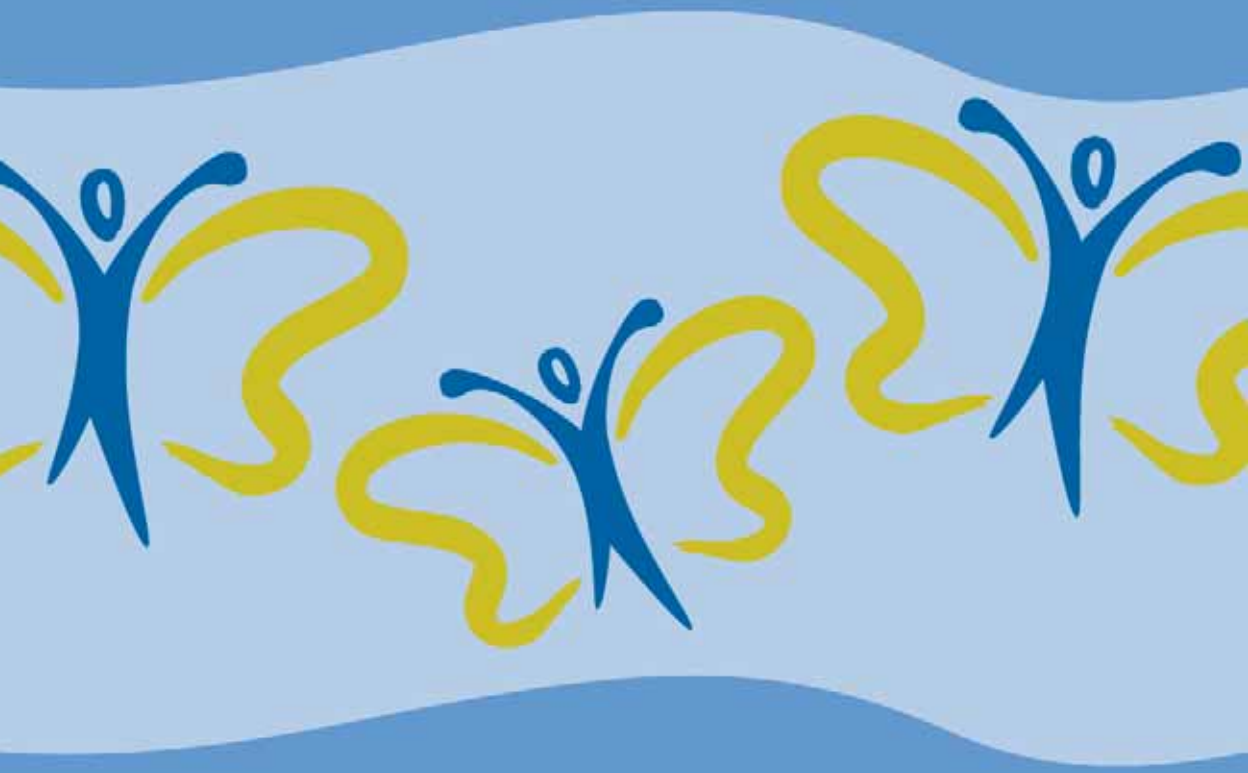
Mental Health
1999-2008

Mental Health Services in Norway

Prevention - Treatment - Care



HELSE- OG OMSORGSDEPARTEMENTET

Norwegian Ministry of Health and Care Services

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1. Introduction

In Norway, like in most western countries, the services for people with mental health problems have gone through major changes over the last decades. The number of patients staying in psychiatric institutions has been drastically reduced and most people with mental problems now live outside institutions. However, provision of services has not kept pace with these developments. A report submitted to the Norwegian Parliament in 1997 pointed out that mental health services were lacking at all levels; preventive measures were insufficient, the services provided by the municipalities were too few, accessibility to specialised services was inadequate, inpatient stays were often too short, and discharge follow-ups lacked sufficient planning, coordination and monitoring. In 1998, the Norwegian Parliament introduced a national mental health programme, calling for a major increase in the funding of mental health related services, as well as a major reorganisation of these services. Implementation of the programme will take place between 1999 and 2008. Recently, new laws regulating mental health services have been introduced. This brochure outlines some main features of the services and policies that have been implemented so far.

Norway, the country and the political-administrative system

Norway is located in the northernmost part of Europe. Stretching 1750 km from north to south, Norway has, next to Iceland and Russia, the lowest population density in Europe. Major exporting industries include oil and gas, shipping, fisheries, and metallurgical and chemical industries based on hydro-electric power.

The Norwegians enjoy a high standard of living, ranking third in Gross Domestic Product (GDP) per capita in the OECD area. The unemployment rate is among the lowest in the OECD.

2. Mental health problems in the population

Life expectancy is high in Norway, compared to most countries in the world.

Life expectancy and mortality 2002

Life expectancy at birth:
Male: 76.4

Female: 81.5

Mortality ratios (pr 100,000)

All causes: 978.4

All mental and behavioural disorders (F00-99) 28.9

Organic, including symptomatic, mental disorders (F00-F09): 17.4

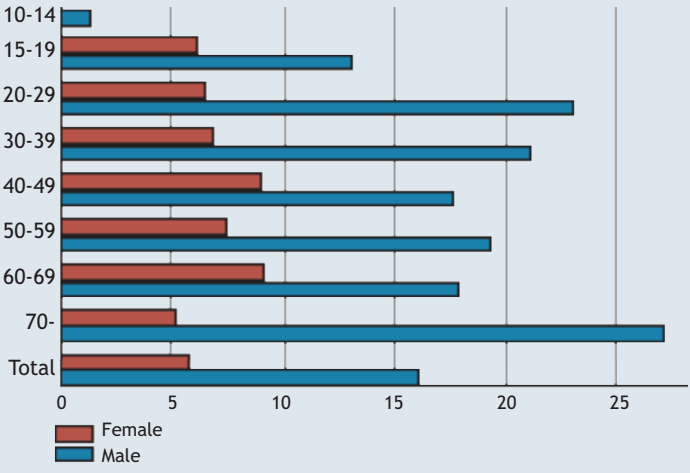
Mental and behavioural disorders due to psychoactive substance use (F10-F19): 10.2

Other mental and behavioural disorders (F20-99): 1.3

Suicide:.....10.9

The rate of suicide is fairly low in comparison with other Northern European countries. Still, suicide is one of the most important causes of death for people under 45 years of age, responsible for 13 percent of all deaths in this age group. The number of suicides has been declining since the mid-1980s.

Suicide by age and gender 2002
Ratios per 100,000 inhabitants



The estimates on the prevalence of mental disorders vary considerably, according to methods and diagnostic criteria used. Norwegian and international studies alike, have estimated that 15-20 percent of the population has some kind of mental problem, and that 3 percent has a serious mental illness. Of the population aged between 16-67, 3.1 percent receive disability pensions based on a psychiatric diagnosis. This constitutes 30 percent of all people on disability pension. An additional 0.6 percent of the population is on long-term sickness leave because of a mental health condition. Three percent of the adult population visits a mental health outpatient clinic and 0.8 percent receives treatment on an inpatient basis at least once a year. Three percent of children and adolescents under the age of 18 receive treatment from specialised mental health services, 95 percent of these on an outpatient basis.

Use of specialised mental health services by age group. Ratios per 10 000 inhabitants. 2003.

Target group:	Children and adolescents (0-17 years)	Adults (18 years or older)	All services
Inpatient days	828	4788	3852
Discharges	17	115	92
Day-patient days	299	474	432
Outpatient consultations	2797	2031	2212

Disability pensions for mental and behavioural disorders. Ratios per 10 000 inhabitants aged 16-67. End of 2003.

	Males	Females	Total
All mental and behavioural disorders (F00-99)	329	279	300
Organic disorders (F00-09), Schizophrenia, schizotypal and delusional disorders (F20-29)	59	32	44
Mental and behavioural disorders due to psychoactive substance use (F10-19)	33	6	18
Mood disorders (F30-39)	40	49	45
Mental retardation (F70-79)	52	34	42
Other mental disorders (F40-69, F80-99)	145	158	152

Key demographic and economic indicators

(2003)

Population:
4.577.000

0-17 years:
1.082.000

18 years +:
3.495.000

Area:
324.000 sq km

Population density:
14 per sq km

GDP pr capita:
USD 48,400
(at current exchange rate)

Unemployment rate:
4.5 %

Organisation of health services in Norway

Norway is a constitutional, hereditary monarchy with a parliamentary system of government. Despite a unitary constitution, locally elected bodies, the municipalities, are responsible for many welfare services.

Despite a low population density and long travel distances, equal access to health services is a central aim of government policy. As a consequence, though health services are seen as a national concern, service delivery is highly decentralised. These principles also apply to mental health services. Public authorities finance and run most services. Private sector services are in most cases fully embedded in the public system.

3. Policies

In 1998, The Norwegian Parliament adopted a National Programme for Mental Health, calling for major investments, expansion and reorganisation of the services.

The programme aimed at

- strengthening the users' position,
- increasing public awareness on mental health issues through information programmes,
- strengthening community based services provided by the local municipalities (including prevention and early intervention),
- expanding and restructuring specialised services for adults,
- expanding specialised services for children and adolescents,
- improving labour market services,
- assisting with accommodation and housing and
- stimulating education and research.

Emphasising the users' perspective

Fundamental for the reform of mental health care in Norway is the emphasis placed on the users' views and perspectives on services. The experience and knowledge possessed by users and their relatives, is unique and necessary in improving and optimising services and treatment. Participation is also vital for empowerment and for the ability to master one's own life. This is of great value and a central vision of the National Programme for Mental Health.

Users and close relatives should be involved at all levels in the decision-making process. At the system level this implies organised participation by users and relatives in planning processes, legislation, implementation of treatment programmes etc. It is of major importance that users' perspectives are taken into consideration in decision-making throughout the services (political, administrative and professional) and at all levels (Ministry, municipalities, hospitals etc.). Accordingly, national as well as local authorities should be co-operating with users' organisations and unions in these matters. At the individual level, the policy implies a legal right to participate in the management of necessary services.

In order to implement this policy

- The Ministry has established a consulting group, represented by all major user organisations, whose aim is to discuss all important issues concerning the mental health programme
- Government funds have been made available to strengthen the users' organisations
- New laws adopted by Parliament, aim to improve the rights of patients, including the right to take part in the planning and coordination of their own services, and the right to decide where to receive treatment
- Specialised services are now required by law to establish systems for obtaining patients' and users' experiences with, and views on services
- A new system for quality assurance is being implemented in the specialised services. This system strongly emphasises indicators measuring users' experience and satisfaction with services. A similar system will be developed for community based services.

Guidelines for the mental health policy

Preventive measures:
Mental problems can in many cases be prevented. Early intervention and close monitoring can make the course and outcome more benign.

Integration of services:
Services to people with mental problems shall be provided by the agencies responsible for providing services to people in general.

Users' perspective:
The needs of users must guide the provision of services. This requires involvement and cooperation with users and their families, both on a system level and on an individual level, more differentiated services, as well as coordination of services from different agencies.

Focusing on voluntary treatment:
Treatment shall, if possible, be received on a voluntary basis, in open and normalised settings, and preferably on a daytime basis.

Living a normal life:
Services shall promote independence, improved living conditions, quality of life and participation in ordinary life.

Regional level

Since 2002, the central government is responsible for the provision of specialised health services. Five Regional Health Authorities (RHAs) have been set up, each responsible for providing specialised health services to the population in their region. The RHAs are separate legal entities owned by the central government through the Ministry of Health and Care Services. The RHAs can either provide services, through hospital trusts (owned by the RHAs) or through contracts to private service providers. However, most specialised mental health services are owned and run by the RHAs.

Specialised mental health services should be fully integrated with, and run according to the same principles as other specialised health services. In 2003, there were 25 hospital trusts providing mental health services to the population in their catchments areas. The population in these areas range from 55,000 to 375,000.

Regional Health Authorities (RHA) and Population 2003

Information strategy

The need for more information on mental health matters is emphasised in the national program for mental health. The Ministry, in cooperation with users' organisations, two other ministries and several non-governmental organisations, has developed an information strategy. The purpose of the strategy is to increase public knowledge about mental health, reduce prejudices and increase openness on mental health problems. Hopefully, this will also increase peoples' ability to take care of their own mental health and reduce the harmful effects of stigma and discrimination by dismantling the myths and putting a public face on mental health and mental disorders.

The information strategy has three main target groups:

- children and adolescents (in cooperation with the educational system)
- the labour market (employers and employees)
- professionals at all levels within the sector as well as users

Information has, and will also continue to be directed to the general public.

National level

The Ministry of Health and Care Services is responsible for the formulation and implementation of health policy, public health, health care services and health legislation in Norway. This includes responsibility for providing the population with adequate health care services, based on the principle of equality, independent of age, sex, ethnic origin, place of residence and financial circumstances. The Ministry directs the health care services through comprehensive legislation, annual budgetary allocations, governmental institutions, regional health authorities and local establishments, including hospital trusts.

The Ministry of Labour and Social Affairs is responsible for labour market policy, work environment and safety policy, social insurance policy, welfare policy, as well as alcohol and drug policy.

Local level

The 434 municipalities (with locally elected boards) have populations ranging from 200 to 520,000. Half of the municipalities have a population of less than 4500. Services are financed through local taxes (income tax), government block grants, special government reimbursements grants, and fees. The municipalities are responsible for providing primary health care and social services, including primary mental health care services.

4. The services

Municipal services: Co-ordinated services in the local community

In the mental health program, increased emphasis has been placed on primary health care services as well as social services and the labour market services. Services for people with mental health problems shall be provided by the same agencies that provide services for the public in general.

The municipalities are responsible for preventive efforts and for providing primary health care services, nursing and care services as well as social services. The municipalities therefore play a key role in the provision and co-ordination of services for people with mental health problems.

At the end of the 1990s, the services provided by the municipalities were lacking in several respects. There was a lack of funding, a lack of competent personnel, and a lack of competence on the planning, organisation and integration of services. The central government has actively encouraged local planning of services. Special grants, aimed at improving services for people with mental health problems have been made available from the central government through the mental health program. Over the programme period, these grants will finance an increase in the annual running costs for such services by 95 USD per capita (2003), equivalent to the growth in expenditures for specialised mental health services. Grants are only made available provided that the municipalities do not reduce their own spending in this field.

Special attention has been given to people with serious mental problems, requiring co-ordinated services over a longer period of time. This applies to 0.75 to 1 percent of the adult population. Making individual plans that co-ordinate necessary services has become a mandatory task for the services, and a legal right for the patients.

Of particular importance for this and other groups with chronic health problems is the introduction of the list-patient system from

2001, giving all citizens the right to have a personal GP.

In the planning of services for adults, special emphasis has been placed on

- user participation in treatment and services
- satisfactory housing with sufficient assistance
- possibility of participation in labour market activities or other meaningful activities
- possibility of social contact and integration, as well as cultural and physical activities
- necessary health and social services

In planning the services for children and adolescents, special attention has been given to those already having developed problems or those in the danger zone. In addition, priority has been directed at preventive measures. User and relative participation is equally essential for children and adolescents. The supply of qualified personnel has been increased by expanding and reforming education given at colleges and universities.

Specialised mental health services

Government guidelines emphasises that specialised mental health services are to be integrated with, and run according to the same principles as other specialised health care services.

In 2002, the responsibility for specialised health services was transferred from the counties to the central government. Five regional health authorities (RHA) are now responsible for providing specialised health services. The RHAs are separate legal entities, controlled by the central government in capacity of owner and provider of resources. Services are provided by the hospital trusts, which are owned by RHAs, or contracted out to private service providers.

Expenditures and financing of specialised services

- Total expenditure for specialised mental health services amounts to USD 345 per capita (investments and capital costs not included), or 0.7 percent of the GDP (2003).

Other important institutions on the national level include

The Norwegian Institute of Public Health

The Institute's main responsibility is to improve the general health of the population by strengthening the preventive work. The Institute monitors public health as well as the somatic, psychiatric and social circumstances that influence health. Furthermore, the Institute conveys knowledge and advice regarding possible instruments that may improve general health and prevent disease and health injuries.

The Directorate of Health and Social Welfare

is a professional body within the field of health and social affairs and has legal authority within this field. The Directorate also contributes to the implementation of national health- and social policy, and it serves as an advisory body to central authorities, municipalities, Regional Health Authorities and voluntary organisations. An essential task for the Directorate is to develop and strengthen the preventive work and the availability of services within the field of health and social affairs. The patients' ombudsmen, one in each county, report to the directorate.

The Norwegian Board of Health

is a national supervisory authority with responsibility for general supervision of health and social services. The Institution oversees the population's need for health- and social services, and sees that services are run in accordance with adequate professional standards. The Board also collaborates in preventing failures and mistakes within the health care system. Locally, supervision is carried out by the Governmental Regional Board. In matters of health and social affaires, the regional boards report to The Norwegian Board of Health.

The National Insurance Administration

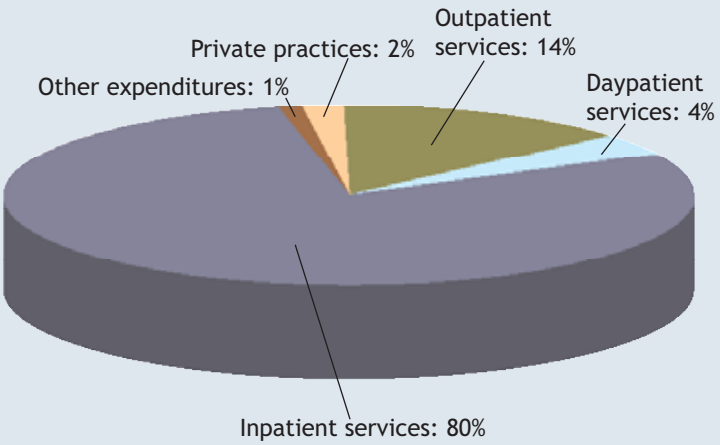
is responsible of securing the rights of the individual in matters relating to health and social insurance. The National Insurance Administration manages the National Insurance Act and other regulations in the area of social insurance and allocations of subsistence allowances.

This represents a 16 percent real growth in expenditures since 1998. Expenditures are mainly channelled through publicly run institutions and services.

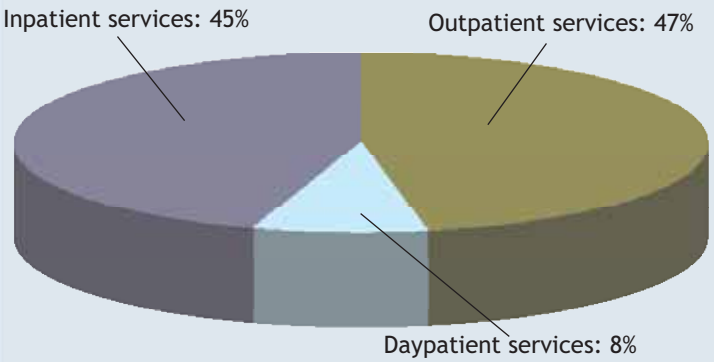
- Services for adults account for 85 percent of the total costs. Inpatient services accounts for 80 percent of these costs. In services for children and adolescents, inpatient services account for less than 50 percent.
- Expenditures are mainly financed through general (block) grants from the central government to the regional health authorities (78 percent), special government grants for mental health services (12 percent), central government reimbursements for outpatient treatment (7 percent) and other income (4 percent).

A new financing system, that places more emphasis on the production of services, is under development.

Distribution of expenditures by type of service. Mental health services for adults. Estimates for 2003.



Distribution of expenditures by type of service. Mental health services for children an adolescents. Estimates for 2003.



Specialised mental health services for children and adolescents

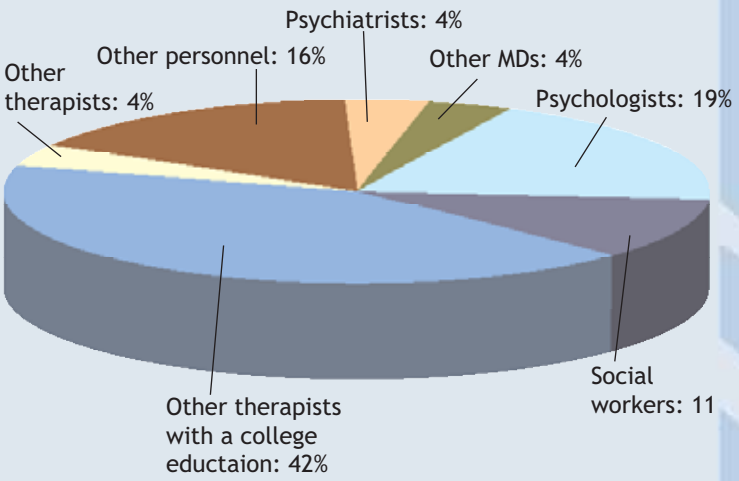
Mental health services for these groups have traditionally been provided on an outpatient basis. 95 percent of the patients receive treatment in this way. Outpatient treatment is usually delivered at units attached to general hospitals.

There are currently 337 beds available for inpatient treatment (2003), 36 more beds since 1996. This gives a bed ratio (per 10 000 inhabitants, 0-17 years of age) of 3.1. According to the national mental health plan, 500 beds should be available by the end of the programme period (2008). Due to the development of new treatment programmes, the government has proposed that this target should be reduced to 400 beds.

The professional qualifications of personnel in these services are generally high. 27 percent of all personnel have a university degree, and an additional 53 percent have a college degree. The number of man-years has increased by 38 percent since 1998.

Three percent of the population aged 0-17 currently receives child and adolescent services (2003). This is an increase of about 50 percent since 1998. However, according to the mental health programme, five percent should be receiving these services by the end of the programme period (2008).

Personell by profession in services for children and adolescents 2003.



Specialised mental health services for adults

The national mental health programme calls for a restructuring of the mental health services for adults, based on three pillars:

- Hospital wards shall provide highly specialised services (acute wards, specialised functions)
- District Psychiatric Centres (DPCs) shall provide less specialised services on a more decentralised level
- Psychiatrists and psychologists in private practice shall provide services in cooperation with other mental health services.

According to the programme, the number of beds should increase considerably in DPCs and slightly in the hospitals. Other institutions, mainly psychiatric nursing homes, should gradually be closed down. The total number of beds should remain fairly stable.

So far, the number of hospital beds has remained fairly stable, although hospital staff has increased.

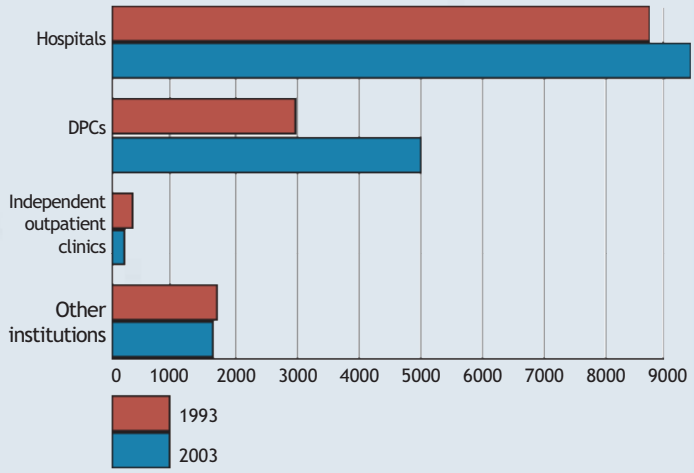
The DPCs are to play a major role in the development of services. A DPC shall provide the following services:

- Outpatient clinics/ambulant services
- Daytime treatment
- Short-time inpatient treatment
- Long term treatment and rehabilitation
- Consultation, supervision and support for staff in primary care services
- Acute services (if long distance to mental health hospital) and crisis intervention.

Since 1998 there has been a considerable expansion of these institutions. Although some DPC will need further expansion in order to provide all necessary services, 71 DPCs, covering 86 percent of the population have already been established. Twelve more centres covering the remaining population, will be established over the coming years.

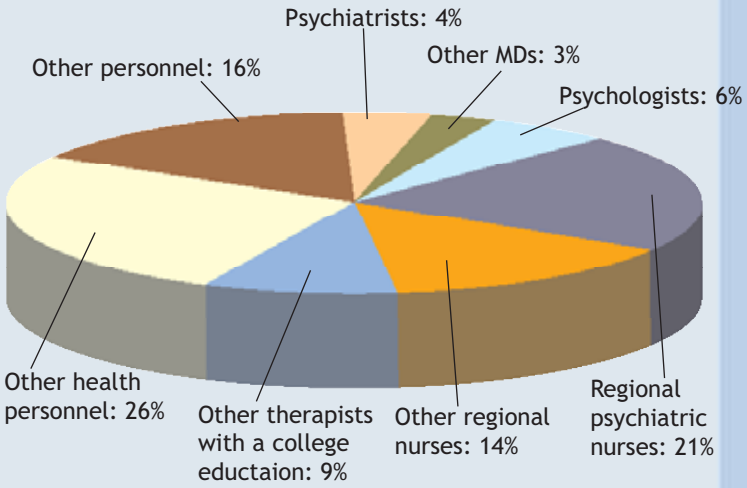
However, other institutions have been closed down at a much faster rate than planned, reducing the total number of beds available.

Personell by institutional setting.
Mental health services for adults.
Full time equivalents in 1998 and 2003.



The number of man-years in specialised services for adults rose by twelve percent from 1998 to 2003. The professional qualifications of personnel have also risen considerably: Thirteen percent of all personnel now have a university degree, and an additional 44 percent have a college degree.

Personell by profession in services for adults 2003.



Specialised mental health services for adults have become more easily accessible over the last five years (1998-2003): The number of people receiving inpatient services has increased by 30 percent, and the number of outpatient consultations has increased by 68 percent.

5. Compulsory detention and treatment

The use of compulsory admission is, by international standards, high in Norway. Reducing the use of coercion has been given high priority in government policy. Making services more accessible will hopefully prevent crises at an earlier stage.

A new law covering the use of compulsory admission, treatment and other forms of coercion was implemented in 2001.

Compulsory admission and treatment requires that patients have a serious mental illness and that at least one of two additional criteria is met:

- the possibility of cure or considerable improvement will be lost, or
- the patient represents a considerable danger to himself or to others.

Patients can also be compulsory admitted for observation, lasting up to ten days.

According to the new law, acceptable voluntary solutions shall be tried whenever possible.

Compulsory treatment can be given on an inpatient or an outpatient basis, thereby preventing unnecessary admissions. The law specifies acceptable types of coercive treatment and expands the patients' rights of appeal to a supervising commission or to the courts.

The results of these reforms are so far inconclusive.

6. Strengthening patients' rights

Parliament has also implemented a new law codifying and expanding patients' rights. These rights include:

- the right to necessary treatment and care.
- the right to an evaluation of the need for treatment within a maximum of 30 days.
- the right to an individual plan for treatment and care.
- the right to a second opinion.
- the right to choose where to receive treatment.

This applies to hospitals as well as district psychiatric centres.

- the right to be heard, give consent to and to receive necessary information on treatment.
- the right to see the medical journal.
- special rights for children.
- an independent patients' ombudsman in all counties.

7. Challenges for the future

Four years into the implementation of the Mental Health Programme, considerable improvements in services have been achieved. More people seek help, and more people get the help they need. The capacity of the services has increased more than the increase in spending on services would indicate. Decentralised services are being developed and services have become more readily available.

Still, services are lacking in several respects. Community based services, provided by the municipalities, are not sufficiently developed to meet requirements. Cooperation between services and coordination of services on the individual level are also lacking in several respects. As a result, the pressure on specialised services, especially acute services, becomes unnecessary high, leading to unnecessary waiting and to misplacement of patients in institutions.

Despite the development of community based services and a policy of deinstitutionalisation, 80 percent of the resources in specialised services for adults are still spent on inpatient treatment, in many cases providing services to patients primarily in need of community based services. To meet this challenge, the government is reconsidering the distribution of resources between hospitals, DPCs and services provided by the local councils, and will propose further expansion of the community based services, including supported housing. During 2005 and 2006 ambulatory teams will be organised at all DPCs.

Not all service providers have adapted to the challenges raised by the user perspective on services. Cooperation with users and relatives on an equal basis has still to be considerably improved.

The government will also focus on the need to develop knowledge on how to prevent and treat different forms of traumas. Groups exposed include children and adults having experienced violence (domestic or otherwise), sexual abuse, rape and/or torture, refugees, asylum-seekers, veterans from UN/NATO operations and personnel having taken part in international relief work.

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Published by the
Norwegian Ministry of Health and Care Services
Further copies can be ordered from
Statens forvaltningstjeneste
Informasjonsforvaltning
P.O. Box 8169 Dep, 0034 Oslo, Norway
E-mail: publikasjonsbestilling@ft.dep.no
Fax: +47 22 24 27 86
Please quote publication number I-1105-E
Internet: http://odin.dep.no/hod/engelsk

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January 2005