KNOW & POL
Knowledge and Policy
in education and health sectors

The social and cognitive mapping of policy

Mental Health in Norway
Actors, Organisation and Knowledge

Helge Ramsdal
Gunnar Vold Hansen
Marit Helgesen
Marte Feiring

Orientation 1

Final Report

WP6

February 2008

www.knowandpol.eu

Project n° 0288848-2 co funded by the European Commission within the Sixth Framework Program

Table of contents

1. Introduction: A context shaped by history

This report presents and discusses the Norwegian Mental Health field in three parts: The first part offers a diachronic overview over major developments in the field. The next part describes the structure, the prevailing knowledge and important actors, and the third part discusses some aspects of mental health policy developments that seem important for the relationship between knowledge and politics in the mental health field in Norway.

1.1 General description.

Norway is a unitary state, politically and administratively divided into 19 county regions and 431 municipalities, and a variety of state administrative regions. Among them there are 19 regional state agencies which inspect and audit local service provision, including municipal mental health services. The county regions have delegated authority on secondary education, dentistry, preventive health care, including public health, and regional communications and transportation. Since 2002, the counties no longer are in charge of specialised health (hospital) services. These services comprised appr. 65 % of county budgets.

Municipalities have delegated authority in all aspects of welfare services. These include primary schools, social services, care services and health care, including care for the mentally ill. The municipalities are diverging in size ranging from the smallest with about 300 inhabitants to the biggest, Oslo, with 520 000 inhabitants. Half of the municipalities have 4500 inhabitants or less. Although they vary in size and therefore also in administrative capabilities, municipalities are supposed to function in a generalist capacity. Firstly, this implies that they are to ensure a de-facto opportunity for inhabitants to participate in municipal decision making. Secondly, they have comprehensive responsibilities with regard to efficient delivery of adequate quality services. Thirdly they are responsible for ensuring legal protection for individuals, and fourthly they are charged with the responsibility for promoting community development. In short, the municipalities are the most important welfare state institution, also with regard to general mental health services for the population.

Government guidelines emphasise that specialised mental health services should 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. Four regional health authorities (RHA) are now responsible for providing specialised health services. The RHAs are separate legal entities, controlled by central government in capacity of owner and provider of resources. Services are provided by hospital trusts, which are owned by RHAs, or – to a limited extent - contracted out to private service providers.

The most important law in the mental health field is the Mental Health Care Act (Lov av 02.07.99. nr. 62). This regulates specialised mental health care conducted in hospitals and outpatient institutions. The Health Personnel Act regulates professional work in hospitals, outpatient institutions and municipalities (Lov av 02.07.99 nr. 64). This law pertains among other things to the health personnel obligation to conduct work so as to ensure coordination of mental health services between service levels and within different departments of the community health care. The Act relating to the Municipal Health Services (Lov av 19.11.82. nr. 66) regulates the distribution of health services in municipalities. In this law health services are defined as public health and medical treatment within both the somatic and mental health fields. The Act Relating to Social Services (Lov av 13.12.91 nr. 81), pertains to the eligibility for community care, coordination of the set up and implementation of individual care plans and user involvement. Thus, the most important law regulating individual care plans is the Act relating to Patients' Rights (Lov av 02.07.99. nr. 63). This also pertains to the eligibility to health services in both the community health care and specialised health care.

Guidelines for mental health services in Norway are based on a belief that mental problems in many cases can be prevented. Early intervention and close monitoring which can make the course and outcome more benign are important policy goals. In this respect, municipalities are important service providers. Furthermore, provided services are to be guided by the needs of users. This requires involvement and cooperation with users and their families, both on a system level and on an individual level. It also requires more differentiated services, as well as coordination of services from different agencies. Services shall promote independence, improved living conditions, quality of life and participation in ordinary life. If possible treatment shall be received on a voluntary basis, in open and normalised settings (I-1105-E 2005).

User involvement and participation is regarded as vital for client empowerment. Empowerment is both an important objective and a value embedded in present mental health reforms. The experience and knowledge possessed by users and their relatives is considered to be unique and necessary in improving and optimising services and treatment. 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 considered to be of major importance that users' views are taken into consideration in decision-making throughout the services (political, administrative and professional) and at all levels (Ministry, hospitals, municipalities). Accordingly, national as well as local authorities should be co-operating with users' organisations in these matters. At the individual level, the policy implies a legal right to participate in the management of necessary services (I-1105-E 2005). This is followed up by a strengthening of patients' rights embedded in law. Rights are defined to be:

- 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 and 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

1.2 Main characteristics

Norway is belonging to the Scandinavian Social Democratic Welfare Regime as denoted by Esping-Andersen (1990, 2002). Historically the social democratic welfare regime meant a "fusion of welfare and work". A society where the right to work was equally important as the right to income protection and where the costs of maintaining such a system implied that social problems had to be minimised (Esping-Andersen 1990: 28). The Scandinavian welfare state model has been based upon a complex relationship between the state and municipal bodies in which most service provision is undertaken by the local authorities (Page, 1991). Traditionally, the role of the state has been to define the target groups for welfare reforms and set national goals and standards for service quality, size and volume. By means of legal, economic and ideological steering instruments, standardized state policies have been implemented in the municipalities. Amongst these steering instruments were detailed requirements for the service organisation structure as well as for what competencies (i.e. professional groups) should be represented in municipal services. As the policy ambitions for welfare state service provision rose, municipalities were increasingly treated and acted as local implementing bodies of the state policies.

Thus, the system of welfare provision was a centralised system also as hospitals were made a county level responsibility. Towards the 1980's this system was put under pressure, as it was argued that the professionalisation of services now opened up for more decentralised authority to both counties and municipalities. Successive Labour and Conservative governments argued for the "idea of the new municipality" - that state-local relations should be organised in a management by objectives (MBO) manner. State authorities now should formulate national welfare goals, establish audit systems, and help securing the funding through block grants. Municipalities are now in principle free to find adequate means of implementation. This includes the design of the service providing organisations and also the professional background of the service providers. Welfare policy reforms expect the municipalities to be organised in accordance with NPM

principles. Consequently, mental health service provision at the municipal and RHA levels must adapt to these general principles of governance.

1.3 Mental Health Policies and Service System in Norway

The development of psychiatric and mental health services in Norway follows the general pattern of welfare state dynamics, but with some peculiarities. Modernisation of national welfare policies has up until recently, in general terms, primarily been the result of broad alliances between political and professional actors. The health sector – by some authors labelled "the Queen of the Welfare State" (Slagstad 1998) - incarnated the integration of political ambitions and professional management. From its beginning, psychiatric services have, for their part, been dominated by the medical profession and political bodies were reluctant to challenge suggestions put forward by psychiatrists. Thus, psychiatrists attained monopoly over what was regarded as relevant knowledge, simultaneously administrating the mental health central administration and dominating the local implementation of mental health policies in the capacity of combined professional and administrative leaders in the mental health hospitals.

The "professional iron triangle" on the part of the medical profession thus dominated education and research, central administration (the Directorate of Health in particular) and service provision. One aspect in this development was a strong emphasis on hospitalisation and institutionalisation. The peak of hospital bed numbers was reached in 1965, with more than 8500 beds. Since then there has been a substantial reduction up to the present; the number of hospital beds is appr. 2000 (Pedersen 2002). In contrast to the high-profiled de-institutionalisation mental health policies in some other countries – USA and Italy in particular - the Norwegian experience continued without much attention – even in Norway. It was widely regarded as a "silent revolution"; the main explanation being the decentralised structure of Norwegian politics. The nineteen counties, as semi-autonomous political and administrative bodies, reduced hospital beds in incremental processes. State policies played a minor role and comprehensive national programmes for mental health reforms did not exist.

De-institutionalisation in this period reflects, at least partly, a change in the system of professions and knowledge of mental health. During the 1970s and –80s, the mono-professional domination of the medical profession came under pressure. First of all, new professional groups, such as psychologists, nurses and social workers claimed influence. Secondly, the growth of local health and social services following the Municipal Act of General Health Care in 1982 specified all citizens' rights to preventive measures, treatment, medical rehabilitation and community care, etc., without mentioning people with mental disorders specifically. In a governmental directive three years later, the municipalities were reminded that people with mental health disorders were also to be

granted local services in line with other citizens. Thus, mental health service provision in the municipalities, at least formally, slipped out of the hands of the psychiatrists, as GPs, nurses and social workers ran municipal services. Finally, through extensive reorganisations of the state administrative system of health services – in particular by limiting the status and power of the Health Directorate – the medical "professional triangle" was broken, and political bodies strengthened their capacity to steer national health policies.

The combined results of these developments, which took place as incremental, uncoordinated processes, implicated at the beginning of 1990s not only a substantial reduction of mental hospital bed numbers, but also a differentiation of services. Now, a more complex system of extramural specialised services – policlinics in particular – was implemented, and the extension of municipal general services added to the complexity. The medical profession was challenged as new professions were introduced in mental hospitals, but first of all in the municipalities. Thus, biomedical knowledge came under pressure - both from within as medical knowledge itself became more diverse - and from the outside, as psychological and sociological paradigms presented alternative therapies and work organizations.

1.4 Recent Changes

Since the beginning of 1990's several reforms have changed policies regarding targets groups, the formal structure of service organisations, scientific approaches to mental health work, and the relations between professional actors and governmental bodies at different levels. These changes are reflections of the general trends towards new governance systems in the European welfare state, but also some distictive developments within the mental health field in the country. Three developments have particular implications for the structuring of general (municipal) and specialised (hospital) services. These developments are embedded in reforms at the municipal level (the new Municipal Act of 1992) and in specialised services (the hospital reform of 2002), and the Mental Health Action Plan of 1998 – 2009. These reforms have had a great impact upon the way structure, actors and knowledge intertwine in the present mental health field.

State initiated reforms in mental health – The Action Plan 1997 - 2009.

During the 1990s mental health services were put under heavy pressure. In the media, several murder cases were said to be caused by lack of adequate municipal services in the wake of the de-institutionalisation and reductions in hospital beds. Also, expectations rose as mental health was expected to be subject to "the next reform" – that is, after a previous comprehensive reform of services for people with learning disabilities/mentally

retarded in which all institutions were closed and the responsibility for services was handed over to the municipalities, in accordance with the principles of normalisation and integration. The crisis in mental health policies was defined as a resource crisis, with a need for more professionals at all levels of the services, and particularly lack of resources for building up community services as the de-institutionalisation took place. Due to huge problems of coordination between specialised and (what existed of) municipal community services, patients were falling into the cracks of the system, it was said. The need for a national comprehensive programme to reform mental health services gained support from all political parties, and all other actors in the field. Accordingly, the Mental Health Care Action Plan was implemented in 1999 and was projected to spend 24 billion NOK in the years up until 2006 (St prp. 63 1997-98, Chap. 2, p. 1). In 2006, the Action plan period was extended two years, mainly due to the need for more time to implement the housing projects at the municipal level.

The goal of the Action Plan is threefold. First of all, it is to strengthen the general/municipal and specialised/DPS mental health care. Secondly, it is to improve coordination and cooperation within and between the two levels. Thirdly, it is to promote user perspectives and user rights. Formally, the municipal psychiatric service administration is regulated by the Local Authority Health Care Act and the Social Services Act, while secondary care was until 2002 a responsibility for county councils. To give the Action Plan a local foundation, there was set up a substantial system of mental health planning at both municipal and county (later RHA's) levels. Administrations had to develop detailed local plans of needs for services and what action they considered to be necessary in order to reach the targets of the Action Plan. Municipal plans were to be updated each year; county council (and RHA) plans were to be approved by the Ministry. All mental health plans were to be politically approved in the respective councils of the administration levels they belonged to. To be granted funds municipal plans had to be passed on to the medical bureaucracy of the local state administration at the county level which coordinates, supervises, and recommends that municipals are admitted necessary funding. Furthermore, the Action Plan strongly recommends that municipalities establish an integrated mental health service and a closer analysis of municipal plans revealed that most municipalities had no specific mental health service agencies at the time when the Action Plan was initiated, and started from scratch when they implemented the plan (Helgesen 2003). In most municipalities, mental health was considered a responsibility for specialised services/hospitals. Consequently, the Action Plan caused mental health to become part of the political agenda, and the construction of considerable service provision agencies, recruitment of professionals based upon earmarked granting from the state. In spite of the formal responsibilities, having been neglected for so long, the formation of mental health service provision as a "new" municipal responsibility represents in some ways the encounter between "traditional" welfare state reform designs and the system of state-local relationships under the "new municipality" regime.

Several issues related to knowledge/politics in the mental health field in the country should be seen in the light of the ambiguities this setting implies for political governance.

The goals of the Action Plan are extensive and specified in actual numbers of new personnel positions, housing projects, day care centres, appointed support persons and possibilities for mental health service receivers to take part in culture and leisure activities. [1] Municipalities are also supposed to hire psychologists and other college-educated health care personnel. In education, multi-professional collaboration is given priority. The municipalities are supposed to develop services directed at children and young people in addition to adults. This is to be done by strengthening the school health services and public health centres (St.prp. nr. 63, 1997-98).

In specialised services, substantial restructuring has taken place. In actual numbers, specialised mental health care is to be increased by 1185 new beds that are supposed be established in connection to policlinics; existing psychiatric hospital facilities are to be thoroughly restructured into locally based psychiatric centres (DPS). DPS's comprise policlinic treatment, which is increased by 220 000, and day care which is increased by 90 000 users. An increase in treatment capacities by private consultants (psychiatrists and psychologists) of 50% was planned. (op cit). [2]

The need for personnel to implement the growth of specialised psychiatric services is immense. It is estimated that there will be a need for a total of 375 physicians, 940 psychologists and 4360 college-educated personnel, which represent the welfare professions mentioned above in order to implement the Action Plan. To accommodate the demand for college-educated personnel, specialisation in psychiatric health is given within most health care educational programs (Ludvigsen 2001).

Administrative reforms

The 1992 Municipal Act

The Action Plan was initiated at the end of 1990s, and in accordance with the idea of the "new mulicipality" of state-local relations, only reluctantly indicated how municipal

[1] The 3400 new personnel positions are supposed to be more or less unskilled health care workers. Further numbers are: 3400 dwellings in housing projects, 4500 more people than in 1998 are to use day care centres, 10000 more are to be given appointed support persons, 15000 are supposed to take part in culture and leisure activities.

[2] The secondary care is regulated by the Psychiatric Services Act.

services should be organised. However, the Directorate of Social and Health Affairs recommended that the organisation of service provision should be implemented as an "integrated model" in which people with mental health problems should be offered services by agencies also directed towards other target groups. This was in accordance with the principle of "administrative normalisation". At this time, municipalities realised their newly won freedom given them by the Municipal Act from 1992. Accordingly, 70 % of the municipalities established service agencies design for the mental health target group. The Act also provided the municipalities with a broad framework for organising their activities. This implies that they are in a position to implement the diverse tools from the NPM tool-box. In general, the political-administrative system is "modernised" in different ways, leading to an increasing fragmentation in organisational structures among municipalities. Many municipal modernizers advocate provider-purchaser models, "short and flat" structures, and other models of governance inspired from ideas of "privatization from within" (Ramsdal and Hansen 2006, Ramsdal and Skorstad 2004). Presently, most municipal services to people with mental health problems are organised as a combination of "specialised general services" (mental health teams) and integrated services.

The Hospital Reform

In 2002 the hospital reform was implemented. Due to the reform, hospitals are opted out of the political governmental hierarchy of the county council and its service delivery system. Hospitals are now organised as 33 public enterprises accountable to one of four regional public enterprises which again are accountable to the Ministry of Health. Consequently devolution has taken place. The regions are granted autonomy with regard both to appointment of boards and to organization structure (Lægreid et al. 2003). The processes of reorganisation are still not complete within all regions and enterprises. This applies first and foremost to the psychiatric institutions which were included in the reform at a late stage. More hospitals thus may comprise one public enterprise, and psychiatric hospitals and policlinics may be organised as one or more enterprises within a region. A system of free choice of hospitals is being elaborated and a system of internal pricing has been in effect for several years.

In summary, both the Municipal Act and hospital reforms may be classified within the NPM concept, addressing what was considered to be problems of responsibility and accountability. The Municipal Act outlined a scheme for a management by objectives in the relation between the state and municipalities, and organisational measures were to be put into effect that sharpened the division between political and administrative leadership in municipalities. The overall goal of the Hospital Reform was for the Minister of Health to control the hospital financing and resources. This was rendered ambiguous in the county council model of organising hospitals where both the county council and the Minister of Health had political and economical responsibility. The schedule of the

Hospital Reform implementation did not take into consideration the Mental Health Care Action Plan, and the combined implementation of the two reforms added to the complexity in the implementation organisation at the level of specialised services. [3][3]

1.5 Change processes in mental health

To sum up this chapter we will direct our attention on two processes taking place simultaneously. When the Action Plan was firstly implemented in 1998, municipal health care, including the care for the mentally ill, was, exposed to processes both of centralisation in the stated goals for municipalities to fulfil and to decentralisation in the design of cooperative and coordinating mechanisms. The process of centralisation also implied a depolitisation as well as devolution of the health/hospital policies, moving them away from popular control at the county level and accentuating the professional, managerial and budgeting functions. The decentralisation process implied that the municipalities took on more responsibilities for the mentally ill. Within the frame of empowerment municipalities are supposed to provide the mentally ill with adequate housing and care and health services. Municipalities are, however, not supposed to give any treatment, treatment is centralised to RHAs, who are supposed to treat in cooperation and coordination with municipalities.

[3] Important, but not to be treated here, is the supposed cost reduction that also includes psychiatry. Hospitals therefore, are expected to keep record over extended services due to the Action Plan and be able to point directly to what measures are funded with Action Plan money.

2. The mental health sector

As indicated above, the sector can be described as being exposed to new trends and the ambiguity these trends imply for governance. Processes of centralisation make hospitals autonomous actors with delegated authority being active in a process that may be described as governance rather than government. Governance is, as put forward by Pierre, concerns how to maintain a steering role of political institutions despite the internal and external challenges to the state (Pierre 2006). On the one hand the processes of decentralisation regulate the municipal service provision in new ways. On the other hand their autonomy is strengthened and their ability to cooperate and negotiate with hospitals is enhanced, as is mental health service provision organisations' ability to negotiate with other municipal service providing organisations. The process from government to governance, therefore, also can illustrate the development at the municipal levels as well as the relation between municipals and the state. As will be shown below other actors also hold delegated authority in their domains, whether it is decision making, control and audit tasks, or research.

2.1 The bodies

At the state level health care is governed by the Ministry of Health and Care Services (HOD). HOD is the main decision body and has both a political and an administrative leadership. The political leadership depends on what party or parties win the election. [4] The ministry is responsible for providing good and equal health and care services for the population of Norway. As such the ministry is the policy making body responsible for the formulation and implementation of health policy, public health, health care services and health legislation. The ministry governs the health care services through comprehensive legislation, annual budgetary allocations and governmental institutions. The RHAs are governed by boards accountable to the minister of Health and Care Services. The ministry is funding most of the research on mental health. This is included in their money transfer to the Research Council of about 45 % of its annual budget. [5]

Directorate of Health and Social Affairs (SHD) is the expert body also in charge of professional, technical and administrative functions. In addition to being subordinate to the Ministry of Health and Care Services it is also subordinate to the Ministry of Labour

[4] The political leadership at the time is social democratic, the Minister of Health Care is Sylvia Brustad. She holds no academic degree.

[5] In 2007 it was approximately NOK 381 million.

and Social Inclusion. SHD has been delegated advisory, administrative and certain executive functions. The former encompasses advising the national authorities on health and welfare policy, strategy and legislation. It also includes the implementation of certain components of health and welfare legislation, initiation and sustenance of inter-departmental cooperation. The SHD also formulate national guidelines to enhance the health and welfare services. Guidelines are to be implemented in municipals, hospitals, DPS' or BUPs. Examples of guidelines are how to set up an individual plan for recipients of two or more health or welfare services, what services the municipal provision must comprise according to the perspective of empowerment and guidelines for treatment of specific mental illnesses in DPS. The SHD also can fund projects initiated in various levels of the service system. These can, if proven appropriate, be incorporated into the set of national norms. The directorate also commission investigations, evaluations and assessments of different aspects of the Norwegian mental health care field. In the role of expert implementing body the directorate also is in charge of implementing the mental health Care Action Plan spanning during the years 1998-2008.

The inspection and auditing of health services are coordinated by the Norwegian Board of Health Supervision (SHT) which is a national supervisory body. SHT is an independent supervisory authority, with responsibility for general supervision of health and social services in the country. The Norwegian Board of Health Supervision directs the supervision authorities at the county level: the offices of the county governors, which have responsibility for supervision of social services, and the Norwegian Board of Health Supervision in the county, which have responsibility for supervision of health services and health care personnel and municipalities. It offers advice to the ministry and the directorate, to social and health services in hospitals and municipalities, as well as to political bodies at national and municipal level. In its role as an expert body it also informs about international developments in social and health services.

Among its tasks is the monitoring of health and social services in relation to the needs of the population and the demands of society for services. The supervision of health services and health care personnel carried out by the Norwegian County Boards of Health Supervision are dealing with matters concerning serious deficiencies in health services and when there are reasons; it issues administrative reactions to health care personnel or instructions to institutions/activities. County Boards can direct the processing of complaints concerning the rights of the population to services, for example according to the Social Services Act and the Patients' Rights Act. They also disseminate information gained from experience of supervision to relevant agencies as state government administration and municipal health and social services.

The tasks of the Norwegian Board of Health Supervision in the counties include control and auditing the health services through organisational audits, surveys and other methods – partly as nationwide supervision as decided by the Norwegian Board of Health Supervision and partly as a regional/county decision. The offices of the county governor

have many other tasks relating to social services. These tasks are mostly instructed by the Norwegian Directorate for Health and Social Affairs.

Within the RHAs the psychiatric hospitals, which also are state hospital trusts or enterprises, are supposed to provide highly specialised services and acute services. The object of the Action Plan is to transfer the long term treatment from inpatient treatment in hospitals to outpatient treatment in District Psychiatric Centres (DPC). Thus, they shall provide less specialised and decentralised services. DPC' of which there were established 71 in 2003, are supposed to provide short time inpatient services, daytime treatment, services for acute treatment and provide clients with long term outpatient treatment and rehabilitation. These are services for adult clients. In addition DPCs are supposed to provide consultation, supervision and support for primary health care personnel. They are supposed to work close to and cooperate with municipal services. Specialised cervices for children and adolescents are provided by regional and local centres for psychiatric treatment of children and adolescents, in Norwegian Barne- og ungdomspsykiatriske sentre (R-BUP and BUP). Specialised services for children and adolescents mostly consist of outpatient treatment, but inpatient treatment is to some degree offered in both R-BUP and BUP (Hagen and Ruud et al 2004, I-1105-E 2005).

Today 431 municipalities, greatly diverging in size, produce and provide all kinds of welfare services including services for the mentally ill. As shown they vary in size and therefore also in administrative capabilities. Nevertheless they are supposed to function in a generalist capacity. Firstly, this implies that they are to ensure a de-facto opportunity for inhabitants to participate in municipal decision making. This is important because local political bodies are actively taking part in decisions on welfare priorities and user stakes are supposed to be represented in the decision making process. (Vabo 2000). Secondly, they have comprehensive decentralised responsibilities with regard to efficient delivery of adequate quality services. 6 Thirdly, they are responsible for ensuring legal protection for individuals, and fourthly they are charged with the responsibility for promoting community development (Helgesen 2004).

Based on the notion of empowerment, municipal services provide housing, necessary health and social services, cultural and leisure activities as well as jobs or work related activities for adults. For children and adolescents services are provided by the community health nurse often in collaboration with day care centres and schools. A distinction is made between treatment and sustaining a level of individual functioning of which municipal activities are supposed to be confined to the latter. Necessary health services

[6] This they have according to the Municipal Act (Lov av 25. September 1992 nr. 107) that provides municipalities with a broad framework for organising their activities. Welfare service at municipal level beside health care also include primary schools, social services and care services.

include services for mentally ill people and 90 % of the municipalities services are provided by a municipal service providing organisation often recently established for the purpose (Myrvold 2006). Traditionally municipalities have employed psychiatric nurses to provide the services, while the new policies recommend a more multi-professional staff. In detail services consists of individual consultations either in the clients home or in the providing organisation.

In addition to universities and university colleges, **research** is organised through a combination of well-established research institutes and new "knowledge centres" established in the wake of the hospital reform.

The Norwegian Research Council (NFR) is funding research, while the funding is provided mostly by government ministries. Some of the programs directly address development of knowledge about mental illness and the mental health sector. There is a program on Mental Health Research. The primary objective of the programme is to generate knowledge that is relevant both to promoting mental health and to increase the knowledge about the relationship between mental health disorders and substance abuse. During the years 2003-2007 the council has been funding a research programme that evaluated the Action Plan. The Norwegian Institute of Urban and Regional Research was, together with SINTEF Helse, two of the main contractors of this evaluation. 7

RHAs also conduct most of the Norwegian research in the mental health field in cooperation with the universities. Another research institution to be mentioned is the Norwegian Institute of Public Health (IPH). The institute describe its aims as to provide a good overview of the health conditions of the population, to provide reliable knowledge of the factors that influence health and to provide information that can lead to the improvement in health. The institute works with preventative medicine in the fields of contagious diseases, environmental medicine, epidemiology and forensic medicine, alcohol and drug research and psychiatry (IPH homepage).

Much research is also conducted by the private institution The Foundation of Scientific and Industrial Research at the Norwegian Institute of Technology (SINTEF) which have a department for health research, SINTEF Helse. SINTEF conduct research and development with the aim of raising standards of health and quality of life, in collaboration with the authorities, the health sector and the users of the health and social services (SINTEF homepage).

The Norwegian Knowledge Centre of the Health Services (HTA) is an expert institution owned by HOD. It gathers and disseminates evidence about the effect and quality of

[7] Two additional programmes "The research programme on public health" and "medical and health science research" also cover themes of mental health.

methods and interventions within all parts of the health services, as well as with the uptake of this evidence by the health services. Among its tasks is also to support the government, the RHAs and the health service in general to incorporate evidence into their practice (I-1105, homepage of HTA). There is also a set of Regional Knowledge Centres (RNC) aiding municipalities in their implementation of different aspects of health care.

The Ministry has established a consulting group, Council for Mental Health, in which all major civil society organisations in the mental health field have representatives. This is a highly politicized council taking part in all major political decisions in the mental health field. Presently it is led by a former minister of health and social policy. The overall aim of the council is to discuss and give advice to government bodies on all important issues concerning mental health, the implementation of the Action Plan, user involvement and new laws. The council also organizes conferences and cooperates with other types of civil society organisations (Home page of Rådet for mental helse). Organisations having representatives in the council are first and foremost Mental Helse, which organises users of mental health services on an individual basis. It is one of the most profiled user organisations in the Norwegian welfare sector. As a result of the Action Plans emphasis on empowerment, the user organisations have been strengthened quantitatively and qualitatively the last 10 years. According to the empowerment perspective users are supposed to be included in decision making also at local level and to ensure that this takes place municipal obligatory plans for their mental health service provision will not be accepted by the regional audit boards if users are not a part of the planning process. Also the organisation for recipients next of kin, Landsforeningen for Pårørende i Psykiatrien, and Adults for Children, an organisation working for resilience and strength during childhood, are prominent members along with a range of smaller organisations not yet organised on a national scale. The role of the council is to channel the views and preferences of mental health civil society organisations into the decision making body. It has also established a "Department of Knowledge and Research" which both produces analyses about developments in the mental health field, and commission individual research projects.

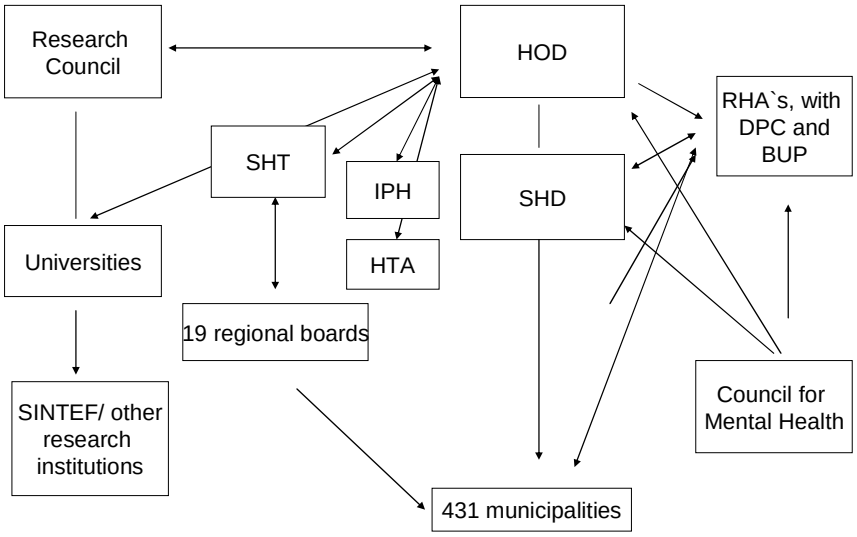
The last body of actors related to governance, in the zone between formal bodies of public responsibilities for services and the research bodies mentioned above, are the organisations for health and social professionals. These are regarded as vital non-governmental bodies influencing mental health policies by means of producing statistical information, analyses and research about the field. In historical perspective, these organisations have been regarded as integrated with governmental bodies since before the origins of welfare state policies. For instance, both individual psychiatrists and the Department of Psychiatry within the Norwegian Medical Association (DNL) have played important roles as entrepreneurs in mental health, both related to information about international developments, and as lobbyists for specific issues within the field.

Presently, the DNL, as well as the Norwegian Association of Psychologists (DNP), the Norwegian Association of Nurses (NSF) and of social workers (FO) also play significant roles as lobbyists, producing and disseminating knowledge in order to influence the way mental health policies are formulated and implemented.

2.2 Conclusions

All presented actors have delegated competencies in their domain. In a unitary state the only legislative level is the state itself. All other kinds of autonomy and competencies are subject to withdrawal by the state, but this must be done through new legislation approved of by the parliament. Political actors are the ministry, HOD, and municipalities. Municipalities having the competency to decide on prioritising between welfare tasks and to organise and design their service provision as they find best. It should be considered as essential, but the municipal autonomy in making their decisions is under exposure from governmental steering in the form of earmarked grants in both the mental health and other welfare fields. SHD have essential expert and administrative competencies and amongst others decide on the content and the form of the Action Plan. SHD of course act under the political control of HOD. Also the SHT has administrative competencies and can decide on what and when audits and controls will be performed. Together with the regional audit boards they are autonomous in their decisions. The RHAs have competencies to decide on budgets and management of hospital enterprises. This includes decisions on the establishment of DPCs and BUPs and outpatient treatment. They are, however, under the political control of HOD. The Research Council is dependent of the ministries for research funds. Ministries also have representatives in all boards and steering groups functioning according to research programmes. The Council nevertheless is autonomous when decisions are made on what research and what institutions to fund. Universities, as well as SINTEF, are those research institutions in this overview that depends on Research Council funding. HTA and IPH are funded directly by the state but acts autonomously in their professional fields. The civil society user organisations included in this overview are very well organised in the Council for Mental Health. This council takes part in decisions made at national level in the field of mental health. At the municipal level and in relation to the hospital enterprises, its member organisations are represented in decision making. Professional organisations are autonomous in deciding on what and why they will act as lobbyists and on what questions they will produce statistical information, research and analyses of their respective fields. Relations among actors are presented in figure 1.

Figure 1: Relations among actors in the Norwegian mental health field



3. Three dimensions: Structure, Actors and Knowledge

As the main characteristics of the sector should be analysed as a process from government to governance, the knowledge and the regulations pertaining to it to sustain efficiency, Pons and van Zanten 2007), is based in skills that either enables, activates or gives actors possibilities to orchestrate in order to negotiate or persuade others to take part in something. When "the new concept of governance" is used negotiations or interaction also are the tools for ensuring consensus and reaching mutually acceptable decisions and thereby legitimisation for public actions among actors (Peters, 2000). Nevertheless, governance represents a challenge to how consensus or legitimation is reached and to how knowledge circulates among actors. Professions are seen as one possible facilitator or mediator, as well as evidence based policy (EPB). EPB as implemented by Norwegian authorities, HOD and SHD, is an emphasis on systematic reviews of research. In KnowandPol deliverable 4 this approach is described as seeking to identify, select and synthesise findings from all relevant studies to inform political and professional choices. Knowledge can circulate by "knowledge entrepreneurs" or by how it is received and co-produced by other actors. Knowledge entrepreneurs can be individuals or groups forming so called "policy communities", "advocacy coalitions" or networks of actors with a shared cognitive understanding.

3.1 Structure

SHT and the SHD are subordinate, but semi-autonomous bodies, in relation to the ministry. They are nevertheless, in charge of extensive tasks formally (and in reality) exercised with professional and legal discretion. The relationship between these bodies has been reorganised in order to separate discretionary professional and legal aspects (SHT/SHD) from strategic and political (HOD) considerations. These reorganisations partly affect the ATH and IPH, which also are subordinate, but semiautonomous in the relation to HOD. The formal relations between them according to knowledge are cooperative. Both the research/knowledge institutions deliver knowledge to the ministry and the SHD in their respective fields. ATH also arranges seminars and courses on the topics on which it works. One example is a course given to bureaucrats, hospital staff and municipal employees on how to conduct searches for evidence based knowledge. This was arranged for the first time in 2006 and is supposed to be an annual event.

The bodies HOD and SHD play different formal roles in the production, dissemination and implementation of knowledge. Firstly, they have no specific and separate unit for research, but are very much involved in knowledge production as commissioners of research, the Ministry also by funding research organised by the Research Council. The Ministry has departments of analyses in which research and knowledge production are

scrutinised and dissemination of knowledge is regarded a central tasks. Three typical ways of addressing research issues are identified: Firstly, individual analyses of the implications of specific research results are made. Analyses are about what significance certain research results have for policy and which policy implications should be drawn from them. In such processes individual researches are asked to present their results to representatives of the ministry/directorate. Secondly, internal hearings are held. In such hearings several researchers are invited to discuss for example how to improve services. These hearings often take the shape of ”expert panels” where different and some times contradictory results are evaluated. Typically, these hearings constitute an arena for discussion and information. The ministry’s/directorate’s representatives bring these discussions into their respective institutions for further discussions about policies. Thus, discussions might include the political leaders at the Ministry (Minister/Secretaries). The hearings often imply that quantitative and qualitative results are taken into consideration, and that contradictory or different results related to specific issues are discussed. (One interesting question raised in some of these hearings presently, is about the status and role of evidence-based medicine – for example presented in The Cochrane reports - versus situated “local” knowledge produced by social scientists). Thirdly, research conferences are held. Some of them are annual events where researchers, professional organisations, user organisations, politicians and the bodies presented here encounter. These conferences, when arranged by the ministry/directorate, have a ”semi-official” status, and both the programme, the speakers and the results presented indicate both the definition of knowledge production demands from these bodies, as well as the scientific ”profile” of their research priorities.

SHT does not commission research, but synthesises and disseminates knowledge from national and international research institutions. Examples are research related to social and health care service provision and epidemiology. It also produces knowledge by conducting extensive analyses on quality developments related to specific issues, as well as by initiating audits on quality measures performed by the county governor. SHT also plays an important role through the arrangement of conferences and hearings. These make SHT a mediator of knowledge between service providers, political bodies and researchers.

The bodies, HOD, SHD and SHT, also have formal cooperation through a number of joint committees. Typically, these committees have the role of expert committees, drawing heavily upon research (medical and social science). They also formally cooperate in Nordic, EU and WHO networks and committees, particularly expert committees about quality issues related to developments in health service provision, guidelines etc. International categories about the volume and quality of health measures are being used to compare health and social issues in the population and service provision. In particular, statistical information/ epidemiological data are compared. References are also made to

strategic documents and international research about specific issues. In mental health, the WHO report "New Understanding – New Hope" (WHO 2000) plays an important role.

In the mental health field municipalities cooperate formally with RHAs and the state. Municipalities have in many respects an obligation to be open to their environment. This is so especially when it comes to the health and care services where municipalities are not able to deny providing services to eligible individuals, although they have some discretion on how much and how often services are to be provided. They cooperate with the state by implementing the care aspects of the Action Plan and in this respect they receive and from this produce situated knowledge. One example is the obligation for municipalities to provide acceptable housing for mentally ill people. When they can not live at home and the help they need exceeds simple care services special housing services have to be provided. This is housing that should not be an institution, but nevertheless have to have a staff that provides service, helps and protects the residents. Municipalities respond to this challenge in various ways and some are able to transform their experiences to knowledge usable also for others (Storbyprosjektet 2007). This they do by assessing and evaluating their services either as a result of their own decision or it is done by the SHD. 8 SHD has in some instances established networks of different kinds of municipalities to share their experiences and the municipalities also establish their own networks in which the state authorities do not take part. The SHD also invite municipal representatives to come to meetings held either by the SHD themselves or by the county governors. Such meetings also have the sharing of experiences as a goal.

With the RHAs municipalities cooperate according to the treatment of individual patients. An example of situated experience transformed to become knowledge shared by all municipalities and hospitals are the contracts made on admittance and discharge from hospitals. Municipalities have for a long time perceived cooperation on these matters as uncontrollable, they being at the receiving end not knowing when patients are discharged from hospitals or having to wait to admit very ill patients. To resolve this problem one municipality and one hospital started a project that specifies what level and which professionals are responsible, when and how (Helgesen, 2006). This contract now applies to the relation between all hospitals and the municipalities within the territory it covers (HOD, 2006).

[8] In both instances they can commission evalutations from research institutes.

3.2 The circulation of knowledge and its mediators

The governmental bodies described in chapter 2 are predominantly bureaucratic in structure and function. In principle they are organised as hierarchies, but also with elements of matrix organizations. The matrix elements implies that projects can be established and closed down and that staff can move between projects, be a part of multiple projects, and at the same time have an organisational basis in one department. For instance, SHD in many respects works as a matrix organisation. It is also open to its organised environments, especially HOD, municipalities and hospitals by, on a temporal basis, hiring staff employed here to take part in projects. Staffs also go between SHD and HOD, and professional organisations. In particular, the mix of staff from different disciplines in different bodies is important. In this way, staffs in different bodies share a cognitive understanding because they have a similar professional background, and thereby belong to the same professional organisation. Law, medicine, psychology, nursing, social work, and other professions like economists and sociologists, are represented in several other state agencies as well. On the one hand each discipline has its own professional organisation that contributes to unite their members cognitively in professional matters. This includes staff members in municipalities. On the other hand, staff representing the different disciplines work together to establish and implement projects. In this manner networks of professionals are built who share a cognitive understanding of problems and their solutions.

3.3 Knowledge

The welfare state system of professional "iron triangles" – or "knowledge regimes" (Slagstad 1998) - described in chapter 1, had profound significance for the relationship between knowledge and politics. The system represented an integration of knowledge and actors within welfare sectors, and paved the way for a social engineering approach, based upon scientific knowledge, on the formation and implementation of policies in the health sector. Since 30 years, the political sentiments regarding the functioning of this system has changed. What was considered a success story of welfare state organizing, now was defined as the main reason for the steering problems facing the modern welfare state. This has important implications for the way knowledge relate to policies in the health sector presently. First of all, the fragmentation of knowledge considered relevant for policy formation and implementation, now makes this relationship more complex than before. In the context of mental health, several kinds of knowledge bases influence the definition of target groups, strategies and organizational measures.

One way of organizing different knowledge bases is to make a differentiation between four types of knowledge. These types are, in different ways that should be scrutinized

through case study research - used as a tentative framework for presenting the knowledge bases of Norwegian mental health sector.

3.4 Some points on Knowledge

In accordance with the theoretical perspectives in the KnowandPol project, knowledge is considered as culturally specific and socially constructed. It comprises symbolic and structural elements; and it is logical, contextual, relational and collective (See guidelines). In this work we understand knowledge as all of the following: (1) collective representations held by all members in society – i.e. lay knowledge; (2) competence and skills held by some specially trained professions – i.e. professional knowledge; and (3) scientific knowledge held by persons working with abstract and logical procedures (i.e. biomedical knowledge, social science etc.(Durkheim and Mauss 1963; Feiring 2007 u. a.)

Knowledge is both a construction for somebody (a given purpose) and by someone.
It is the symbolic and cultural tool that agents apply in interaction with one another (see guidelines).

(1) As lay person we shape pictures of reality, and user knowledge is often a product of this category and must be held separate from "user perspective" when applied by professionals or policymakers and means what is best for the user seen from an external agent.

(2) Knowledge produced in the professional field (clinic or face to face with clients) are outlined by several authors (Abbott 1988; Freidson 1988 (1970)). There are blurred boundaries between this type of knowledge and scientific knowledge

(3) Knowledge produced in the scientific field is both academic for the field of science and applied for society in general.

(4) Hybrid forms of knowledge may be added as a fourth category. The different types of knowledge often express itself in mixed forms. For example lay knowledge is always an aspect in professional as well as scientific knowledge. Political knowledge is a hybrid form, based on lay knowledge although applies what ever knowledge they find suitable in solving social problems. Administrative knowledge is a combination of political and technical forms. This is outlined in Starr (1987) .

Mental health scientific knowledge

Historically, the dynamics of mental health services are reflected in the struggles between scientific paradigms and developments in scientific knowledge more than political and administrative initiatives on their own terms. The problem of governance in mental health services indicates the relationship between different ideological and professional approaches that were achieving a political mandate at different times in the development of the welfare state (Foucault 1979, Rhodes 1996, Bogason 2000). Thus, it seems necessary to understand the intrinsic dynamics of mental health knowledge in order to understand the way service provision is organized.

In accordance with the World Report, mental health disorders might be understood differently based upon a biological, psychological or sociological paradigm respectively. While the biological explanations of mental disorders concentrate upon "understanding the brain" and emphasise the advances in neuroscience, psychological explanations stress the need for un- or re-programming the personality, while sociological approaches generally see poverty, urbanization, and deterioration of social networks in the local community as the main explanations to mental health problems (WHO 2001:6).

Epistemologically speaking these basic understandings are regarded as alternatives, and are often seen as theoretically contradicting. This is particularly the case when it comes to implications for the esteem and power of mental health professional groups – where the biomedical profession has had the upper hand in modern mental health through psychiatry as a medical speciality. In addition, competing ideologies and therapeutic approaches imply different principles of organisational design. As a deduction of the biomedical paradigm, the principles of service provision organisations were hospitalisation and institutionalisation. A psychological approach is individualistic or group oriented, but are adaptable to both hospitalisation and community work frames. Psychosocial and sociological approaches strongly oppose institutionalisation, favouring preventive strategies and normalization as a "new" paradigm in service provision.

Still the World Report maintains that the *" …artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental and behavioural disorders. In reality, these disorders are similar to many physical illnesses in that they are the result of a complex interaction of all these factors*" (WHO 2001:10). Consequently, an "integrated knowledge model" of mental health service provision is recommended. The problem is, of course, that in making the service provision integrated, you have to clarify which professionals are to do what and where in the service chain, which distribution of resources between hospital beds, community care, and preventive strategies are considered adequate, etc. Here, one would expect professional pigeon-holing and parochialism, often in the shape of symbolic struggles on "how many beds are necessary in 'modern' mental health treatment?" The lack of political responses to mental health problems in society is consequently not merely a

simple lack of interest in deviances and stigmatized groups, but also the lack of scientific unification upon which social engineering and political clout can be constructed.

Professional knowledge

The development of mental health service systems are grounded in a "field logic", in which it is primarily the capacities of professional knowledge in mental health and psychiatry that have triggered the reforms, and also pointed at system changes recommended. However, as Saltman (2002) maintains, health reform is not a linear function. On the contrary, reforms typically take place in a variety of political and operational levels, often with different paces and with different degrees of success. In the case of present mental health reforms, the "field logics" or professional knowledge on its own terms is not a unified, integrated, evidence-based knowledge system, but rather a diverse, disintegrated and often conflicting field, where professional actors seek political legitimacy and support for a variety of ideological and treatment strategies. As many authors argue, these ideological foundations function as a mirror to reflect the way society at large understands human nature and human rights in general – through its treatment of deviant behaviour and devalorised persons (Kristiansen 1996). Professional knowledge thus represents more than scientific evidence – it is by its nature interacting with political and ideological sentiments as well. More than many other fields, mental health service provision, ideological grounds and treatment models are embedded in scientism, and scientific knowledge lays the groundwork for reform policies and political decisions.

Professional knowledge is strongly connected to scientific knowledge. In many ways, scientific knowledge is the legitimate basis for professional work and jurisdiction (Abbot 1988). Through legislation of the medical sector, especially the specialist sector, the medical profession has the last word in conflicts about what service to provide. This is one of several reasons for the strong position biomedical knowledge has in this sector. Another explanation is the current development against evidence-based medicine also in the mental health sector. Several different professions provide the service provided in the sector. Although the medical profession has a strong position when conflicts arise, the ecletive ideology gives the service providers opportunities to choose between great ranges of actions. In this way, the professional knowledge becomes more multifaceted than the formal position of biomedical knowledge should indicate. This means that both psychological and sociological perspectives are common knowledge in the professional work.

In the municipalities a great amount of the service are provided by nurses, social workers and groups with a stronger focus at care and organization of everyday life, than on treatment. This means that the knowledge base is even more multifaceted in the

municipalities than in the specialist sector. The Norwegian municipalities are mostly organized as functional line organizations. The strive for making comprehensive services, results in need for coordinating the different services and their actions. One way to achieve this is creating matrix groups in the line organization. The service providers themselves are responsible for coordinating the actions. This way knowledge about organization and collaboration also are central. Therefore, it is impossible to provide the service building their competence on one scientific knowledge base.

Lay knowledge

The mental health service provision was challenged by the ideology of normalisation. In Scandinavia this ideology stated that welfare policies were supposed to give mentally ill similar living conditions as the rest of the population (Askheim 2003). For hospitals this meant that outpatient treatment should be prioritised for this group. For municipalities it implied that their services were extended to cover the mentally ill. In accordance with this psychiatric nursing slowly moved out from hospitals to municipalities and became a part of municipality provision of care services without the mentally ill being prioritised. The normalisation paradigm also meant that the biomedical mental health regime was questioned and challenged by both a psychological and a sociological regime. Still, the ideology of normalisation was not able to deliver as promised (Askheim 2003).

The ideology of empowerment challenges the expert role towards the sick and towards the system. The perspective is normative to a grater extent than the ideology of normalisation and defines a completely new range of roles for the professional and the expert knowledge. In short the professional should no longer be in a position to define the problem of recipients, rather the recipient is supposed to be treated as a partner, one who by himself shall define what is his problems. The professional also is supposed to see herself as a resource for the recipient and as a mediator of institutional resources to be used by the recipient. Thus, the process of empowering the recipient can take place (Askheim, 2003, Andersen et al, 2000, Stang, 1998).

Hybrid knowledge

The political sector has to deal with all these types of knowledge. In addition to this the decision makers also has to deal with political ideologies. In Norway (as in many other European countries), this especially means NPM-ideologies. There is no precise definition to NPM, but in Norway, it often includes a transfer of power from professionals to user and bureaucrats (Ramsdal & Hansen 2005). The empowerment ideology is therefore followed up by legislation giving the user different rights to participation in planning and decision-making the content of the service provided. The central question will be what

kind of knowledge has priority when it comes to political decisions? A hypothesis would be that arguments embedded in more than one knowledge forms would have priorities.

As commented upon above, scientific knowledge has played an important role in the formation and implementation of mental health policies. The fragmentation of knowledge made Norwegian mental health policies being defined as "eclectic", and this has up to now been a major response to disagreements between representatives of different scientific paradigms. One implication has been the legitimation of "negative coordination" in service provision agencies – and a way to avoid debates between professionals and academics representing different scientific approaches to mental health problems. The Action Plan is regarded primarily as an expression of sociological paradigms on mental health, both in the way sociological and organization theory approaches have paved the way for the principles of normalization, integration and empowerment. Still the developments in specialised services seem to take another direction, towards bio-medical paradigms, and an emphasis on evidence-based medicine/practice. Presently, clinical guidelines/pathways is a strategic priority in hospital services. To a certain extent, these developments seems to pave the way for a division between the scientific approaches – and therapies as well – between the municipal services on one hand, and specialised services on the other.

3.5 Mental Health – Professional Knowledge Systems and Mental Health Policy

The World Report on Mental Health 2001 reflects an optimistic view on the present knowledge status of mental health disorders and future treatment strategies ("Mental Health: New Hope, New Understanding"): "Efficient solutions for mental disorders are available. Advances in medical and psycho-social treatment means that most individuals and families can be helped" (WHO 2001:109). Still, the present status of mental health policies worldwide is critical: "Only a few countries have adequate mental health resources. Some have almost none" (ibid.). The World report states that one third of the European countries still do not have a specific mental health policy, and among those that do, 70% were developed in the last ten years. As Knapp et al. argue, being generally neglected as a policy field, there is a huge variety in service provision, as well as in professional capacity (Knapp et al. 2002).

According to Knapp et al., this view on political neglect and service provision variation represents a challenge to policy makers, and particularly those seeking to harmonise healthcare provision in Europe. While actual policies vary substantially, there seems, however, to be agreement about the road ahead for mental health reforms, first of all: to

establish national policies, programmes and legislation, to de-institutionalize services by reducing hospitalisation (i.e. ”non-institutional based care should be provided wherever possible”) , to strengthen community and primary care through decentralization, and evidence-based policies. These developments are, as pointed at in the WHO report, ”interestingly, … initially stimulated by ideology, the development of pharmacological and psychotherapeutic treatment models, and the belief that community treatment could be more cost-effective” (op cit 105).

4. Discussion

Norwegian mental health service provision has, in accordance with European trends, changed through three major developments: from an "era of the asylum", via the rise of mental health hospital systems to present-day vertical and horizontal extension of mental health care (Shorter 2007). The Mental Health Action Plan 1998 – 2008 has played a major role in developments in the last phase. Mental health service provision now see a substantial extension in policy ambitions and services, which makes new (evidence- and practice-based) knowledge and issues related to collaboration and coordination of services focal points in the implementation of the Action Plan.

The mental health reforms (The Action Plan) and the administrative reforms (municipal and hospital) were initiated in the 1990's, and have changed the design of service provision substantially. Three major developments can be identified:

Firstly, the mental health field has seen a growth in economic resources, number of patients, mental health professionals, and service agencies. The evaluations of the Action plan conclude that the quantitative targets of the reform have been fulfilled.

Secondly, there is agreement that the qualitative aspects of the reforms have not been reached. This relates partly to the problems of coordination of service provision. Here, the lack of coordination at the state level in the design of the reform initiatives would be one important explanation: For specialised services, the hospital reform did not refer to the Action plan, and vice versa. While the Action Plan was designed according to "traditional" welfare reform implementation tools, the hospital reform was a comprehensive New Public Management reform. For general – municipal – services - the idea of the "new municipality", and the "governance" - partnership model of state – local relations led to a complex web of semi-autonomous municipal decisions about the organisation of municipal mental health services on the one side, and state audit systems on the other. State governance about how to organise specialised and general services, increasingly has been performed by state guidelines, but in close collaboration with local actors.

Thirdly, there is agreement in the evaluations and among national political decision makers that the users' perspective has not been sufficiently elaborated in service provision. This arguments should, however, be modified: while empowering users through legal rights of individual patients are strengthened by a new Law on Patients' Rights, there still is a problem to make patients having influence upon their treatment therapies and social roles in everyday life. As we see it, two developments are particularly interesting for the understanding of the relationship between knowledge and politics in the Norwegian mental health field. First is the formal restructuring of services. The policy of formal restructuring/decentralization of service provision includes two

interconnected issues: an emphasis upon organizing general/municipal services and a regionalization (i.e. decentralization) of specialized/hospital services (DPS).

While the implementation of the restructuring has been subject to substantial evaluation research, the genealogy of the knowledge processes - particularly about the relationship between bio-medical/psychiatric knowledge and socio-psychological/sociological scientific knowledge, and learning from international developments - has not been subject to analysis yet. The restructuring/decentralization seems to be informed mainly by two kinds of knowledge: scientific approaches, in which the way bio-medical, sociological and psychological understanding of mental health are represented and balanced, and administrative approaches, in which cost-efficiency in service provision both in hospital reforms and in municipal service provision are represented. Likewise, the interplay between (different) scientific knowledge(s) about mental health problems and treatment strategies on the one side and administrative approaches on the other, in processes of restructuring services should be scrutinized.

Here, research questions should concentrate upon where and by whom knowledge production takes place, how knowledge producers advocating decentralization where given priority in the formulation of mental health reform policies, and how it was operationalized. Different types of knowledge are mobilised in the restructuring process, both regarding the extent of decentralization, and the design of service provision organizations (tasks, size, management, recruitment/competencies). Knowledge and actors should be seen to interplay in complex ways that need to be analysed through case studies. We suggest some tentative hypotheses about the relationship between knowledge and actors: The distribution of knowledge/actors follow a pattern in which bio-medical knowledge is represented in psychiatric hospitals, and tend to defend existing structures by the mobilization of evidence-based medicine, while the actors advocating a restructuring/decentralization are represented in DPSs and municipalities, on the basis of sociological approaches to mental health problems.

Second, the emphasis on user/citizen involvement, and the policies of empowerment should be further analysed. The policy of user/citizen involvement represents as we see it a "paradigm shift" – as the Action Plan has formulated the need for increased influence of users/citizen perspectives on service provision. One important aspect of this policy is the separation of professional/specialized knowledge and the user/citizen perspectives or knowledge. This contrasts the historical development of welfare state policies, in which professional knowledge was said to include "user/citizen perspectives" as well. Here, one should ask where and by whom the knowledge production takes place, what is meant by "user/citizen involvement" in policy formulations, how this policy influence the relations of power between professionals and users, and how this policy has been included as a specific, central goal of the reforms.

The policy of user perspectives in service provision are based upon, or related to, different kinds of knowledge: primarily users' knowledge based upon their own experiences of the quality of services, and subjective interpretations of the users' needs. However, "empowerment" is related to ideas about how administrative and professional actors can strengthen the users position in service provision, e.g. along theories on integration, normalization or care management. The administrative/professional strategies for "empowerment" are in its turn based upon a changing role for themselves found in scientific/evidence-based knowledge. Users' perspectives therefore comprise divergent knowledge systems (e.g. "subjective impressionistic" – "objective scientific) – that not necessarily overlap.

There are different interpretations on how "user perspectives" should be understood, and implemented in service provision. In particular, the relationship between subjective definitions of user needs ("lay knowledge") and the ideas of "empowerment" is complex, sometimes contradicting each other. Thus the sociological approach to mental health problems advocates that user organisations should be included in municipal decision making while professionals will argue that they themselves are in the position to empower individual users. These issues will be addressed in the next phases of the Know&Pol project.

5. Bibliography.

Abbott A. (1988), *The System of Professions. An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press.

Act Relating to Patients' Rights (Lov av 02.07.99. nr. 63).

Argyris, C. and D. A. Schön (1978). *Organizational learning: A theory of action perspective*. Reading, Mass., Addison-Wesley Pub.

Askheim, Ole Petter (1998): *Omsorgspolitiske endringer – profesjonelle utfordringer*. AdNotam forlag

Bay, Ann-Helen et al.(1999): "*Konkurranseutstting av velferdsstaten? Konsekvenser av anbudskonkurranser og fritt brukervalg*. Handelshøyskolen BI Rapport nr. 7/1999

Bogason, Peter (2000). *Public Policy and Local Governance: Institutions in Postmodern Society*. Cheltenham: Edward Elgar.

Bourdieu, Pierre (1975). "*The Specificity of the Scientific Field and the Social Conditions of the Progress of Reason*". Social Science Information, 14: 19-47.

Bourdieu, Pierre (1977*). Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Brunsson, N (1989): *The Organization of Hypocracy*. New York: John Wiley et sons

de Swaan, A. (1988). *In Care of the State: Health Care, Education and Welfare in Europe*. Cambridge, Polity Press.

DiMaggio, Paul andW.W.Powell (ed.): (1991). *The New Institutionalism in Organizational Analysis*. Chigago. The University of Chicago Press.

Esping-Andersen, G. (2002): *Why we need a New Welfare State*. Oxford University Press, Oxford

Esping-Andersen, G.: (1990): *The Three Worlds of Welfare Capitalism*. Cambridge Polity Press

Feiring, M. (2007 u. a.). Sources of Social Reforms: A Preliminary Draft. Institutt for sosiologi, Universitetet i Oslo (Department of Sociology and Human Geography). Oslo, Universitetet i Oslo (University of Oslo).

Ferlie E. et al (1996): *The New Public Management in Action*. Oxford University Press, Oxford

Foucault, Michel. (1991). "Governmentality". I: G Burchell, C Gordon, & P Miller, red., *The Foucault Effect*. London: Harvester.

Freidson, E. (1988 (1970)). *Profession of Medicine. A Study of the Sociology of Applied Knowledge*. Chicago, University of Chicago Press

Hagen, Helge og Torleif Ruud (2004): Pasienter i psykisk helsevern for voksne 20 november 2003. Sintef helse rapport ¾.

Helgesen, Marit (2003): *"Brukerinvolvering i psykisk helsearbeid i kommunene"*. NIBR Working paper

HOD (2006) Kartlegging av oppgavefordelingen mellom kommunenes helse- og sosialtjensten og spesialisthelsetjensten.

Johnson, Terry (1995):Govermentality and the institutionalization of expertise. I Johnson et al (red): *Health Professions and the State in Europe*. Routledge: London.

Kjellberg, Fransesco (1991):Kommunalt selvstyre og nasjonal styring. Mot nye roller for kommunene? I Norsk Statsvitenskapelig Tidsskrift 1: 45-63

Knapp, Martin et al (2002) *Mental Health policy and practice across Europe. The future direction of mental health care*. The European Observatory on Health Care Systems, http://www.euro.who.int/observatory/Studies/2002114-4

Kristiansen, K. (1994): Normalisering *og Verdsetting av Sosial Rolle*. Kommuneforlaget, Oslo.

Lægreid, Per et al. (2003): *"The Norwegian Hospital Reform – Balancing political control and enterprise autonomy"*. Paper to be presented at the 17th Nordic Conference on Business Studies 14 – 16 August 2003, Reykjavik

Lov av 25. september 1992 nr. 107: Om kommuner og fylkeskommuner

Ludvigsen, Kari (2001): *"Utforming av faglighet i psykisk helsearbeid"*. Rokkan-senteret Working paper

Mental Health Care Act (Lov av 02.07.99. nr. 62)

Myrvold, Trine (2003): *"Et helhetlig tilbud til mennesker med psykiske lidelser? Kommunenes arbeid med integrering av tjenestetilbudet"*. NIBR Working paper

Myrvold,Trine (2005): Kommunenes iverksetting av Opptrappingsplanen for psykisk helse - Foreløpige resultater fra tre forskningsprosjekter, NIBR-notat 2005:133 NIBR-notat 2004:136

Nordby, Trond (1981): Karl Evang. *En biografio*. Universitetsforlaget, Oslo

Page, Edward C. (1991) *Localism and Centralism in Europe. The Political and Legal Bases of Local Self-Government*. Oxford University press.

Pedersen, Per Bernhard (2002): Deinstitusjonaliseringen av det psykiske helsevernet, I Norvoll, R. (red.): *Samfunn og psykiske lidelser. Samfunnsvitenskapelige perspektiver – en introduksjon*. Gyldendal Akademisk 2002.

Peters, B. Guy (2000): *Institutional Theory in Political Science. Continuum*, London/New York

Pierre, P.: (2006): *The welfare state in the European Union : economic and social perspectives*, Oxford University press

Pons, Xavier and Agnes van Zanten (2007): *Knowledge circulation, regulation and governance*, KnowandPol deliverable 4, Litterature review

Ramsdal, H., J. Jacobsen, S. Michelsen og T. Aarseth (2002): Profesjoner, stat og lokalstyre, i . Bukve, O. og A.Offerdal (red.): *Den nye kommunen?* Samlaget

Ramsdal, Helge og Egil Skorstad: Privatisering fra innsiden. Om sammensmeltningen av offentlig og privat organisering. Fagbokforlaget 2004.

Ramsdal, Helge og Gunnar Vold Hansen: Om sirkelens kvadratur. Psykisk helsearbeid møter bestiller-utfører-organisasjonen. I *Tidskrift for psykisk helsearbeid*, Vol.2. nr. 1, Universitetsforlaget 2005.

Ramsdal, Helge og Kari Ludvigsen (1998): "Kompetanseutvikling og profesjonsorganisering i psykiatrien". I Andersen, A.J. og B. Karlsson (red.): *Psykiatri i endring - forståelse og perspektiv på klinisk arbeid*. adNotam Gyldendal.

Ramsdal, Helge: Psykisk helsearbeid i lokalsamfunnet. Noen organisasjonsteoretiske synspunkter. *Tidsskrift for psykisk helsearbeid*, Vol 1. nr. 2, Universitetsforlaget 2004.09.17

Rhodes, R.A.W. (1996). "*The New Governance: Governing without government*". Political Studies, 44: 652-667.

Riksrevisjonen: Dokument nr. 3:5 (2002-2003) Riskrevisjonens undersøkelse av psykisk helsevern – opptrappingsplanen 1999-2006

Robberstad, H. (2002): *Kommunepsykiatri – Pionerar, vekst og utvikling*. Bergen, Fagbokforlaget.

Saltman, R.: The *Western Euopean Experience with Health Care Reform*, The European Observatory on Health Care Systems, WHO 2002.

Slagstad, Rune (1998): *De nasjonale strateger*. Oslo, Universitetsforlaget.

Sosial- og helsedepartementet: Rundskriv 1-44/97: Forslag til statsbudsjett 1998: Øremerket tilskudd til styrking av tilbudet til mennesker med alvorlige psykiske lidelser - foreløpig orientering.

Sosial-og helsedepartementet: Rundskriv 1-4/99: Opptrappingsplan for psykisk helse – utbygging av kommunale tiltak. Øremerket tilskudd til kommunene 1999.

Sosial-og helsedepartementet: Rundskriv 1-14-98: Statsbudsjettet 1998: Styrking av tilbudet i kommunene til mennesker med alvorlig psykiske lidelser og til forebyggende psykososiale problemer blant barn og unge.

Sosial-og helsedepartementet: Rundskriv 1-14-98: Statsbudsjettet 1998: Styrking av tilbudet i kommunene til mennesker med alvorlig psykiske lidelser og til forebyggende psykososiale problemer blant barn og unge.

Sosial-og helsedepartementet: St.prp. nr. 63 (1997-98): Om opptrappingsplan for psykisk helse 1999-2006. Endringer i statsbudsjettet for 1998.

Starr, P. and E. Immergut (1987). *Health Care and the Boundaries of Politics. Changing Boundaries of the Political*. C. S. Maier. Cambridge, Cambridge University Press.

Stortinget: Innst. S. Nr. 222. Innstilling fra sosialkomiteen om opptrappingsplan for psykisk helse 1999-2006.

Stortingsmelding nr. 25 (1996-97): Åpenhet og helhet. Om psykiske lidelser og tjenestetilbudene. Sosial- og helsedepartementet.

Stortingsproposisjon nr. 63 1997 – 1998: Opptrappingsplan for psykisk helsearbeid

The Act on Municipal Health Services (Lov av 19.11.82. nr. 66)

The Act Relating to Social Services (Lov av 13.12.91 nr. 81)

The Health Personnel Act (Lov av 02.07.99 nr. 64).

Vabo, Signy Irene og Inger Marie Stigen (2000): *"Kommunal organisering 2000. Redegjørelse for Kommunal og regionaldepartementets organisasjonsdatabase*. NIBR Notat 2000:128

World Health Report 2001. *Mental Health: New Understanding, New Hope*. WHO 2002

Zeuthen Bentsen, Eva et al (ed.) (1999): *Når styringsambitioner møder praksis*. Handelshøjskolens forlag