanted to keep an open scope for as long as possible to gain a broad understanding before making an educated decision of how I could have an impact through design interventions.



Process

The diagnostic phase

The diagnostic phase has mainly been about desktop reserach and document studies and involving experts, young adults and parents through semi-structured interviews and digital workshops, as well as analysis and synthesis.

The search for impact

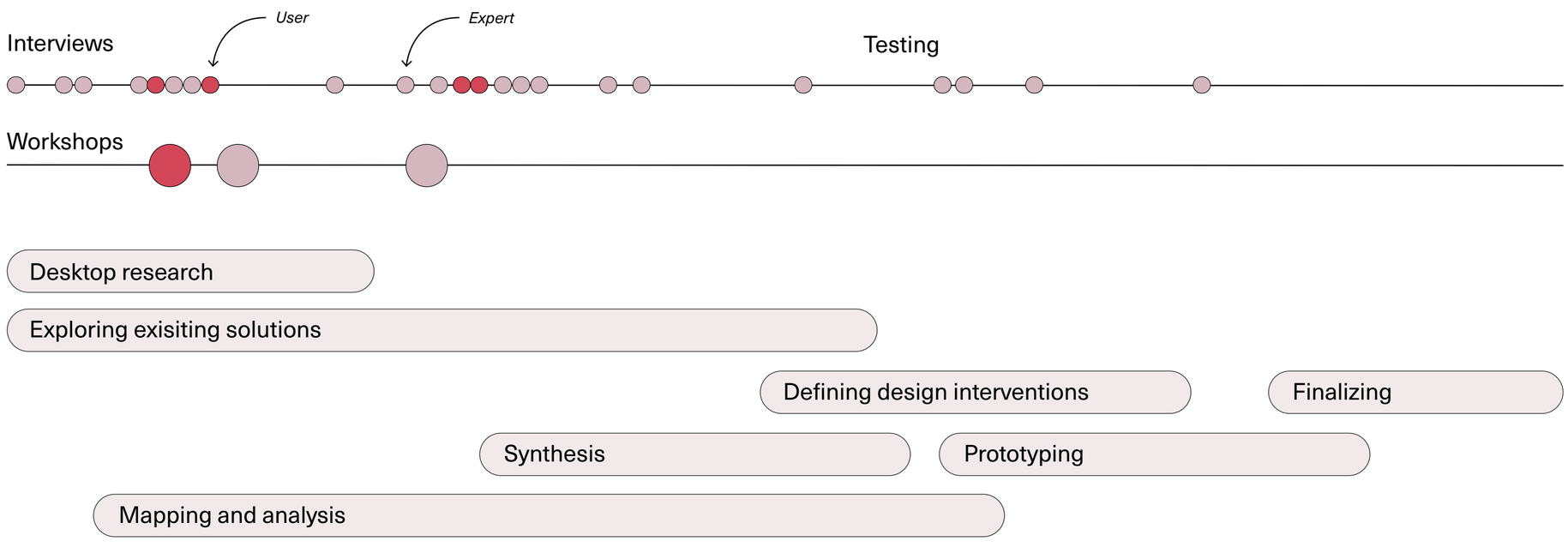
Defining opportunity areas, searching for potential and ways to define a scope for impact through interventions.

The making

Prototyping and testing. Shaping design interventions and involving experts to test and discuss them.

Communicating it

Finalizing and creating the storyline, communicating context, process, findings, and design proposals.



The people involved

I have involved both young adults and parents as well as continuously involving experts with different backgrounds gain a nuanced understanding. Some youth had good transitions, others did not, some services follow new guidelines, others were small organisations with close connections, and others had few structures for thoughtful transitions in place. There are differences and similarities, and I assume that they represent only a fraction of the variation out there.

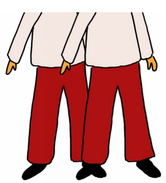
The user perspective

Parallel to the first interviews with experts, I explored the user perspective. Getting in touch with people in potentially vurnerable situations is a challenge, but I managed to get in touch with two mothers and young adults with experience in both somatic and psychiatric healthcare.

Youth council

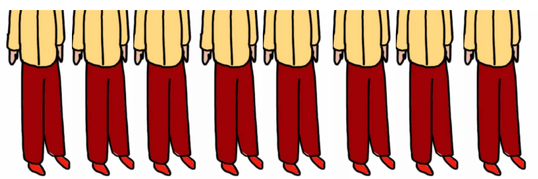
The young adults I have involved were recruited through a youth council at a hospital - all above the age of 18. There are pros and cons to talking to so-called “professional users”. In my experience it was really useful to have the perspectives of someone who knows the system, know stories beyond their own and can share typical challenges.

On the other hand, I could feel that they had talked about this before, which meant they sometimes might have lost the depth of their stories. I have had to keep in mind that they are not typical users, and not everyone know the system dynamics like they do.



2 x in depth interviews with mothers

2 x in depth interviews with young adults

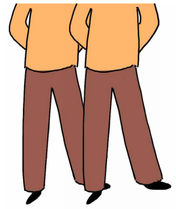


Workshop with 8 x young adults

The service/expert perspective

I wanted to involve various roles and perspectives of the system. First of all I wanted to hear from the different "sides", but also from both municipal and specialist services. They have different ways of seeing both the transition, the collaboration, needs and challenges from their different professional contexts.

Municipal leadership/admin



Leader, housing

Leader, habilitation

Municipal front line

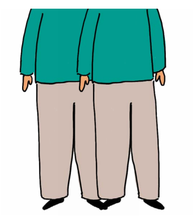
Coordinators

Physio therapist

Occupational therapist

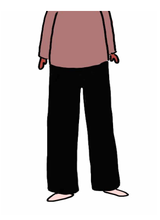
Vernepleier

State/specialist leadership/other



The Directorate of Health

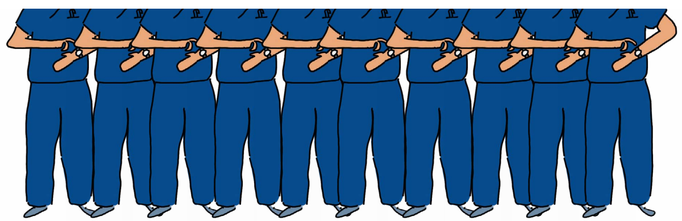
Leader, child and youth clinic



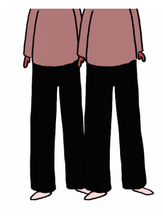
Child and youth psychiatrist, hospital

Chief of quality, hospital

Specialist healthcare



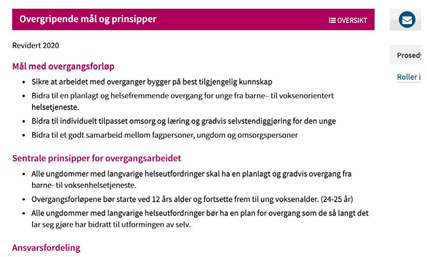
Coordinators with different health care backgrounds, counsil for youth health (workshop x2)



Psychologists BUP/DPS

Key methods

Desktop research

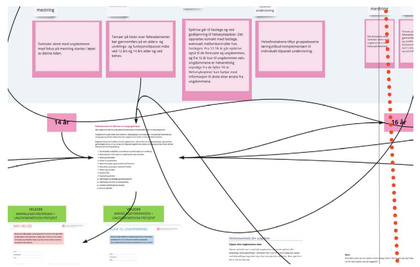


Researching documents, articles, guidelines, best practice and relevant projects to understand how transitions are handled today and why.

Interviews

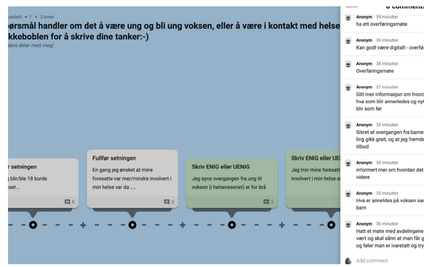
Semi-structured interviews, done digitally, to uncover needs, challenges, ideas and potential.

Analysing existing solutions



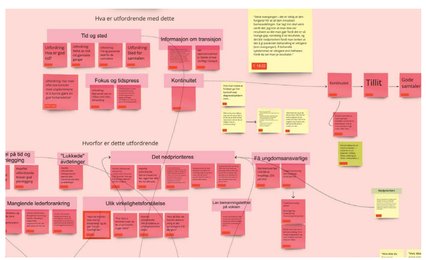
Studying a set of existing guidlines to compare and merge them, looking for missing links and pieces.

Workshop x 3



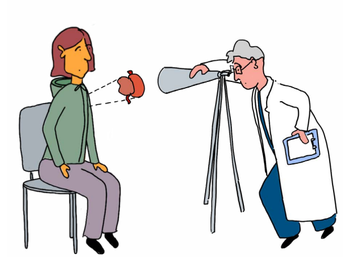
Digital workshops with about 10 participants each, using padlet.com which allowed for everyone to write their thoughts as well as share and discuss in between questions.

Mapping, analysis and ideation



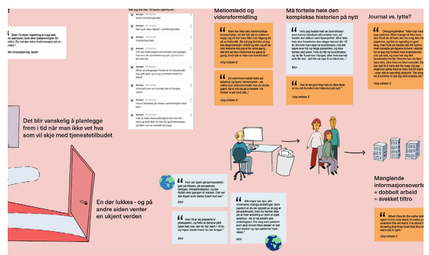
Parallel activities of mapping and analysing quotes and insights. Thematic clustering on different levels, searching for leverage points and ideas.

Illustrations and synthesis



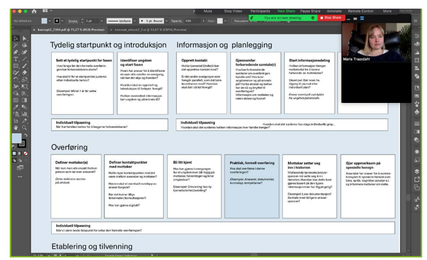
Using illustrations actively during mapping as a way to synthesise and create depth beyond post-its. A constant reminder of the human aspects.

Map of findings

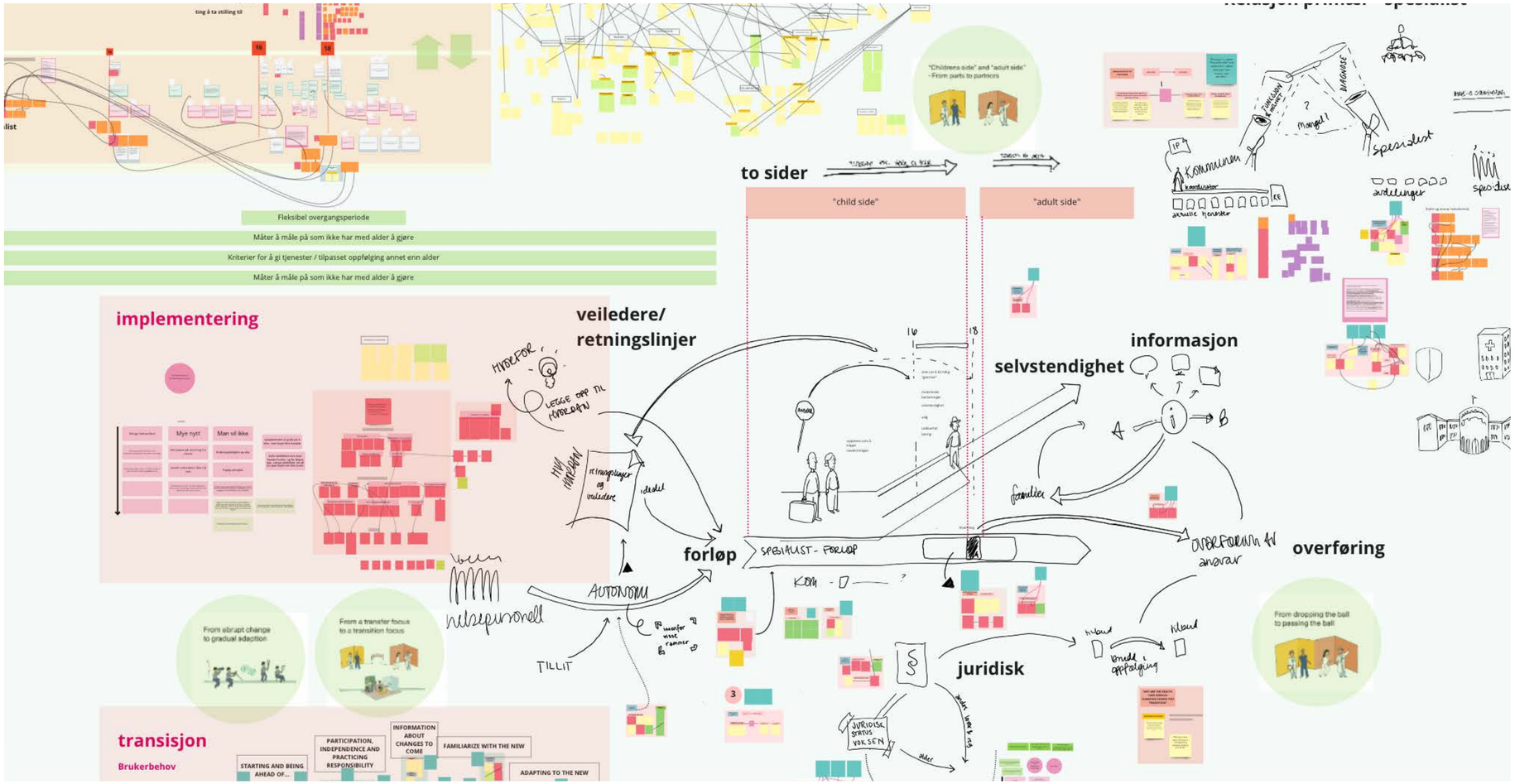


A way of processing and presenting the findings on one surface to help sort, summarize and communicate the findings.

Prototyping and testing

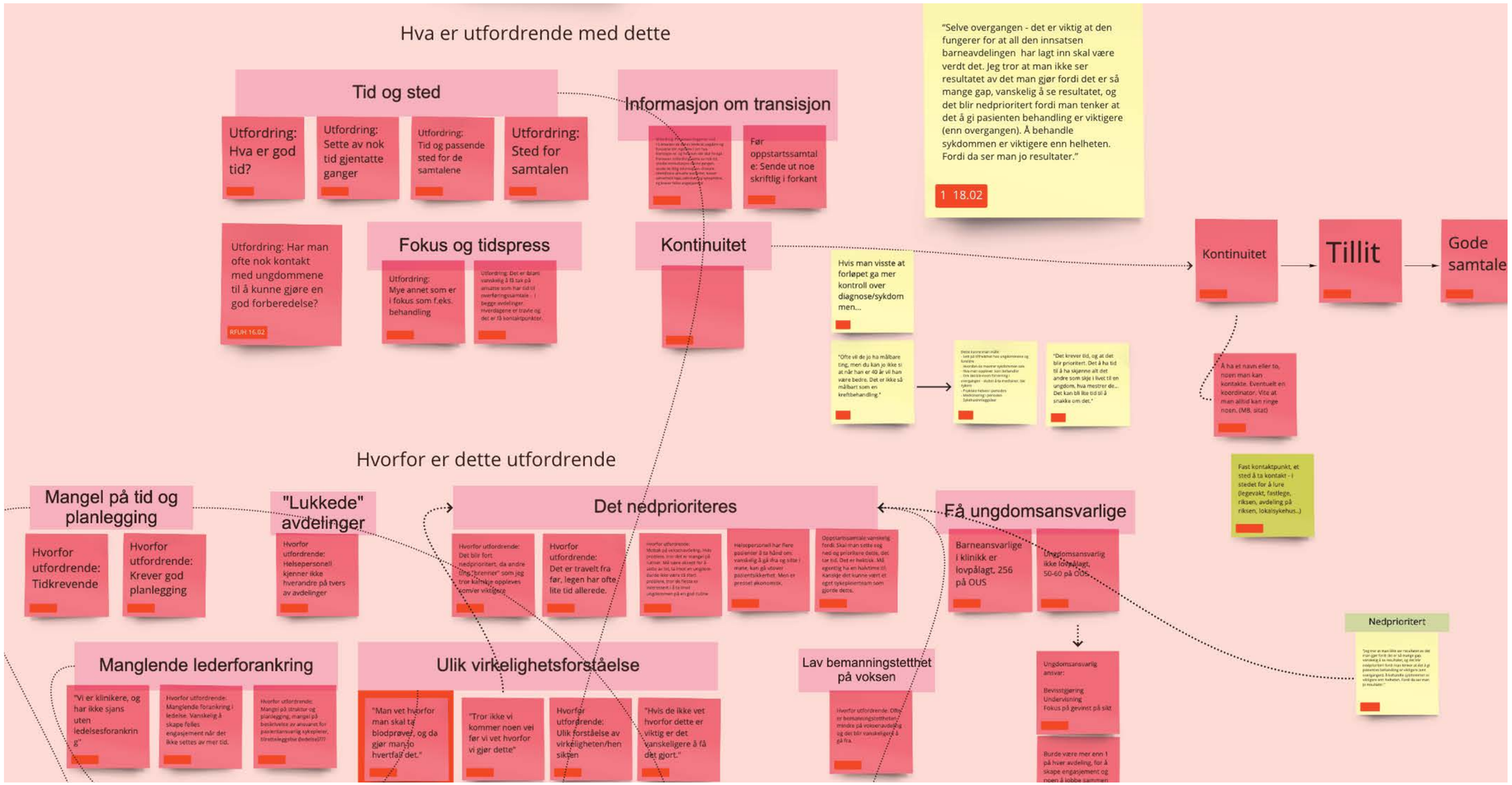


Testing for input and feedback continuously from an early, conceptual beginning to the more detailed proposals. Iterating between sessions.



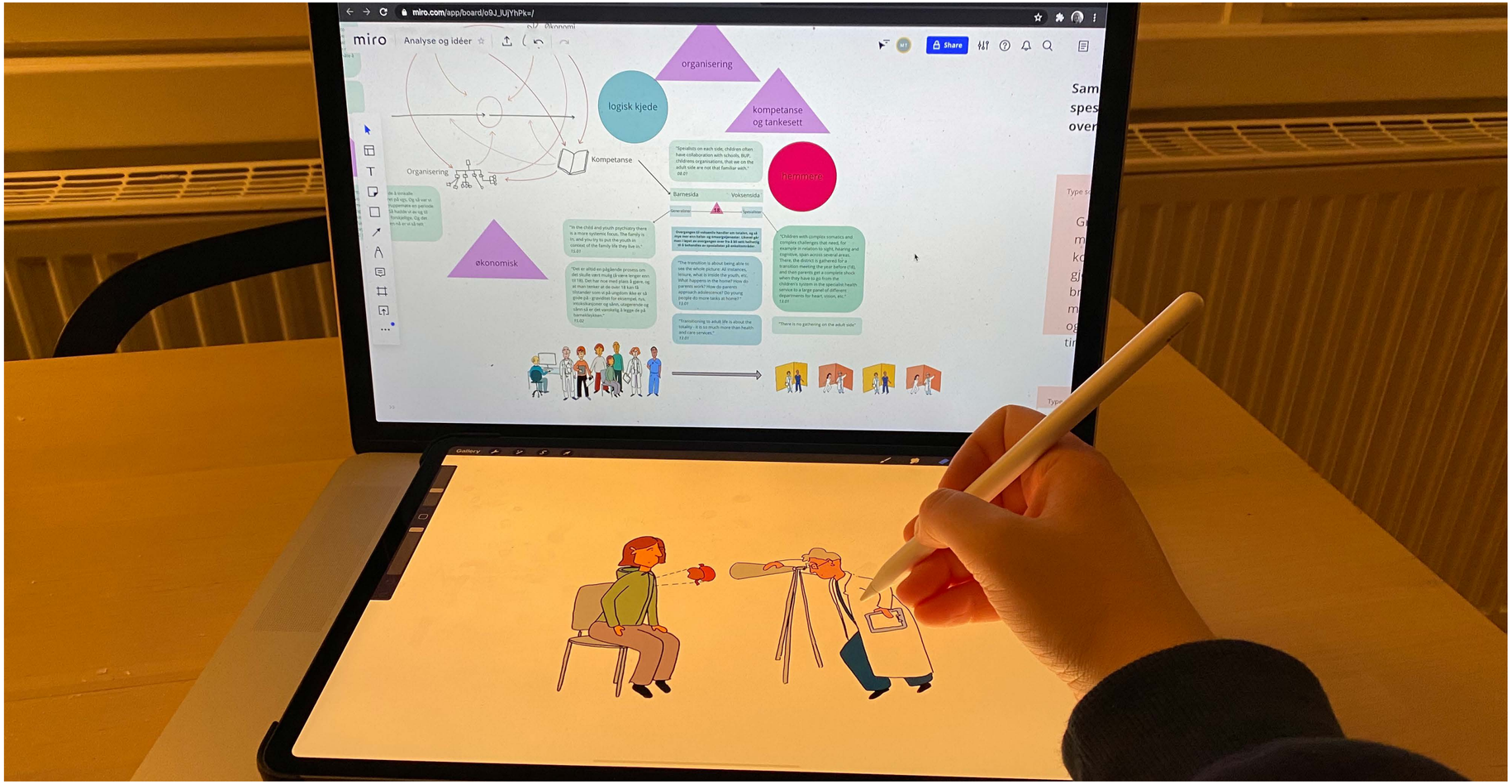
Explorative mapping with thematic clustering and realtions. This has been in continuous development throughout the process as a way to structure my thoughts and learnings and visualise it, as well as keep all the information connected. This was also a way to not underestimate the complexity at hand.

It might seem both messy and unstructured, and parts of it probably is, but for me it is an essential tool for reflection and synthesis. Combining different elements such as hand drawn visuals, illustrations, logical chains, thematic clusters, quotes and findings inspire the emergence of new relations, and seeing the whole instead of just the parts.



Parts of the mapping have been concentrated on making logical chains, always attempting to grasp the complexity one or two layers down from the need, experience or challenge. Why is this the case, why is it challenging? And why is that so?

2 The designerly approach



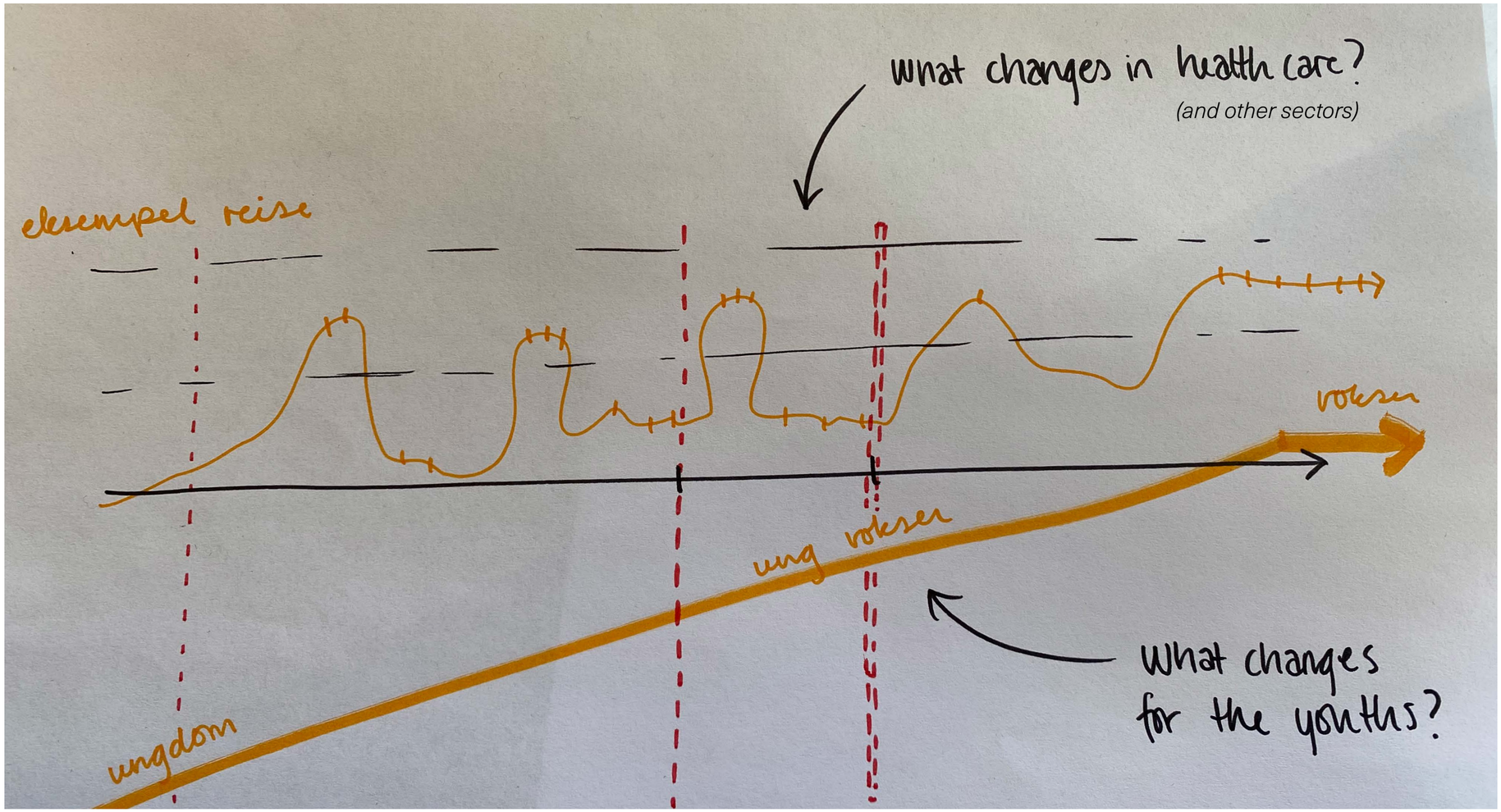
I have been illustrating parallel to mapping. This has helped me connect to human aspects of the project and not get lost in the more systemic qualities.

3: The research and findings

Chapter three

This chapter covers findings from research and analysis, as well as glimpses into the process and involvement of users and experts.

Exploring ... The state of the art / The experience / The meeting between service and user / Why the services struggle to meet needs / Structures in the system



This sketch describes my research in a nutshell.

The research and findings are categorized in this way:

1 : Exploring the state of the art

2 : Exploring the needs

3 : Exploring the meeting between service and user

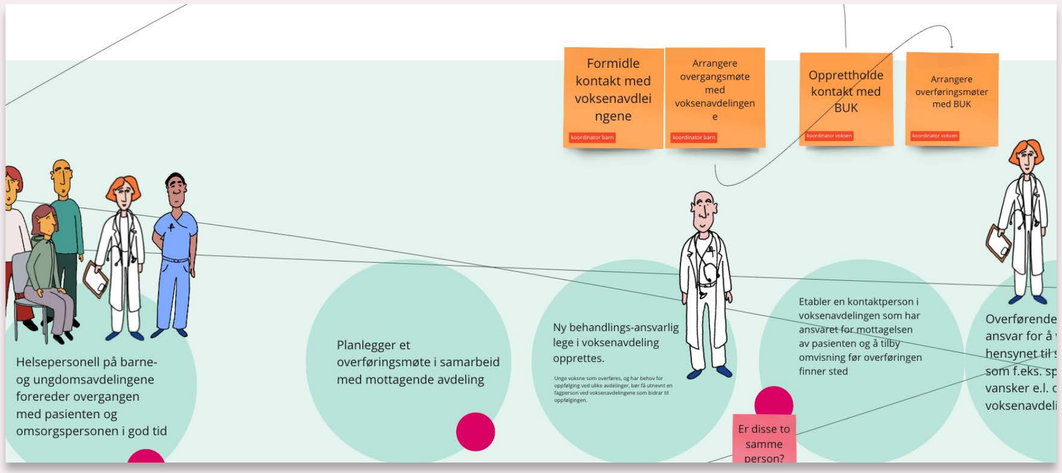
4 : Exploring why services struggle to meet the needs

5 : Exploring structures of the system

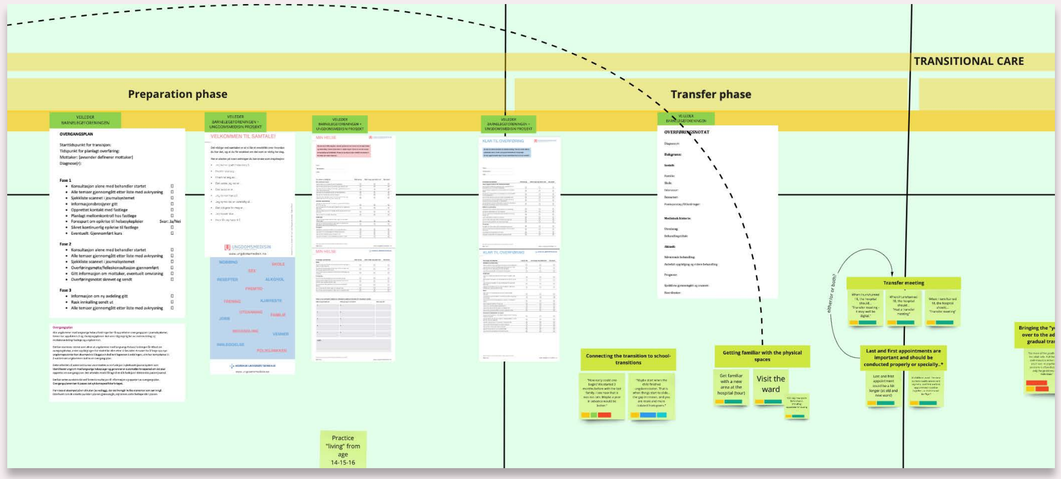
Reflections

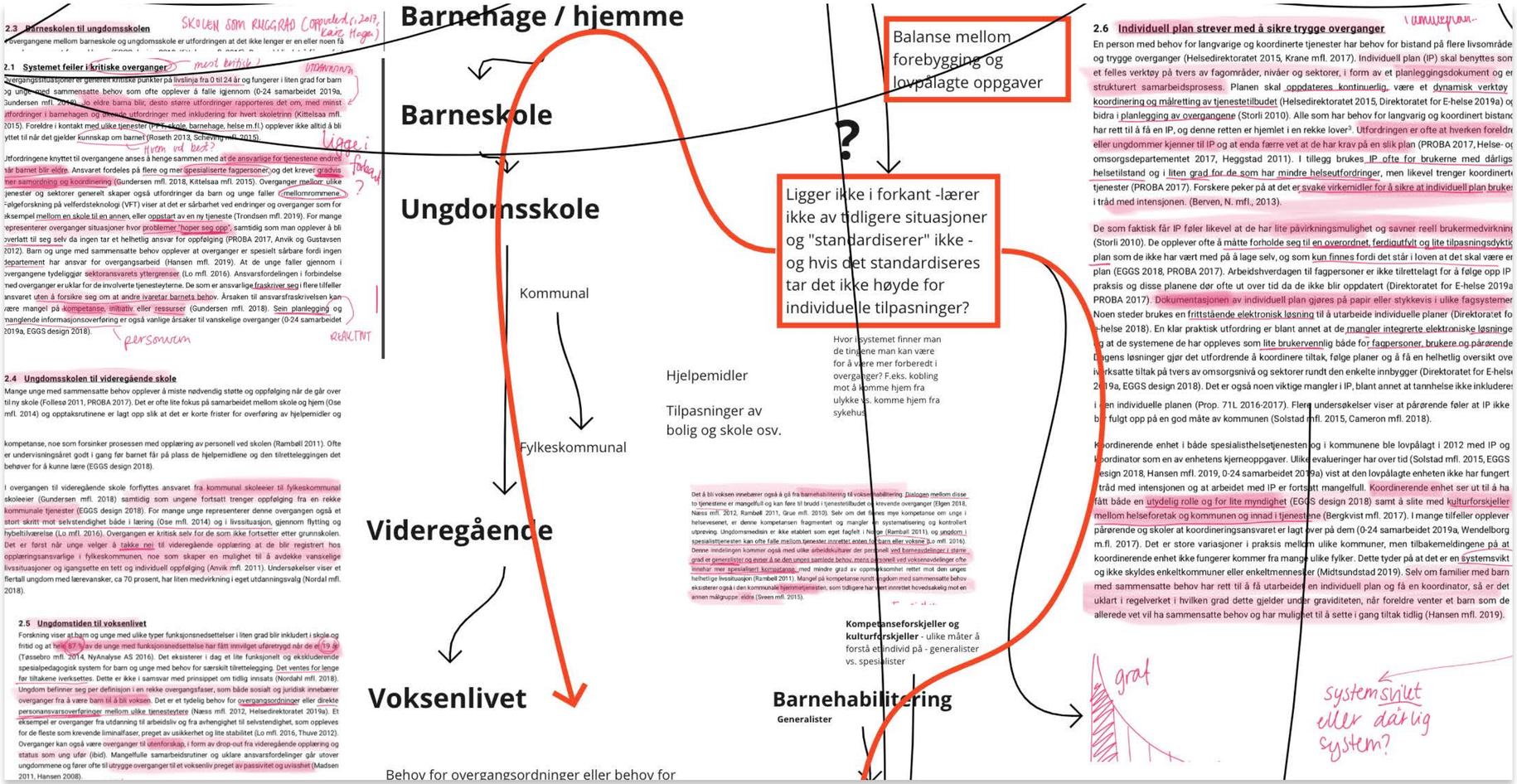
1: Exploring the state of the art

Parallel to the first round of interviews and workshops, I started an in depth examination of existing guidelines and projects. I wanted to see what I could learn about transitions from them, what they were missing and potential ways to add to this. Still within healthcare, where I could find the most recent examples, I chose to examine a project from Akershus University Hospital (AHUS) and guidelines from Oslo University Hospital (OUS) and The Norwegian Pediatric Association. I transformed them into post-its in Miro, analysed and compared them, and put them together to see if they could complement each other.



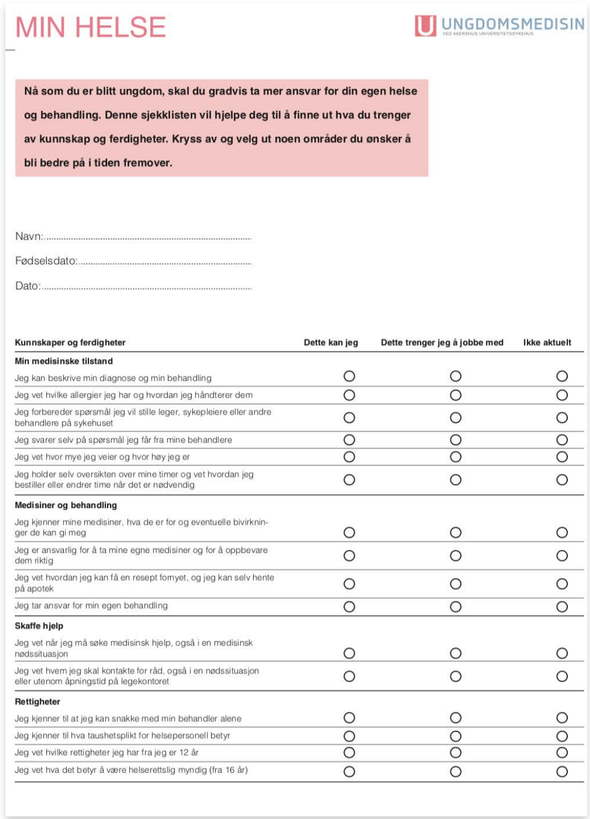
It is interesting how their recommendations are similar in several ways, but the way they transform it into tools, information material, check-lists, tasks and roles varies. AHUS uses ungdomsmedisin.no to convey their project and their material to both youth and health personnel. OUS´guideline seems to be more internal and formal. In contrast to classical service design deliveries, the recommendations are not particularly organized in time, and do not differenciate what are background tasks or what connects directly to user experience.





I also started with a thorough analysis of the report *Hvor skal man begynne? (The Norwegian Directorate of Health, 2019)*, that summarize prioritized areas within the life event and why.

Examples of typical existing solutions



MIN HELSE

UNGDOMSMEDISIN

Nå som du er blitt ungdom, skal du gradvis ta mer ansvar for din egen helse og behandling. Denne sjekklisten vil hjelpe deg til å finne ut hva du trenger av kunnskap og ferdigheter. Kryss av og velg ut noen områder du ønsker å bli bedre på i tiden fremover.

Navn:.....

Fødselsdato:.....

Dato:.....

Kunnskaper og ferdigheter	Dette kan jeg	Dette trenger jeg å jobbe med	Ikke aktuelt
Min medisinske tilstand			
Jeg kan beskrive min diagnose og min behandling	○	○	○
Jeg vet hvilke allergier jeg har og hvordan jeg håndterer dem	○	○	○
Jeg forbereder spørsmål jeg vil stille leger, sykepleiere eller andre behandlere på sykehuset	○	○	○
Jeg svarer selv på spørsmål jeg får fra mine behandlere	○	○	○
Jeg vet hvor mye jeg veier og hvor høy jeg er	○	○	○
Jeg holder selv oversikten over mine timer og vet hvordan jeg bestiller eller endrer time når det er nødvendig	○	○	○
Medisiner og behandling			
Jeg kjenner mine medisiner, hva de er for og eventuelle bivirkninger de kan gi meg	○	○	○
Jeg er ansvarlig for å ta mine egne medisiner og for å oppbevare dem riktig	○	○	○
Jeg vet hvordan jeg kan få en resept fornyet, og jeg kan selv hente på apotek	○	○	○
Jeg tar ansvar for min egen behandling	○	○	○
Skaffe hjelp			
Jeg vet når jeg må søke medisinsk hjelp, også i en medisinsk nødssituasjon	○	○	○
Jeg vet hvem jeg skal kontakte for råd, også i en nødssituasjon eller utenom åpningstid på legekontoret	○	○	○
Rettigheter			
Jeg kjenner til at jeg kan snakke med min behandler alene	○	○	○
Jeg kjenner til hva taushetsplikt for helsepersonell betyr	○	○	○
Jeg vet hvilke rettigheter jeg har fra jeg er 12 år	○	○	○
Jeg vet hva det betyr å være helserettslig myndig (fra 16 år)	○	○	○

Ungdomsmedisin.no

Tools and check-lists

I have been told that detailed check-lists are not used as much as first intended, but they inspire or remind health care workers of certain things to remember to ask or do.

Verdt å vite

Kanskje har du hatt sykdommen i mange år, men foreløpig ikke tenkt så mye på hva den egentlig innebærer? Kanskje er det foreldrene dine som frem til nå har hatt "styringen" og hatt mest kontakt med leger og annet helsepersonell? På tide å ta mer ansvar selv?

Etter hvert som du blir eldre, bør du skaffe deg mer og mer kunnskap. Sjekk om du kan svare på følgende spørsmål:

- Hva er navnet på sykdommen din?
- Hva er navnene på medisinene dine og hvordan skal de tas?
- Hva er de vanligste bivirkningene til medisinene du bruker?
- Hva gjør du om du opplever bivirkninger?
- Hvem skal du kontakte hvis du trenger nye resepter eller legeerklæringer?
- Hvordan kan du skaffe deg mer informasjon om sykdommen din?
- Har du oversikt over avtalene du har med helsepersonell?

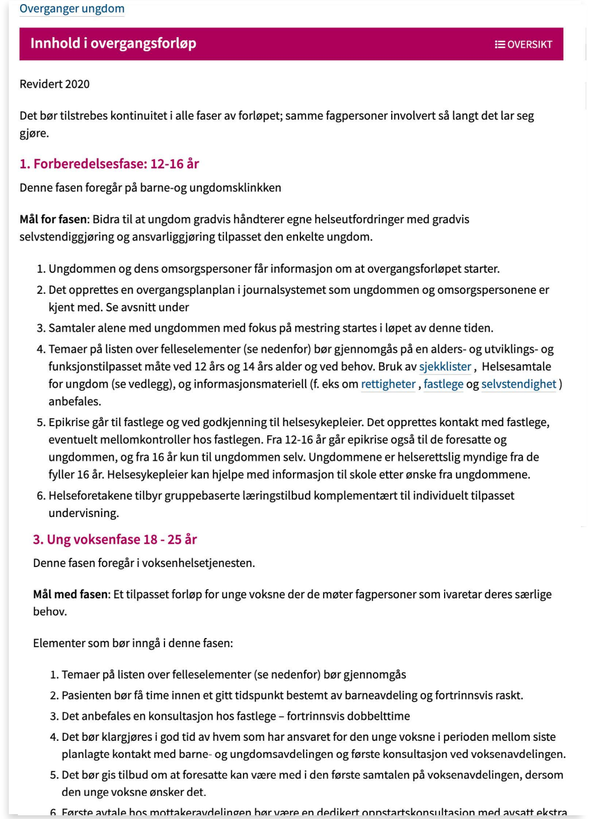
Om det er noe du ikke klarte å svare på, kan det være lurt å gå gjennom spørsmålene med foreldrene dine eller helsepersonell.

Tenk gjennom ...
Ettersom du blir eldre ønsker vi å snakke enda mer med deg direkte. Selv om vi også snakker med foreldrene dine, er det du selv som kjenner din hverdag og som kan svare best på spørsmål som angår deg. Det kan derfor være lurt å tenke gjennom hvordan sykdommen din påvirker deg og hverdagen din.

Oslo Univercity Hospital, 2019

Information sheets

There are a few of these "all the things to need to remember or know"-information sheets, that might be overwhelming but also useful for conversations or preparing for the transition.



Overganger ungdom

Innhold i overgangsforløp ☰ OVERSIKT

Revidert 2020

Det bør tilstrebes kontinuitet i alle faser av forløpet; samme fagpersoner involvert så langt det lar seg gjøre.

1. Forberedelsesfase: 12-16 år

Denne fasen foregår på barne-og ungdomsklinkken

Mål for fasen: Bidra til at ungdom gradvis håndterer egne helseutfordringer med gradvis selvstendiggjøring og ansvarliggjøring tilpasset den enkelte ungdom.

1. Ungdommen og dens omsorgspersoner får informasjon om at overgangsforløpet starter.
2. Det opprettes en overgangsplanplan i journalsystemet som ungdommen og omsorgspersonene er kjent med. Se avsnitt under
3. Samtaler alene med ungdommen med fokus på mestring startes i løpet av denne tiden.
4. Temaer på listen over felleselementer (se nedenfor) bør gjennomgås på en alders- og utviklings- og funksjonstilpasset måte ved 12 års og 14 års alder og ved behov. Bruk av sjekklister , Helsesamtale for ungdom (se vedlegg), og informasjonsmateriell (f. eks om rettigheter , fastlege og selvstendighet) anbefales.
5. Epikrise går til fastlege og ved godkjenning til helsesykepleier. Det opprettes kontakt med fastlege, eventuelt mellomkontroller hos fastlegen. Fra 12-16 år går epikrise også til de foresatte og ungdommen, og fra 16 år kun til ungdommen selv. Ungdommene er helserettslig myndige fra de fyller 16 år. Helsesykepleier kan hjelpe med informasjon til skole etter ønske fra ungdommene.
6. Helseforetakene tilbyr gruppebaserte læringstilbud komplementært til individuelt tilpasset undervisning.

3. Ung voksenfase 18 - 25 år

Denne fasen foregår i voksenhelsetjenesten.

Mål med fasen: Et tilpasset forløp for unge voksne der de møter fagpersoner som ivaretar deres særlige behov.

Elementer som bør inngå i denne fasen:

1. Temaer på listen over felleselementer (se nedenfor) bør gjennomgås
2. Pasienten bør få time innen et gitt tidspunkt bestemt av barneavdeling og fortrinnsvis raskt.
3. Det anbefales en konsultasjon hos fastlege – fortrinnsvis dobbelttime
4. Det bør klargjøres i god tid av hvem som har ansvaret for den unge voksne i perioden mellom siste planlagte kontakt med barne- og ungdomsavdelingen og første konsultasjon ved voksenavdelingen.
5. Det bør gis tilbud om at foresatte kan være med i den første samtalen på voksenavdelingen, dersom den unge voksne ønsker det.
6. Første avtale hos mottakeravdelingen bør være en dedikert oppstartskonsultasjon med avsatt ekstra

Norsk Barnelegeforening, 2020

Guidelines (veiledere)

The most extensive solutions to this date are guidelines, either witihin a hospital or from a national assossiation. They divide the transition into three stages; preparation, the transfer, and the young adult stage.

2: Exploring the needs

The next section shows an extraction of key findings related to user needs, mainly focused on youth but also touching upon the needs of next of kine.

Key takeaway

What I learned from this analysis is that the transition is just as much about the process of becoming independent, and balancing that with parents involvement, as the transfers from one "side" to the other. This needs to be a process, not just a handover.

The best things about being young is...

Anonym en time
Muligheten til å kunne være litt bekymringsløs

Anonym en time
Frihet til å være hvem man er og hva man vil

Anonym 45 minutter
Er at mange har mange muligheter og framtiden foran seg.

Anonym 44 minutter
Muligheten til å kunne ta litt mer dårlige valg, og det ordner seg som oftest for det

Anonym 44 minutter
å ha livet foran seg

Anonym 44 minutter
Å finne ut hvem man er

Anonym 39 minutter
man får være både barnslig og voksen på en gang

The worst part of getting older while in touch with the health care system is...

Anonym 44 minutter
Overganger

Anonym 44 minutter
Mer ansvar uten at man alltid er klar for det

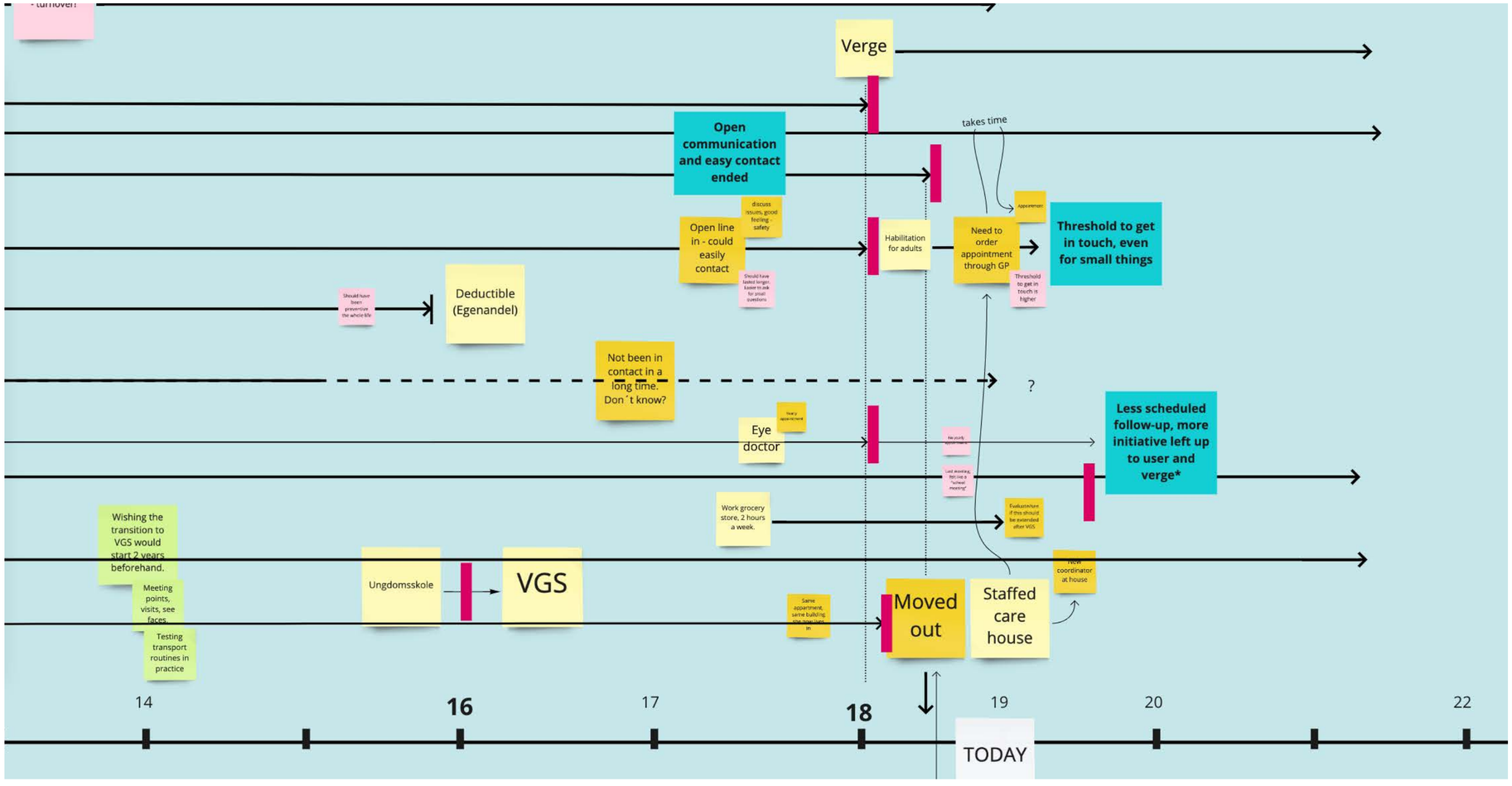
Anonym 42 minutter
Brått mer ansvar for egen helse når man fyller 16 uten at pårørende nødvendigvis er forberedt på det

Anonym 41 minutter
Vanskelig overgang om man ikke føler seg klar for det

Anonym 41 minutter
Overgang

Anonym 32 minutter
For å utdype: Jeg opplevde at mine foreldre reagerte negativt på å miste ansvar ovenfor min helse, forholdet deres til sykehuset endret seg også da de mistet innsyn noe de mislikte der og da. For min del var det positivt å få mulighet til å ta egne valg.

Screenshot of answers from a workshop with young adults.



User case

Mapping out this user journey based on an interview with a mother made it even more clear that keeping the scope of healthcare is too narrow. This totality is what is challenging, and what no one really has the responsibility to see or manage. This experience was a turning point in the process, making me open up to sectors beyond healthcare.

Findings

Being acknowledged

For a long time, youth have been an “in between” group, perhaps forgotten between the two more recognized “boxes”, children and adults. Being acknowledged as a group, with its own needs and situations, is important to be able to give services adapted to their stage in life.

”It’s just like youth is a separate diagnosis. You should not really complicate it more than it is, but the brain is not fully developed until you are 26 years old. (...) I think it’s just the knowledge about being young, you should not be afraid of young people but just know how to meet them.”
- Young adult 2

The safe and the familiar

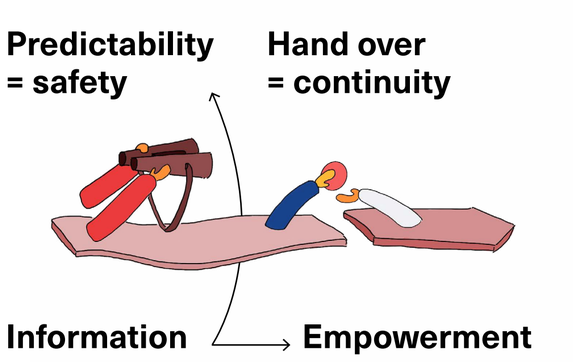
There is security in having a consistant person to lean on. Someone to help relieve the stress of all the changes, the new surroundings, expectations and so on.

“We had a family in transition. We were going to pull out, and experienced it as a big wound for the family. My mother is still contacting me. They want closer follow-up, even though we actually planned to withdraw.”
- Occupatinal therapist, municipality

Transition as a process, not a transfer

For youth it is important to see the transtion as a process, with stages and steps, facilitating for them to evolve into their new role. This competes with the services´ tendency to put emphasis on the formal transfer, or referral, as it is easier and less time consuming.

“If the transition is not a process, but just happens. I think that could result in ”water over your head”, or not feeling secure. Might handle the disease worse in that periode because things are changing in the health services.”
Young adult 2



The right information at the right time

Information at the right time, with the right content, is key to ensure both predictability and empowerment. What makes the transition predictable is among other things seeing the handovers coming up, and create the feeling of continuity, knowing what will happen.

What would have made me more ready to take care of my own health could have been ... "become more prepared for what becomes more my responsibility." - Young adult 6

"You could only get like basic information about it, I think: now you have turned 16 ... Whether it happens at the GP or whatever, but possibly the GP, that they can have an automatic "now you have turned 16". - Young adult 3

Taking "readiness" into account

Not everyone is ready for change, taking responsibilty and making choices. A flexible system taking individual variations into account could help individualize and adjust the transition accordingly.

"What's wrong with age: It's so easy for health 'care professionals. You're 18, then you´re going over there. Other criteria too, and being ready, would have been better. And to raise awareness."
- Young adult 3

The opportunity to slowly start preparing, practicing and learn

Making time for a slow start step by step, from as early as 12 years old, according to existing guidelines, could help soften the blow of the transition. Practicing setting the agenda, learning about your condition, treatment or follow-up, different services, requirements, choices etc.

"It is important that health professionals and we as parents together can try to mature them - it does not necessarily happen at the 18th birthday. It has to happen without me feeling left out or feeling insecure." - Mother

Help seeing the red threads

Having someone to help to see the red threads, make the collaboration happen and see the whole picture from day to day is important, a great resource that contributes to a feeling of continuity.

"This is what makes the transitions abrupt for many - that you do not have any fixed points. Nothing is fixed from time to time. No one sees the red threads. Must have a person who knows what happens, what offers you get. "
- Young adult 3

"Before I had my mother, now I have a coordinator. Mom did all this before, then the coordinator took over to get everyone to work together on the same plan." - Young adult 3

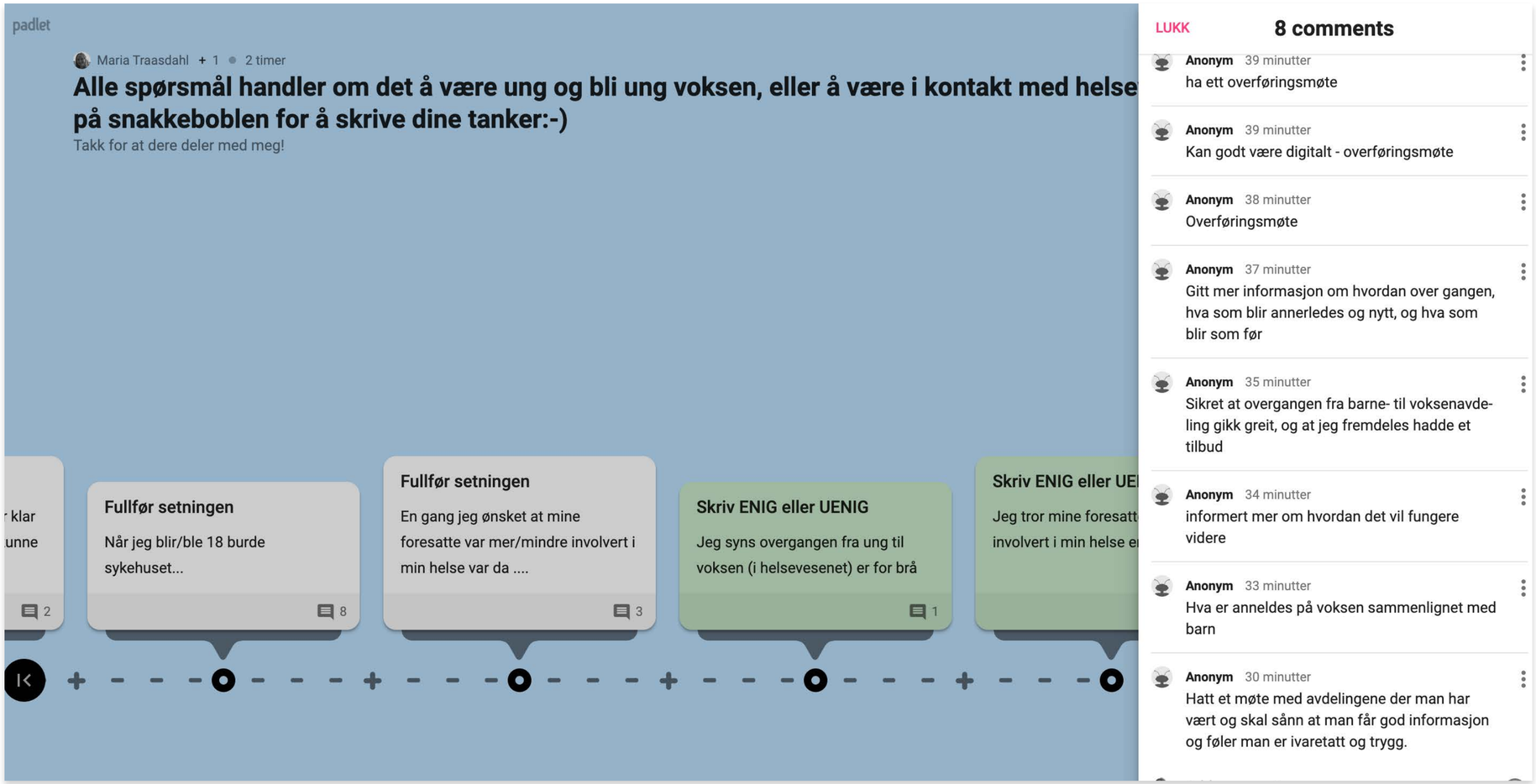
3: Exploring the meeting between services and users

Knowing some of the important needs in the transition, lets see an excerpt of what the experience is when youth and parents meet the services.

The basis for the findings in this section are both interviews with youth and parents, the workshop with the youth council, interviews with experts and a workshop with health care workers in a hospital.

Key takeaway

The key thing I took away from this analysis is that the transfers often constitute an abrupt shift from parent-led care to a “take responsibility yourself”-approach and users having to reach out more actively for support and information.



Screenshot of questions and answers from workshop with a youth council at a hospital.

Workshop with youth council

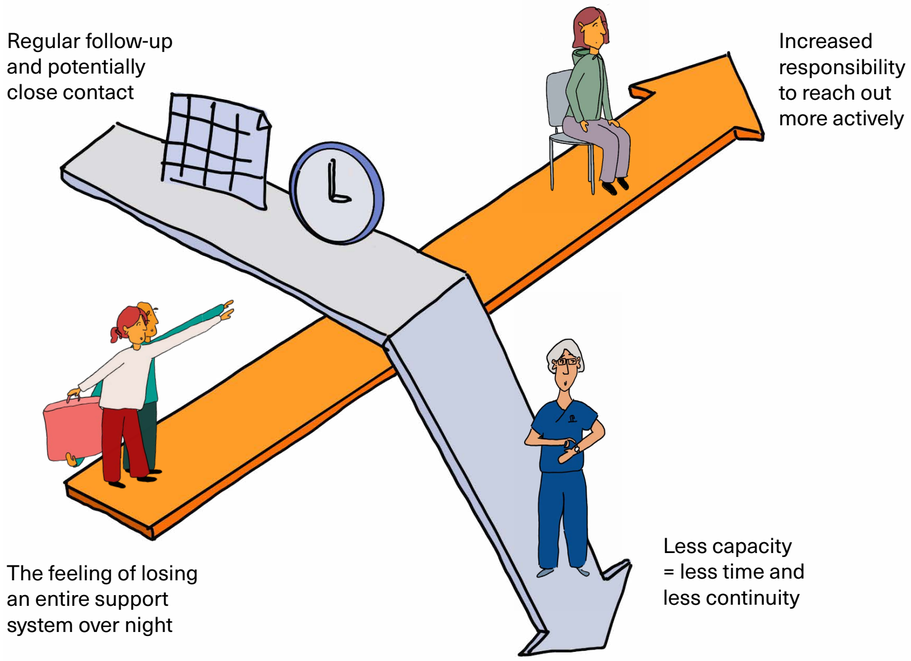
Through this workshop I was reminded what it is like to be around the age of 18. They also shared their thoughts on beeing a youth, on transitions, parents involvement and on their wishes.

Findings

More responsibility, less time for support and follow-up

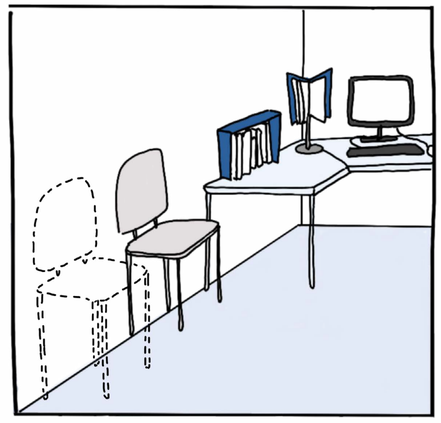
The family can experience having less follow-up and continuous support after 18 - especially in healthcare. Youth are supposed to be more in control, even though they are still new to the situation.

"You are followed up closely as a child, and are let go at 18. You loose a lot of follow up from the specialist health care, and are in an ordinary track like every other adult,"
- Leader housing, district



Parents sometimes feel rejected, and youth are met with expectations to "manage on your own"

The transition comes with a change in roles and expectations, for both parents and youth themselves. These abrupt changes might mean parents suddenly feel rejected and not prioritized, and the youth are met with sudden expectation to be responsible and independent.



"(...) you may forget to include the parents, and run a professional program and emphasize the participation of the user."
- Leader housing, district

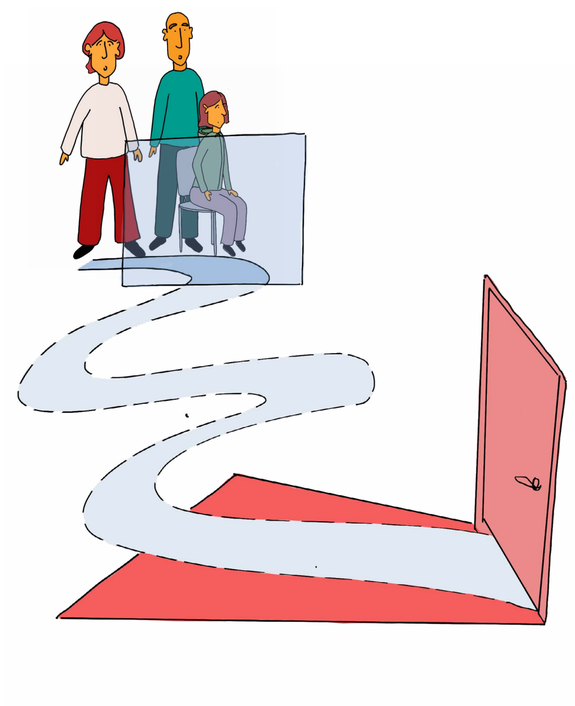
"I got cancer, and then you get the message that "bring a person with you, because there is a lot of information to take in", but youth do not necessarily get the same." - Mother

Not knowing what will happen, when or why

Today it may feel difficult to see what is coming up ahead, even though there are potentially a lot of choices and considerations to make. Families might wonder that structures are in place to take them through the transition coming up.

"Information about the transition is often given based on the parents' needs. If you notice that they are insecure and have many questions."
- Coordinator, coordinating unit

"After 18, nothing happens by itself. More applications, which increase the strain on parents. You have to search for information in a new way." - Leader housing, municipality



A door closes, a new world opens up

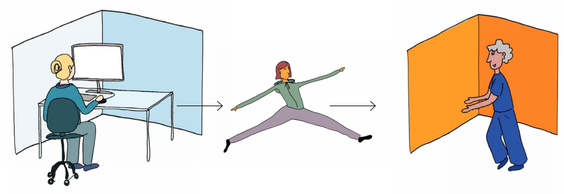
Being transferred to a new service may feel like leaving the safe world behind, and entering a new world - emotionally, and also almost symbolically, leaving youth behind.

"At the age of 18, we passed the glass hallway, and felt the doors closed behind us, where you have been for 18 years, and no one knew who you were anymore."
- Mother

The users are messengers and have to repeat the story - again

Youth and/or next of kin often have to tell their story on repeat, to new people and services. This might also effect the trust, for instance if a new service repeat the tests you have just done somewhere else - making it seem as if they question the work of the previous service.

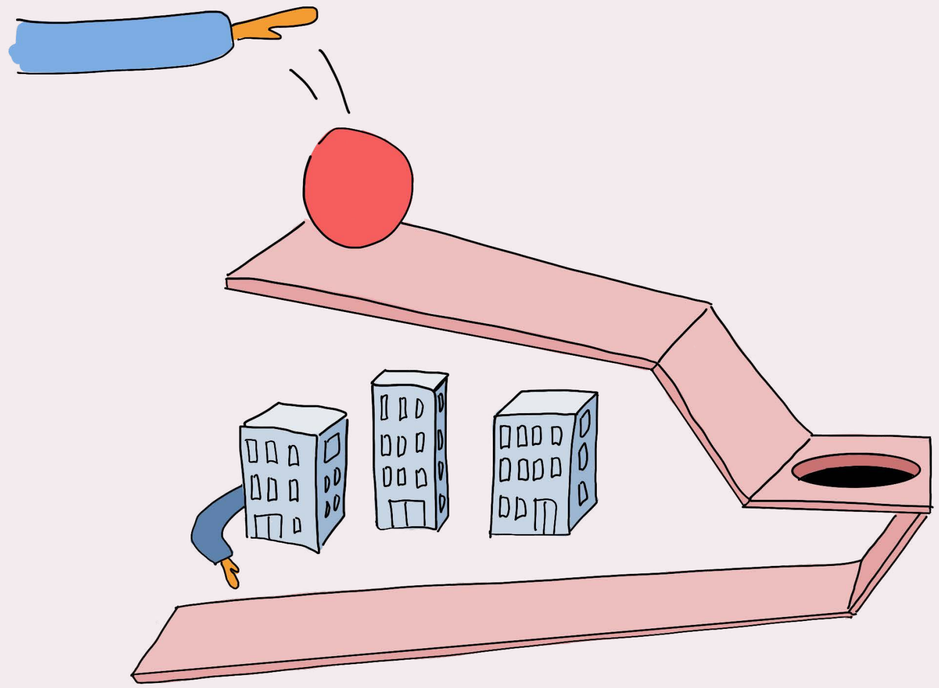
"You do not have that communication portal, so in a way it is a dip, and then you do not have access to all of the history. Then I have to say that I was diagnosed in 2000 and that, and all of my story I have to tell for the x´th time(...)"
- Young adult 2



4: Exploring why the services struggle to meet the needs

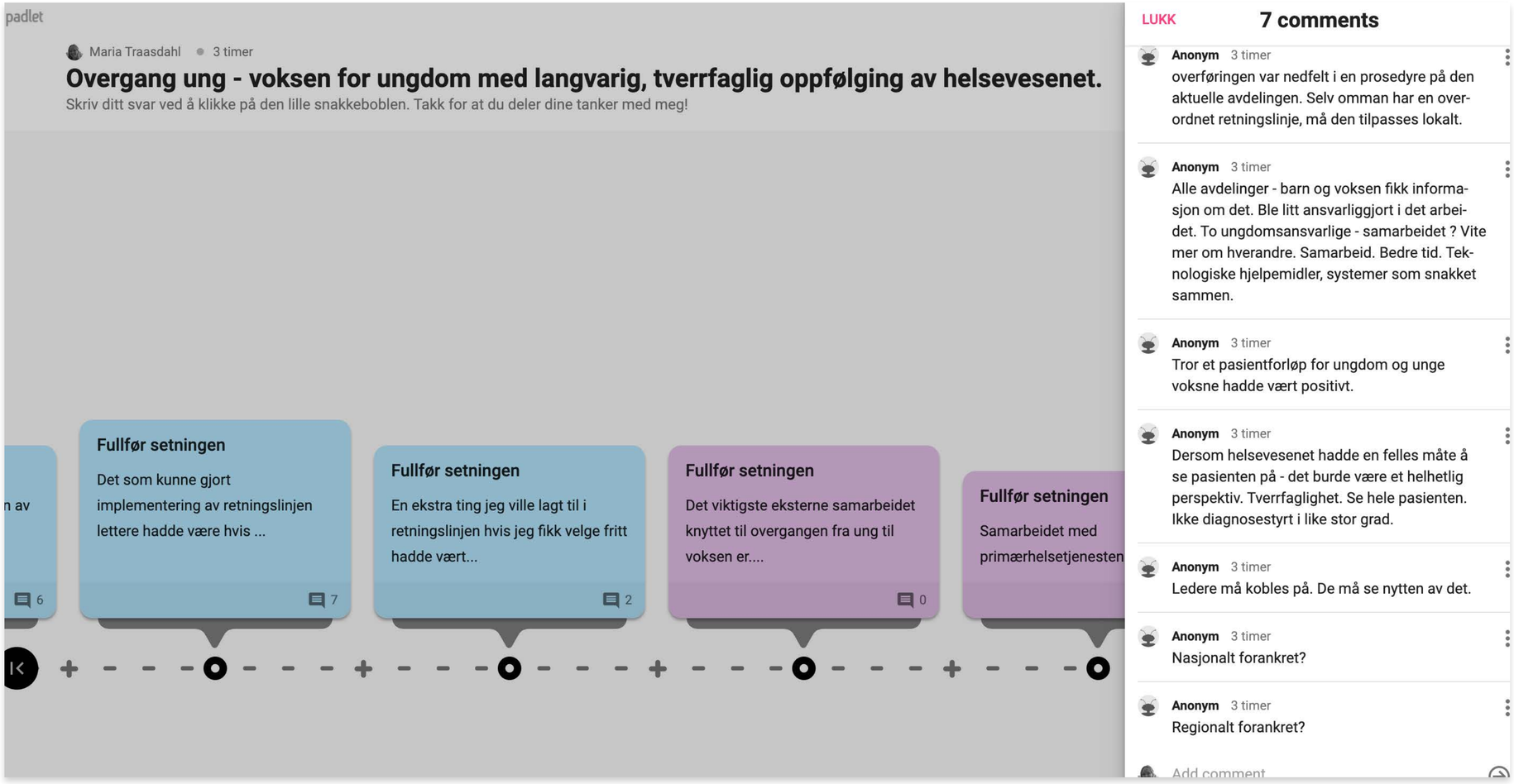
The next part is the why - why the services struggle to meet the needs.

This is mainly based on a workshop with health care personell/coordinators at a hospital, as well as several of the expert interviews, that all touch upon several of the aspects I mention here. Research from the StimuLab-project also point to several of the same findings.



Key takeaway

Key things I learned from this analysis revolves around the differences and distance between services and their tendency to push responsibility further or to the other side due to a lack of resources and time.



Screenshot of questions and answers from workshop with a health care personell/coordiantors at a hospital.

Workshop with coordinators at a hospital

The health care workers participating in this workshop coordinate those responsible for following up on youths in the different wards at a hospital. We talked about their guideline for the transition, why transitions are challenging and why it is hard to implement the guideline. I wanted to gain a more nuanced understanding of what it is like to manage the transition in practice.

Findings

Two different worlds

There seems to be large differences between ”the child side” and ”the adult side”, for instance in psychiatry, that can strengthen the feeling of change, unfamiliarity and not feeling safe or understood.

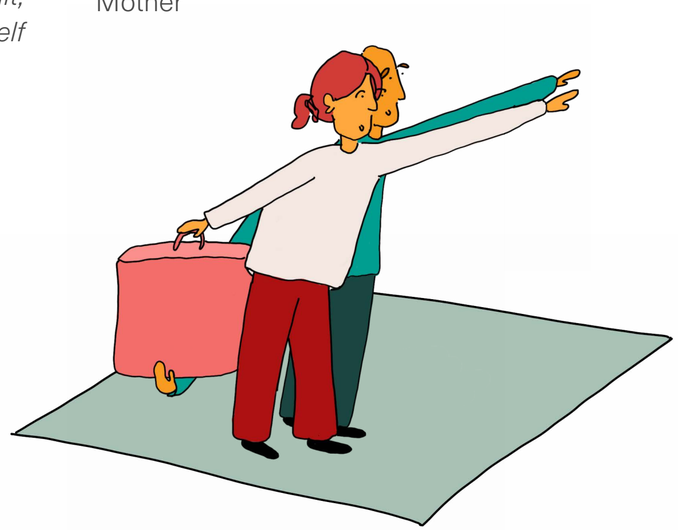
“There is a big difference between child and adult psychiatry. The culture is very different, and the approach is very different. How you have been met and seen as an individual and a patient and a person. I think the treatment is much ”harder”, and more ”you are an adult, take responsibility for yourself and pull yourself together.”
- Child welfare/psychiatry coordinator

Balancing the involvement of parents and independence

It is tricky to balance honoring the rights of the young adults, acknowledging that they are legally adults, and making space for some to involve parents more than others, depending on their wishes.

“When they turn 16, they have self-determination, and the right to talk and things like that; we try as far as possible, although parents often want control, so it varies a lot how much we get the youth to participate.”
- Coordinator, coordinating unit

“It’s about being seen as a resource, and not being seen as ”Oh god she comes with her mom again, then she can sit in the hallway again.” - Mother



Lack of awareness and knowledge

Emphazising transitions is relatively “new”, and to my knowledge there is not a lot of focus on it either in education or training, and the awareness varies from person to person. This also means there is a lack of a clear, common picture of the reasons to do this, resulting in a varying degree of awareness and engagement.

“When someone has been ill for a long time, the parents have often taken responsibility until they are 18. It is easy to think that they know a lot but they don´t.”
- Health personnel/coordinator, hospital

Lack of clear starting points

Today there are few set starting points for the various transitions, often resulting in preparations starting too late. Among other things, this could be because it is unclear who should start it and how.

“How early can you start? We started 3 months earlier with the last family. I see now that it was too late. Maybe a year in advance would have been better.”
- Occupational therapist, municipality

All the different municipalities

For specialist services, knowing what the different municiplaities are doing, what they offer and who to contact is a challenge given the variations between them. This is a barriers for collaboration.

(Transition hospital - municipality)
"It is challenging; all municipalities are so different, and with silos - I do not even know everything we do in the municipalities. And it is more difficult for hospitals to know what exists."
- Leader housing, municipality

Information is lost in the transfers

Digital systems used today often have limited opportunities for sharing data. Together with privacy laws and lack of time, this increases the chances of information getting lost, or left behind, in transfers.

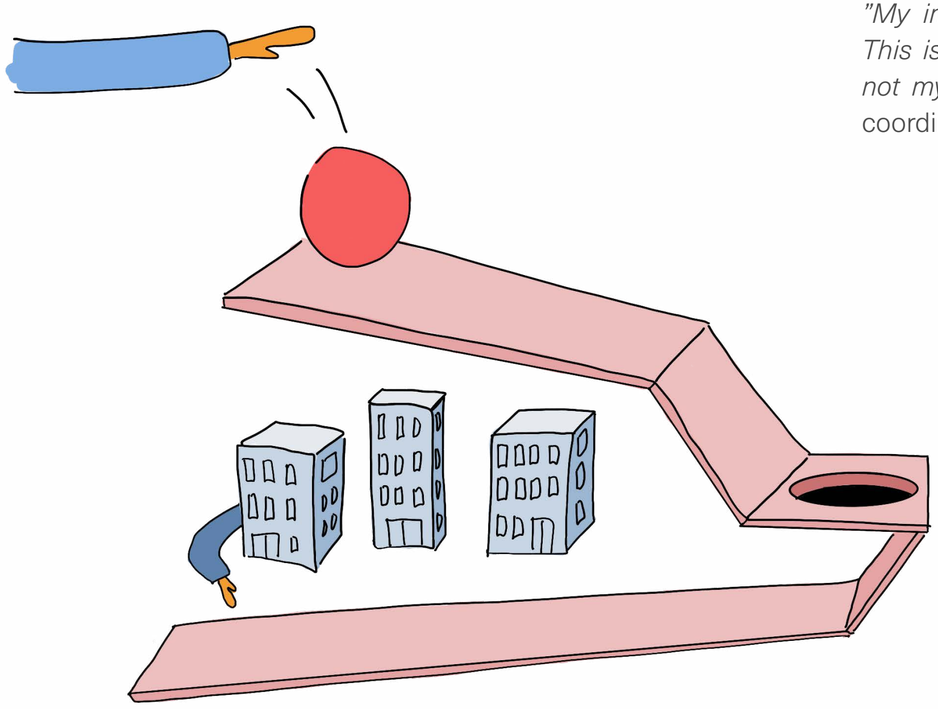
"A lot of information is lost in the transfer. Things do not follow. New tests are being taken, for example, and it's almost like starting over." - Young adult 2

Disclaiming responsibility

There is a general tendency to disclaim responsibility. This seems to be mainly for resource reasons, but also because there are few set structures for the transfers - at least not as a longer, collaborative process.

"There is a lot of arguing about where they (youth) belong; the day they turn 18, or the year they turn 18, for example."
- Leader housing, municipality

"My impression is that everyone is like this: This is my table, and now you turned 18 and not my problem." - Child welfare / psychiatry coordinator, municipality



5: Exploring structures in the system

The last part of the reaseach and findings chapter is an even more in depth research on the why, on a more structural level.

Key takeaway

The key thing I took away from this analysis is that there are several long standing and valid reasons for having the divide between the two ”sides”. I also point at some of the key reasons why implementation is a challenge.

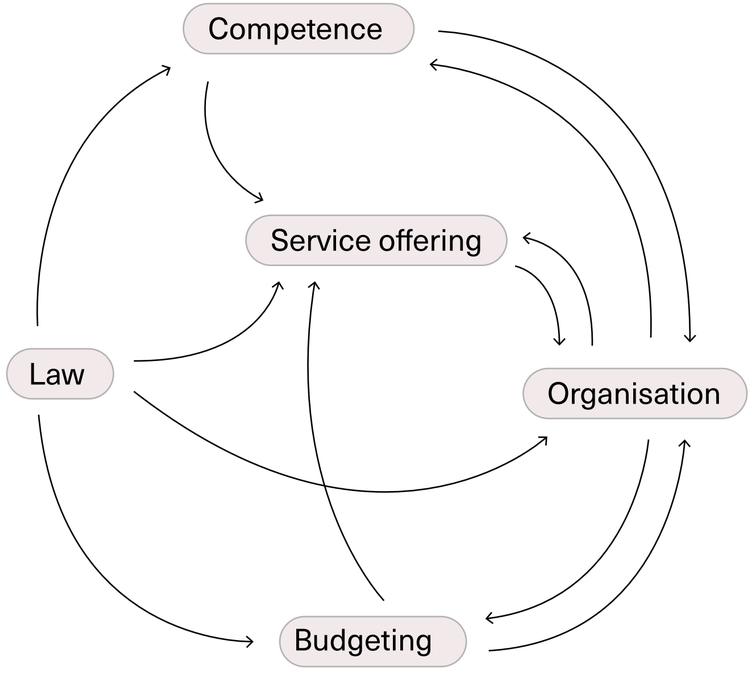
“It is easier to create the guidelines than to implement them. It requires time, facilitation and commitment from various professionals.”

- Health care personnel/coordiantor, hospital

Findings

Why is it that the composition of services change during the transition? There are complex and long standing structures that create the two ”sides”, summarized on this page.

This model shows how I would visualise the realtions between different, key structures that create the ”sides”. The arrow represent ”*affects”*.



Law

“The law is clear in separating children and adults.”
- Leader housing, municipality

Competence

“Specialists on each side; child often collaborate with school, child psyciatry and child organisations, that we are not so familiar with on the adult side.”
- Leader housing, municipality

Organisation

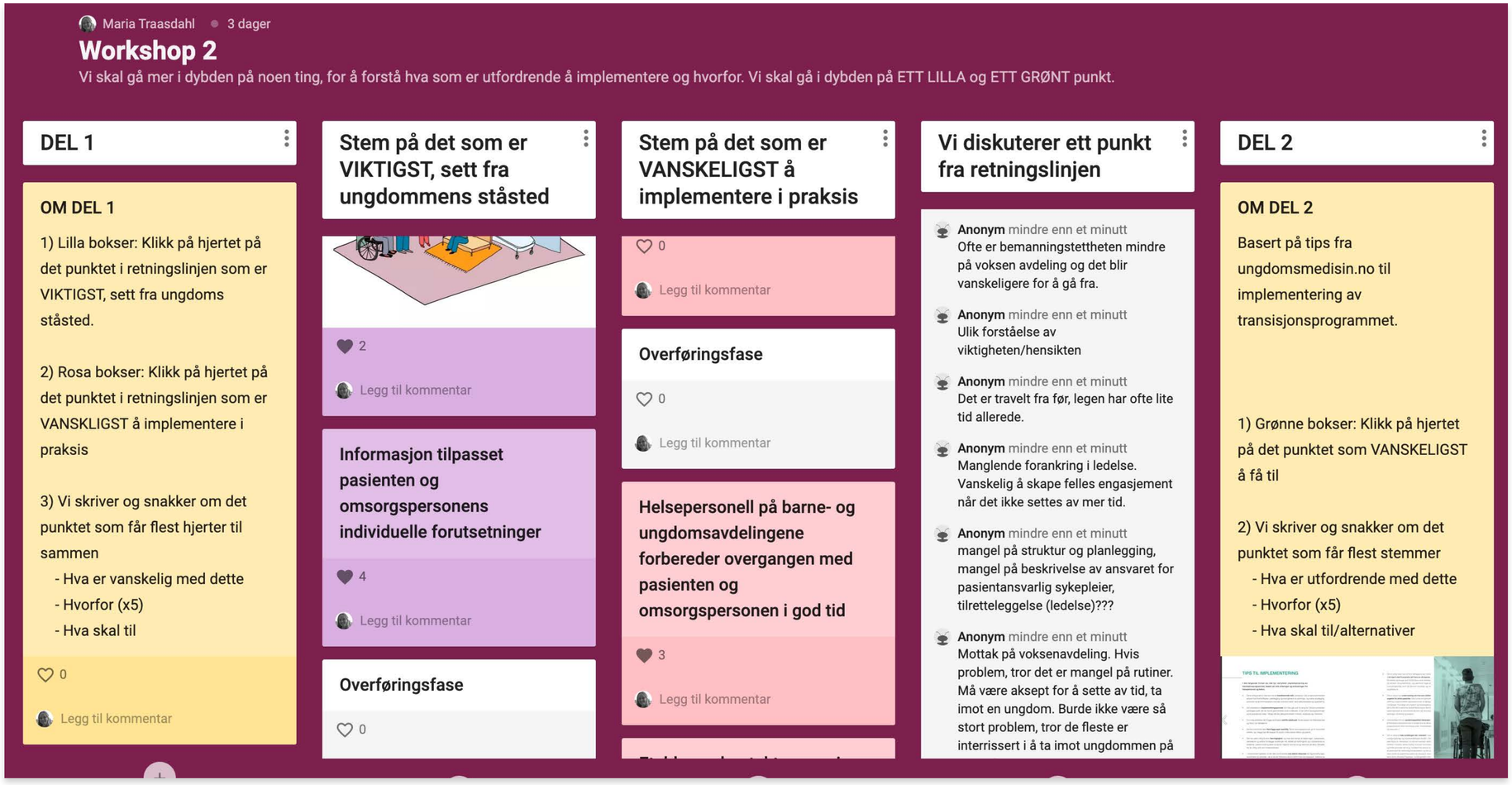
“Before they used to convene the adult side second year in high school. And then we were in the responsibility group-meetings for a periode and then we took over. Then we sometimes had conversations with the different ones. And that worked well. But now we are so closely organized.”
- Coordinator, city district

Generalist

“In child- and youth psyciatry there is more of a systems focus. The family is in, and you try to put the youth in context of the family life they live in.”
- Coordinator child protective services/psychiatry, municipality

Specialist

“Children with complex somatics and complex challenges that have needs for instance related to sight, hearing and cognitive, span across several areas. Then the city district is convened to a transition meeting the year before (18), and then the parents have a complete shock when they are going from the child system in specialist health care to a large panel of different wards for heart, sights, etc. There is no gathering on the adult side.”
- Coordinator, coordinating unit



Screenshot of tasks and answers from workshop with a health care personnel/coordinators at a hospital.

Second workshop with coordinators at a hospital

In the second workshop with the coordinators we zoomed in on their guideline for the transition. We discussed the part of the guideline that in thier mind is most important from the youth, and most challenging to implement.

Findings

Not prioritized

It is easier to prioritize the things with clear value, that you are taught and told to do, rather than the ”extra” measures regarding the transition.

”It is often not priotized, as other things ”burn” which I think may be perceived as/are more important.”
- Health personnel/coordinator, hospital

”I think you do not see the result of what you do because there are so many gaps, it is difficult to see the result, and it is downgraded because you think that giving the patient treatment is more important (than the transition). Treating the disease is more important than the whole. Because then you see results.” - Young adult 2

Measuring the benefits/value

There are few known or practiced ways to measure the effects of good transitions. The benefits are often qualitative or long term. This is one of the reasons that it is hard to prioritize, and it addition to the lack of a widely recognized reason to do it.

”Do not think we will get anywhere until we know why we are doing this.”
- Health personnel/coordinator, hospital

”If they do not know why this is important, it is harder to get it done.”
- Health personnel/coordinator, hospital

Not knowing each other

Physical, professional and cultural gaps between different services or stakeholders makes it harder to collaborate in general - also for transitions.

“There is a big gap between different clinics and everyone is busy with their own things.”
- Health personnel/coordinator, hospital

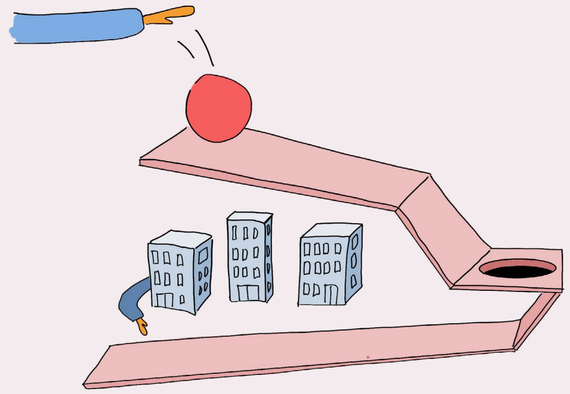
Time constraints

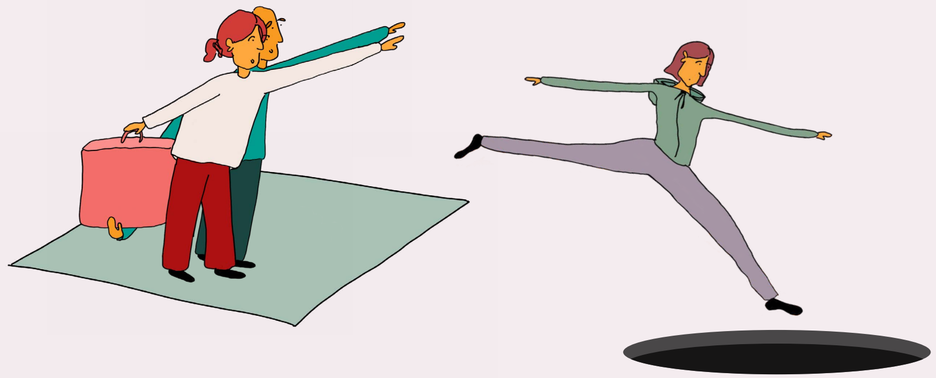
Finding time to follow through on making an ideal transition process over a period of time is a challenge due to schedules and turnover, among other things.

“It is sometimes difficult to get employees who have time for a transfer conversation - in both wards. Days are busy and there are few contact points.”- Health personnel/coordinator, hospital

Reflections

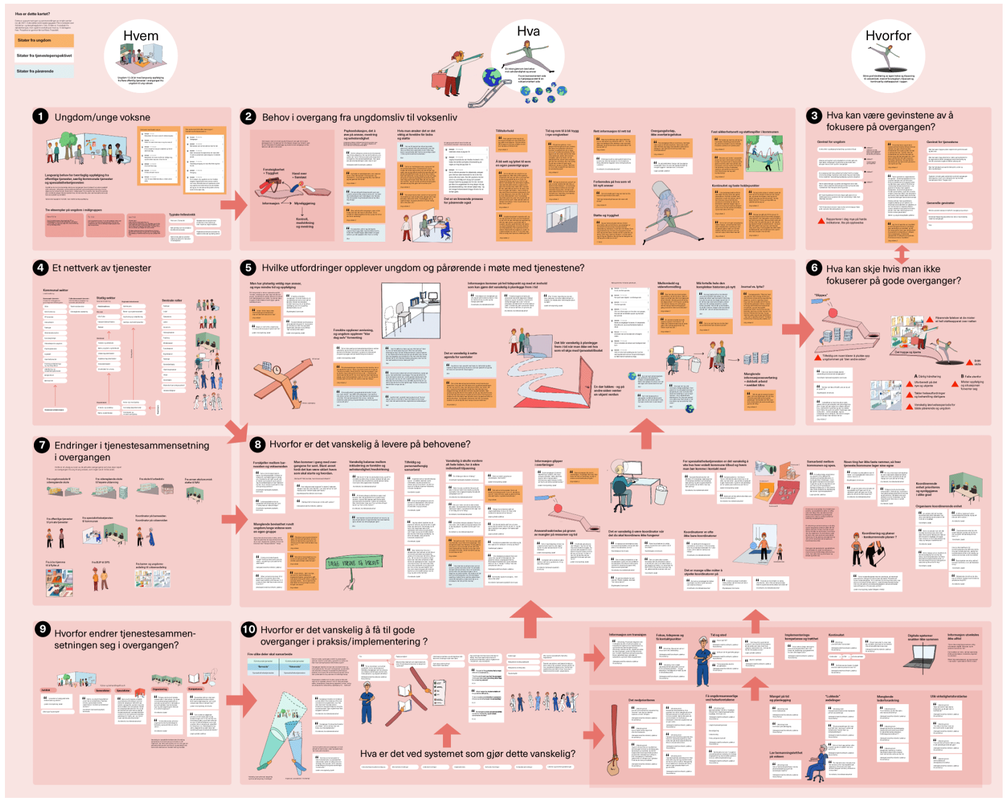
Taking a step back after going through the research and findings, I see a need for increased knowledge about the transition and youth´s needs in that transition, defining the quantifiable benefits of it and creating lasting, collaborative stuctures that can help facilitate the transition. Empowering the users by informing and preparing them for the changes to come, and enabling them to influence their service offering, is also important. The risks and long term costs of a fragmented transition needs to be defined across professional silos, to establish a common way of seeing and valuing the transition.





The map of findings

I gathered these findings and more in map. The hope is that it will be a basis of knowledge for further work and prioritization in the context of internal and cross-service innovation. Zooming in and looking at the different quotes, people can analyze and discuss the different aspects further.



See the full version attached.

The different parts of the map are:

1) User group
2) Needs in the transition from youth to adulthood
3) What might be the benefits of focuing on the transition?
4) A network of stakeholders
5) What challenges do youth and next of kin experience meeting the services?
6) What might happen if you do not focus on good transitions?
7) Changes in the composition of services in the transition
8) Why is it challenging to deliver on the needs?
9) Why does the service composition change in the transition?
10) Why is it challenging to make good transitions work/ implement them?

4: The search for impact

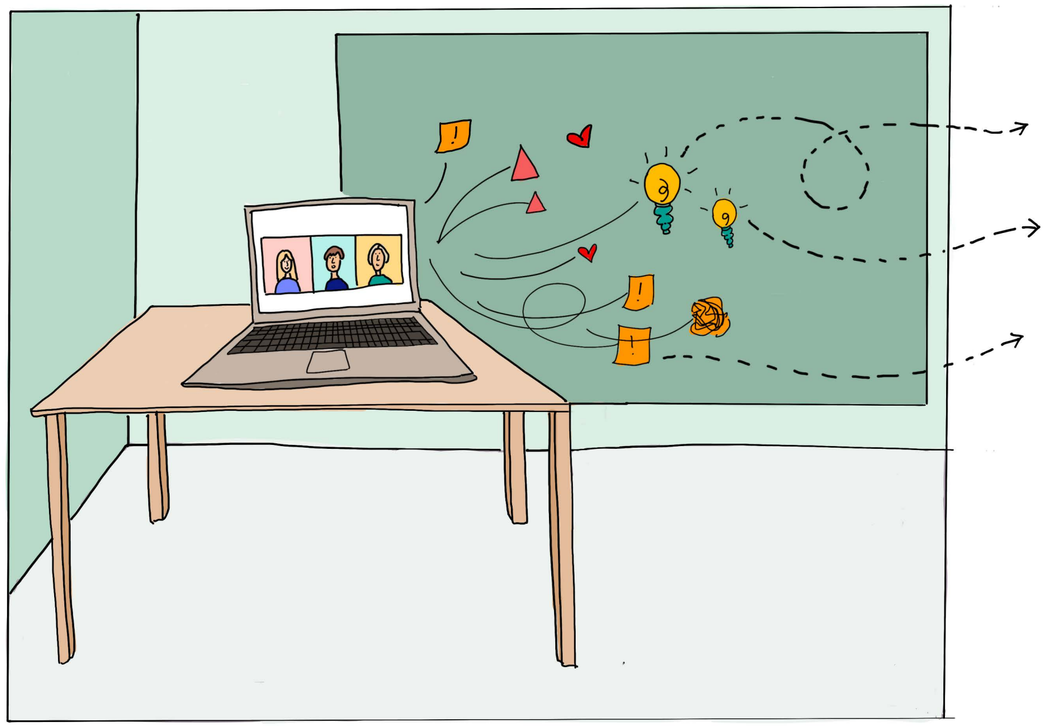
Chapter four

This chapter gives a glimpse into the move from diagnosis through opportunity areas towards a scope for design interventions.

Parallel research and ideation / Overall opportunity areas

Parallel research and ideation

Throughout the research phase, I explored and talked to my interviewees about potentials and ideas. I kept the end result open for quite some time while researching, being open to input from the participants. This ment that by the time I got to scoping, it was quite apparent to me what I wanted to dig further into. Rather than having an extensive ideation phase, I jumped quite quickly from diagnosis to design interventions. I therefore adjusted and tested the interventions while making them - learning through doing.



I gathered all of the ideas from participants in this way, initially without any strategic thought. In the search for an impactful scope, however, I grouped and evaluated these and more, trying to see where I could use most of myself as a designer and contribute to the overall mission of the life event.

The overall opportunity areas

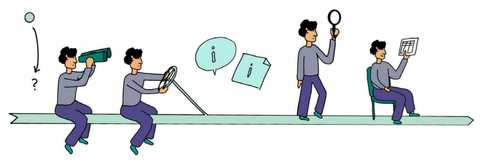
I defined six overall opportunity areas. These represent overall shifts that I believe would contribute to improve the transition.

From a transfer focus
to a transition focus

"Childrens side" and "adult side"
- from fronts to partners

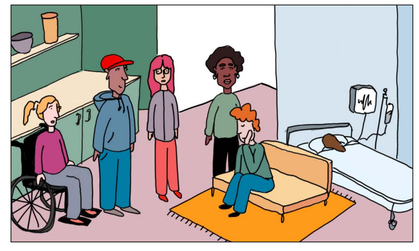
From equal parameters
to individual adjustments

From abrupt change
to gradualt adaption



From dropping the ball
to passing the ball

From unwanted variations
to equally emphazised transitions



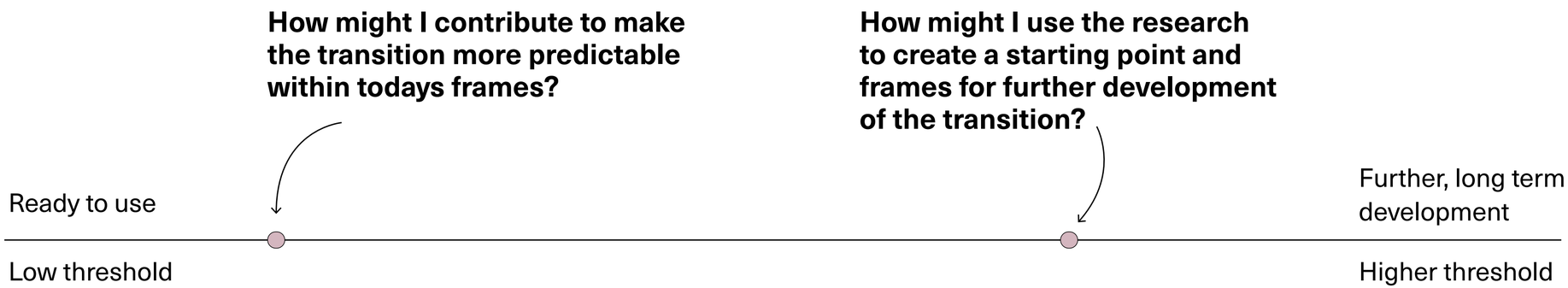
5: The design interventions

Chapter five

An introduction to and overview of the design interventions.

The prompts

With the findings, my perspective and the opportunity areas in mind, I made prompts for exploring design interventions. I chose not to focus on one opportunity area, but rather use the input to narrow my focus down to these two prompts:



Towards one transition

The level of complexity in unpacking this transition is massive, and I have barely scratched the surface of the problematique. Taking a step back, I see the overall transition as a journey through a stage of life, with the milestones, development, challenges and changes that it entails. I propose that this stage in life is seen as a whole, rather than sector by sector, going along with the prioritized focus on life events and situations as frameworks for developing more cohesive services in recent public sector strategies. Health is connected to work, which is connected to the economy and so on.

In reality this means long term, cross-sectoral work. Involving a broad range of stakeholders and disciplines is key to ensure ownership and in turn secure successful implementation.

In the next pages I present a summary of my interventions, seen in connection to each other.

The interventions

I propose four interventions, on different levels, that are intened to inspire, impact and contribute to frame further development of the transition, as well as improve exisiting solutions.

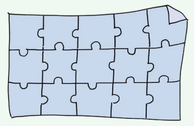
Interventions

"The action of becoming intentionally involved in a difficult situation, in order to improve it or prevent it from getting worse."

Definition from Cambridge Advanced Learner's Dictionary & Thesaurus

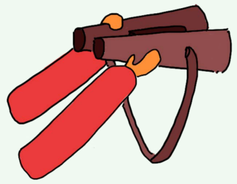
A : Vision: A seamless transition

Future, ideal state of the transition from youth to adulthood.



B : Overall principles for the transition

Twelve overall principles to steer the development of the transition.



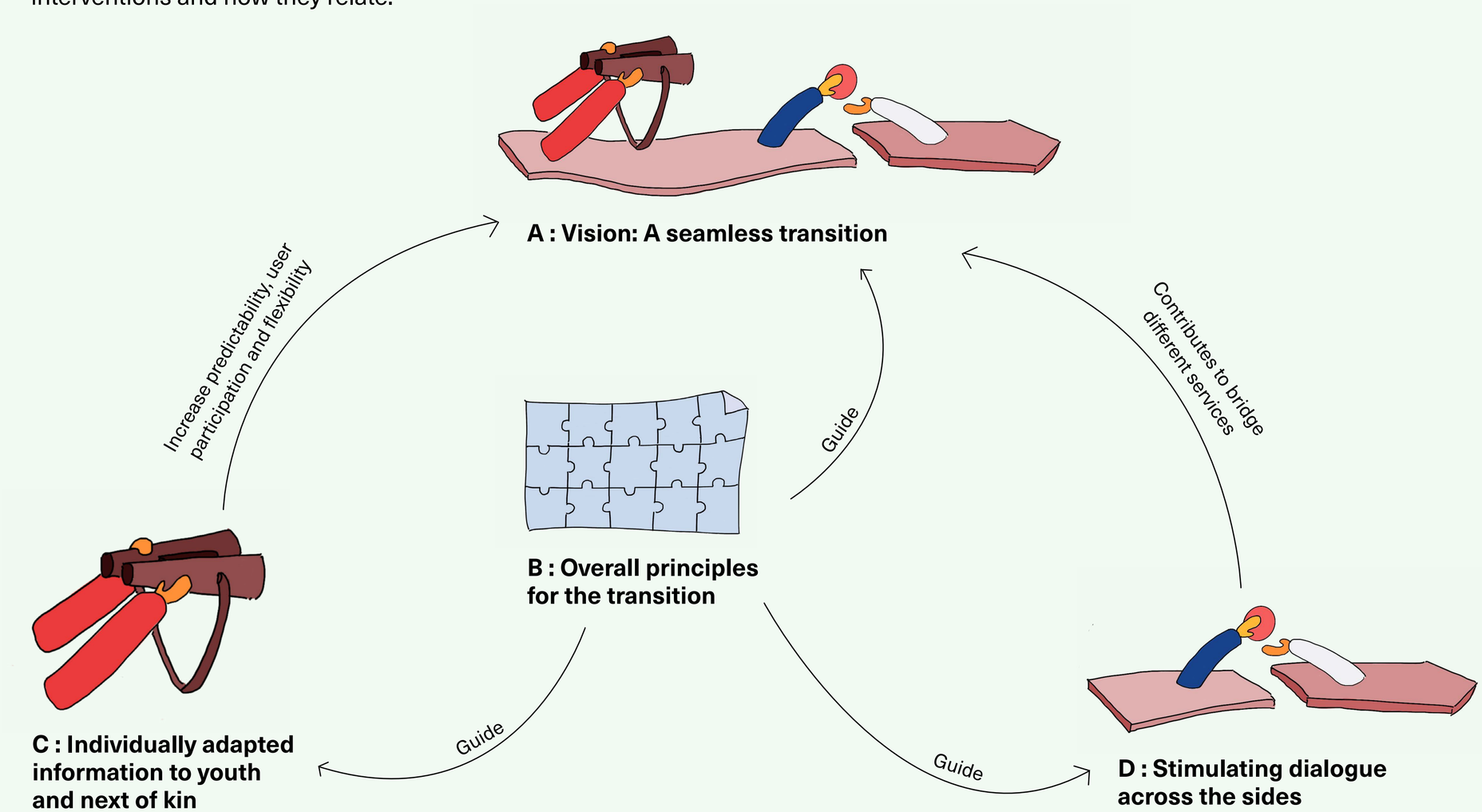
C : Individually adapted informition

A tool for coordinators to adjust information about the transition to the needs of each youth and their next of kin. The tool is made in familiar formats to distinctly lower the threshold for implementation.

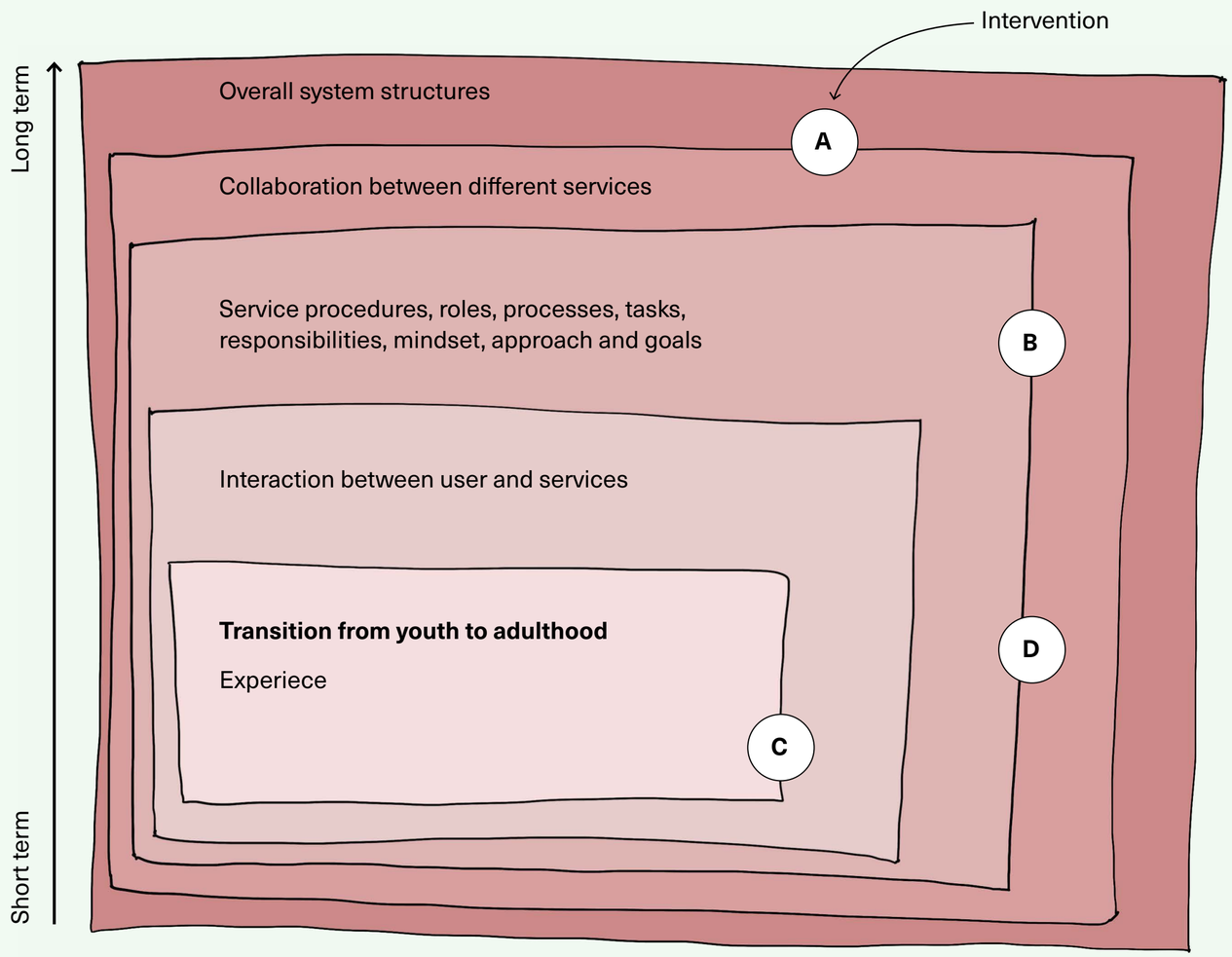
D : Stimulating dialogue across the sides

Dialogue cards - a starting point for dialogue between services on the different sides, triggering reflection, awareness and potential new structures of collaboration.

This is an overview representing the interventions and how they relate.



5 The design interventions: Overview



The interventions are designed to intervene in different levels of the system, from close to the user experience to nudging more collaborative processes and the overall systemic structures. They are all part of a bigger context, and I see it as is important to approach the development from these different angles and levels simultaneously.

A: The vision and B: The principles

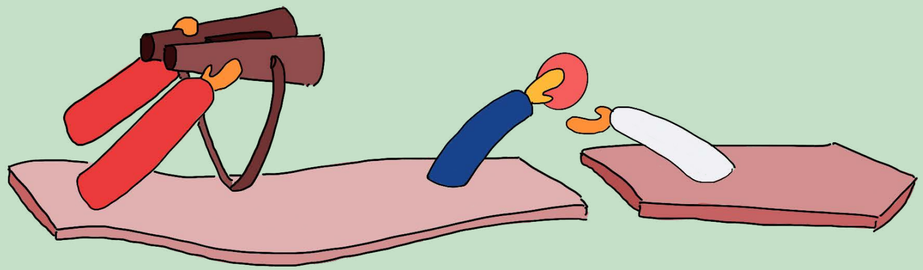
Design interventions: The overall, future vision of the transition and complementing principles.

Vision: A seamless transition / Principles / Why principles / Principles in context

Vision: A seamless transition

In the future, public sector´s way of facilitating the transition is seamless, predictable and safe. It is personalized, and flexible to a degree that does not create unwanted variations. The transition is seen as a process rather than a set of transfers, and rather than dropping the ball services are now passing the ball, ensuring a continuous follow-up across services and people. Different sectors see it as their mission to work together to create a safe passage into adult life and the changes that entails. Smaller transfers are connected, coordinated and seen in relation to each other when relevant. In Norwegian this would be named *overgangsforløp*.

The next few pages describe the principles that are ment to help guide and the set the standards for the development of this seamless, holistic transtion. Examples of where these principles could live are also included.



Predictable, safe and seamless

Principles

I created a set of principles for the overall, seamless transition and the transfers within it, based on conversations, findings, similar principles and best practice, intended to help steer the development of the transition. The visuals could be posters, printed out and hung to work as a reminder in the busy day to day work. The visuals graphically illustrate the content they represent.

Legg til rette for individuelle behov

Individuelt tilpasset tilbud

Alle ungdommer er ulike. Individuell tilpasning bør skje på bakgrunn av hva som er viktig for ungdommen, samt behov, forutsetninger og modenhet.

Balansert involvering av foreldre

Ikke alle er klare for fullt ansvar selv om de er juridisk voksne. Avklar ungdoms ønsker, og finn en god balanse mellom selvstendighet og hjelpebehov.

Modenhet fremfor alder

Alder tilsvarer ikke behov eller modenhet. Unge voksne er fremdeles i utvikling og har andre behov enn de mer erfarne og eldre brukerne.

Se, snakk om og ta hensyn til helheten

Å være ungdom

Ta hensyn til at ungdom kan styres av ønsket om å være som ungdom flest og at dette kan være vanskelig forenelig med oppgaver og krav.

Hele livet

Ta hensyn til helheten - skjer det andre ting i livet til ungdommen? Hvordan påvirker det overgangen, når og hvordan den bør skje?

Snakk om overgangen

Samtalene kan tas mens man gjør andre ting - tar en blodrpøve, venter eller lignende. Samtaler om overgagen kan bidra til en forventingsavklaring.

Skap en trygg prosess, ikke bare en overføring

Beskriv veien videre

Gi informasjon om hva vil være det samme, hva vil endre seg, hva familien må gjøre og hva som skjer av seg selv.

Gradvis læring

La ungdom gradvis øve på det de snart skal klare seg - samtaler, valg, ansvar og agendasetting.

Kjent med nye omgivelser

La ungdom bli trygg i nye omgivelser, for eksempel ved en omvisning på forhånd.

Ikke slipp før noen har tatt over aktivt

Skap et trygt mellomrom

Organiser fellesmøter mellom nye og gamle ansvarspersoner ved behov. Det gir et trygt rom for overføring av sensitive historier.

Ikke start helt på nytt

Det skal ikke føles som om man starter helt på nytt når man bytter ut en offentlig tjeneste. Det er en fortsettelse.

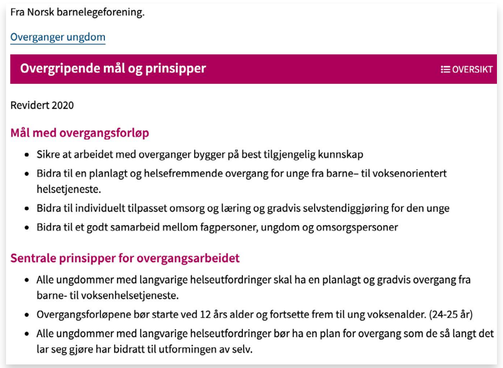
Rask kontakt etter overføring

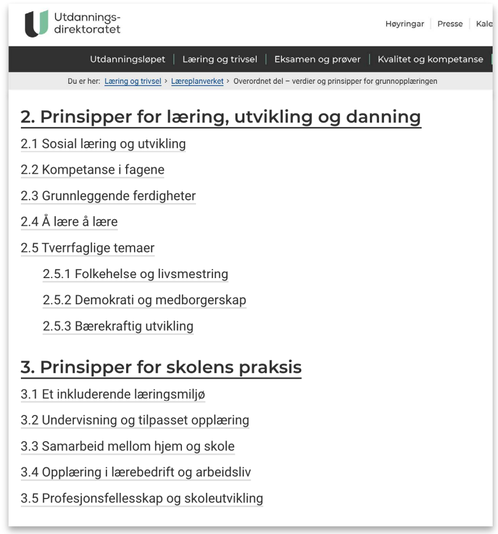
Innkalling til første møte etter ansvarsforflytning bør skje så fort som mulig, slik at man kan etablere trygghet og en relasjon. Avsender bør ikke slippe før dette.

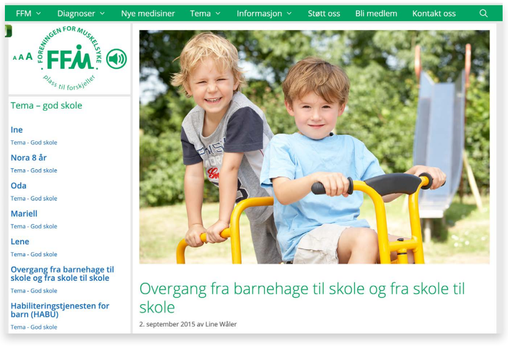
Why principles?

Principles can help build the bridge between todays practice and new practices. These principles are cross-sectoral, in contrast to several existing principles. This is a potentially unifying measure, having everyone oriented towards the same principles - regardless of sector, service or role.

I propose that these principles are put to use to provide a common goal to stretch towards and a basis for the continual development of services. They are meant to increase awareness of the importance of the transition and clarify measures that increase the likelyhood for good and seamless transfers.





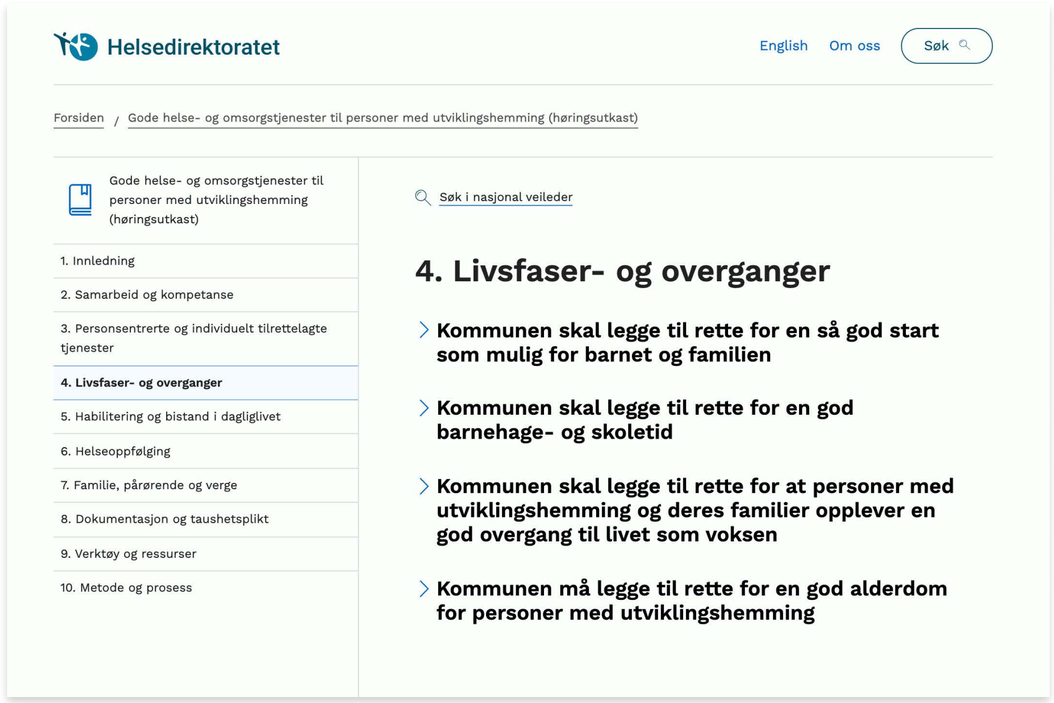


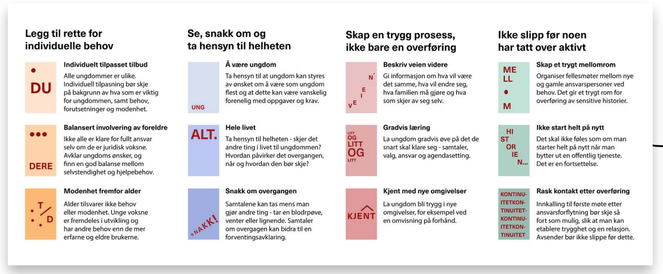
Examples of where principles are used - here in education and health care.

In context

The principles could live in several places, among them national health related pages like The Norwegian Directorate of Health, in documents like guidelines or standard processes (pakkeforløp for instance).

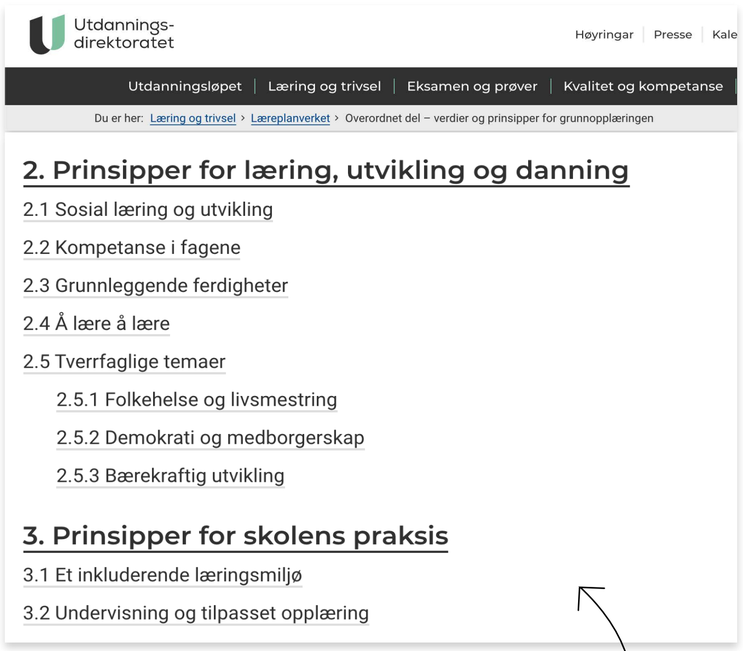
The Norwegian Directorate of Health creates and recommend guidelines and practice, and could be one of several distributers of the principles. In the example to the right I exemplify how the principles could fit into an existing document, for instance under this headline *Life stages and transitions*. The users of documents like this are numerous, from leaders to front line workers in different professions.



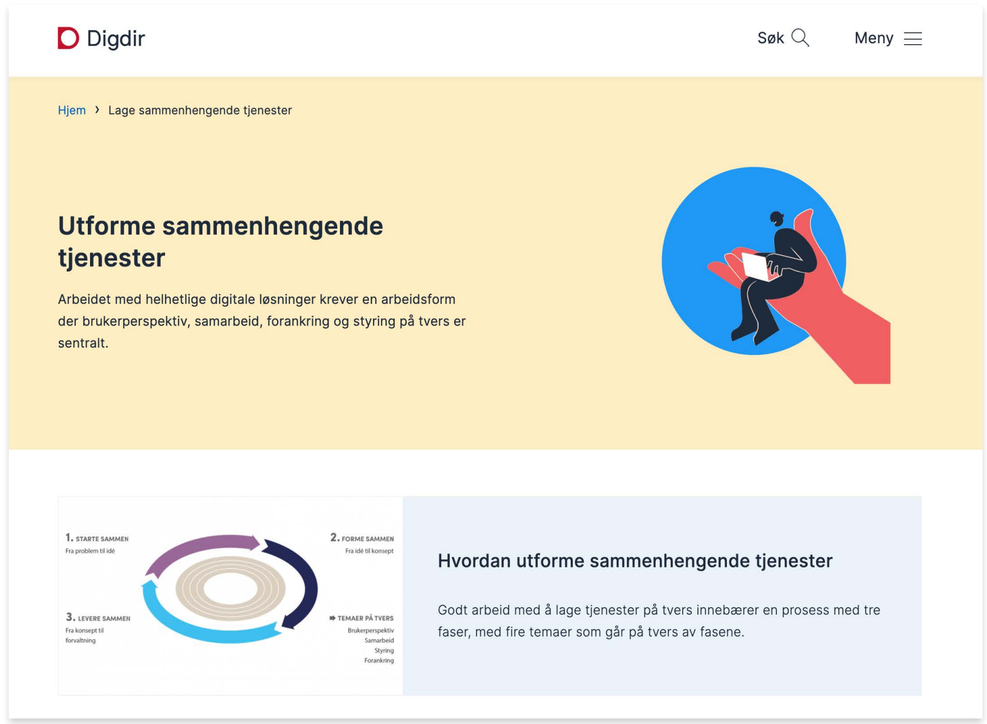


Principles for the overall transition from youth to adulthood

Another example could be the Norwegian Digitalisation Agency (Digdir), in this example to the right, within the page *Creating cohesive services*. Digdir is an overarching stakeholder, reaching a broader audience with inspiring frameworks and methods for innovation in the public sector. Another example could be The Norwegian Association of Local and Regional Authorities (KS), or The Norwegian Directorate for Education and Training (below).



Principles for the overall transition from youth to adulthood



Principles for the transition from youth to adulthood, and the numerous transfers between different services in this life stage.

C: Individually adapted information

Design intervention: This is the intervention with the lowest threshold for implementation, giving coordinators a tool for adapting preliminary information about the upcoming transition to each youth and their next of kin.

Individually adapted information / Use case / Value proposition / A tool - ready to use now / By coordinators, before 16 / Inspired by an existing solution / The iterative making / The guide / The template / The type of information / A stepping stone

Individually adapted information

A tool for coordinators to adapt information about the transition to the needs of each youth and their next of kin. The tool is a template, made in familiar formats (PowerPoint), distinctly lowering the threshold for implementation.

The next pages describe this intervention, it´s value, the intended use and process.

“You could only get like basic information about it, I think, like now you have turned 16 and so on. (...) possibly at the GP, that they can have an automatic ”now you have turned 16.”

- Young adult

Use case

A short story about the design intervention in use:

Next of kin and child oriented service have been in control between 12 to 16 years, but now the youth is partly independent, learning, participating and approaching more responsibility.

1: In an intial conversation the coordinator is looking to uncover questions, needs and wishes. How does the family imagine the transition? This could be a conversation in several parts, for instance with the youth and a trusted teacher, youth and next of kin, or youth and next of kin separately, to give the coordinator a nuanced perspective on the needs.

2: Second, the coordinator use a PowerPoint-template to adapt information according to the youths needs, transfers and relevant service offerings.

3: Lastly, the coordinator, youth and next of kin sit down for a conversation about the changes to come. What will change, what will be their responsibility and what happens on its own? The information material is a basis for the conversation, that can be done digitally or in person. The information material is also handed out digitally or on paper.

Value proposition

For the youth and next of kin, this individually adjusted information and the conversations would contribute to create a more predictabile and safe transition. It could also leave them empowered, knowing what to do when and why, and what will happen on its own.

Predictability

A predictable service offering means less stress and worry, and being assured that there are procedures in place for the upcoming changes in entering a new stage in life. Knowing someone will be taking over, for instance, can contribute to a feeling of safety - potentially even more so for the parents than the youth.

Empowerment

Empowering the family is important to create a good relation between them and their services, where there is a balance in knowledge and systems understanding. This means the family can more easily claim what they are entitled to, influence the service offering and do their part of the work.

Participation *(medvirkning)*

The process emphazise the voice of the youth, in addition to their next of kin. Creating this ”space” for the users to involve and raise their voice and opinion about the service offering is a central right that is generally hard to follow through on.

A tool - ready to use now

The tool and related information is gathered in a folder, ready for coordinators to start using.

The folder

The tool is basically a Power Point-template (with and without illustrations) supported by a guide that explains why and how to adapt the information material. An example of what the information material could look like using a municipal visual profile is also included.

Low threshold implementation

This intervention exemplifies how simply you can have impact through low hanging fruits. Using familiar formats that require no onboardning, having a short guide with steps, proposed process, tips and examples lowers the threshold to spread and make use of the solution. This can also be further developed and adapted by each coordinator.

While we are "waiting"

Evidently, the process of creating more cohesive services is slow and complicated, so why not use some of the low hanging fruits to improve the user experience in the mean time?

By coordinators, before 16

Before 16

Based on experience in Bydel Nordstrand, youth and next of kin should receive the preliminary information before 16. At this age, youth are “helserettslig myndig”, and supposed to be more involved and active in follow-up and treatment, especially in healthcare.

Should the family request information earlier, there should be no hessitance in giving it earlier.

Coordinators

The most natural role for this task is the municipal coordinator. Several of these youth have a coordinator that is supposed to have the required knowledge to navigate, understand and bring together the different services.

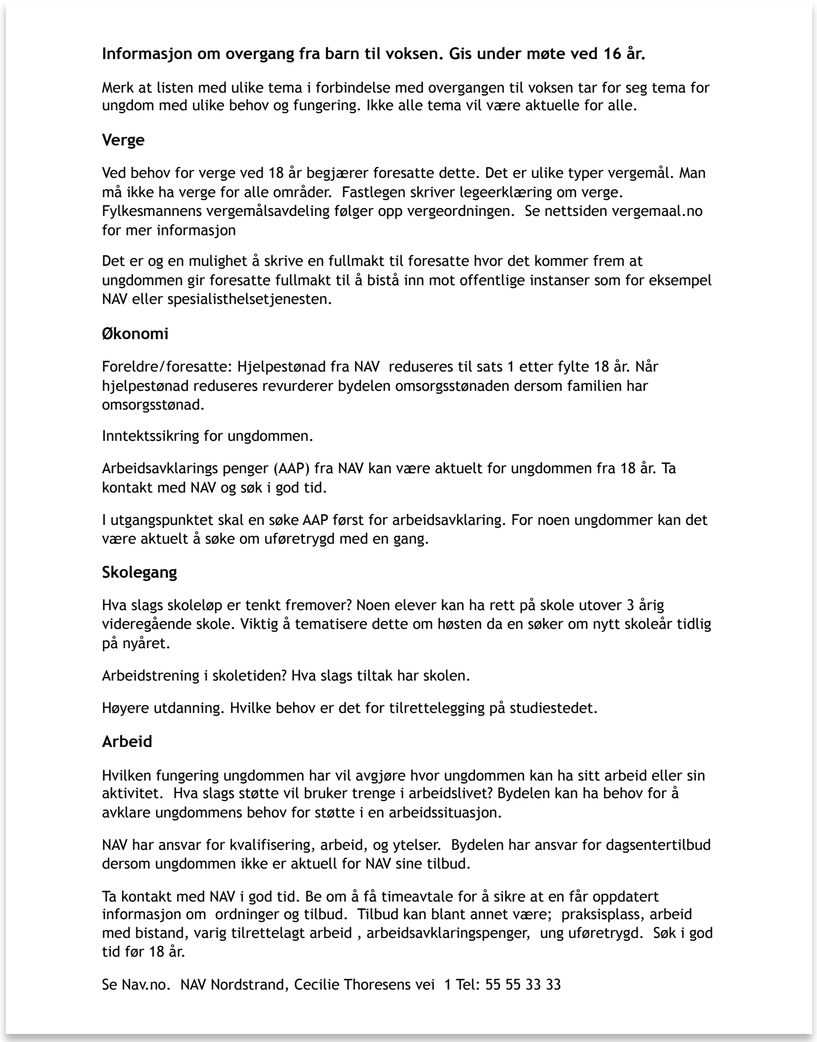
This is however just an example of the type of role that could be responsbile for the information material. If the youth do not have a coordinator, it could be someone else, like a *sosionom*.

“We need to make it work for coordinators who are not 100% coordinators. They may be the coordinator for 1 or 2 children. It’s just a function of many. ” - Coordinator, coordinating unit

Today coordinators navigate the same complexity as their users. They google a lot, and there are a number of “nieche” brochures that they can hand out. Having a tool like this would also simlify their work and potentially save them time.

Statens undersøkelseskommisjon for helse- og omsorgstjenesten, opplæringsmateriell uavklarte tilstander, 2020

Inspired by existing solution



Informasjon om overgang fra barn til voksen. Gis under møte ved 16 år.

Merk at listen med ulike tema i forbindelse med overgangen til voksen tar for seg tema for ungdom med ulike behov og fungering. Ikke alle tema vil være aktuelle for alle.

Verge

Ved behov for verge ved 18 år begjærer foresatte dette. Det er ulike typer vergemål. Man må ikke ha verge for alle områder. Fastlegen skriver legeerklæring om verge. Fylkesmannens vergemålsavdeling følger opp vergeordningen. Se nettsiden vergemaal.no for mer informasjon

Det er og en mulighet å skrive en fullmakt til foresatte hvor det kommer frem at ungdommen gir foresatte fullmakt til å bistå inn mot offentlige instanser som for eksempel NAV eller spesialisthelsetjenesten.

Økonomi

Foreldre/foresatte: Hjelpestønad fra NAV reduseres til sats 1 etter fylte 18 år. Når hjelpestønad reduseres revurderer bydelen omsorgsstønaden dersom familien har omsorgsstønad.

Inntektssikring for ungdommen.

Arbeidsavklarings penger (AAP) fra NAV kan være aktuelt for ungdommen fra 18 år. Ta kontakt med NAV og søk i god tid.

I utgangspunktet skal en søke AAP først for arbeidsavklaring. For noen ungdommer kan det være aktuelt å søke om uføretrygd med en gang.

Skolegang

Hva slags skoleløp er tenkt fremover? Noen elever kan ha rett på skole utover 3 årig videregående skole. Viktig å tematisere dette om høsten da en søker om nytt skoleår tidlig på nyåret.

Arbeidstrening i skoletiden? Hva slags tiltak har skolen.

Høyere utdanning. Hvilke behov er det for tilrettelegging på studiestedet.

Arbeid

Hvilken fungering ungdommen har vil avgjøre hvor ungdommen kan ha sitt arbeid eller sin aktivitet. Hva slags støtte vil bruker trenge i arbeidslivet? Bydelen kan ha behov for å avklare ungdommens behov for støtte i en arbeidssituasjon.

NAV har ansvar for kvalifisering, arbeid, og ytelser. Bydelen har ansvar for dagsentertilbud dersom ungdommen ikke er aktuell for NAV sine tilbud.

Ta kontakt med NAV i god tid. Be om å få timeavtale for å sikre at en får oppdatert informasjon om ordninger og tilbud. Tilbud kan blant annet være; praksisplass, arbeid med bistand, varig tilrettelagt arbeid , arbeidsavklaringspenger, ung uføretrygd. Søk i god tid før 18 år.

Se Nav.no. NAV Nordstrand, Cecilie Thoresens vei 1 Tel: 55 55 33 33

The process and template is inspired by an existing information letter given at 16 in Bydel Nordstand. Every youth with a coordinator and several services involved receive this. It is the same for everyone, with no individual adjustments - for instance, not everyone needs a care home or a guardian (verge). There is also a lot of potential in the language and tone of voice, as it is not directed towards the user. I mentioned this information sheet when interviewing experts in other municipalities, and they were very interested and asked me to send it to them. So I thought, why not improve something that already exist?

Fysioterapi gis etter 18 år hovedsakelig ved privat institutt. Fastlegen skriver henvisning. Bydelen har ergoterapeuter som bistår ift hjelpemidler og tilpasninger.

Individuell plan og koordinator

Ved overgang til 18 år kan det være at behov er endret og dermed at tjenestene endres. Søk om fortsatt individuell plan (IP) ved behov, 16 uker før. En har rett til IP og koordinator når en har 2 eller flere kommunale helse- og omsorgstjenester og behovet er langvarige og koordinerte tjenester. Søknad sendes til Avdeling Oppvekst, Team habilitering barn og unge.

Bydel Nordstrand har råd og veiledningsplikt og kan stille på møter ved behov, selv om en bruker ikke har individuell plan og koordinator.

Har en bruker ikke koordinator kan det under planlegging av overgang til voksen være aktuelt at det er skolen som kaller inn aktuelle rundt brukeren til et møte. Dette møtet kalles tverrfaglige møte.

Utredning

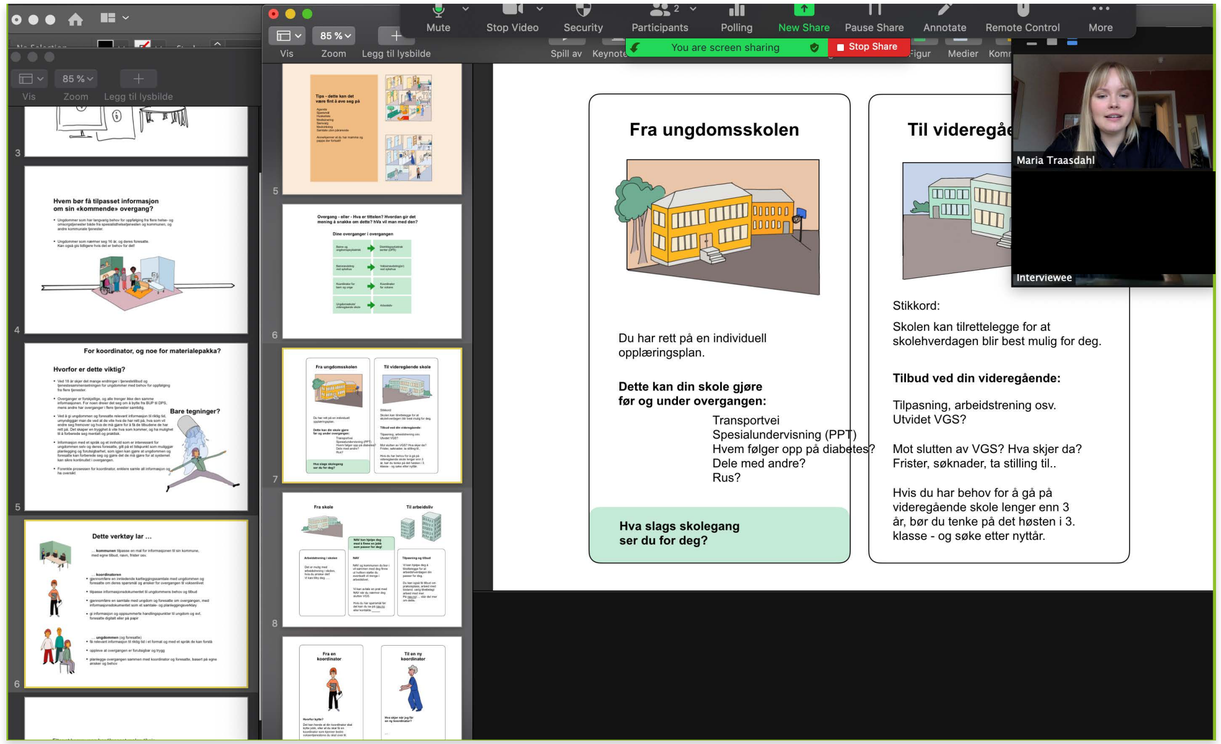
Utredning ved Avdeling for nevrohabilitering kan være aktuelt for å sikre voksenperspektivet for ungdommen fremover. Fastlegen henviser. Har ungdommen oppfølging fra barnehabiliteringen henviser de i noen tilfeller til utredning. Barnehabiliteringen pleier å innkalle til informasjonsmøte i forbindelse med overgang til voksen.

The iterative making

Making the tool has been a co-creative process. Talking to three coordinators, I tested the information material at different stages of the process, from low to high fidelity, from concept to detailed written content.

I would have loved to test this on end users, but chose to concentrate the testing to coordinators, since they are the users of the tool, emplying their knowledge to adapt it to each individual´s needs.

The finished folder is now sent to five coordinators in both the Oslo and Agder area. The goal is for those who received this to test it in context and with their users, take ownership of the template and make the process their own.



"I would have liked to have tested this with real families."

- Vernepleier, municipality

"It has already started a process here, and increased the awareness!"

- Occupational therapist/coordinator, municipality

The guide

Explaining this step by step, I made a guide for the coordinator. This is mainly an introduction and suggested procedures, and it makes it easier for spreading the tool. Keeping both the process and guide short, simple and to the point has been key to lower the threshold for onboarding and start using it use. These are some of the key parts of the guide:


Mellom ung og voksen

Verktøy for individuell tilpasning av informasjon om overgangen fra ung til voksen

Verktøy utviklet som en del av en masteroppgave av Maria Traasdahl Arkitektur- og designhøgskolen i Oslo, 2021


Hvorfor er overganger viktige?

Ved 18 år skjer det mange endringer i tjenestetilbud og tjenesteansvarsområdet for ungdommer med behov for oppfølging fra flere tjenester.

Veien mot voksenliv og selvstendighet oppleves ulikt for alle ungdommer, men er ekstra kompleks og krevende for de som har oppfølging fra flere tjenester gjennom overgangen. Kombinasjon og intensivitet av tjenestetilbud og byttene fra tjenester for barn og unge til tjenester for voksne er forskjellige for hvert individ, og vil oppleves ulikt avhengig av blant annet deres livssituasjon, nettverk, helse og modenhet.

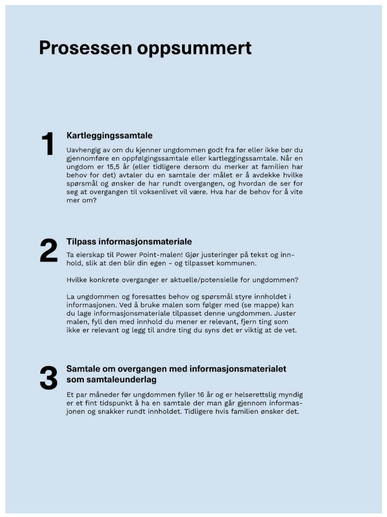
For å forhindre at overgangen kommer brått og snur ting på hodet i en ellers sårbar periode i livet, er det first å snakke om overgangen i god tid. Da kan overgangen oppleves mer forutsigbar, og ved å gi ungdommen og foresatte relevant informasjon til riktig tid, myndiggjør man dem ved at de vet hva de har rett på, hva som vil endre seg fremover og hva de må gjøre for å få de tilbudene de har rett på. Det skaper en trygghet å vite hva som kommer, og ha mulighet til å forberede seg mentalt og praktisk.

Alle ungdom vil derfor ikke trenger den samme informasjonen om overgangen, men en samtale tilpasset deres situasjon og behov. For noen dreier det seg om å bytte fra BUP til DPS, mens andre har overganger i flere tjenester samtidig.

Det er viktig at informasjonen gis med et språk og et innhold som er forståelig og relevant for ungdommen selv og deres foresatte, og gis på et tidspunkt som muliggjør planlegging og forutsigbarhet. Da kan de enklere forberede seg og gjøre det de må gjøre for at systemet kan sikre kontinuitet i overgangen.

"Hvis overgangen ikke er en prosess, men bare skjer. Jeg tror det kan føre til "vann over hodet", eller dot å ikke føle seg trygg. Kanskje takler man sykdommen dårligere i den perioden fordi ting endrer seg i helsevesenet."
– ung voksen som har vært gjennom overgangen

See the full version attached.


Prosessen oppsummert

1 Kartleggingssamtale

Uavhengig av om du kjenner ungdommen godt fra før eller ikke bør du gjennomføre en oppfølgingssamtale eller kartleggingssamtale. Når en ungdom er 15,5 år (eller tidligere dersom du merker at familien har behov for det) avtaler du en samtale der målet er å avdekke hvilke spørsmål og ønsker de har rundt overgangen, og hvordan de ser for seg at overgangen til voksenlivet vil være. Hva har de behov for å vite mer om?

2 Tilpass informasjonsmateriale

Ta eierskap til Power Point-malen! Gjør justeringer på tekst og innhold, slik at den blir din egen – og tilpasset kommunen.

Hvilke konkrete overganger er aktuelle/potensielle for ungdommen?

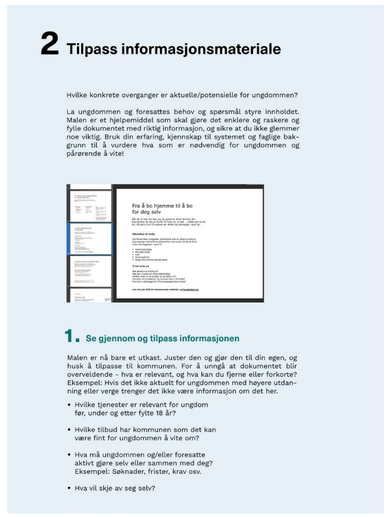
La ungdommen og foresattes behov og spørsmål styre innholdet i informasjonen. Ved å bruke malen som følger med (se mappe) kan du lage informasjonsmateriale tilpasset denne ungdommen. Juster malen, fyll den med innhold du mener er relevant, fjern ting som ikke er relevant og legg til andre ting du syns det er viktig at de vet.

3 Samtale om overgangen med informasjonsmaterialet som samtaleunderlag

Et par måneder før ungdommen fyller 16 år og er helserettslig myndig er et first tidspunkt å ha en samtale der man går gjennom informasjonen og snakker rundt innholdet. Tidligere hvis familien ønsker det.

The process

A summary of the process, consisting of three main steps.


2 Tilpass informasjonsmateriale

Hvilke konkrete overganger er aktuelle/potensielle for ungdommen?

La ungdommen og foresattes behov og spørsmål styre innholdet. Malen er et hjelpemiddel som skal gjøre det enklere og raskere og fylle dokumentet med riktig informasjon, og sikre at du ikke glemmer noe viktig. Bruk din erfaring, kjennskap til systemet og faglige bakgrunn til å vurdere hva som er nødvendig for ungdommen og pårørende å vite!

Fra å bo hjemme til å bo for deg selv

1. Se gjennom og tilpass informasjonen

Malen er nå bare et utkast. Juster den og gjør den til din egen, og husk å tilpasse til kommunen. For å unngå at dokumentet blir overveldende – hva er relevant, og hva kan du fjerne eller forkorte? Eksempel: Hvis det ikke aktuelt for ungdommen med høyere utdanning eller verge trenger det ikke være informasjon om det her.

- Hvilke tjenester er relevant for ungdom før, under og etter fylte 18 år?
- Hvilke tilbud har kommunen som det kan være first for ungdommen å vite om?
- Hva må ungdommen og/eller foresatte aktivt gjøre selv eller sammen med deg? Eksempel: Søknader, frister, krav osv.
- Hva vil skje av seg selv?

The adjustments

A step by step guide to adjusting the template and what considerations to take when doing it.


3. Retningslinjer for språk

Når du nå skal skrive til ungdommen som hovedmottaker, er det viktig å være bevisst på språket du bruker. Selv om foresatte også er mottaker, bør du rette deg mot ungdommen. Tenk på hvordan du bygger opp setningene. Ha gjerne et muntlig språk som er lett å forstå.

Mange ord og uttrykk du er vant til å bruke og forstår godt kan være ukjente for ungdom, og dette kan være et first tidspunkt for de å lære. Pass derfor på at du forklarer hva begreper betyr.

Språket bør vekke tillit og skape trygghet, og defor være profesjonelt men også vise empati.

Huskeliste

- Skriv direkte til brukeren – skriv du, dere og vi
- Unngå forkortelser
- Ikke bruk metaforer
- Bruk et aktivt og konkret språk
- Skriv hele setninger
- Bruk korte punktlister med hele setninger
- Velg ord som mottakeren forstår, og forklar faguttrykk
- Spør deg selv: Hvordan ville jeg sagt dette muntlig? Poenget er ikke å skrive akkurat som vi snakker, men å sørge for at teksten er forståelig
- Kort er ofte godt. Korte og presise tekster øker sjansen for at alle leserne får med seg poenget

Kilder: NAV Designmanual og Oslo kommunes språkprofil.

The language

Language guidelines adapted from NAV Desing system and Oslo municipal language profile.


3 Samtale om overgangen med informasjonsmaterialet som samtaleunderlag

Et par måneder før ungdommen fyller 16 år og er helserettslig myndig er et first tidspunkt å ha en samtale der man går gjennom informasjonen og snakker rundt innholdet.

1. Bruk informasjonsmaterialet som samtaleunderlag

Ved å åpne filen på storskjerm,delt skjerm eller printe det ut eller har dere en agenda for møtet, og en huskeliste for ting å snakke om.

2. Spørsmål det kan være fint å stille under samtalen

- Hva syns du virker utfordrende?
- Hva er viktig for deg?
- Hva trenger du?
- Hva trenger du hjelp til?
- Hvem kan hjelpe deg med hva?

Husk å gi ungdom og pårørende informasjonsmateriale i etterkant av møtet, slik at de kan se på det selv.

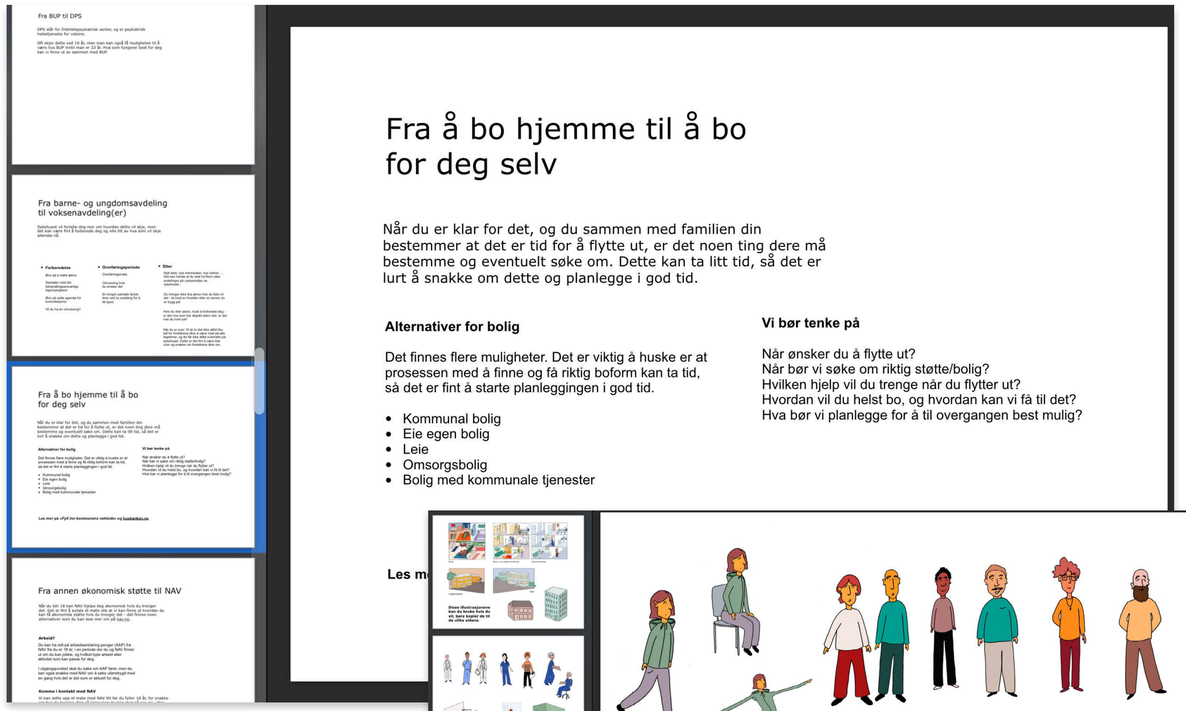
The conversation

Suggested questions to ask during the conversation, using the information material as a basis for the meeting.

A flexible template

The template is more of a framework than a ”complete” template. It is a draft, outlining suggested content based on my limited knowledge of the different types of information that could go into such a document. This gives the coordinators the chance to fill the framework with content based on experience and knowing their user, making it their own and feeling ownership.

It is important to point out the value of asking the users what they want to know and need, before shaping the adjusted version of the information material. To my knowledge this is rare, due to the general standardisation of information, and could provide more relevant information.



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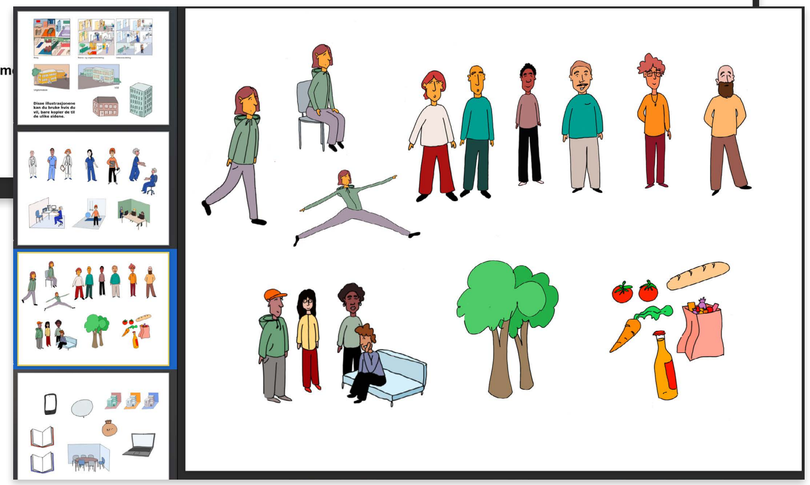
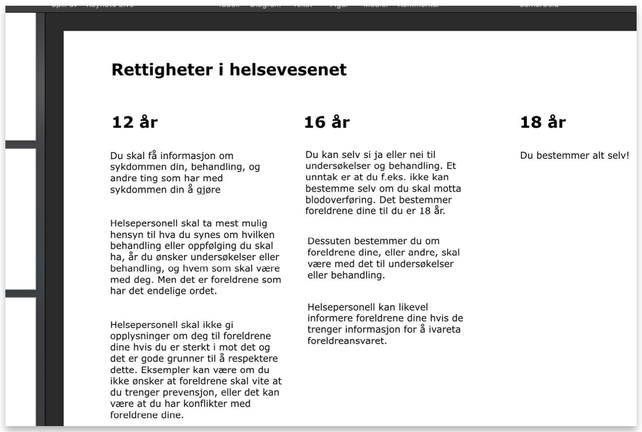
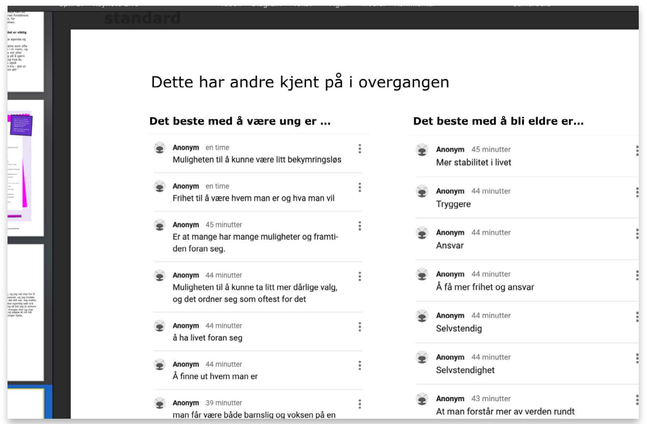


This is the illustrations library in the bottom, that can be used if the municipality does not have its own visual profile.

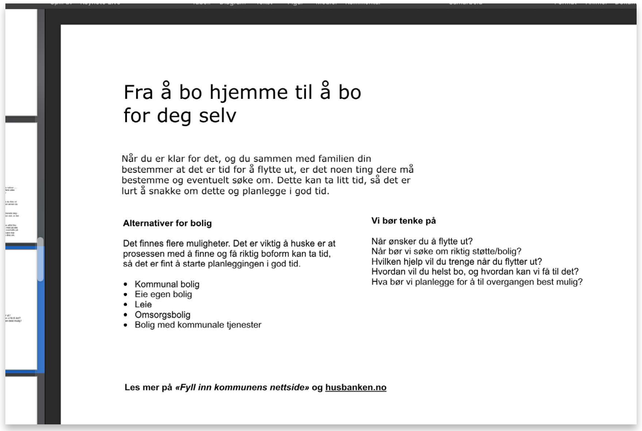
The suggested information



Introduction and rights



What other youths have said about the transition from youth to young adult

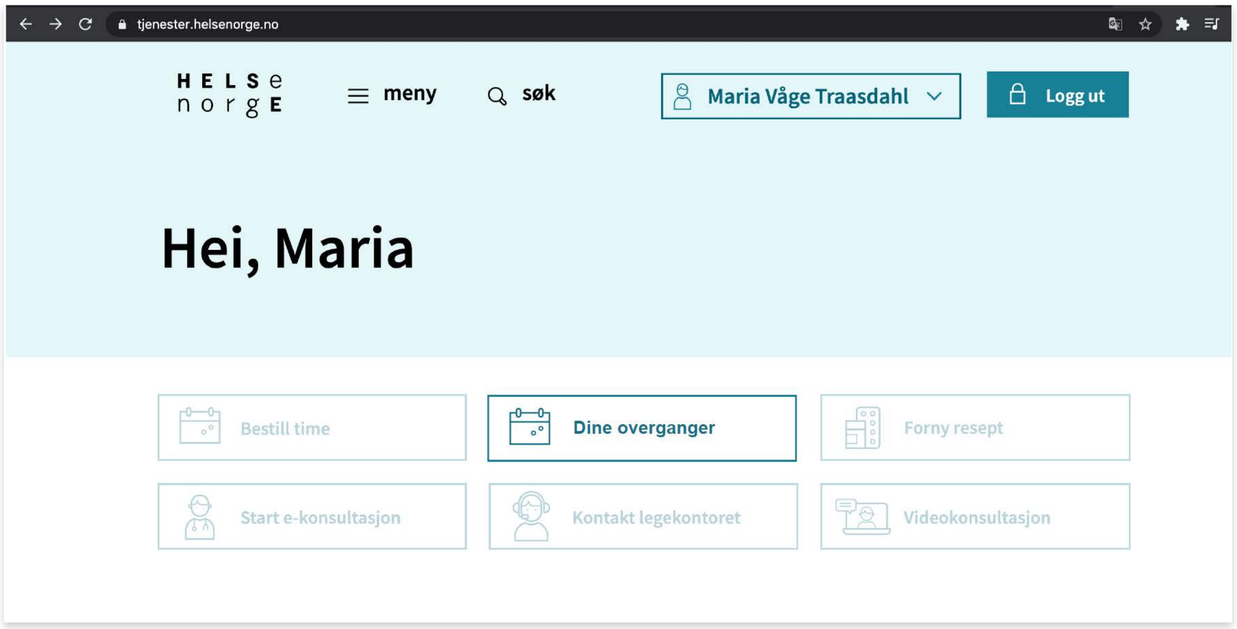


The specific, potential transfers within the transition for this youth

Frameworks for planning or summarizing, to be done in the end of the conversation

A stepping stone

The content and process of this tool can be further developed and expanded. The content exemplifies relevant information, even if the format and tool can be further developed and digitalized. Hopefully this can be a stepping stone into further digital development. It could perhaps integrate into already existing platforms or future stuff, like helsenorge.no, that seem to be growing recently.



Screenshot of helsenorge.no modified to exemplify a potential future feature.

D: The dialogue

Design intervention: Cards as a starting point for dialogue between services on the different sides, triggering reflection, awareness, and potential new structures of collaboration - shifting towards a transition focus, rather than transfer focus.

Stimulating dialogue / The cards / The ideal conversation: From transfer focused to transition focused / Learning from ”the golden standards” / Testing the conversation / The puzzle pieces could become a produce / Digital co-creation / Reflections

Stimulating dialogue

This intervention is a deck of cards intended to spark dialogue between services at each side of a transfer. A potential starting point for reflection, new approaches and establishment of new collaborative structures before, during and after the transfer.

"Today it's just a referral. Sometimes a joint session with the former therapist." - Psychologist, DPS

Reflecting on the gap

Bridging the sides is key to improve the experience of the overall transition. Lets say a service, child and youth psychiatry (BUP), have acknowledged that they struggle in transferring their young adults to adult psychiatry (DPS). Agreeing there is a gap between them, they now want to discuss the transition in detail to explore why this gap is what it is and what it would take to bridge it. This is when the cards are relevant. The prompts for discussion are generalised to be relevant for (almost) any transition between two public services.

This design intervention could contribute to bridge today´s practice with the new practice through reflections on differences, raised awareness and new views on the process and how it can be done.

The cards

These are conversation starters focused on different issues that require discussion and new procedures to mature. The cards highlight the individual leverage points, and together they represent a relatively holistic set of possibilities. These cards could be used both digitally and physically, as conversation pieces or puzzle pieces of a procedure.

The first card (on the right) is an introduction, followed by an overview of the suggested stages; before, during and after the formal transfer. These are given different colors.

In the bottom part of each card there is a “why”-section. This is a response to the finding regarding lack of a common understanding of the reasons to prioritize transitions - like a coordinator said: *”I do not think we will get anywhere until we know why we are doing this."* This reasoning could help professionals see the value of paying more attention to the user needs in different parts of the transition, or discuss it further if the disagree.

Examples of the in total 20 cards. See them attached.

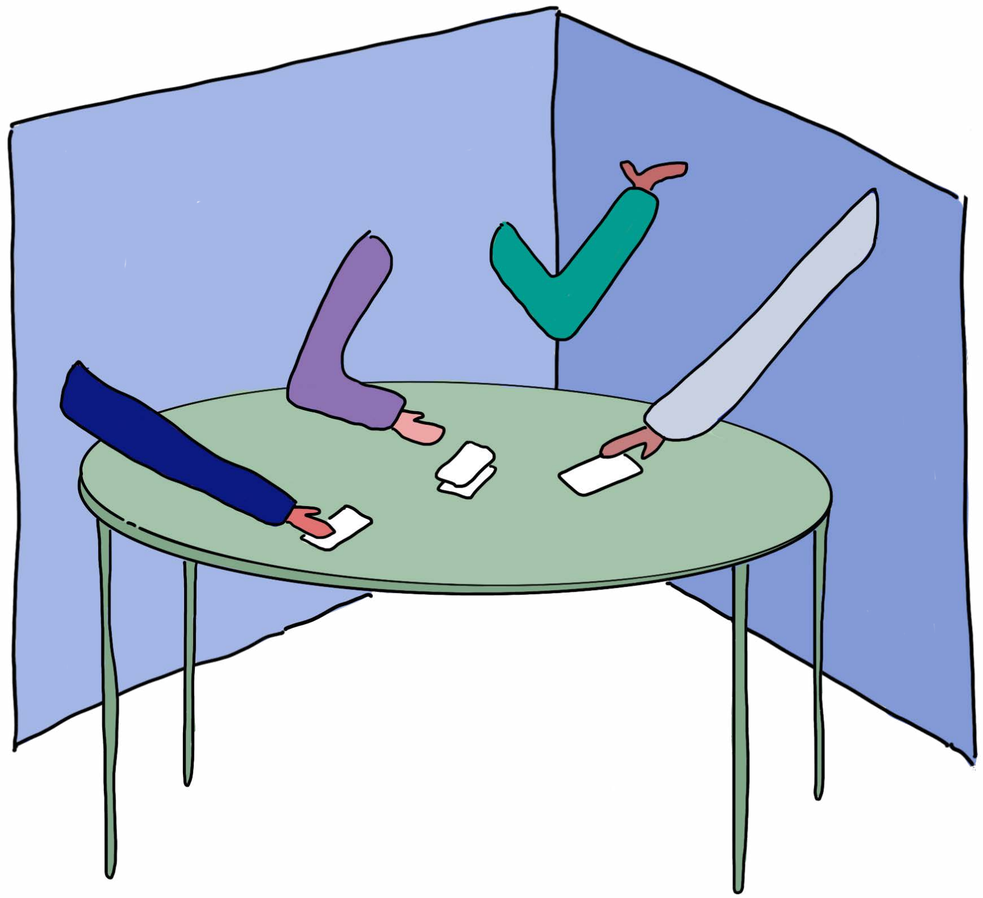
The ideal conversations: From transfer focused to transition focused

The cards are intended to stimulate conversations about differences, mindsets, user experience and potential processes.

In a dream scenario, the services and roles on opposite sides of the transfer would get together and have sessions of discussion and reflection, sharing and listening to each other´s perspectives on the transfer.

Ideally, the conversations would stimulate reflections that are generally not prioritized across professional silos. A deeper understanding of "the other side" could broaden the perspective of the transfer, and shift the focus towards the longer, fragile transition and the user experience in this period that stretches from one serive to another.

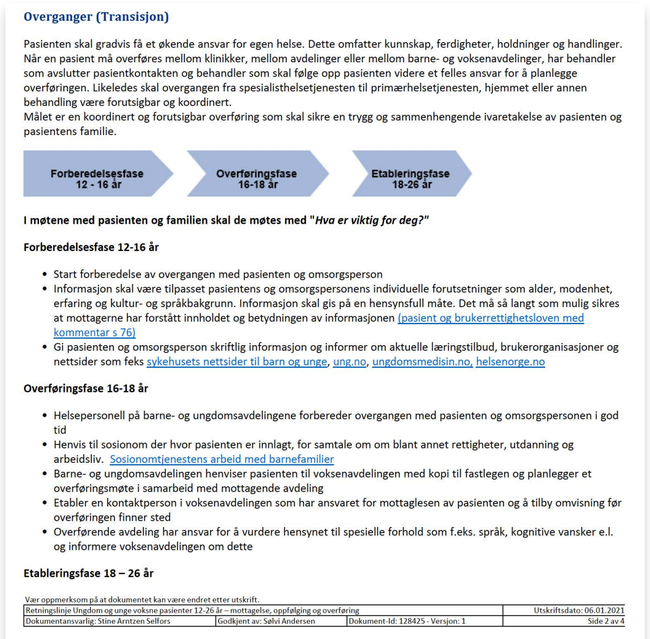
The dialogue could create less "competition" or disclaiming responsibility, and knowing what ”the other part” expects, wish for, contribute to or see potential in. What are the differences between them and where could they go the extra mile, even though it benefits the other service more?



Learning from ”the golden standards”

This concept was an opportunity to use and summarize the learning from researching existing solutions and practice. I based the cards on healthcare-focused guidelines, or “golden standards”. These references inspired the content of the dialogue prompts.

The two examples below are both developed in close collaboration with youth counsils at the two hospitals, which strengthens the viability and credibility of the recommendations.



Overganger (Transisjon)

Pasienten skal gradvis få et økende ansvar for egen helse. Dette omfatter kunnskap, ferdigheter, holdninger og handlinger. Når en pasient må overføres mellom klinikker, mellom avdelinger eller mellom barne- og voksenavdelinger, har behandler som avslutter pasientkontakten og behandler som skal følge opp pasienten videre et felles ansvar for å planlegge overføringen. Likeledes skal overgangen fra spesialisthelsetjenesten til primærhelsetjenesten, hjemmet eller annen behandling være forutsigbar og koordinert.
Målet er en koordinert og forutsigbar overføring som skal sikre en trygg og sammenhengende ivaretakelse av pasienten og pasientens familie.

Forberedelsesfase 12 - 16 år → Overføringsfase 16-18 år → Etableringsfase 18-26 år

I møtene med pasienten og familien skal de møtes med "*Hva er viktig for deg?*"

Forberedelsesfase 12-16 år

- Start forberedelse av overgangen med pasienten og omsorgsperson
- Informasjon skal være tilpasset pasientens og omsorgspersonens individuelle forutsetninger som alder, modenhet, erfaring og kultur- og språkbakgrunn. Informasjon skal gis på en hensynsfull måte. Det må så langt som mulig sikres at mottagerne har forstått innholdet og betydningen av informasjonen (pasient og brukerrettighetsloven med kommentar s 76)
- Gi pasienten og omsorgsperson skriftlig informasjon og informer om aktuelle læringstilbud, brukerorganisasjoner og nettsider som feks sykehusets nettsider til barn og unge, ung.no, ungdomsmedisin.no, helsenorge.no

Overføringsfase 16-18 år

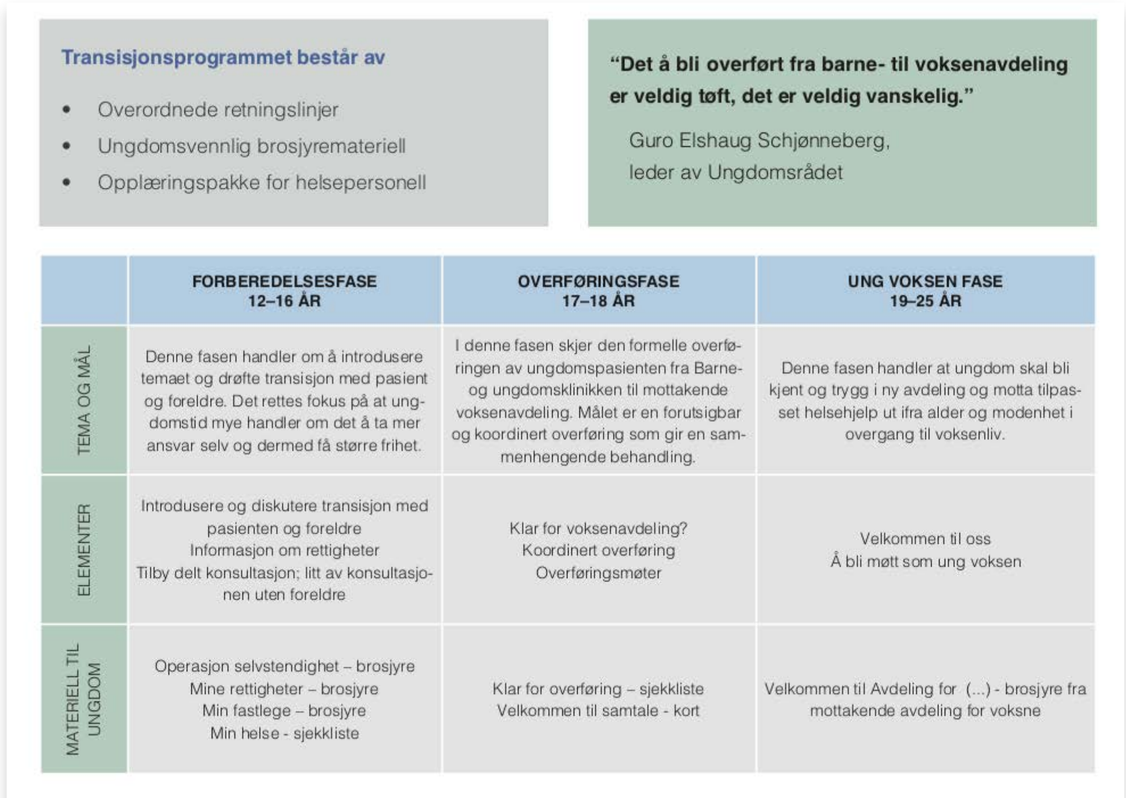
- Helsepersonell på barne- og ungdomsavdelingene forbereder overgangen med pasienten og omsorgspersonen i god tid
- Henvis til sosionom der hvor pasienten er innlagt, for samtale om om blant annet rettigheter, utdanning og arbeidsliv. Sosionomtjenestens arbeid med barnefamilier
- Barne- og ungdomsavdelingen henviser pasienten til voksenavdelingen med kopi til fastlegen og planlegger et overføringsmøte i samarbeid med mottagende avdeling
- Etabler en kontaktperson i voksenavdelingen som har ansvaret for mottaglesen av pasienten og å tilby omvisning før overføringen finner sted
- Overførende avdeling har ansvar for å vurdere hensynet til spesielle forhold som f.eks. språk, kognitive vansker e.l. og informere voksenavdelingen om dette

Etableringsfase 18 – 26 år

Vær oppmerksom på at dokumentet kan være endret etter utskrift.

Retningslinje Ungdom og unge voksne pasienter 12-26 år – mottagelse, oppfølging og overføring			Utskriftsdato: 06.01.2021
Dokumentansvarlig: Stine Arntzen Selfors	Godkjent av: Sølvi Andersen	Dokument-Id: 128425 - Versjon: 1	Side 2 av 4

Guidelines for the transition by Oslo University Hospital



Transisjonsprogrammet består av

- Overordnede retningslinjer
- Ungdomsvennlig brosjyremateriell
- Opplæringspakke for helsepersonell

“Det å bli overført fra barne- til voksenavdeling er veldig tøft, det er veldig vanskelig.”

Guro Elshaug Schjønneberg,
leder av Ungdomsrådet

	FORBEREDELSESFASE 12–16 ÅR	OVERFØRINGSFASE 17–18 ÅR	UNG VOKSEN FASE 19–25 ÅR
TEMA OG MÅL	Denne fasen handler om å introdusere temaet og drøfte transisjon med pasient og foreldre. Det rettes fokus på at ungdomstid mye handler om det å ta mer ansvar selv og dermed få større frihet.	I denne fasen skjer den formelle overføringen av ungdomspasienten fra Barne- og ungdomsklinikken til mottakende voksenavdeling. Målet er en forutsigbar og koordinert overføring som gir en sammenhengende behandling.	Denne fasen handler at ungdom skal bli kjent og trygg i ny avdeling og motta tilpasset helsehjelp ut ifra alder og modenhet i overgang til voksenliv.
ELEMENTER	Introdusere og diskutere transisjon med pasienten og foreldre Informasjon om rettigheter Tilby delt konsultasjon; litt av konsultasjonen uten foreldre	Klar for voksenavdeling? Koordinert overføring Overføringsmøter	Velkommen til oss Å bli møtt som ung voksen
MATERIELL TIL UNGDOM	Operasjon selvstendighet – brosjyre Mine rettigheter – brosjyre Min fastlege – brosjyre Min helse - sjekkliste	Klar for overføring – sjekkliste Velkommen til samtale - kort	Velkommen til Avdeling for (...) - brosjyre fra mottakende avdeling for voksne

Transition program by AHUS (ungdomsmedisin.no)

Testing the conversation

The 'final form' of the intervention emerged thanks to a testing session. The participants were a psychologist at the child side (BUP) and a psychologist at the adult side (DPS).

We had a digital session, where I explained the overall concept and discussion points, and they were asked to discuss them and co-make an ideal process using a digital work sheet (to the right). The conversation turned into an in depth reflection between them. *"We do not talk that much about what the transistion is like, and we are a bit bad at assessing what it is like,"* the psychologist on the child side said, and the other replied with saying *"These are questions that needs discussion, and it sheds light on some issues. We can dicuss it, and that in itself is valuable to be able to change it."*

The test validated the proposal, but they were also questioning the making of an ideal procedure based on these leverage points, given the frames of the system today.

Sett et tydelig startpunkt for fasen

Hvor lenge før den formelle overføringen bør forberedelsene starte? (Eksempel: Minst 6 mnd. før overføringen)	Tematisere overføring 4-5 mnd før tenkt avslutning ved BUP.

Identifisering av ungdom

Hvem har ansvaret for å identifisere de som står overfor en overgang? (Eksempel: Behandler, sekretær, avdelingsleder)	Behandler i samtale med kollegagrupper

Oppstart

Hvordan skal oppstart og introduksjon til forløpet foregå? (Eksempel: Samtale, informasjonsskriv eller lignende)	Foreligge henvisning, og gjort en vurdering om at pasienten har rett til helsehjelp i spesialisthelsetjenesten. Samtykke fra pasient om at vi kan kommunisere må foreligge. Ødeleggende at tidligere behandling fortsatt fungerer som behandler etter overføring. Samhandling bør skje ved nytt behandlingssted, ny behandling tar ansvar, og tidligere behandling fungerer mest som en støtte. Ugunstig med parallelle løp.
Hvilken overordnet informasjon bør ungdom og pårørende få om overgangen?	Vurdere mengden... Det handler ikke bare om å bytte tjenester, men å tre inn i en voksen verden.

Opprett kontakt med mottakende tjeneste

Hvilke rolle(r) i mottakende tjeneste bør det opprettes kontakt med? (Eksempel: Leder, behandler, kontaktperson, sekretær)	Ny behandler

Koordinering med andre tjenester

Hvis andre overføringer foregår parallelt, hvordan bør eventuelt koordinering foregå? Eller andre tjenester man bør være i kontakt med.. (Eksempel: ...)	Fastlege Barnevern

The particpants were asked to summarize their answers while discussing each point.

These are some of their reflections:

“A smooth transition can contribute to a cultural change because the transition may be a bit cunstructed. It is sometimes tough when I think of those who are going over to DPS, because the frames are narrower there and the patient must be able to make changes themselves. If you are not there, we will end the treatment.“

- Psychologist, BUP

“I can imagine that it (joint session with old and new psychologist) is very popular for BUP psychologists and very unpopular for DPS psychologists. We get to come with and make it safe, because it can feel quite brutal to just send them out into adulthood.”

- Psychologist, BUP

”I do hear of people who follow them to the first session at DPS, it happens, but maybe as a psychologist in DPS you might be more overwhelmed by it - that you feel that you are taking over another psycologist´s project - and that it can be a clinch between BUP and DPS. ”

- Psychologist, BUP

”Yes, feeling that now the previous treatment will set guidelines for how I should do the treatment...” - Psychologist, DPS

”It says that you should cooperate with next of kin, but no one does. It is more gathering information than collaborating.”

- Psychologist, DPS

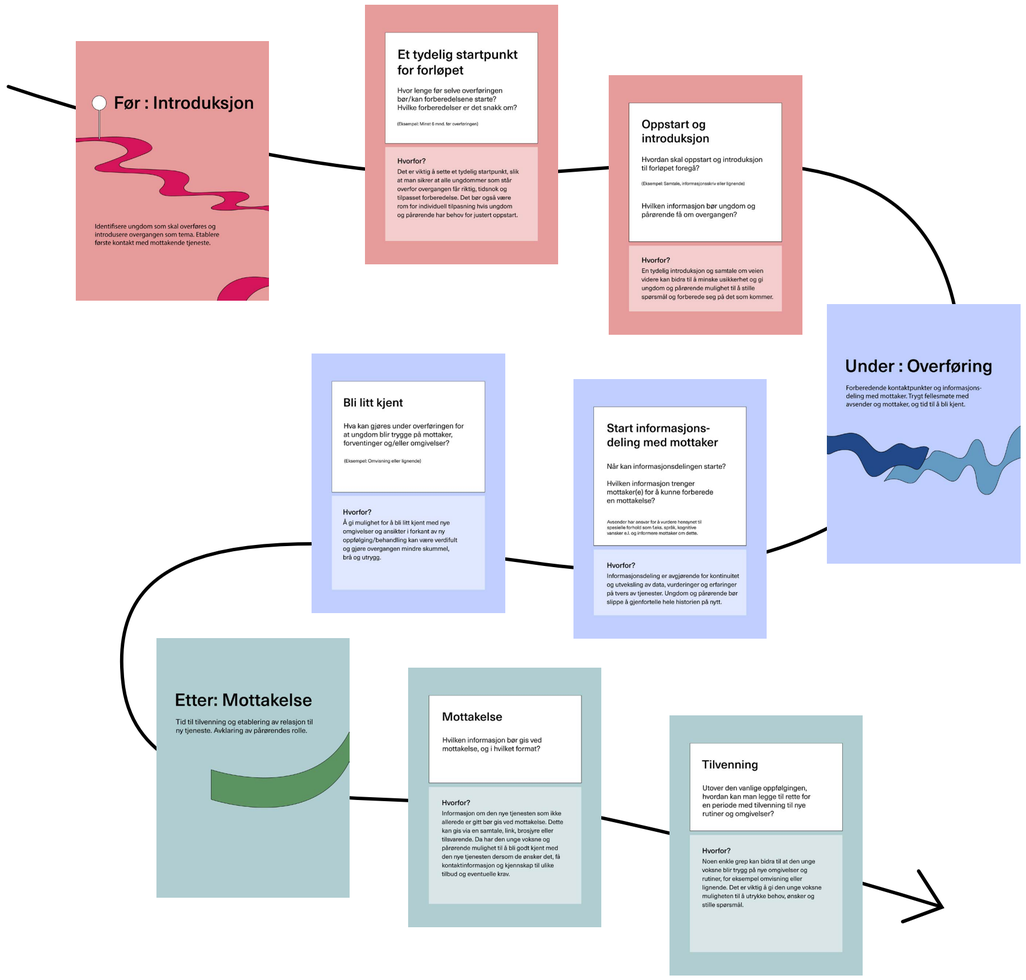
“I also think it’s about who ends up working with adults and who works with children. Some are concerned with accountability (...). And those who are young fall a bit between right there - those who are not quite there, that they are not completely responsible yet.”

- Psychologist, DPS

From puzzle pieces to process

In the long run, I imagine that conversations like this could spark new initatives and turn into new ways of seeing and doing transfers.

Imagine that a cross-service work group is established and use the cards to start the process of defining new routines for the transfer. They could sit down together and dig into the practicalities of the process, from beginning to “end”, using the cards/leverage points as promts and to lay out the steps of the process. This would be followed up by a period of testing and implementation. Ideally, various roles within each service are involved.



Digital co-creation

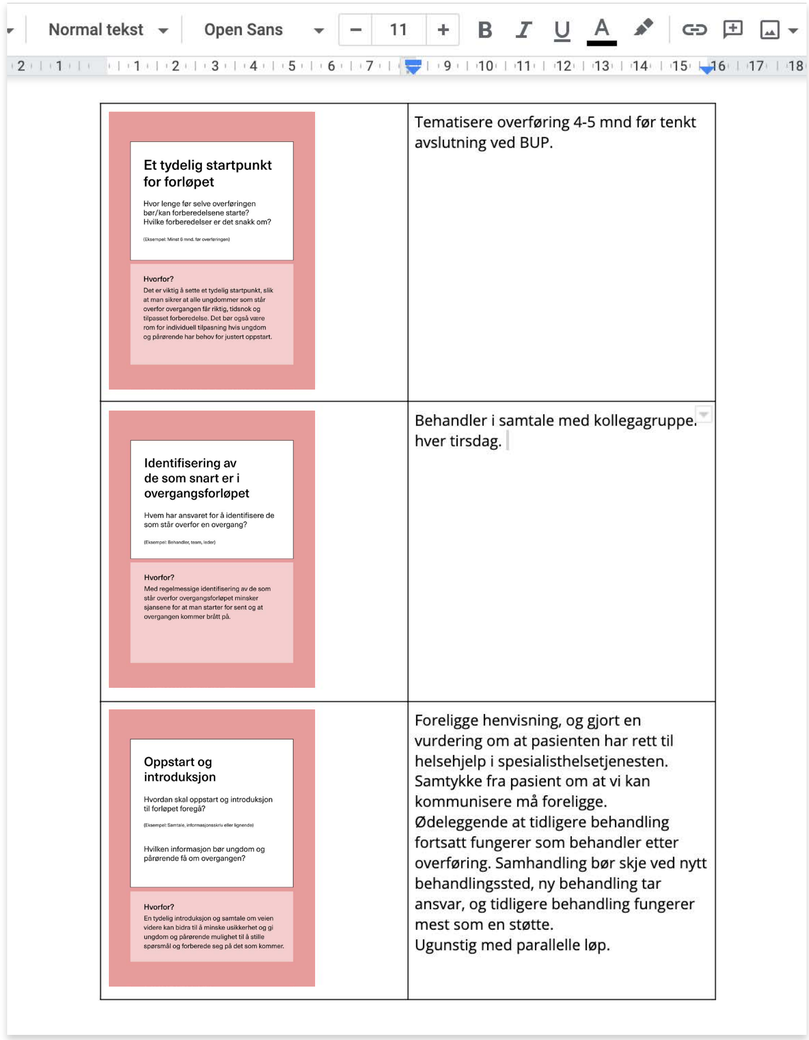
This is an example of what I imagine a co-creation work sheet to look like, using the cards as a framework for co-creating and documenting procedures/routines. Ideally this would be a digital, living document, that several people could co-create at the same time.

The familiar

I chose to exemplified the use this way because the format is familiar to the services. This can lower the threshold for use, and simplify the process of simultaneously creating the procedure - even across services and distances.

The formal

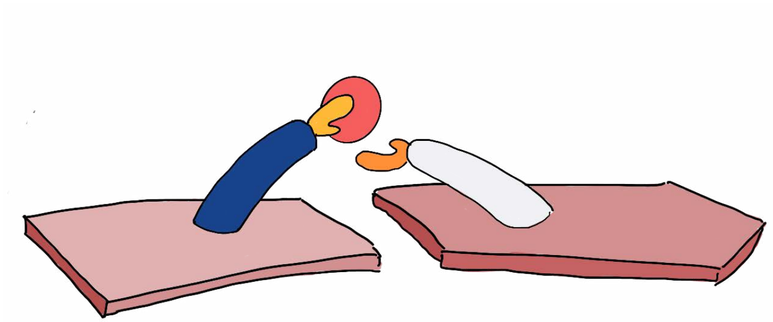
A typical document like this also brings with it a level of formality that can help raise the credibility and trust towards the content and purpose.



Reflections

“It (the conversation) can be a good start, even if the framework is not realistic with the framework you have today. It will be a pilot, bring out where the challenges lie, what do we need to clarify, the law...”

- Psychologist DPS



I believe this intervention has more to it than I have been able to portray and detail. To extract value beyond the conversations and reflections, this could benefit from being developed further by someone with the resources, competence and incentives to bring it to the next levels.

Testing the transition focus, I saw that there are interesting tentions between user needs and professional procedures. It is safe to say that this is bigger than converastions and will to change. There is clearly a distance between today´s system and a system that facilitates for these seamless transfers. Still, I believe the value of having services be more aware of each other, willing to share benefits and take part in a collaborative process is key to reach the vision of a seamless transition. You have to start somewhere.

6: The long term, systemic change

Chapter six

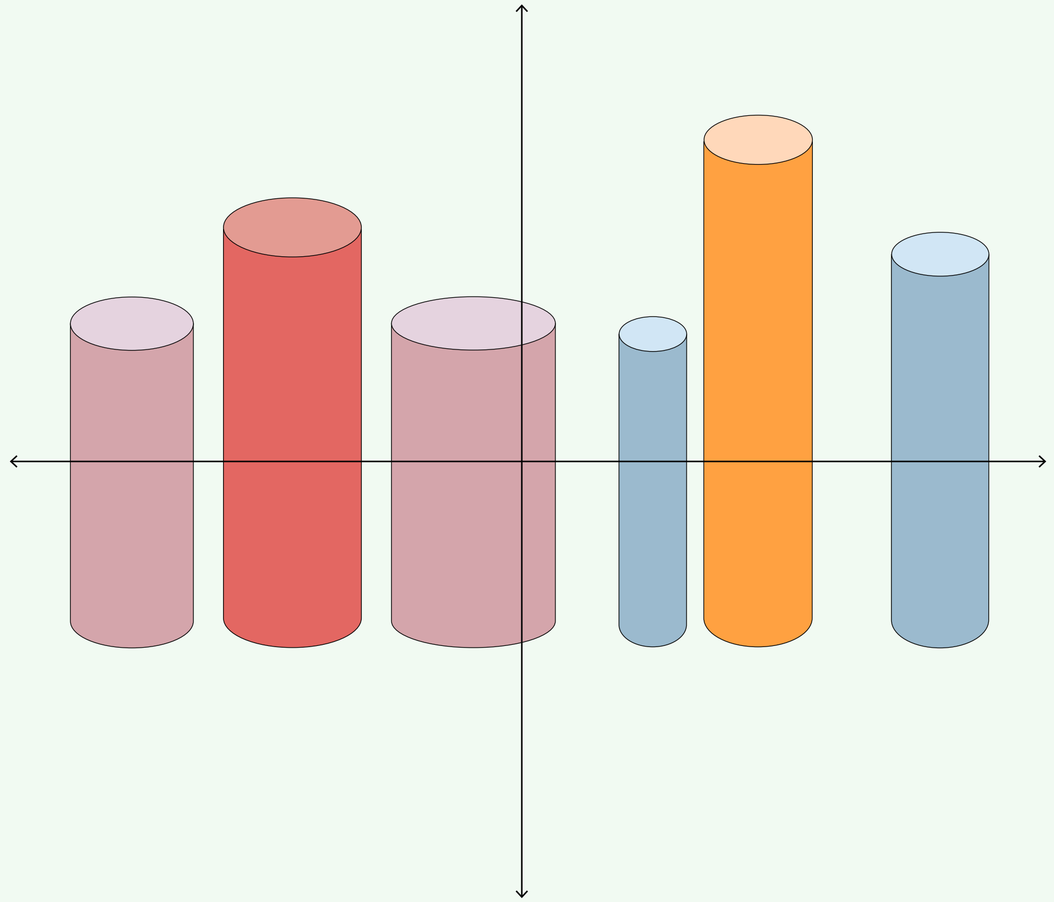
The previous interventions are examples of how more low hanging fruits can be leveraged to bridge today´s practices and new practices. This chapter, however, outlines some of the more systemic and long term work required to reach the overall vision of a seamless transition.

Beyond the low-hanging fruits / The complex barriers / A longer process / Potential stakeholders / Connecting to existing initiatives

Beyond the low-hanging fruits

The interventios are examples of smaller steps to start exploring the overall transiton. Critics might say that the interventions are “quick fixes” to challenges that require a more systemic approach by detangling structures all the way from user experience to laws, organisational structures and finances. I believe both approaches can be true at the same time and coexist. I am in no way claiming that the previous interventions are enough to solve this complex transition - but they are stepping stones into a public sector that is more aware and focused on proper transitions, rather than just transfers, and how to execute them.

The next page show is a summary of the key, systemic challenges that needs proper attention for the vision of a seamless transition to be accomplished.



The complex barriers

Division of responsibilities before, during and after handovers

Transfers and todays gaps can not be ”no mans land” . Youth should not be left hanging between responsibilities. Boths sides need to take more responsbility for the transition in itself, on top of their own separate tasks, goals and processes.

Knowing and understanding each other across services

A better understanding and communcation across the different services surrounding the youth can make it easier to see measures and plans more holistically, and coordinate them.

Flexibility to adapt to individual needs

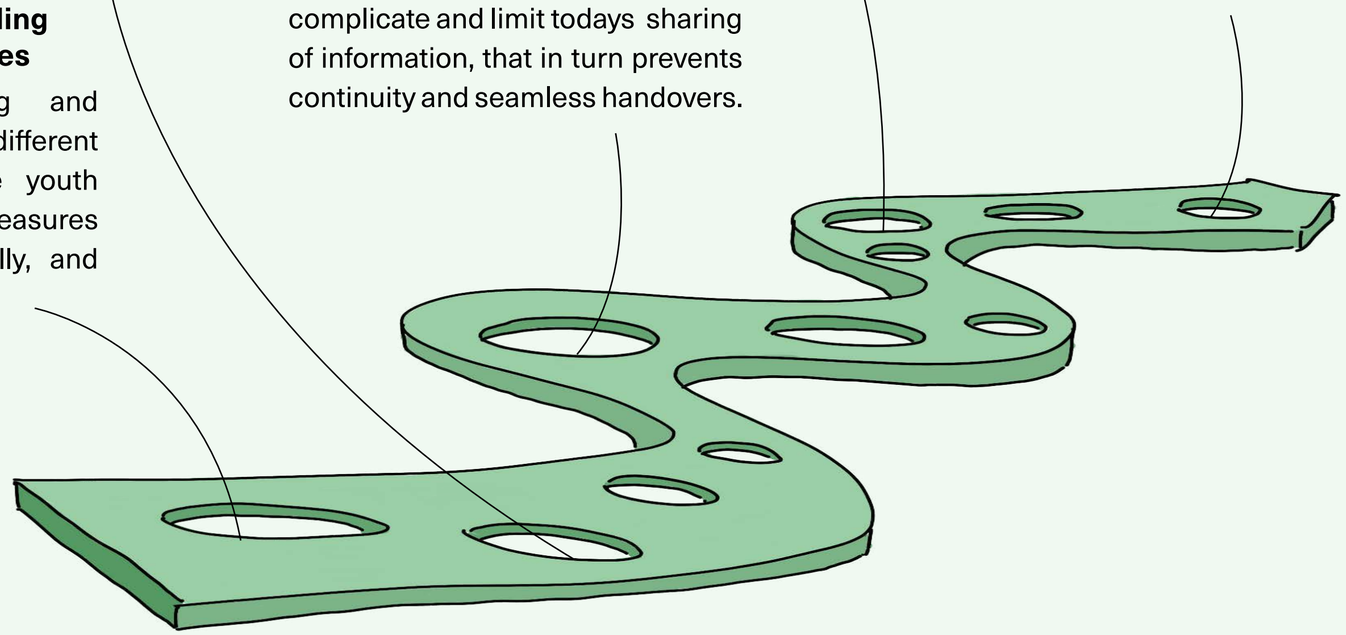
Today´s structures are relatively rigid and focused on equal, standard procedures that limit the level of flexible, individual adjustments.

Sharing of information

Digital legacy systems, as well as privacy laws and other laws, complicate and limit todays sharing of information, that in turn prevents continuity and seamless handovers.

Measuring qualitative and long term value

Long standings structures of measuring numbers and other quantitative benefits compete with the wish to deliver more qualitatively desirable services. This makes it hard to prioritize transitions side by side with other aspects of the follow-up.

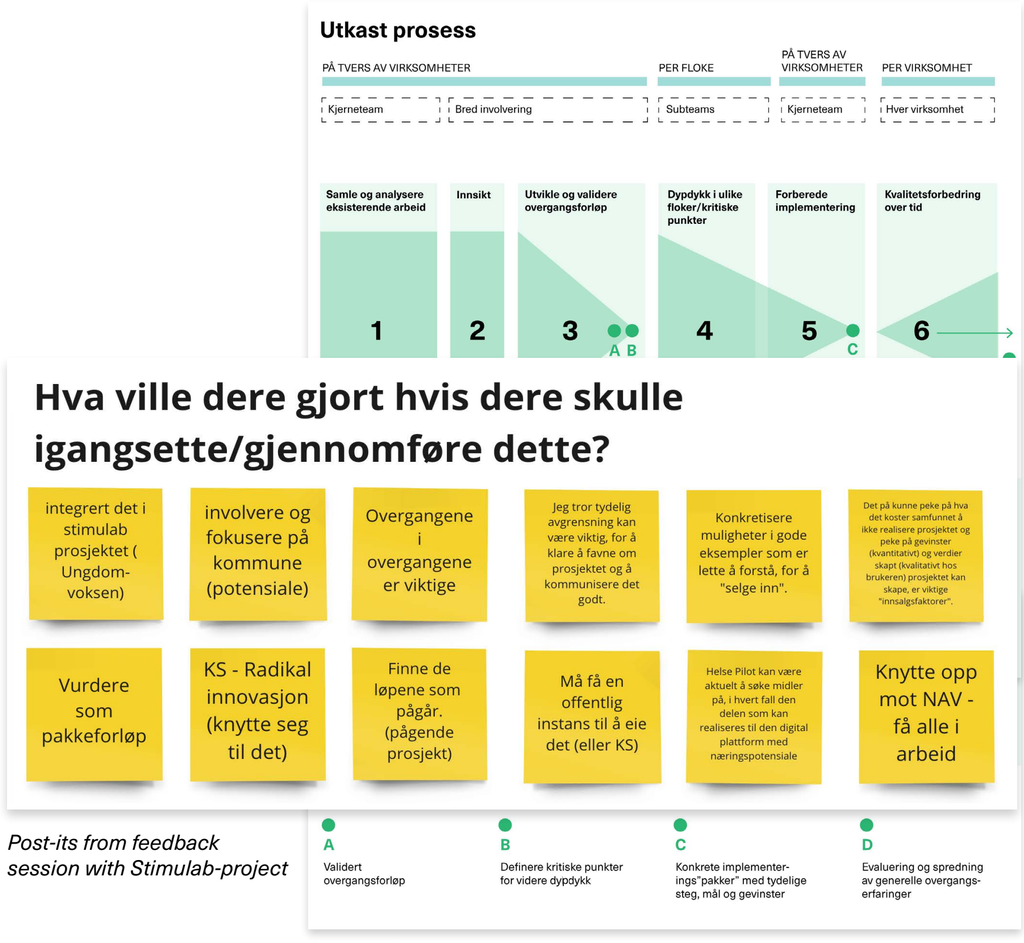


A longer process

Exploring what I imagine as a necessary, longer process to reach the vision of a seamless transition, I sketched a brief for a larger, long term project. This project would create a framework for the holistic, seamless transtion (overgangsforløp) across sectors, services and levels, based on previous work and further research. Getting to implement this would require a series of smaller explorations into the systemic challenges like coordination, sharing of information and benefit realisation, and result in structural changes and quality improvement on specific areas over a longer period.

I tested the draft of the project in conversation with a quality chief at a hospital. This was quite a reality check, where she emphasized some of the key factors needed to include hospitals in the development, and their limitations in terms of time, priorities, budgets, implementation processes and so on. Examples are the importance of ownership, concrete interventions and quality improvement over at least a year.

Last but not least I presentated the idea to the StimuLab project group, with a feedback session in Miro after. See some of their feedback in the post-its to the right.

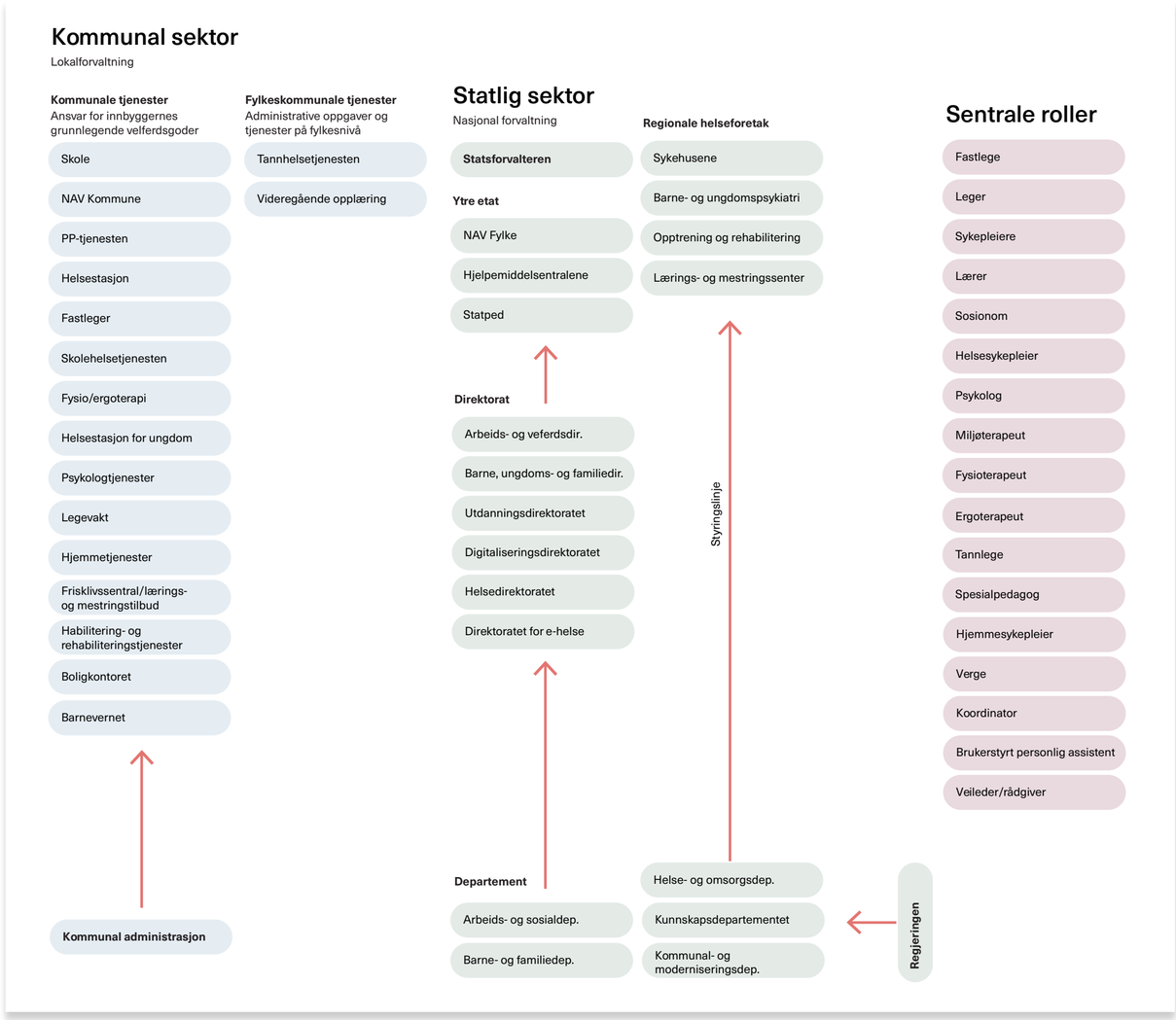


Post-its from feedback session with Stimulab-project

Sketch of a potential process

The potential stakeholders

This is an example of key stakeholders and roles, in different levels and sectors, that could play a part in or be affected by the shift towards a seamless transition. The shift requires collaboration across most of these (some more than others). This shows the complexity and the landscape of different stakeholders, which also says something about the number of professional backgrounds, goals and tasks that potentially meet or overlap in this transition.

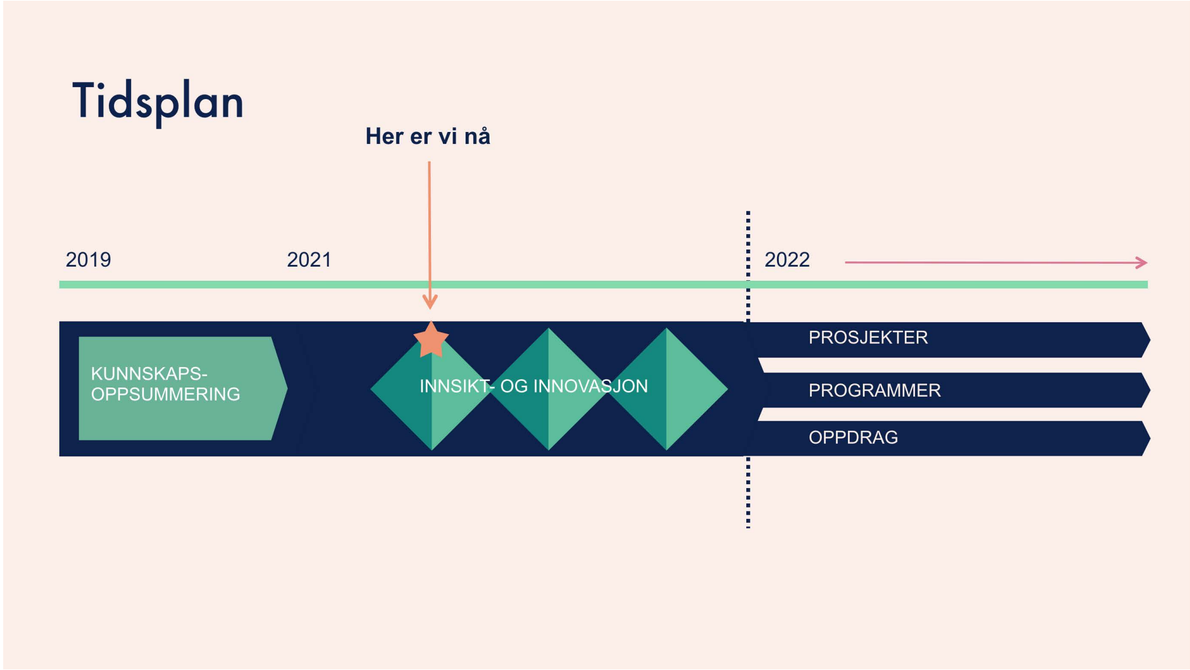


Connecting with existing initiatives

The StimuLab-project will result in several initiatives, from projects to programs and assignments. I imagine that working with this transition could be connected to initiatives in the continuity of this work with the life event.

Another example could be expanding the role of the municiplaities in the existing guidelines, that are mainly developed from a hospital perspective. This could make the transition more holistic and connected to local services as well as the specialist services.

A bill proposed in march by four ministries and the Primeminister´s office propose changes in several relevant laws. This could initiate improvements on several relevant points - even though it is mainly focused towards children.



StimuLab-project plan/time frame

7: The reflections

Chapter seven

My reflections on related themes and the context.

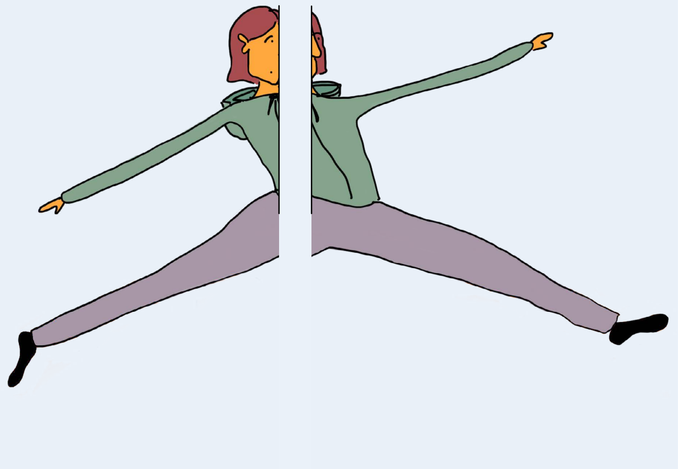
A constructed divide / Standard procedures or individual adjustments? / Meeting in the middle / Evaluation

A constructed divide

All youth are different. Life style, socio economical background, culture, living conditions, family life, social life, health, and so much more, affect what you are like at the age of 16 or 18, or even 40.

Some service offerings are connected to generalized stages in life, not necessarily taking differences into account. Age as a way to categorize citizens goes way back, and this way of sorting people generally works most of the time. It is an example of a tranditional structure, heavily bound by law, organisational structures and financial structures that are hard to uproot. These are not random ages, even though it is a social construction, as the categorization is backed up by scientific perspectives on development, life situations and needs.

I am not proposing that age is removed as a parameter, or removing 18 as the legal age, at all. But I do want to point at the importance of flexibility in public services, to better accommodate the needs of individuals. What other parameters could be used to determine whether someone is mature enough, ready or even prepared for the accountability you are met with at the adult side?



“Age is easy, and needs are more difficult, but better.”

- Leader housing, municipality

The way I see it, the emphasis on age and the sharp divide between the two "sides" are potentially in conflict with the aim of giving adapted service offerings.

Let´s look at two contrasting examples. In psychiatry, there is a relatively sharp divide between the two sides. Trust is key to good treatment and progress, and focusing heavily on age rather than maturity and readiness could break the safe chain of treatment, potentially making you resist further follow-up. *Omsorgsstønad* is an example of a financial measure that is adapted to needs rather than age. This is the financial support parents are given if they perform care tasks that could be done by the muncipiality. This support lasts until the youth moves out, rather than a certain age. To me, this seems to be a more reasonable criteria.

In some of the more theoretical conversations with interviewees, we discussed age as a parameter. Some were willing to join me on my trail of thoughts, agreeing that age might be too limiting, while others were skeptical. I even got “now you are being naive” as a response, followed by an in depth description of the amount of assessments and time it would take to consider every case using criteria besides age.

What if there was a flexible “grey area” from 17 to 19, for instance, where each service transfer was planned and executed according to each individuals needs?

“What’s wrong with age: It’s so easy for healthcare professionals. You’re 18, then you´re going over there. Other criteria too, and being ready, would have been better. And to raise awareness.”

- Young adult 3

Standard procedures or individual adjustments?

There is of course a reason why we have these ages that represent a shift. Age comes with several important rights that we do not want to tamper with. A relevant principle for the public sector is the one of equal treatment, which says that there should not be unfounded discrimination in public services. This, in addition to efficiency, is part of why services have standard procedures and requirements for documentation. This has created a culture and structure that limits both time, competency and resources to assess and adjust service offerings in any comprehensive way - even though there might actually be legal room to adjust according to individual needs.

Is equal treatment competing with a more ”modern” desire for tailor-made services, or can this be balanced in any way? Can we do individual adjustments without compromising equal treatment, or create unwanted variation? What has to be equal, and to what degree can service offerings be adapted to individual needs, situations or wishes? Would this require endless considerations and assessments, and is there competence and capacity for it?

"There is a risk in saying you will assess every case - it would be an awful lot of work. That is when things fail. And then you have not done things by 18."

- Coordinator, coordinating unit

"All patients are supposed to have equivalent health servies and it is not supposed to be if you are "lucky/ unlucky" with the healthcare personnel you have."

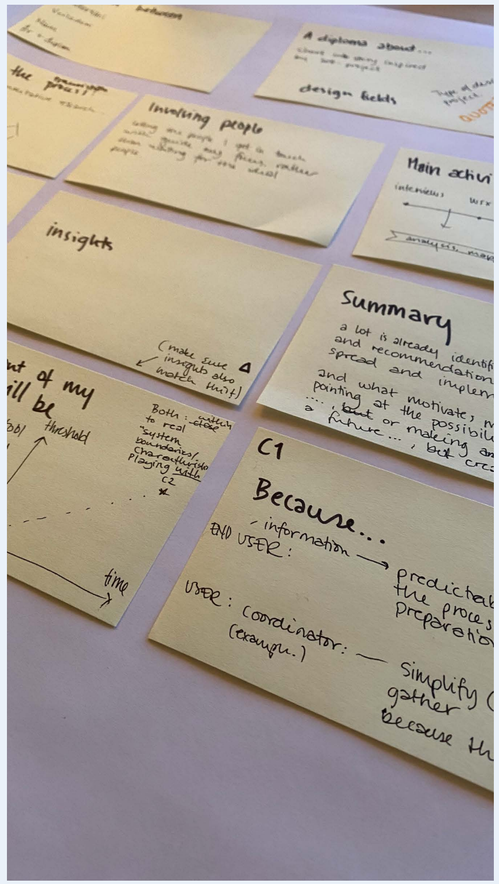
- Healthcare personnel/coordinator, hospital

Meeting in the middle

There are fundamental differences between the different services connected to the transition. They are different, not just in their competency or way of organizing, but in their ways of seeing people, their situations and approaching support or treatment. One side emphazise childrens rights and needs, the other sees you as yet another adult. This all affects their level of flexibility. Bridging such complex stakeholders is time consuming. It requires extensive co-creation to find the proper elements and routines to link and enable good collaboration between them. Long standing legacy structures have to be challenged or left behind. This is tedious, potentially tiring work for the system, as it requires long term investment and engagement across relatively autonomous and different professional opinions and perspectives.

This is not about collaboration for collaborations´ sake. There are important parts of the transition that does not require collaboration, but rather an increaced focus on youth as a group in and of itself, in between and separate from both children and adults.

Reflections on the process



I hope and think that the process in itself has indirectly affected the system through the involved people, as a result of the reflections, discussions and testing of my interventions.

Every conversation brought with it another set of perspectives and reflections. This was very valuable, and I could have always tested more or involved more youth and next of kin. Still, I feel I made a reasonable prioritization for this time frame, scope and intent of this project.

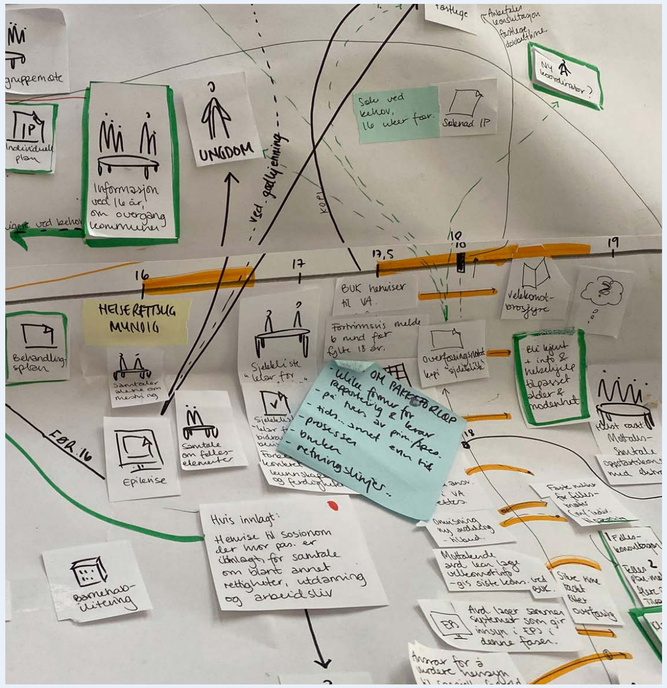
In a continuation of this project, I would have conducted further testing and analysis of what it would take to make the vision of a seamless transition work in practice. This would include exploring the complex barriers, how and where to start, to ensure prioritization and long term investment.

8: The closing thoughts

Small steps to bridge “sides”

My belief in small steps towards larger, systemic change has increased throughout this diploma project. This could of course be complemented with more visionary conceptualization of ideal and future interventions. I see the outlines of this in recent strategies, guidelines and initiatives. Either way, the development of connecting the child oriented and the adult oriented sides of public services is dependant on finding ways to prioritize transitions and transfers side by side with the traditional things that are "burning” here and now. Moving from a short term to a long term perspective would imply a huge leap from todays financial models, but facilitating a safe and proper transition into adult life would be an investment and relieve public sector costs in the long run.

I believe there is a lot to learn from the healthcare sector and improvements initated on the topic of transitions. The real challenge however, is moving past ”the golden standards” and finding new ways to actually implement and expand on the guidelines. Further exploration of the systemic structures that prevent new collaborative structures is crucial, in addition to avoiding the massive steps and interventions that the system can not handle in reality.



Thank you

To those who contributed along the way, took the time to share interesting perspectives and experiences, reflect and discuss openly with me.

Kaja, for uplifting, continuous engagement and valuable feedback emphazising the user perspective, details and realism.

Heidi, for listening to, discussing and enrichening my whims along the way, for sharing my passion for the public sector and always inspiring me.

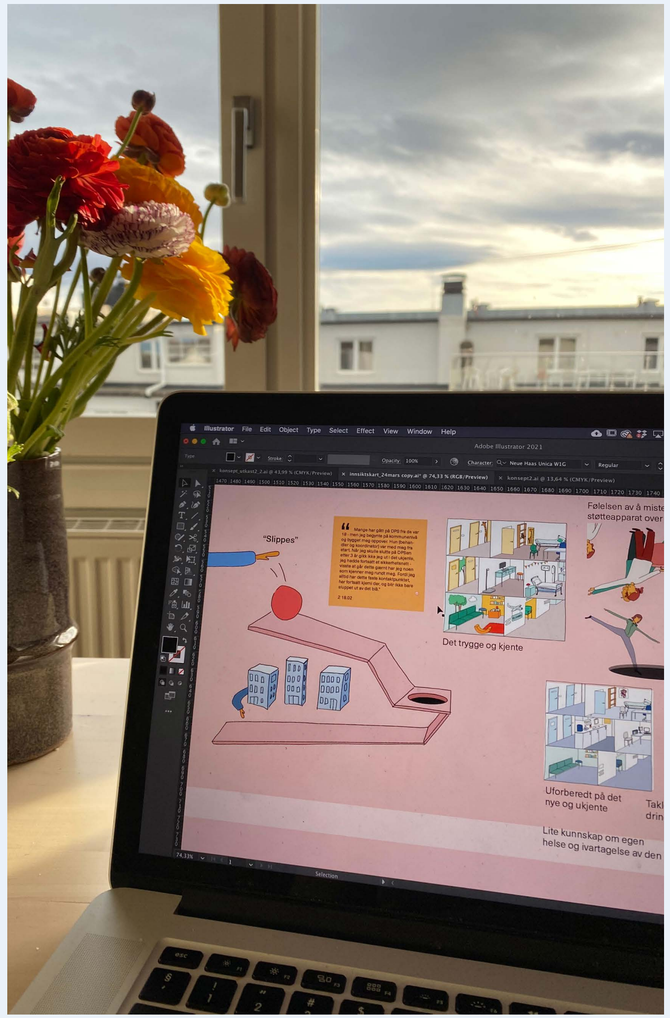
The StimuLab-project *Livshendelsen Alvorlig sykt barn* for having me onboard.

Siri, for sharing your great expertise of designing within healthcare.

Angel and Lene, for sharing hours of work through zoom - always in great spirits!

Ann Kristin and Madeleine, for valuable exchanges of feedback and motivation.

All the others supporting me through my diploma semester!



References

In text

The Ministry of Local Government and Modernisation, 2019. Én digital offentlig sektor. *https://www.regjeringen.no/no/dokumenter/en-digital-offentlig-sektor/id2653874/*

DOGA, 2020. https://doga.no/aktuelt/atte-innovasjonsprosjekter-far-stotte-fra-stimulab-i-2020/

StimuLab-project Livshendelsen Alvorlig sykt barn, 2021.The Norwegian Directorate of Health et.al. *https://alvorligsyktbarn.no/bakgrunn-og-mandat*

Norwegian Society of Pediatricians, 2020. Overganger ungdom. *https://www.helsebiblioteket.no/pediatriveiledere?menuitemkeylev1=12056&key=267164*

Oslo University Hospital, 2019. Retningslinje: Ungdom og unge voksne pasienter 12-26 år – mottagelse, oppfølging og overføring.

Akershus University Hospital, 2016. *Ungdomsmedisin.no*

The Norwegian Directorate of Health, 2019. Hvor skal man begynne? *https://www.helsedirektoratet.no/rapporter/hvor-skal-man-begynne-et-utfordringsbilde-blant-familier-med-barn-og-unge-som-behover-sammensatte-offentlige-tjenester*

Not in text

Dagens medisin, 2021. Vi må skape gode overganger for unge i helsevesenet. *https://www.dagensmedisin.no/artikler/2021/04/16/vi-ma-skape-gode-overganger-for-unge-i-helsevesenet/*

The Norwegian Directorate of Health, 2020. Veileder: Rehabilitering, habilitering, individuell plan og koordinator. *https://www.helsedirektoratet.no/veiledere/rehabilitering-habilitering-individuell-plan-og-koordinator/formal-og-overordnede-prinsipper-for-habilitering-og-rehabilitering-individuell-plan-og-koordinator*

Kunnskapsdepartementet, Arbeids- og sosialdepartementet, Barne- og familiedepartementet, Helse- og omsorgsdepartementet, Statsministerens kontor, 2021. Bedre hjelp til foreldre med barn som har behov for et sammensatt tjenestetilbud. *https://www.regjeringen.no/no/aktuelt/bedre-hjelp-til-foreldre-med-barn-som-har-behov-for-et-sammensatt-tjenestetilbud/id2838495/*

Ungdomsvennlige velferdstjenester, Oslo. Hva er en ungdomsvennlige velferdstjeneste? *http://www.ungdomsvennlig.no/uvv/*

Kristin Briseid, 2019. Personorientering i en norsk velferdsstatskontekst. *https://www.idunn.no/tidsskrift_for_omsorgsforskning/2019/01/personorientering_i_en_norsk_velferdsstatskontekst*

The Norwegian Directorate of Health, 2019. Veileder: Oppfølging av personer med store og sammensatte behov. *https://www.helsedirektoratet.no/veiledere/oppfolging-av-personer-med-store-og-sammensatte-behov*

Oslo University Hospital, 2020. Prosjektrapport barn og ungdom i Nye OUS. *https://oslo-universitetssykehus.no/seksjon/Documents/Prosjektrapport%20barn-%20og%20ungdom%20i%20Nye%20OUS.pdf*

The Royal Children's Hospital Melbourne. Transition resources. *https://www.rch.org.au/transition/resources/Transition_resources/*

Ministry of Health and Care Services and ComteBureau, 2020. En enklere hverdag: utfordringer og muligheter for likeverdsreformen. *https://www.regjeringen.no/contentassets/2bac7c92a50c4a3995b7d98a8531afbe/likeverdsreformen---dialogmoter---rapport.pdf*

The Norwegian Directorate of Health, 2016. Ungdomshelsestrategi. *https://www.regjeringen.no/contentassets/838b18a31b0e4b31bbfa61336560f269/ungdomshelsestrategi_2016.pdf*

Oslo University Hospital. Kommunikasjon med unge pasienter- ungdomsanamnese. *https://ehandboken.ous-hf.no/document/89373*

Ungdomsmedicinsk Enhed, Rigshospitalet. Transitionsforløb. www.*transitionsforløb.dk*

Dansk Sygeplejeråd. Fag & Forskning 2020 ; (3): 52-57, Danske anbefalinger til et ungevenligt sundhedsvæsen. *https://dsr.dk/sygeplejersken/arkiv/ff-nr-2020-3/danske-anbefalinger-til-et-ungevenligt-sundhedsvaesen*

Sources

Screenshot page 66: Principles education. Foreningen formuskelsyke, 2015. *https://ffm.no/2015/09/02/overgang-fra-barnehage-til-skole-og-fra-skole-til-skole/*

Screenshot page 66: The Norwegian Directorate for Education and Training, principles. *https://www.udir.no/lk20/overordnet-del/?lang=nob*

Screenshot page 66: Finnmark Hospital, principles. *https://finnmarkssykehuset.hn.nhn.no/Documents/Ungdomsr%C3%A5d/Prinsipper%20for%20gode%20overganger.pdf*

Screenshot page 66: Oslo Univercity Hospital, Principles. *https://oslo-universitetssykehus.no/seksjon/Nasjonal-Kompetansetjeneste-for-Barne-og-Ungdomsrevmatologi/Documents/Brosjyrer/SnartVoksen_2019.pdf*

Screenshot page 67: The Norwegian Directorate of Health, 2020. Høringsutkast: Gode helse og omsorgstjenester til personer med utviklingshemming. *https://www.helsedirektoratet.no/veiledere/gode-helse-og-omsorgstjenester-til-personer-med-utviklingshemming-horingsutkast/livsfaser-og-overganger*

Screenshot page 74: Statens undersøkelseskommisjon for helse- og omsorgstjenesten, opplæringsmateriell uavklarte tilstander, 2020. *https://ukom.no/media/1659/opplaeringsmateriell-uavklarte-tilstander.pdf?fbclid=IwAR07vrU7faYFtKV1wqgd_v7qkX_i6GWBJwE-kaJ_4-uSEWrJ_5HG_tVJzNQ*