about 100 violent deaths every week. The number of injuries is much higher. Between 1990 and 1999, the annual homicide rate increased in Venezuela from 13 to 25 per 100 000 inhabitants. In Caracas, this rate increased from 44 to 81 homicides for every 100 000 inhabitants in the same period. Most of these violent events take place during the weekends in the area called 'Great Caracas' and other urban areas in the country. This represents an enormous drain on health resources, and has a serious psychological impact, notably anxiety disorders and post-traumatic stress disorders. Such psychological effects have not been properly quantified. Violent events have important physical and psychological consequences for both the victim and others, and this represents a considerable burden for the health and rehabilitation services.

The overall mortality rate is 4.6 per 1000 inhabitants. Accidents are the third most common cause of death, whereas suicides and homicides rank seventh. These two categories account for the highest number of years of life potential lost (in Spanish AVPP), mostly among males. The useful years of life lost as a consequence of accidents and violent events are higher or equal to those caused by cancer or cardiovascular diseases, because they mainly affect the infant, juvenile and young adult population.

Non-governmental organisations

Some non-governmental organisations run ambulatory clinics and there are associations that care for vulnerable groups. These organisations provide their own resources or obtain direct help from the government to carry out their projects, which often involve prevention, treatment and rehabilitation in the area of mental health.

Information systems

Currently there is a lack of an information system or epidemiological study in mental health. The mental health system narrows its scope by reporting exclusively on mental disorders.

Programmes for particular populations

The country has specific programmes for the mental health of children and for people affected by natural disasters. There is a National Institute of Child Psychiatry (Instituto Nacional de Psiquiatría del Niño) and also a 2-year programme for university-level child and adolescent psychiatry (see above). This is the only specialised programme in the field of mental health in Venezuela.

In Venezuela in 1999 there were massive land slides in Vargas state. A plan for psychological care and rehabilitation was created to care for any victims of future similar tragedies.

Conclusion

Venezuela has long had adequate health plans and programmes, which have provided immediate responses, sometimes improvised ones, in the area of mental health. The problem has been in their implementation, since priorities have not been properly ascertained, experiences are not taken into account and on-going training and research are not promoted. Venezuela therefore needs to strengthen the implementation of health plans and policies, to meet needs in the area of health, to protect patients' rights, to preserve mental and physical integrity and, consequently, to guarantee the population a good quality of life.

Further reading

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Venezuela has an internationally high rate of homicide (principally involving young men). Statistics from the Institute of Legal Medicine show a present average of about 100 violent deaths every week. The number of injuries is much higher.

COUNTRY PROFILE

Mental health services in Norway

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Few countries (if any) have experienced the abundance of material welfare Norway has had for the last decades. The report of the Organisation for Economic Co-operation and Development (OECD) for 2004 places Norway on the very top of the list of 'best countries to live in'. One might

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therefore expect that mental disorders would not thrive in Norway, but this is not so.

Norway is a constitutional monarchy: its parliament decides new laws; a government with a parliamentary basis executes political decisions; and the judicial system interprets and enforces the laws.

The total population is about 4.5 million, approximately 1 million of whom are under 18 years of age. The population is concentrated around the major cities in the southern part of the country, Oslo, Bergen and Stavanger; large areas of the country feature only small towns and villages and a scattered population. This creates challenges for the provision of an equal health service to all the country's inhabitants.

The predominant political ideology throughout the last 50 years has been based on social democratic ideas of equality in health and social services and education. Therefore most health services are in the public sector, in which hospital treatments are free and most out-patient services are financed by public means. Patients pay a small amount, not exceeding 150 euros per year. Over the last decade, the number of private services have increased, some of which are purchased by the public healthcare system. In the mental health services, this has given rise to private services for people with less severe disorders, who would otherwise fall outside the priorities of the public system.

The critics say more time is needed to establish new services and establish professional competence locally, and that the psychiatric patients most in need of welfare and treatment are paying the price of an ideologically driven process of decentralisation.

History of mental healthcare

Norway passed a Law of the Treatment and Care of the Insane in 1848. It declared that the responsibility for the care of the insane was the government's. A Control Commission was established to inspect the asylums and the private residencies that lodged people with a mental illness, and it looked after patients' legal rights. The law stated that isolation and restraint should be kept to a minimum.

There is broad political agreement in Norway that the mental health services need to be improved, both quantitatively and qualitatively, especially the services for those under 18 years of age.

This law underwent only minor amendment until it was replaced by the 1961 Law on Mental Healthcare. The major change was that the new law introduced the possibility of admission for observation when there was doubt about the mental state of the patient, that is, whether the patient suffered from a psychosis. This observation period could last up to 3 weeks. In 2001 this law was revised and the maximum observation period reduced to 10 days. The revised law allows more use of compulsory treatment for out-patients.

The mental asylums established from 1865 to 1920 have gradually been replaced by smaller hospitals and psychiatric wards in general hospitals. Over the last 10–20 years, however, decentralisation and deinstitutionalisation have taken place, with a dramatic decline in the number of hospital beds and far greater provision of out-patient services. There is presently an intense discussion – political, professional, in the media and in the public – of whether this has proceeded too quickly. The critics say more time is needed to establish new services and establish professional competence locally, and that the psychiatric patients most in need of welfare and treatment are paying the price of an ideologically driven process of decentralisation. The supporters advocate the local design and implementation of mental health services, with patients living in their homes or in small community health centres. There is agreement, however, that there are too few professionals, principally psychiatrists and clinical psychologists, to assure the professional quality of the many local services. This is indeed a great challenge for the structure of services.

Today's mental health system: economy and personnel

There is broad political agreement in Norway that the mental health services need to be improved, both quantitatively and qualitatively, especially the services for those under 18 years of age. In 1997 the Norwegian parliament approved a plan for better, and more decentralised, mental health services, the so-called Escalation Plan for Mental Health (EPMH). In 1996 the total expenditure on mental health services was about 1.16 billion euros. Over the period 1999–2008 this annual figure is due to increase by some 0.7 billion euros, and an additional investment of around 1 billion euros will be made.

Services for children and adolescents

It has been estimated that 5% of the population under 18 years, or a total of 54 000 young people, require treatment in specialised child and adolescent services, almost entirely on an out-patient basis. In 2003 this number was 33 000. Some 3000 people work in the services for children and adolescents; as of 2003, there were 340 in-patient beds, but expansion to 500 by 2008 is planned. There are 154 doctors working in the out-patient units, 120 of whom are child psychiatrists. There are 450 psychologists working in these out-patient units. Consultations per 'professional year' (i.e. how many consultations each doctor or psychologist has annually) total about 380. This level of 'productivity' is a very much debated subject, as some politicians find this number far too low, given that the norm established by some health trusts is 450.

Adult services

There are about 1050 psychiatrists and 500 residents working with adults; 1525 clinical psychologists work within adult psychiatry. Hospital beds total 5600; the norms set out by the EPMH are 9 hospital beds per 10 000 inhabitants and 6 beds per 10 000 in local district psychiatric centres (an equivalent to community-based mental health centres). The average length of stay is about 42 days (averaged over acute wards as well as long-stay departments).

For out-patient units the norm is one professional health worker per 1500 inhabitants aged over 18 years, and the suggested norm for productivity is 500 consultations per professional year.

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Training

The training period for a resident to become a specialist in psychiatry is 5 years (with an extra half year's training for child and adolescent psychiatry). There are clinical programmes of training in specified fields and areas (acute, long-term, out-patient etc.), and educational (theoretical) programmes covering therapy, service models and the client–therapist relationship, leadership and judicial matters. One year of residency might be in another relevant medical specialty (e.g. in child psychiatry or in research). Psychotherapy education, practice and supervision are for a minimum of 3 years: 2 years with psychodynamically based therapies, and one year with cognitive or group analytic treatment (a minimum of 110 hours). Most psychiatrists go on to further training in cognitive or psychodynamic psychotherapy; group analysis has declined in popularity and training in classical psychoanalysis is undertaken only by the dedicated few. In child and adolescent psychiatry, everybody has 40 hours of psychodynamic therapy and some have a 2-year programme in psychotherapy training. There are also training programmes within psychopharmacology, family therapies and community-based treatment of psychosis.

Fifty per cent of residents start training directly after internship, and 50% after 4–10 years of clinical work, mainly in general practice. There is no examination before approval as a psychiatrist, but the clinical training and the clinical supervisors evaluate personal suitability. Training for child and adolescent psychiatry involves 6 months of paediatric practice.

Main areas of research

The universities and colleges, together with the Department of Health and Social Affairs, support a vast range of research activities. There are major programmes on early intervention in first-episode psychosis and extensive programmes of psychotherapy research, including studies of its effects, patient compliance and combined treatments. A national network is examining the efficacy of group analysis for personality disorders. Epidemiological research is undertaken at both regional and community level. Other important fields of interest are genetics, brain imaging, dementia, neuropsychiatry and neurophysiology, psychophysiology, psychopharmacology, sleep disorders, trauma and forensics. In child and adolescent psychiatry the major areas of research are autism, epidemiology, transcultural psychiatry, eating disorders, low birth weight and behaviour problems.

Norwegian Psychiatric Association

The Norwegian Psychiatric Association (NPA), of which most psychiatrists and residents are members, is part of the Norwegian Medical Association. The NPA is concerned with professional conditions and professional development, and the general conditions and structure of the mental health services. It has special sections on preventive psychiatry, biological psychiatry, psychotherapy, forensic psychiatry, old age psychiatry, emergency psychiatry, private practice, quality issues, basic problems in science and psychiatry, and a section on resident education and specialist approval. The association and its sections work in close collaboration with the Norwegian Medical Association, the health authorities and other professional organisations, especially the Psychologists' Association.

The board meets 8–10 times a year, and the sections 2–6 times.

The NPA takes part in public and political processes in developing and changing mental health services. The restructuring and decentralising of the psychiatric services, together with legislative changes in leadership – reducing the administrative and clinical influence of psychiatrists and putting psychologists forward to equal leadership positions – have greatly influenced the role and function of psychiatrists in Norway. There is also an extensive discussion of quality issues, indicators, diagnostic guidelines and treatments, treatment programmes, and quality assurance.

Conclusions

There is great pressure on the emergency wards in the large cities, mainly due to a combination of the reduction in hospital capacity, increasing drug misuse and drug-related psychopathology, and a failure to provide enough housing and services for long-term patients in the community. Although Norway has more resources at its disposal than most other countries, we are struggling with long waiting lists and unacceptably long waiting times. Hence the government recently has introduced an absolute 'maximum allowed period' for different diagnostic and functional categories; priority is always accorded to the more serious disorders.

The NPA is an active partner in formulating priorities in psychiatry, quality-improvement work and developing quality indicators. There is – and will probably always be – a gap between the expectations of the public and the services that can be provided. The government is determined to give most to those most in need, but in so doing faces the dilemma of how to help those patients with the greatest potential for improvement.

The main ideological basis of modern Norwegian psychiatry rests on a humanistic, bio-psychosocial model of understanding and treating psychiatric illness, with the expressed goal of developing better, more specialised and more differentiated hospital treatment, combined with accessible, low-threshold community-based services.

Most psychiatrists go on to further training in cognitive or psychodynamic psychotherapy; group analysis has declined in popularity and training in classical psychoanalysis is undertaken only by the dedicated few.

The restructuring and decentralising of the psychiatric services, together with legislative changes in leadership – reducing the administrative and clinical influence of psychiatrists and putting psychologists forward to equal leadership positions – have greatly influenced the role and function of psychiatrists in Norway.

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