

Positive changes in Norway, but some gaps in care remain a concern, says OECD

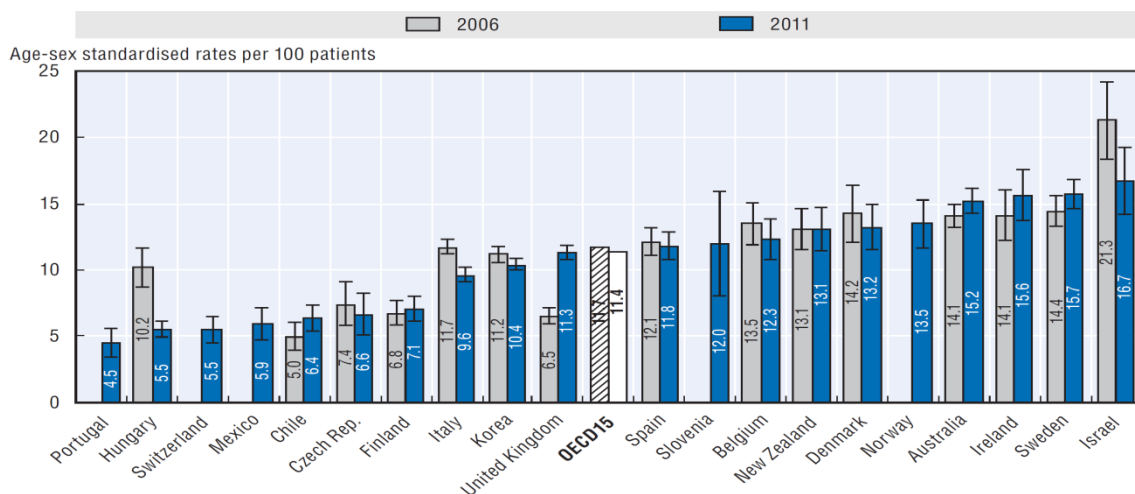
Norway has demonstrated clear commitment to improving mental health care: funding has increased, and ambitious targets and action plans have been established. This commitment appears to be paying off, with falling suicide rates, fewer hospital beds, and more mental health professionals. Despite progress, readmission rates for bipolar disorder and schizophrenia are a cause for concern, and may suggest poor co-ordination of care between hospital and community services. Going forward, Norway will need to pay attention to assuring good care for mild-to-moderate disorders, and for children and young people.

Signs of positive change in the Norwegian mental health system

With 83 beds per 100 000 population, Norway has a higher rate of psychiatric beds than the OECD average of 68 per 100 000, but the rate has been falling in past decades. Norway has made efforts to increase care outside of hospitals. The Escalation Plan for Mental Health 1999-2008 came with an investment of NOK 6.3 billion, and a set increase in mental health expenditure by NOK 4.6 billion through the period 1999-2008. This investment went towards improving community services, establishing more services for children, and strengthening services provided by municipalities. Norway's suicide rate of 12.1 suicides per 100 00 population, just below the OECD average of 12.4, has fallen over the past decade, in line with OECD trends.

An area of greater concern is Norway's within 30-day readmission rate for bipolar disorder and schizophrenia. If appropriate and co-ordinated follow-up is provided after discharges, patients are not usually re-admitted to hospital within 30 days. A high rate of unplanned re-admissions is therefore an indicator of the quality of several dimensions of the mental health system. In 2011 13.9 patients out of every 100 with schizophrenia, and 13.5 per 100 patients with bipolar, were re-admitted to the same hospital within 30 days after discharge, in both cases slightly above the OECD reported average.

Figure 1. Bipolar disorder re-admissions to the same hospital, 2006 and 2011 (or nearest year available)



Note: 95% confidence intervals represented by H.

Source: OECD (2013), *OECD Health Statistics 2013*, OECD Publishing, Paris.

Continued attention to the mental health of children and young people is needed

Children and adolescents across OECD countries experience high rates of mental ill-health, and Norway is no exception. In research conducted by Statistics Norway's Health Interview Survey 2008 16,5 % of the population aged 15-24 reported considerable severe psychological distress, compared to between 8.7% and 10.4% for the population over 24.

Without appropriate treatment, young people with mental ill-health have been found to have poorer educational attainment, and more difficulty transitioning to the workplace. The OECD-wide median age of onset for mental disorders is 14 years, with anxiety and personality disorders beginning at around the age of 11. Without early and effective treatment and inclusion in society young people with mental disorders risk becoming lifetime users of adult mental health services, with the significant economic and social costs that this entails.

Norwegian authorities have already been responding to this challenge. For example, the Ministry of Health and Care Services has been funding psychologists in municipalities, where there is a perceived shortage. In addition 5% of the children and youth in Norway are in contact with specialised mental health care services. This figure suggests generally good access to care, although room for improvements in child and adolescent mental health and wellbeing more widely remains.

GP-provided Cognitive Behavioural Therapy for mild-to-moderate disorders is an innovative approach

Cognitive Behavioural Therapy (CBT) is a form of psychological therapy found to have considerable success in treating mild- to – moderate anxiety and depression. In Norway, CBT training is available for general practitioners, who can deliver CBT and be reimbursed for providing it. The advantage of such a model is that it equips primary care practitioners with an additional tool with which to effectively treat patients that they are already expected to treat. *Making Mental Health Count* found that this is a good way of improving the efficacy and quality of the service already being provided.

Common mental disorders, especially depression and anxiety, are significant drivers of indirect costs such as unemployment, sickness absence and disability, and often have a high associated treatment gap. *Making Mental Health Count* recommends that all countries ensure that high-quality services are in place to treat these disorders, given the high economic and social costs they incur. Having put in place more available services for mild and moderate disorders, Norway should pay attention to whether these services are sufficiently widely available, and whether they are meeting the need for treatment.

More information on **Making Mental Health Count** is available at <http://www.oecd.org/health/mental-health-systems.htm>.

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