Norway, Mental Health and WHO

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1. Introduction

In this report we explore the relationship between the World Health Organization and Norway in the context of mental health. As far as we know, this issue has not been addressed before. First, we outline the historical relationship between Norway and WHO in general, and then in terms of mental health, in particular the Norwegian impact on the 2005 Helsinki Conference that resulted in the Helsinki Declaration and Action Plan. Finally, we discuss that Declaration and Plan and its impact on Norwegian mental health policies. Taking parallelism in time into account, we address throughout the paper the potential circulation of knowledge between the WHO Helsinki Declaration and Action Plan (2005) and the Norwegian Action Plan on Mental Health (1997 – 2008).

1.1 Methodology

The findings reported are based upon policy documents and interviews with informants, mainly from the Ministry of Health and the Directorate of Health, the two significant agencies for mental health services in Norway. At the Directorate of Health we interviewed two persons from the International Department/Secretariat, one of them the manager of the department. We also interviewed representatives of the Department of Mental Health in the directorate and the Ministry of Health, who were in charge of either the Action Plan or WHO/Norway relations. In all, nine semi-structured in-depth interviews were conducted. The literature review examined national health policy documents, plans, reviews and reports and budget submissions.

In addition we have been searching through academic and professional journals to find the ways that WHO and the Helsinki Declaration are addressed in publications during recent years. The journals were:

- Journal of the Norwegian Medical Association (2000-2009)

Surprisingly, in these journals there is only one reference to the Helsinki Declaration (in the Journal of Mental Health), a remark stating that Norwegian mental health policies are in accordance with the Helsinki Declaration. (Actually the Journal of the Norwegian Medical Association has several references to the "Helsinki Declaration", but this is a different declaration, dealing with ethical recommendations for medical research.)

We have also searched the budgets of the Health Ministry for references to WHO. As far as we can see, WHO policies seem to be considered relevant for two reasons; first, WHO is apparently an important instrument in Norwegian foreign policy, since most of the
funds transferred from Norway to the WHO are financed from the budgets of the Ministry of International Development. Norway allocates funds as a general fee to the WHO and also to special programs, amounting to its largest contribution. We will offer two explanations for this. First, funding WHO special programs is a way that the Norwegian government can demonstrate its willingness to help developing countries, while maintaining control over these funds, through detailed specifications in the ministry’s budget documents on those WHO activities to which Norway will give priority. Second, WHO sets up expert committees and publishes expert reports on several topics and is considered to be an important recipient of expert advice from Norway. The informants maintain that these reports have a high status in Norway, and participation in producing these reports is accordingly given high priority. Standards set by WHO are often used as arguments for having corresponding Norwegian standards.

2. The relationship between Norway and the World Health Organisation

In the following, we describe the relationship between WHO and Norway in general, before turning to the mental health field. In short we find that the relationship between WHO and Norway is strong and has become institutionalised since the formation of the WHO in 1946-1948. Nevertheless, the impact on WHO policies seems to be rather superficial and difficult to trace except for some specific issues.

2.1 History of the Norwegian relationship with WHO

Norway has been a WHO member since its foundation in 1948, and has had prominent representatives in central WHO positions. Former Norwegian Prime Minister Gro Harlem Brundtland was Director-General of WHO from 1998 to 2003. The present Director-General of Health, Bjørn Inge Larsen, now heads the board of the WHO Regional Committee for Europe. Today, Norway is the third largest contributor of voluntary additional contributions to the WHO, after the USA and the United Kingdom. Norwegian contributions to WHO are financed mainly through the budgets of the Ministry of International Development, rather than the Ministry of Health.

Since the formation of WHO, Norway has been one of the key actors in the design of the organisation. According to the Norwegian historian Trond Nordby (1994), Karl Evang, the Director-General of Health from 1948-1970, the key entrepreneur behind the Norwegian health system developed in the wake of the second World War, played an important role in designing the WHO organisation. His idea, according to Nordby, was to make WHO a global instrument for health promotion with a role similar to that of the Directorate of Health in the national health care system. (In Norway this system is generally known as the “Evang health system”). Since that time, representatives of the Ministry of Health,
the Directorate of Health, hospitals and the medical profession have participated extensively in WHO work, including its work on mental health. In recent years, the “Knowledge Centre for Health Services,” which has a key role in promoting evidence-based medicine in Norway, has also been involved. Representatives of the Centre today collaborate extensively with WHO. One point that seems important is that there has been until recently a high degree of compatibility between the structure of WHO and the structure of the directorate, and collaboration between the two in the field seems to be eased by their similar organisational structures and policy approaches.

The Directorate of Health has several spheres of activities: public health, specialised services, community/local services and mental health services. Within the directorate, the Department of Mental Health encompasses both specialised and municipal levels of services, but since it is by far the smallest department in the directorate, mental health relations with the WHO seems to be less extensive than for the two larger departments. In those departments, although mental health is not a central task, a tradition of health promotion and decentralisation of health services seems to fit well with the general approaches and structures of WHO.

In 1998, during a period of crisis, Gro Harlem Brundtland, a Norwegian doctor with a special interest in public health in the tradition of the “Evang health system,” took office as director-general of WHO. Representing the Social Democratic Party, she had been Prime Minister three times (1981, 1986-1989 and 1990-1996). To cope with mismanagement, corruption, lack of international esteem and low funding, she supported a so-called new rationalist mode of management, a target-driven managerialism. According to Lerer and Matzopoulos (2000) Brundtland worked hard to improve WHO, applying a strategic process of planning and monitoring, clarifying and articulating its vision and values, formulating its mission and goals, defining priorities and allocating additional resources.

In 1998, in her opening address to WHO, Brundtland highlighted prevention and treatment of mental health problems as one of nine areas of priority. The other main topics were: fighting malaria, HIV/AIDS, tuberculosis; curbing the tobacco epidemic; improving material health; reducing cancer, cardiovascular diseases, diabetes, chronic respiratory diseases; campaigning for safe blood and improving food safety. She also advocated improving national health systems as well as the WHO organisation.

From 1998/1999 to 2000/2001, the WHO funding of the field of “social change and mental health” was increased by 25% from US$30,255 thousand to US$37,719 thousand (Lerer et al. 2001). In 2001 the World Health Report on Mental Health, “New Understanding, New Hope” was presented. Despite these initiatives while Brundtland was
director-general, the mental health issue remained a minor area in WHO (Lerer and Matzopoulos, 2000).

Gro Harlem Brundtland is known for being an eager advocate for WHO to regain its position as the global leader on health issues and health policies. In this respect she followed Karl Evang's vision. According to our informants the structure of the Norwegian government was her model for change. She was more visible than earlier directors-general, making several public appearances a week, writing articles and making contact with political leaders and business players as well as the media. In addition to this, Brundtland developed a new approach for working with donors, emphasizing strong and personal relationships, with the aim of improving the financial situation of the organisation. She spoke out for a rational, evidence-based, programmatic and project-oriented approach to combat the global burden of disease. This included quantifying disability and mortality in order to provide a scientific indicator for involvement, intervention and distribution of resources. According to Lerer and Matzopoulos (2001) she was following the approach advocated by the World Bank in the early 1990s (1993).

Brundtland's own background as Minister of Environment in the 1970s and as chair of the World Commission on Environment and Development in the 1980s made her sensitive to the need to see health and environment as related themes. Brundtland was also advocating economic growth as essential for strengthening the responsibility of households or families for their own health. In Norway, her position in WHO made the organisation well known in the public sphere, and also seems to have had some impact on ongoing concerns with WHO in the health bureaucracy.

2.2 The impact of WHO on Norwegian mental health policies and of Norway on WHO

The WHO Regional Office for Europe (WHO Europe) has a separate unit for mental health issues, with a network of national counterparts on mental health. Dr Mathijs Muijen is the regional advisor on mental health. The Norwegian participants in this network are Thor Rogan of the department of specialist health services at the Ministry of Health and Care Services, and Freja U Kärki of the department on mental health of the Directorate of Health. It is however, the international department of this directorate that is responsible for coordinating all issues regarding WHO, including initiatives taken by other ministries and directorates.¹ The mandate of the international department is to prepare governmental approaches to WHO. The main initiatives from the Norwegian government

¹ There are several agencies addressing the WHO at different levels that do not involve the international department of the HD.
towards WHO are well coordinated and, where necessary, approved by the political or administrative management levels of the Ministry of Health and the Directorate of Health, whereas there is less coordination and systematic review of WHO’s recommendations. To some degree, the agencies within the health and social sectors (in the ministries, hospitals and municipalities) cite WHO when it supports their own arguments, or decisions already taken.

In major Norwegian health policy documents, such as the National Health Plan [Report NO. 41 (1987-88)], mentions of WHO recommendations are somewhat infrequent. In Norwegian mental health policies, such as the Action Plan on Mental Health, there were no references to WHO documents. After the publication of the World Health Report on Mental Health (2001) references to it have sometimes been made, but only at a very general level.

In the Bill leading to the new “Mental Health Care Act” [Recommendations NO 73 to the Odelsting, 1998-99] there is a reference to WHO recommendations on how to treat people in need of coercive treatment, however, the Law does not comply with them. WHO recommends that coercive treatment should be decided by a forum consisting of both medical and laypersons; in Norway, however, decisions on coercive treatment are delegated to psychiatrists. This practice indicates the strong position on specialised mental health services held by the medical profession, and it reflects also a focus on biomedical knowledge as basis for specialised services.

3. The Helsinki Declaration and Mental Health Action Plan

3.1 Prior to Helsinki

As our informants point out, there are great similarities between the approaches to mental health in the Norwegian Action Plan and in the Helsinki Action Plan presented nine years later (Rogan 2008). When WHO put mental health on the agenda, Norway had highlighted this issue for many years. The Action Plan was based on Norwegian policies from the mid-1970s (Evaluation of the Norwegian Action Plan on Mental Health, Final Report 2009). The new national program was published in 1996 (Report NO 25 (1996-97), approved in 1997 (Proposition NO 63, 1997-98) and implemented from 1998 onwards. First an eight-year long action period was proposed, but because the implementation of services in the municipalities went more slowly than expected, the plan was extended until the end of 2008. The overall goal of the Action Plan was founded on a new understanding of mental health service provision, aiming at strengthening community care and including mental health care within general primary health care (Ramsdal et al 2002). To accomplish this, a threefold approach was recommended: development of community care and inclusion of mental health services in primary care
as delivered at the municipal level, improvements in professional cooperation and inter-sectoral collaboration and promotion of users’ perspectives as well as their involvement and participation (Ramsdal et al 2008).

First, municipalities will play a main role in providing as well as co-ordinating services for the mentally ill. The Action Plan highlights satisfactory housing, possibilities for participation in labour market activities and necessary health and social services in addition to increasing focus on preventive measures.

Another characteristic of the Norwegian Action Plan is its focus on human resources, including both health and social professionals in various fields, and unskilled and semi-skilled personnel. The programme details the numbers of medical doctors, psychologists, psychiatric nurses, personnel from other health/social occupations and also the number of unskilled and semi-skilled personnel needed to provide adequate services. The plan also refers to the actual numbers of personnel needed in community care and in specialist care respectively. Moreover, it is seen that an increase in the number of health workers in community care is a prerequisite to improving mental health services at a local level. The aim is to build a “sufficient and competent mental health workforce” and to integrate mental health services with the general services provided at the local level. This integration of services varies in accordance with the existing units that are providing services in communities and municipalities (Myrvold and Helgesen 2009).

A third characteristic of the Norwegian Action Plan is the role to be played by user organisations. In an interview, the administrative leader of the largest user organization on mental health confirmed that without the efforts of the user organisation there would not have been an Action Plan at that time (Høifødt 2005). When the Action Plan was prepared as well as implemented, the Minister of Health arranged at least two formal meetings with the user organizations every year. In addition there were various meetings and forums where user organizations and representatives from the ministry discussed matters of common interest. Norway is a small country, and political leaders, managers and representatives of user organizations attend the same conferences and meetings, forming networks. User involvement and user organizations have for many years been an important element in Norwegian health policies.

The terminology used in other WHO publications resembles the Norwegian Action Plan, particularly in the 2001 WHO report “Mental Health: New Understanding, New Hope”. According to our informants, Norway has been inspired by WHO, while at the same time WHO in many cases has cited Norway as inspiration in the mental health field. Knowledge has circulated between the two agencies for many years; WHO has been influenced by the Norwegian Action Plan as well as by the Norwegian tradition in the mental health
field. Norway, together with several other member states in the WHO, is a country that has a long tradition in policies for providing mental health services and implementing new polices and services, and is a source of inspiration for other countries. However, national priorities, traditions and economic resources vary a great deal among the member states and therefore services, methods and models cannot be transferred without modification.

In 2004, five years after the implementation of the Action Plan, the Ministry published an English summary of the plan, titled “Mental Health Services in Norway”. The document refers to eight main goals of the plan:

- increasing public awareness of mental health issues through information programmes
- strengthening the position of users
- strengthening community-based services provided by local municipalities
- expanding and restructuring specialized services for adults
- expanding services for children and adolescents
- improving labour market services
- assisting with accommodation and housing
- stimulating education and research.

In addition to these objectives, prevention and early intervention, reduction of compulsory detention and treatment and the strengthening of patients' rights were highlighted (Mental Health Services in Norway. Prevention – Treatment – Care, 2004).

According to our informant the action plan was translated into English to inform the group working on the Helsinki Declaration: “Norwegian politicians wanted to inform Europe of their great effort to improve the Norwegian health services in the mental health field”. (Informant) He also says that the political debate on the Action Plan in 1996-1997 pointed to one central concept supposed to be used for understanding the provision of mental health services in Norway: “empowerment” (Rogan 2008). Empowerment is the concept used throughout the WHO 2001 report, and in the Helsinki Declaration there is a chapter devoted to empowerment and mental health advocacy. Empowerment and advocacy are seen as important mechanisms for addressing the challenges in providing mental health and wellbeing all across Europe.

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2 The Norwegian term used in the document referred to above translates as “mastering”. This is not considered a good translation, but in terms of the notion’s content – social coherence and participation – it is the Norwegian equivalent to empowerment.
3.2 The Helsinki Meeting

By the time of the meeting, the Declaration and Action Plan had been drafted, redrafted and crafted for months. The text did not change during discussions at the conference. The main aim was to legitimate and even authorise the documents. The Helsinki meeting concentrated on twelve key areas and the member states were committed to move the mental health services in their countries towards twelve milestones between 2005 and 2010. Another aim of the meeting was to discuss how to make these moves.

The 12 milestones may be summed up as follows: (1-3) to counter stigma and discrimination, and to prevent suicide, (4-5) to develop specialist services for the young, for older people, and for other marginalised groups, (6-9) to develop partnerships and inter-sectoral working, to build a competent mental health workforce, by defining relevant indicators, by confirming funding, regulation, legislation etc., (11-12) to legislate on human rights, increase social inclusion and ensure representation of users and carers at all levels.

The Norwegian initiatives at the meeting were traced through documents written by the delegates, and several of the delegates were interviewed. The following quotation stems from an unpublished minute from the Helsinki meeting:

Norway gives it’s full approval and support to the Declaration and Action plan. However, there are certain aspects of the declaration and action plan that need further comments:

- Even though children and adolescents are mentioned in both documents, there is a need for greater emphasis on the area regarding mental health and well being of children and adolescents, especially children who have parents with mental disorders.

- There is reason to be concerned about how the implementation of these documents will be followed up. The adoption and signing of the Declaration and Action Plan is only a starting point – what about further monitoring and evaluation? (end of citation).

This text tells us that the Norwegian delegation highlighted two issues: (1) services for children and youth and (2) how to construct indicators for monitoring and evaluating that the milestones had been reached. In addition a third theme was underlined, that of user representation (3). According to our informants the most important contribution from the Norwegian delegates in Helsinki was the emphasis on the user perspective. The proposal for the text of the declaration did not contain any strong formulation of this issue, but, as
a result of a Norwegian initiative (we are told), the Helsinki declaration was given a more distinct user perspective. All the delegates played an active role during the meeting, including the user representatives. The delegate representing the authorities expressed the view that the user organisations were constructively active during the whole conference, contributing valuable remarks and viewpoints during the plenary and parallel sessions.

The milestones highlighted users and carers' representation. According to our informants, the Norwegian participants were a notable influence on the issue of "user participation" (strengthening the users' position). They referred to this as the "users' perspective", emphasising the importance of the "users' experiences" of their own situation. In the English summary of the Norwegian Action Plan, this is described as: "Participation is also vital for empowerment and for the ability to master one's own life. This is of great value and forms the central vision of the National Programme for Mental health." (Mental Health Services in Norway. Prevention – Treatment – Care, 2004).

The official Norwegian delegates to the Helsinki Ministerial Conference in 2005 were comprised of two from the Ministry of Social Affairs and Care Services, two from user organizations (Mental Health Norway and Norwegian National Association for the Families of the Mentally Ill), and one from the Directorate of Health. In addition, the research director from a leading research institute on health issues (SINTEF) was invited to join the delegation as an advisor. We assume that several of which according to our informants started in 2003. Unfortunately we have not been able to find out who did represent Norway participated in the preparatory work.

The fact that two of the five delegates represented users’ organizations supports the view that user participation was not only an ideal goal but also a political reality – the users’ organisations were invited into arenas where they potentially could influence European mental health policies. Only 12 of the 52 delegations had representatives for users among them, in spite of the fact that WHO had requested that each country’s delegation should have one or two representatives from user organizations among their official delegates in each delegation.

All in all, the Norwegian approach to the Helsinki Conference may be characterised as ambiguous. On the one hand, it continued to further Norwegian knowledge and

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3 Jan Otto Risbrobakken (State secretary, Ministry of Social Affairs and Care Services, SACS), Thor Rogan (deputy director general, Ministry of SACS. Erling Jahn (mental health Norway, leader in three periods), Bjørg Njaa (NNAF of mentally ill), Dr. John Glad (senior medical adviser in HD) and dr. Thorleif Ruud (research director at Sintef).
experiences regarding services for the young, user representations and work on indicators, monitoring and evaluation. On the other hand, the delegates were influenced by the “crisis definition” in mental health in Norway at that time. The national plan had described the present situation with a much-cited expression: “Svikt i alle ledd” (“failings in all links”). Thus the delegates hesitated to focus on other characteristics of Norwegian mental health services, such as coercive treatment, which was not a practice that should be “exported”. And they were not proud of the high number of psychiatric hospital beds and the use of involuntary admission, restraint and seclusion in particular. Accordingly, the Norwegian delegates representing the formal authorities felt they, “had to keep a low profile” (Informant). It seems as though the delegation made a strategic choice to focus on user participation and services for children and young adults, and the composition of the delegation reflected this.

4. The impact of the Helsinki Declaration and Mental Health Action Plan on Norwegian mental health policies.

4.1 After Helsinki

The Helsinki meeting has mainly had a small and indirect impact on the Norwegian services. Our documentary review tells us that, as far as we have observed, the references to the Helsinki Declaration and the WHO Action Plan were initially almost negligible. The State Budget documents make no reference to WHO’s work ahead of the Helsinki meeting. However, since the WHO World Report on Mental Health (2001) and the Helsinki Declaration and Action Plan (2005) more direct references have been made, for instance in the Norwegian Action Plan Guidelines of 2006/7 on adults, municipal services and children respectively, produced by the Directorate of Health, and also in the Health and Care Ministry budgets since 2006. The reference in the budget proposals in 2006 is only a short description of the main principles in the declaration and a reassurance that the Norwegian Action Plan is founded on the same principles.

According to our informants, these references were mainly included to confirm the principles of mental health service provision that were already approved in the Norwegian Action Plan. Thus, the WHO impact on mental health policies in Norway seems to be vague and indirect at best, probably mostly symbolic in relation to the country’s Action Plan, as national policies would not be challenged or changed because of the WHO recommendations and declarations.

Although the Norwegian Action Plan may be characterised as a comprehensive document, it does not cover all the issues related to mental health, so that the Helsinki Meeting has
provided important arguments, whereas the Norwegian Action Plan had some shortcomings.

4.2 Community Based Mental Health Services and Specialist Services

One issue is the allocation of resources to hospitals or community-based mental health services. The Action Plan is not very explicit on this issue, being an eclectic “compromise” between traditional approaches to mental health (“psychiatry”) and community-based provision of services. Consequently, Norway still has one of the highest numbers of hospital beds in mental health per capita. In spite of the Norwegian Action Plan’s emphasis on community-based services, mental health services still reflect an ambiguous strategy on this point, partly explained by the strong position of the medical profession. The Helsinki declaration and action plan may be used as an argument for more community-based services, sometimes taking the form of a “hidden message” in the texts, obviously so as not to confront “traditional” psychiatry too much. For instance, in the budget documents there are several comments that other countries (UK, Italy etc) are closer to the aim of the Helsinki Declaration and Action Plan, having reduced the number of hospital beds and directed more resources into community-based services. The aim of the Norwegian policies on mental health seems to be increasing the focus on both municipal and specialist services (DPS and BUP). The main summary of the action plan period concludes that the quantitative aims have been reached, with a few exceptions in terms of beds for adults in specialist hospitals.

Representatives from the Ministry and the Directorate are more outspoken than representatives from the municipalities who are in charge of community based services. Here, the Helsinki Conference is used as an argument to convince local authorities of the importance of giving priority to comprehensive local mental health services. Further, the Helsinki Declaration and Action Plan provide arguments for extending the scope of local service provision into other service fields. According to the Helsinki meeting, a well-functioning and comprehensive mental health service must encompass the education and culture sectors as well as the health sector, a point raised by state representatives in meetings with local agencies.

4.3 Human Rights and User Representation

In 1993, the government proposed a separate act on patients’ rights. This was not followed up and one reason for this may have been that it was too ambitious. But in 1999 a new Bill was put forward and this led to a new “Act on patients’ rights”. Norway

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4 DPS = District psychiatric centre, BUP = Children and Adolescents’ Psychiatric Polyclinic Services
was the first country in the western world to have a separate law on patients’ rights. This illustrates the strong place that user involvement and user organizations have in Norwegian policy, balanced by the long-lasting tradition that the health sector is the stronghold of the medical profession – particularly psychiatrists in the area of mental health. Norway enacted a new law on patient’s rights in 1999.

The Norwegian Action Plan had an approach to human rights that differed from the WHO Declaration and Action Plan. The Helsinki documents emphasize the need for actions in order to “tackle stigma and discrimination”, sending strong signals to both local authorities and to professionals. Local services have to be created in such a way that people suffering from mental health problems can participate in the ordinary activities of the society. In this respect, the Helsinki declaration is more explicit than the Norwegian Action Plan, and so representatives from the ministry are using the declaration to argue for the ways that the municipalities should create their services.

The notion of stigma is not included in the early Norwegian political documents on the Action Plan. The theme addressed in “enlightenment by information” campaigns, is the need for the inclusion of people with mental problems in local communities and the incorporation of specialist services in the general primary health care provided in them. The notion of stigma appears first in the preparatory work for new legislation in the field in 2005 (Proposition to the Odelsting NO 65, (2005-2006). At a later date, stigma was discussed in an informative article by Thor Rogan, head of department in the Ministry of Health and Social Affairs (Rogan 2008).

In the Norwegian Action Plan, human rights are included as a theme, qua "patient rights". In the Proposition to the Odelsting NO 63, (1997-98), we can read: "voluntariness as much as possible - the treatment must be offered as open, normalised and voluntary practices." Human rights were included as a theme in the Bill leading to the enactment of “The Mental Health Care Act,” which is the law relating to the provision and implementation of mental health specialist services (Act NO. 62 of 2 July 1999). Consequently, the human rights issue is dealt with in different ways in policy documents regarding specialist services (as a law) and in the municipalities (as general principles of integration of people with mental health problems). Up to a point, this seems to reflect the fact that the state policies addressing mental health exist as two semi-autonomous systems – for the specialised services in hospitals and for the community services provided by the municipalities.
4.4 The baseline study: monitoring mental health

In 2008 the WHO European Region published a baseline study, co-funded by the European Commission: "Policies and practices for mental health in Europe." The main aim was to gather and develop comparative data about the state and progress of mental health services across Europe. The baseline assessment may be seen as a monitor for comparing how the member states met the challenges of the Helsinki Declaration and Action Plan. A senior adviser in the Department for Mental Health of the Norwegian Directorate of Health participated in this work.5

The WHO report admits that there are great weaknesses in ways the indicators were applied, but one finding in the study is that there is great diversity in the ways that mental problems are addressed between European countries. Another insight is that community-based services are growing, but that there is a long way to go to eliminate what are referred to as "poor institutional practices". Third, the most exciting development, according to the Regional Director for Europe, is an increase in empowering services and users’ involvements.

As far as Norway is concerned, the report covers the two tracks of the Norwegian mental health services described earlier. On the one hand, a great commitment to community-based services, where the main focus is on mental health and user involvement, and on the other hand, hospital-based services with a focus on neuropsychiatric disorders, as well as involuntary admission and restraint.

The baseline study shows clearly how Norwegian mental health services follow two tracks; on the one hand they focus on community care, on the other they still provide a large number of institutions and beds for mental health patients. In community-based services, user involvement and strategies for handling mental problems are on the agenda, while the report says that in the institutions psychotropic drug treatment and coercion were important element of therapeutic practice. The comparative study shows that Norway uses more force (exercises more coercion) than many other European countries and that it has more beds per 1000 inhabitants than many other countries. As mentioned above, these facts may constrain Norwegian strategies from taking the offensive in mental health in the WHO setting. And, as our informant says, WHO has ideal goals and the member states are very different in many aspects.

5 Ms Freja Ulvestad Kärki, Senior Adviser, Dept. for Mental Health, Norwegian Directorate of Health.
5. Conclusions

The relationship between Norway and WHO with respect to mental health is embedded in a long tradition of Norwegian support of WHO. Generally, the indication is that Norway is giving WHO high priority, reflected in offering it extensive financial support and expertise. However, in mental health this relationship seems far more complex and ambiguous than would be expected on the basis of this tradition, for both cultural and knowledge-related as well as structural issues. One might conclude that the relationship between Norway and WHO in this field appears to be:

- Focussed upon community-based mental health services, particularly in the public health tradition, and to a limited extent upon specialised services.

- A shared view that mental health services should be based upon provision of community-based service.

In Helsinki, Norway’s contribution particularly dealt with presenting user empowerment, while keeping a low profile on other issues due to its ambiguous approach to mental health development divided between specialised/hospital services and community-based/municipal services.

All in all, WHO recommendations are not changing Norwegian mental health policies, but subsequent to the World Health Report, the Helsinki Declaration and the WHO Action Plan are being cited to support policies already approved.

The image of Norway as an active partner in WHO seems to be related to the history of the relationship between the two (particularly to the role of some high-profile participants), to the extensive funding from Norwegian governments, and to health issues not related to mental health. There are few indications that Norway has played an important role in the work on the Helsinki Declaration and the WHO Action Plan – apart from the issue of user perspectives/participation and services for children and adolescents.

Anglo-American countries, the UK in particular, seems to have attained a prominent role in WHO, and according to our informants, WHO was particularly concerned with mental health developments in Eastern and Central Europe, and was looking for examples of strategies for closing down the asylums and strengthening community-based services. At the time of the Helsinki Meeting, it seems as though Norway did not represent an example to follow, given the structure of their services, apart from the ambitions of the Action Plan. At that time, mental health in Norway was a policy field where the strategies
were based upon the declaration of crises. Also, characteristics of the specialist services were regarded as contradictory to the WHO recommendations, and consequently a low-profile strategy seems to have been adopted. In addition, since the Norwegian Action Plan had a sociological profile advocating a build-up of community services, there was still ambiguity about reduction of hospital beds.

At the Helsinki meeting Norway could not merely present good intentions. The Norwegian Plan at that time had been in action for some years, and Norwegian representatives had to be prepared to answer questions about what they had achieved from it. In the beginning of the Action Plan period the researchers studying the implementation of the plan reported little progress, which might be one reason that Norwegian representatives kept a relatively low profile, except for the issue of user perspectives.

Another explanation could be that the Helsinki Declaration was an initiative from the regional branch, WHO Europe. For some reason it seems that Norway has a weaker connection to WHO Europe than to the global WHO. Many European countries have their own WHO office – Norway does not.

In spite of shared ideology, in the Norwegian Action Plan and the Helsinki Declaration, of ways to develop mental health services, there are no indications of reciprocal influence between the two documents and the processes around them. This, however, does not reflect the circulation of knowledge and shared service ideologies. The important finding is that there is a continuous exchange of ideas and practices, based upon a public health perspective as a shared knowledge base. Thus, it seems that WHO has contributed not so much to formulating national regulatory instruments for implementing mental health policies, as to represent an agency to form a “public health alliance,” strengthening the arguments for community-based services in the country.
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