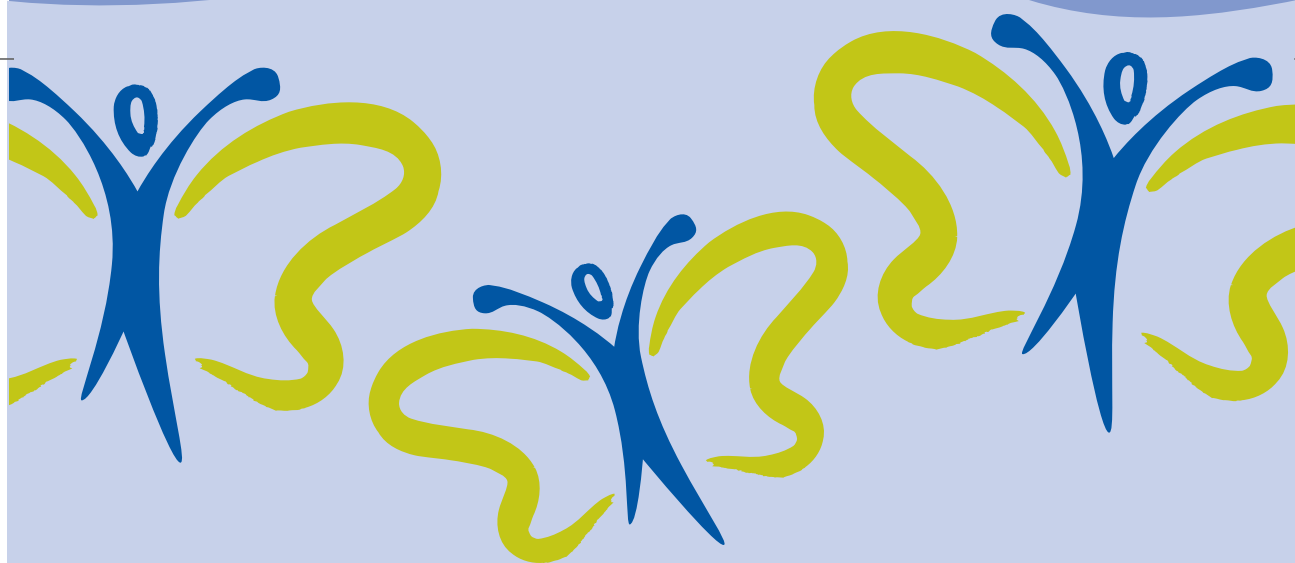




**Mental Health**  
1999-2006

# Mental Health Services in Norway

Prevention Treatment Care



SOSIAL- OG HELSEDEPARTEMENTET

*Norwegian Ministry of Health and Social Affairs*

# Contents

<b>1. Introduction</b> .....	s. 3
<b>2. Mental problems in the population</b> .....	s. 4
<b>3. Policies</b> .....	s. 6
User's perspective .....	s. 6
Information strategy .....	s. 8
<b>4. The services</b> .....	s. 9
Municipal services: Co-ordinated services in the local community .....	s. 9
Specialised mental health services .....	s. 10
<b>5. Strengthening patients' rights</b> .....	s. 19

# 1. Introduction

In Norway the services for persons with mental health problems have gone through major changes over the last decades. The number of inpatients has been drastically reduced and most people with mental problems now live outside institutions. Provision of services has, however, not kept pace with these developments. In report no 25 (1996-97) «Openness and comprehensiveness» submitted to the Norwegian Parliament in 1997, it was pointed out that the services were lacking at all levels: Preventive measures are too weak, the services available from the municipalities are too few, accessibility to specialised services is not good enough, inpatient stays are often too short, and discharges lack sufficient planning and monitoring after the discharge.

In June 1998, the Norwegian Parliament adopted a national programme for a major increase in the funding, and revision on the organisation of the services during the period 1999 - 2006. New laws regulating the services were put in force January 1st 2001. This brochure outlines some main features of services and policy.



## Norway, - the country and the political-administrative system

*Norway is located in the northernmost part of Europe.*

*Stretching more than 1600 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, metallurgical and chemical industries based on hydroelectric power, shipping and fisheries.*

*The Norwegians enjoy a high standard of living, ranking as number 3 in gross domestic products (GDP) per capita in the OECD area. The unemployment ratio is the second lowest in the OECD.*

## 2. Mental health problems in the population

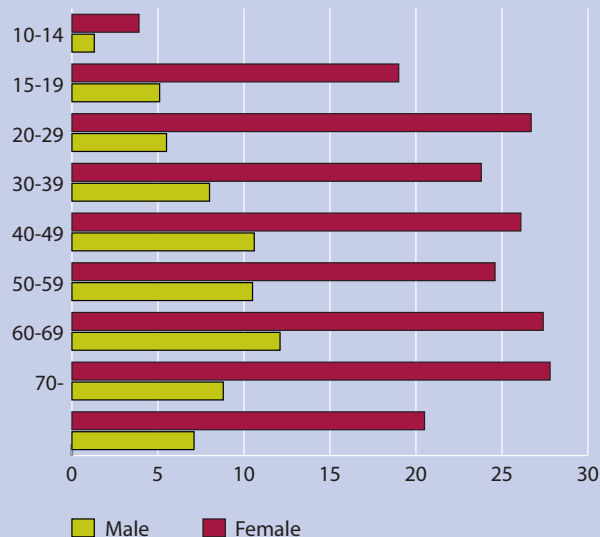
Life expectancy is high in Norway, compared to most countries in the world.

### Life expectancy and mortality 1996

Life expectancy at birth:	Male: .....	75.4
	Female: .....	81.1
Mortality ratios (pr 100,000)		
All causes:	.....	999.8
Organic, including symptomatic, mental disorders (F00-F09):	.....	15.3
Mental and behavioural disorders due to psychoactive substance use (F10-F19):	.....	9.2
Other mental and behavioural disorders (F20-99):	.....	1.0
Suicide:	.....	11.8

The rate of suicide is fairly low in comparison with other Northern European countries. Still, suicide is the single most important cause of death for people under 45 years of age, responsible for 15 percent of all deaths in this age group.

### Suicides by age and gender. Average annual ratios 1991-95. Ratios per 100,000 inhabitants



Estimates on the prevalence of mental disorders vary according to methods used and diagnostic criteria. Based on Norwegian and international studies, it has been estimated that 15-20 percent of the population have some sort of mental problem, and that 3 percent have a serious mental illness. 0.75 to 1 percent of the population have a serious mental illness that requires much assistance and co-ordination of public services. 2.9 percent of the population aged 16-67 receive disability pension based on a psychiatric diagnosis. An additional 0.6 percent are on long-term sickness leave due to a psychiatric diagnosis.

0.5-0.7 percent of the adult population visit an outpatient clinic, psychiatrist or clinical psychologist during a fortnight, while 0.6 percent receive inpatient treatment at least once a year. Two percent of children and adolescents under 18 years of age receive treatment, 95 percent of these on an outpatient basis.

**Use of specialised mental health services by age group. Ratios per 10 000 inhabitants in age group. 1998**

Target group:	Services for children and adolescents (0-17 years)	Services for adults (18 years or more)	All services (Total pop.)
Inpatient days	738	5675	4519
Discharges	12	86	69
Day-patients days	334	888	758
Outpatient consultations	1398	1379	1394

**Disability pensions for mental and nervous diseases. Ratios per 1 000 inhabitants aged 16-67. End of 1996**

	Male	Female	Total
Psychosis	4.9	4.3	4.6
Neurosis, per. disorders	10.2	17.2	13.6
Alcoholism, drugs	2.6	0.5	1.6
Learning disabilities	4.6	4.1	4.4
All mental diseases	22.3	26.2	24.2

**Key demographic and economic indicators**

*Population (1998):*

4.445.000

*0-17 years:*

1.040.000

*18 years +:*

3.405.000

*Area:*

324.000 sq km

*Population density:*

14 per sq km

*GDP pr capita (1998):*

249.000 (USD 32,850)

*Standardised*

*unemployment ratio (1998):*

3,3 %

## Administrative structure

*Norway is a constitutional, hereditary monarchy with a parliamentary system of government. Despite a unitary constitution, locally elected bodies - the municipalities and the county municipalities - run most welfare services. The municipal sector accounts for almost 3/4 of all man-years in the public sector, and expenditures are equivalent to 19 percent of the GDP.*

*There are 435 municipalities with a population ranging from 200 to 500,000. 50 percent of the local municipalities have a population of less than 4300. Services are financed through local taxes (44 percent), mainly on income, government block grants (21 percent), special government reimbursements and grants (12 percent), plus fees (18 percent).*

## 3. Policies

The Norwegian Parliament has recently (1998) adopted a national programme for mental health. Important overall targets in the programme are a major expansion and reorganisation of mental health services.

Main areas for improvement are:

- strengthening user's position and emphasizing information
- strengthening the municipal services (especially prevention and early intervention)
- expanding and restructuring of the services for adults (e.g. district psychiatric centres (DPCs))
- expanding children's and adolescent's services
- improving labour market services
- stimulating education and research

### User's perspective

Fundamental for the reform of mental health care in Norway is the user/participant perspective. This is a principal recognition of different issues, among them:

- The experience and knowledge possessed by users and their relatives, is unique and necessary in order to obtain optimal services and treatment.
- Participation is vital for empowerment and to master one's own life. This is considered a value of its own as well as a central vision for the National Programme for Mental Health.

The aim of this policy is that users and close relatives should participate at all levels. At the system level this implies organised user/relative participation in planning processes, legislation, treatment procedures etc. It is of major importance that this comprises all parts of the services including political, administrative and professional leaders at all levels (Ministry, municipalities, hospitals etc.). Accordingly, central as well as local authorities should be co-operating with user organisations and unions in these matters.

At the individual level the user/relative perspecti-

ve implies legally established rights of participation in arranging daily life activities, the meeting between patient/user and staff etc.

### **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 other people.

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

**Focusing on voluntary treatment:** Treatment shall, if possible, be provided 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.

### **Some actual consequences of the user perspective is that;**

- The Ministry of Health has established a consulting group in which five major organisations for users of mental health services are represented. All major issues of the mental health programme are discussed in this group.
- Earmarked state funding of the user organisations of mental health (these are traditionally weak and need strengthening to become vital).

New laws governing mental health services have been adopted by The Norwegian Parliament (1999):

- A new law on specialised health services will

*There are 19 county municipalities, with a population ranging from 75,000 to 500,000. One half of the counties have a population of less than 210,000. Services are financed through local taxes (42 percent), mainly on income, government block grants (26 percent), special government reimbursements and grants (25 percent), plus fees (3 percent).*

## Organisation of health services

*Despite a low population density and long travel distances, equal access to health services is a central aim of the government's policy. As a consequence, health services are, on the one hand, seen as a national concern. The delivery of services is, on the other hand, 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.*

replace the existing law on mental health.

- A new law on the establishment and implementation of mental health care will regulate compulsory admissions and treatment.
- A new law on patients' rights codifies and extends the rights of patients.
- A new law on health personnel.

Of importance is also the adoption of «the list patient system», providing all citizens with a personal regular general practitioner.

## Information strategy

As an important part of the national programme for mental health, the Ministry of Health and Social Affairs has emphasized information on mental health. The Ministry has recently presented a information strategy. This has been worked out in collaboration with user organisations, two other ministries and non-governmental organisations. A main objective for this plan is information regarding mental health problems and disorders and openness in general about these issues. Information leads to dissemination of knowledge about people's own mental health and how to prevent such problems. Further on, higher awareness will 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
- the labour market (employers and employees)
- staff on all levels as well as users within the sector

The Ministry collaborates with different groups and organisations depending on the target group.

As a part of the programme and in order to highlight mental health issues, the international World Mental Health Day the 10. of October is expanded to one entire week. The Ministry of Health and Social Affairs is funding local activities like fairs, professional meetings and open houses in mental hospitals and clinics during this week.



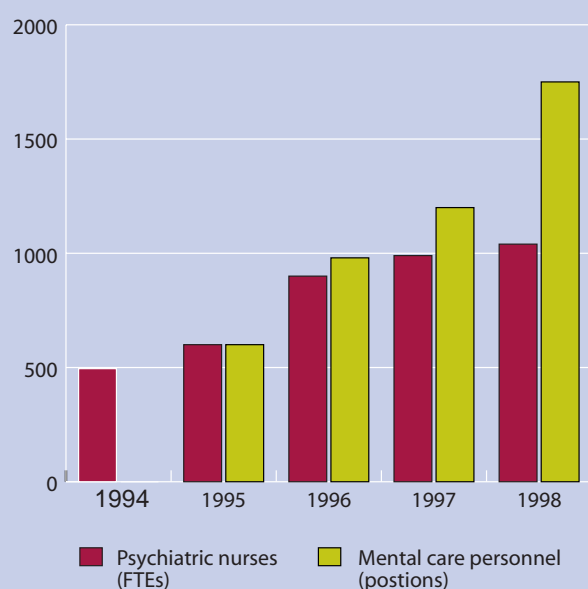
## 4. The services

### Municipal services: Co-ordinated services in the local community

The municipalities are responsible for preventive efforts and for providing primary health care, nursing and care, and social services. These laws also apply to people with mental problems.

According to the policy guidelines, increased emphasis will be placed on primary health care as well as the social services and the labour market services. Services for people with mental problems shall be provided by the same agencies that provide services for the public in general.

**Numbers of personnel qualified in mental health care 1994-98. (Full time enqiuvalents)**



The municipalities will play a key role in the provision and co-ordination of services to this group. The services provided are, however, still lacking in several respects. There has been 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 attention has

### Municipalities

*The municipalities are responsible for preventive efforts and for providing most primary health care and social services. This also applies to people with mental problems. The services provided include GP services, health visitors, support for children and their families, housing, supportive services in the homes, residences providing continuous care (ordinary nursing homes etc), social support and leisure activities, day-centres, training and work.*

been given to people with serious mental problems, requiring co-ordination of services over a longer period. 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 municipalities, and a legal right for the patients.

Regarding adults, special focus is being placed on

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

Regarding children and adolescents, services are directed towards the ones who already have developed problems or are in the danger zone. In addition, increased priority is given to preventive measures. User and relative participations are equally essential for children and adolescents.

Earmarked grants from the central government have been supplied for expansion of services provided by the municipalities. Over the period 1999-2006 annual cost of services to people with mental problems will increase by 500 NOK per capita (USD 60), equivalent to the growth in expenditures for specialised mental health services.

The supply of qualified personnel has been increased by expanding and reforming education given at colleges and universities.

### **Specialised mental health services**

The counties are responsible for providing necessary specialised health services. The Norwegian Parliament has recently adopted (1999) a new law on specialised health services, replacing these laws.

By integrating the two laws, the government wants to emphasise that mental health shall be integrated with, and run according to the same principles as other health services. The counties will still be responsible for providing services to the population. This responsibility is, however, defined by type of specialised functions, rather than a list of types of institutions. The law makes regional health plans a mandatory task. For people with long-lasting health problems, counties must establish an individual plan, co-ordinating necessary services for each patient.

### **Expenditures and financing of specialised services**

- Total expenditure for specialised mental health services amounts to NOK 1 680 (USD 225) per capita (investments and capital costs not included), or 0.7 percent of the GDP (1998). Expenditures are mainly channelled through publicly run institutions and services, accounting for about 90 percent of total costs.
- Services for adults account for 88 percent of the total costs. Inpatient treatment still accounts for nearly 80 percent of expenditures in adults' services. The percentage is less than 50 in children's and adolescents' services.
- Counties finance 80 percent of the costs. Government grants have, however, increased over the last years, now financing 17 percent. This trend will continue.
- Most inpatient services are free of charge.

### **Children and adolescent mental health services**

Child and adolescent mental health services have traditionally been provided on an outpatient basis. 95 percent of the patients are receiving treatment in this way. Outpatient treatment is usually delivered at units attached to general hospitals.

Inpatient treatment is delivered at clinics and treatment-homes. The clinics are usually attached to a general hospital. There are currently 328 beds in these institutions (1998), giving a

## **County municipalities**

*The county municipalities are responsible for providing specialised health services. These include all mental health institutions (including psychiatric nursing homes) as well as outpatient clinics, plus psychiatrists and clinical psychologists in private practices. Besides financing these services, the counties also own and run most institutions.*

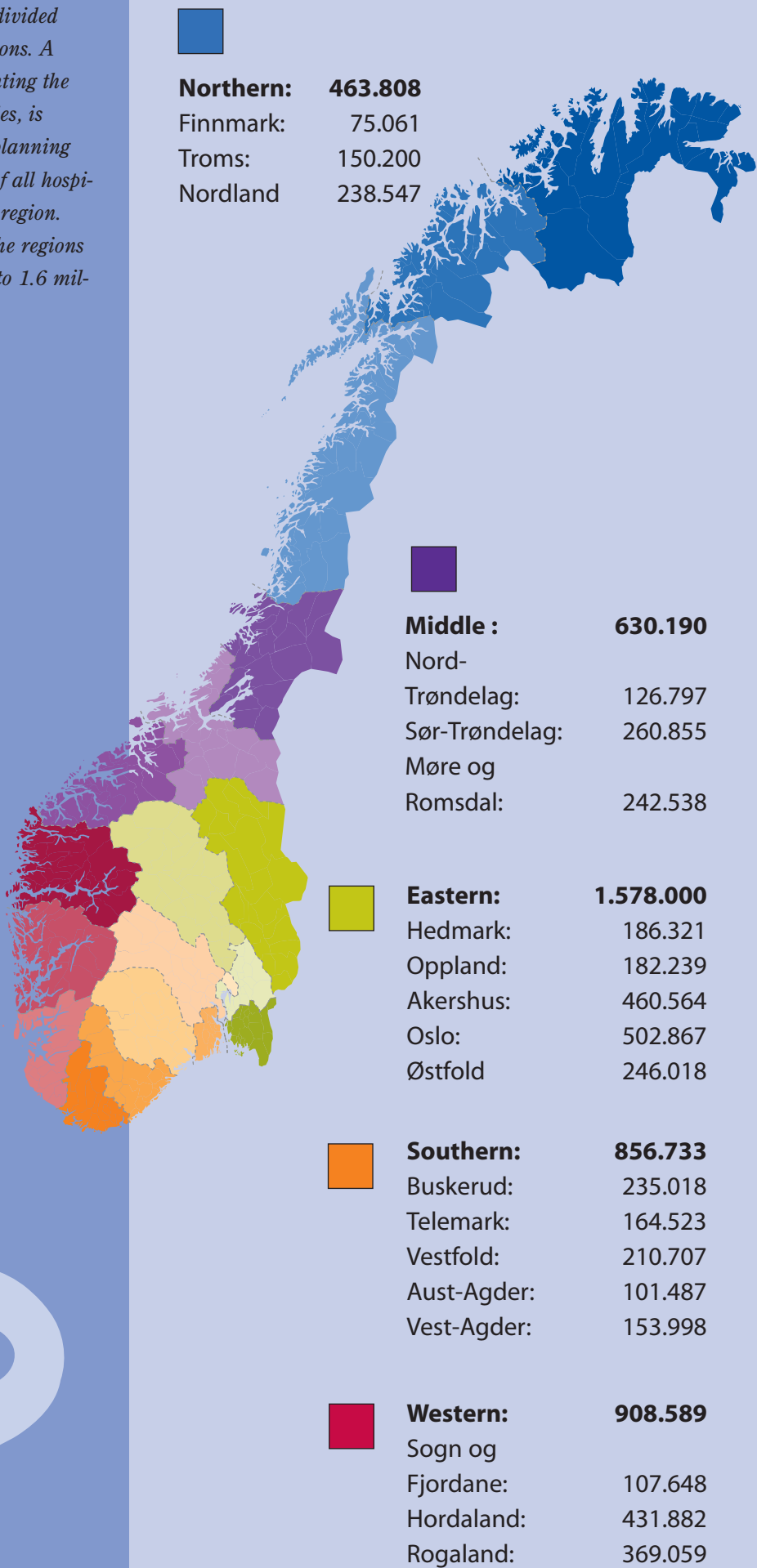
*A new bill: Transferring the responsibility for the specialised services*

*In April 2001, a bill was submitted to the Parliament where the responsibility for the specialised health services is suggested transferred to the state, to what is called state health enterprises.*

## Health regions

*For highly specialised functions, the country is divided into five health regions. A committee, representing the county municipalities, is responsible for the planning and co-ordination of all hospital services in each region. The population of the regions varies between 0.5 to 1.6 million people.*

## Norway: Health regions and Population 1998



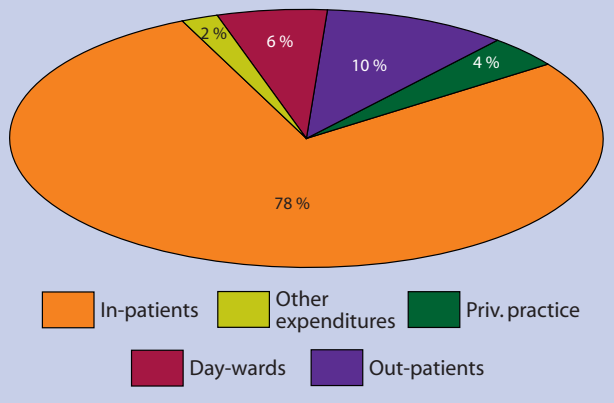
bed ratio (per 10 000, 0-17 years of age) of only 3.2. The child-protection services are, however, also providing institutionalised care. The roles of the different agencies are under consideration.

The staff qualifications are generally high. 25 percent of all personnel have a university degree, and an additional 50 percent have a college degree. The staff has increased by almost 25 percent over the last five years. There are still large regional variations in the provision of qualified personnel. Regional centres have been set up to improve this situation.

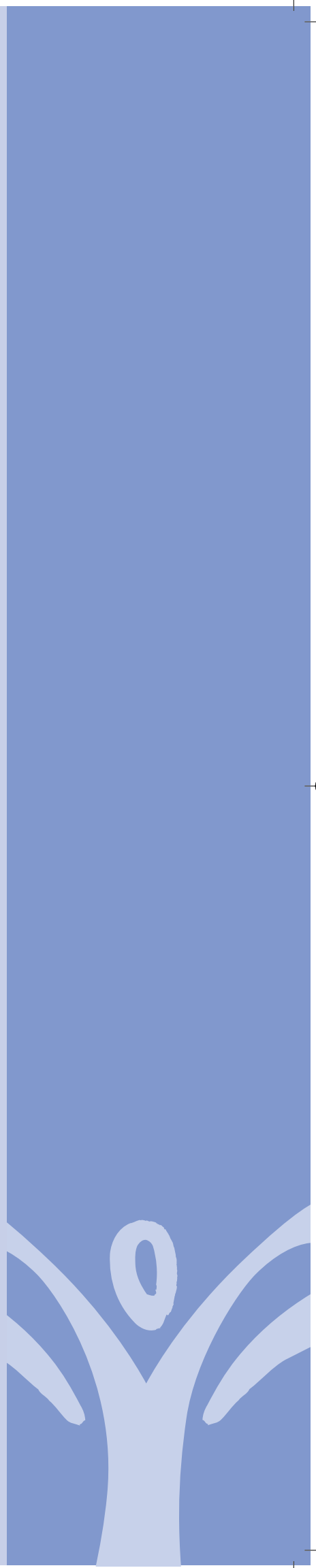
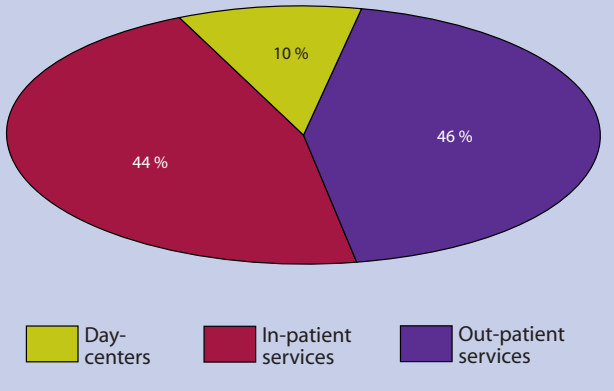
Two percent of the population aged 0-17 is currently receiving services from child and adolescent services. According to professional norms, five percent are in need of services. The government's policy is to achieve this level over the period 1999-2006. Regarding this group, main focus is on outpatient and family-based services.

### Expenditures for mental health services by type of service. 1996

#### Adults' services



#### Children and adolescents' services



## National level

*The Ministry of Health and Social Affairs is responsible for the formulation and implementation of the national health policy and policy guidelines. This includes legal, financial and organisational aspects as well as setting priorities on the national level. The Ministry supervises the distribution and co-ordination of services between administrative levels and agencies. The Ministry must sanction local plans on hospital developments.*

*The Norwegian Board of Health, assisted by County medical officers, supervises the running of services according to our medical and legal standards. The National Insurance Scheme, run by the central government, is responsible for providing sickness benefits, rehabilitation benefits and disability pensions.*

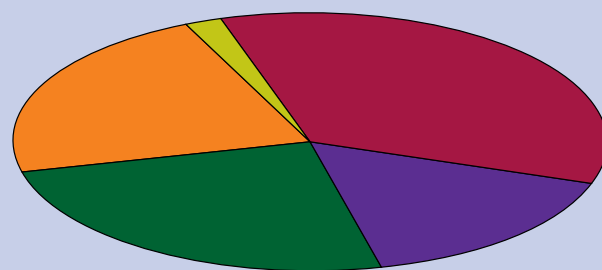
*The central government is also responsible for financing research and for the training of personnel at colleges and universities.*

## Mental health services for adults

There are currently (1998) 5975 beds in adult psychiatric institutions, half of them in psychiatric hospitals, clinics and psychiatric units in general hospitals. Since the end of the 1970s when each institution was given responsibility for a defined area, these institutions generally perform the same tasks. The hospitals still have some additional, more specialised wards. There are no forensic hospitals, but 150 beds in ordinary institutions are staffed for handling dangerous patients.

### Beds in psychiatric institutions for adults. 1998

Beds in all: .....	5975
Per 10,000 18 years and older: .....	17.5
Per 10.000 all age groups: .....	13.4



- Nursing homes
- Other institutions
- DPCs\*\*\*
- Psychiatric hospitals\*\*
- Psychiatric Clinics and GHUs\*\*

- Includes beds in psychiatric hospitals formally organised as GHUs (16 % of all beds)
- General hospital units
- District psychiatric centres (DPCs)

The specialised services shall give guidance to the municipal services. It is a goal to establish a comprehensive and coherent treatment network based upon user's participation.

The restructuring process of the specialised services is characterised by:

**De-centralisation:** There seems to be a growing understanding that maybe the most important task of the specialised services is the one of making the municipalities able to solve their tasks concerning people in need of services. This includes the capacity of giving back-up when

specialised competence is needed or specialised intervention (acute or not) is requested. The major instrument in this respect is the one of establishing district psychiatric centres (DPCs) throughout the country.

In the future the specialised mental health services for adults will consist of three elements:

- specialised mental hospital wards (acute illnesses, specialised functions)
- district psychiatric centres (general psychiatric services within a geographically limited area)
- specialists (psychiatry, psychology) with a country municipality contract.

The volume expansion of the services will be implemented through polyclinics and day treatment.

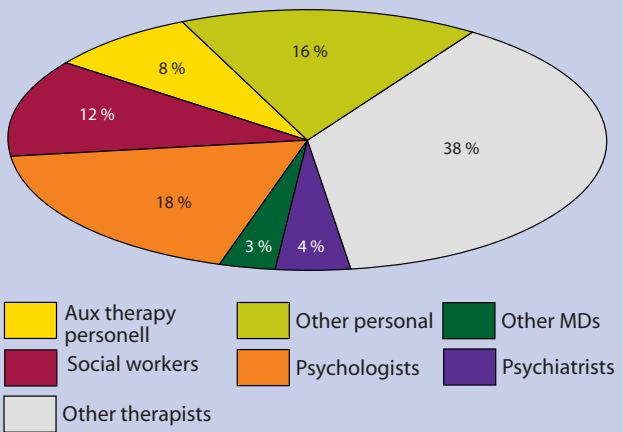
**Specialisation:** The other important task of the specialised services is to develop and provide more differentiated treatment for patients with special needs, for instance intervention techniques and treatment programmes for severe psychosis, serious depressions, eating disorders etc.

A major element in the National Action Programme for Mental Health is establishing DPC throughout the country. The DPC concept is still under development and the DPCs will hopefully

**Personnel in child and adolescent services 1998. By profession**

*Personnel in all (full time equivalents): 2155.*

*Ratio per 10 000 aged 0-17: 20.7*



over time develop optimal functions adapted to local conditions.

It is assumed that an appropriate coverage for a DPC should include 30.000 - 50.000 inhabitants, depending on local geography.

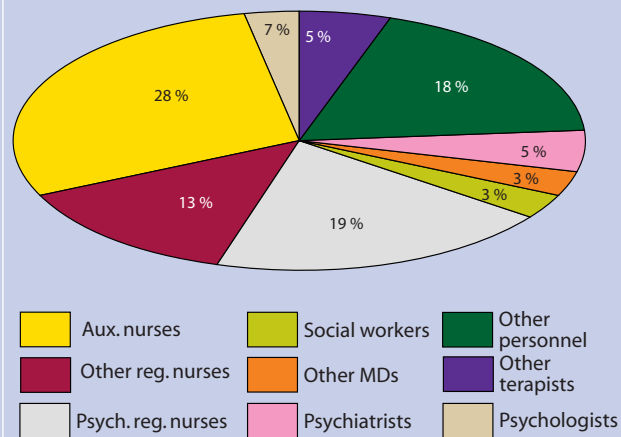
To ensure a focus on local needs and on close collaboration with municipal staff DPCs are recommended as professional independent units. As to administrative structure a formal connection to a local general hospital should be considered.

**A DPC should provide the following services:**

- Outpatient clinics/ambulant services
- Daytime treatment
- Short-time inpatient treatment
- Long term treatment and rehabilitation
- Consultation, supervision and support of municipal staff
- Acute services (If long distance to mental health hospital) and crisis intervention

**Personnel in adult psychiatric services.  
Full time equivalents 1998**

Personnel in all (full time equivalents): ..... 14,200  
 Per 10,000 18 years and older: ..... 41.7  
 Per 10,000 all age groups: ..... 31.9



Other services that may be considered are interdisciplinary teams for so called «double diagnosis» (drugs and mental illness) or for other



patient groups needing special competence. Acute services are to be considered in cases of long geographical distances to mental hospital.

In general, staff qualifications have risen considerably over the last decade: 15 percent of personnel now have a university degree, and an additional 40 percent have a college degree.

Over the last 20-30 years, there has been a marked reduction of inpatient days, a slight increase in admissions and a considerable increase in outpatient consultations. The Norwegian Parliament has voted against further reductions in bed capacity until alternative services have been established.

### **Compulsory detention and treatment**

The use of compulsory admissions 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 on an earlier stage. Criteria for the use of force will also be stricter. Coercion shall only be used in cases where acceptable voluntary solutions cannot be found.

A new law covering the use of compulsory admission, treatment and other forms of coercion has recently been passed by parliament. Compulsory admission and treatment requires that the patient has a serious mental illness and that at least one of two additional criteria are 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 accep-

table types of coercive treatment and expands the patients' rights of appeal to a supervising commission or to the courts. Recent studies indicate a drastic reduction in the use of mechanical restraints and isolation over the last two decades.



## 5. Strengthening patients' rights

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

- Right to necessary treatment and care.
- Right to an evaluation of the need for treatment within a maximum of 30 days.
- Right to an individual plan for treatment and care.
- Right to a second opinion.
- Right to choose where to receive treatment. This applies to hospitals as well as district psychiatric centres.
- Right to be heard, give consent to and to receive necessary information on treatment.
- Right to see the medical journal.
- Special rights for children.
- An independent patients' ombudsman in all counties.

*During the last decades, the mental health services in Norway have undergone significant changes. In June 1998, the Norwegian Parliament adopted the National Programme for Mental Health (Proposition no 63, 1997-1998). The National Programme represents a major expansion and restructuring of the mental health services. This brochure gives a general introduction to the mental health services and policy in Norway.*

Published by the

## **Norwegian Ministry of Health and Social Affairs**

Further copies can be ordered from  
Statens forvaltningstjeneste  
Informasjonsforvaltning  
P.O. Box 8169 Dep, 0034 Oslo, Norway  
E-mail: publikasjonsbestilling@ft.dep.no  
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Please quote publication number I-1025 E

Internet: <http://odin.dep.no/shd/engelsk/publ/veiledninger/>



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