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ORIGINAL ARTICLE

Internet-based Mental Health Services in Norway and Sweden: Characteristics and Consequences

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Abstract Internet-based mental health services increase rapidly. However, national surveys are incomplete and the consequences for such services are poorly discussed. This study describes characteristics of 60 Internet-based mental health services in Norway and Sweden and discusses their social consequences. More than half of the services were offered by voluntary organisations and targeted towards young people. Professionals answered service users' questions in 60% of the services. Eight major themes were identified. These characteristics may indicate a shift in the delivery of mental health services in both countries, and imply changes in the understanding of mental health.

Keywords Internet-based services · Mental health · E-mail · Voluntary organisations · Governmentality

This is an original paper. The total results from this study have not been published previously in print or electronic format. Some preliminary results from the study were presented at a meeting in University of Pisa, Italy in 2009, and at the University of Agder, Norway in 2010. The paper is exclusively submitted for Administration and Policy in Mental Health and Mental Health Services Research.

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Introduction

The demand for Internet-based mental health services has increased dramatically. Researchers argue that the Internet can change the way people seek and get help (Griffiths et al. 2006; Ybarra and Eaton 2005). Accessible by the general public, several websites offer various services (e.g., therapy, counseling, self-help, peer-support, information) in various ways, including discussion forums, chats, support groups, and e-mail and with various means of connecting with persons in the services (e.g., professionals, laypeople). It is, indeed, a heterogeneous field, and the research literature currently fails to distinguish between the different kinds of services.

Several studies have investigated this field. A majority explored e-therapy (Alemi et al. 2007; Heinlen et al. 2003; Postel et al. 2008; Recupero and Rainey 2006), and most describe experiences with cognitive behavioral therapy (Andersson et al. 2008; Burns et al. 2007; Christensen et al. 2004; Griffiths and Christensen 2006; March 2009; Przeworski and Newman 2006). Some report that women use such services more frequently than men (Cook and Doyle 2002; Griffiths et al. 2006; Hall and Tidwell 2003), and others report a higher frequency of male users (Heinlen et al. 2003). Thayer and Ray (2006) determined no significant differences in user gender.

Evidence about age is more reliable, and several studies show that young people are the most frequent users of Internet-based mental health sites (Kurioka et al. 2001; Mehta and Chalhoub 2006). Most significant, however, is the finding that relates to the duration of Internet use. Generally, frequent use of the Internet increases the use of Internet-based services (Thayer and Ray 2006). Several articles argue that Internet-based mental health services are especially suitable for young people, an observation that

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generated increased access to these services by young people (Fukkink and Hermanns 2009; Rickwood et al. 2007; Swanton et al. 2007). Other studies cast doubt on such advice. Katsumata et al. (2008) identified a significant association between a lifetime history of suicidal ideation and "a history of searching the Internet for information about suicide or self-injury, experiences of anxiety or emotional pain" (p. 744). Griffiths et al. (2006) suggest that Internet-based mental health services may reinforce suicidal tendencies. They indicate that these services may reduce isolation but cannot replace face-to-face contact.

In spite of these reservations, recent evidence emphasises the advantages of Internet-based mental health services, presenting convenience and anonymity as major benefits (Griffiths et al. 2006; Kummervold et al. 2002; Richards 2009; Umefjord et al. 2003): people save both time and money. The services are particularly valued in rural areas (Farrell and McKinnon 2003; Griffiths and Christensen 2007; Meyer et al. 2005; Proudfoot 2004). The Internet increases access to services and reduces waiting lists as well as the time needed to visit mental health services (Griffiths et al. 2006; Richards 2009). In addition, the Internet services are cost-effective for both users (Bundorf et al. 2006) and providers (Andersson et al. 2008; Proudfoot 2004). Studies also emphasise the importance of having sufficient time to express your agenda (Mehta and Chalhoub 2006; Richards 2009; Sheese et al. 2004), and some people even prefer written communication (Cook and Doyle 2002; Umefjord et al. 2003).

Intervention studies have shown that Internet-based services reduce stigma and isolation and increase help-seeking behavior and the availability of professionals (Burns et al. 2007; Burns et al. 2009). Others report that users experience an increased feeling of well-being (Fukkink and Hermanns 2009). Despite opposing assumptions, most studies suggest that Internet-based services increase contact with traditional mental health services (Rickwood et al. 2007) and complement the traditional methods of delivering such services (Burns et al. 2007; Burns et al. 2009; Richards 2009; Ybarra and Suman 2006). Importantly, however, Internet-based services do not merely represent a first step toward traditional services. The Internet attracts people who are unsatisfied with or distrust traditional services as well as those seeking a second opinion (Burns et al. 2007; Umefjord et al. 2003).

Earlier research emphasizes that human relationship is the major predictor of good outcomes in mental health care (Miller et al. 1999; Wampold 2001). This concept increases the importance of questioning the quality of online relationships. Several studies suggest that many people prefer the Internet over face-to-face services; they answer questions more sincerely and display greater comfort with self-disclosure in the Internet setting (Cook and Doyle 2002; Farrell and McKinnon 2003; Griffiths et al. 2006; Richards 2009). Others studies express concern about Internet-based services, arguing that the anonymity of the Internet encourages people toward premature self-disclosure (Jøraas et al. 2009; Kassaw and Gabbard 2002). They also worry about the lack of therapeutic control in such settings. In a study that explored the relationship between childhood identity and social networks both on- and offline, Valentine and Holloway (2009) showed that information-based services and communication technologies increase children's control over their identities because asynchronous communication gives them time to think about what they want to say and how they want to present themselves. They further argue that children's on- and offline worlds are similar, and mutually enrich each other.

E-mail is a particularly popular vehicle for communicating about mental health (Fukkink and Hermanns 2009; Griffiths et al. 2006; Styra 2004; Ybarra and Eaton, 2005); some studies even suggest that people prefer e-mail counselling over traditional settings (Cook and Doyle 2002). This study examined e-mail services that were made possible by the Internet, and focused particularly on Norwegian and Swedish services. We aimed to describe the characteristics of Internet-based mental health services in Norway and Sweden and to discuss some possible consequences of the policies of such services. Our study explored only e-mail services that are directed toward the general public.

Methods

We systematically mapped existing websites published in Norwegian and Swedish, using keywords inspired by two recognized national e-mail services. The Norwegian keywords were "psykisk helse" (mental health), combined with either "meldingstjeneste" (message service), "svartjeneste" (answering service), or "mailtjeneste" (e-mail service). The Swedish keywords were "psykisk hälsa" (mental health), combined with "nättjänst" (webservice), "mailtjänst" (e-mail service), "mejltjenst" (e-mail service), "mail nätforum" (e-mail web-forum), "chatte mail forum" (chat e-mail forum), or "jourmail" (emergency mail). The search engine used in this study was Google.

The search, which was conducted during the spring of 2009, yielded 502 hits. After briefly reviewing the hits, we narrowed the scope of our search by excluding irrelevant sites. Snowball sampling (Bowling 2002) (i.e., including references and recommendations to other websites mentioned on relevant sites) increased the sample. We aimed to remain as open-minded as possible during the sampling process, and we included all websites that offered some sort of mental health services by e-mail. This process

yielded 69 Norwegian and 82 Swedish websites. Next, we investigated and read those websites thoroughly, and ultimately retained only websites that offered an intentional and easily accessible e-mail service. At the completion of this review process, our sample comprised 28 Norwegian and 32 Swedish websites, which we divided into three types of services: (i) those that made communication between the service and the service-user publicly available (often one-time contact) and also provided technical solutions that guaranteed total anonymity; (ii) those that offered total anonymity but closed public access to all email communications; and (iii) those that required service-users to use an identifiable e-mail address and blocked public access to all communication.

Although manageable, our material was still too comprehensive. Therefore, we narrowed our focus to four research questions:

- What is the origin of the services?
- Who are the target groups?
- Who answers the e-mails?
- What are the major themes?

These four questions served as a lever during the data analysis process. We thoroughly examined each website, collected information from each site, and sorted the information using Microsoft Word. Next, we narrowed our categories, thereby reducing the amount of data, and transferred the data to an Excel document to ease comparison. As a part of the validation process, we ended our analysis by returning to the original websites and comparing our categories with theirs.

Results

Our study included 60 websites. To highlight the characteristics of the sites, the results presented here focus on origin, target groups, counsellor qualifications, and major themes.

What is the Origin of Internet-based Mental Health Services?

Because the e-mail services in this sample were developed between 1998 and 2008, we were able to identify four major reasons for establishing the web services.

- A majority of the services were developed as an expansion of existing telephone services and as a direct consequence of technological development. For example, Mental Health Norway established a telephone service for the general public in 1992. Technological advancements allowed the organization to initiate an e-mail service in 2006 as an attempt to reach younger citizens, thus complementing its existing service.
- Other sites were established exclusively as Internet-based services by public authorities, independent professionals, or private individuals who regarded the Internet as an effective tool to process counseling and promote mental health. For example, two psychologists initiated a website in 2003 as a way of offering therapy and support to people with mental health problems.
- Some services were established primarily on the basis of people's own experiences with specific life challenges and/or as a reaction to inadequate public attention and insufficient support for public mental health services. One of these services is delivered by a voluntary organisation initially established by two girls who had personally experienced self-harm and eating disorders. This site distributes experience-based knowledge and offers an e-mail service, where people can get advice and support during their recovery-process.
- Voluntary organisations, public services, and/or public authorities initiated many of the sites studied here to improve on the existing model of face-to-face services. An Internet-based service developed in Bodø Municipality, Norway, is part of that city's outreach work among young people. It is widely regarded both as a service in its own right and as an entry portal for other services.

Funding sources and ownership vary in the study sample, but we opted to categorize service origin in terms of public, private, or voluntary sector. "Public sector" refers to services initiated, owned, and delivered by national, regional, and/or local/municipal authorities and financed by taxes. "Private sector" refers to services outside public control, demanding some sort of self-financing, and sometimes run for profit. Services in this category are offered as payment services or financed by advertising revenue and/or private sponsors. The "voluntary sector" is more diverse and complex, and includes nonprofit and nongovernmental organizations. These services were mainly established and delivered by humanitarian, political, religious and user- and self-help organizations, women's organizations, and nonprofit foundations. The services were financed through different sources, including membership fees, project funding, advertising revenues, lotteries, sponsors, and the sale of books or courses. Most services were partly financed by public authorities and some were fully financed by the government. Figure 1 shows the distribution of these criteria.

Our results show that the voluntary sector accounts for more than half of Internet services in our study. The distribution between the sectors is similar in both countries.

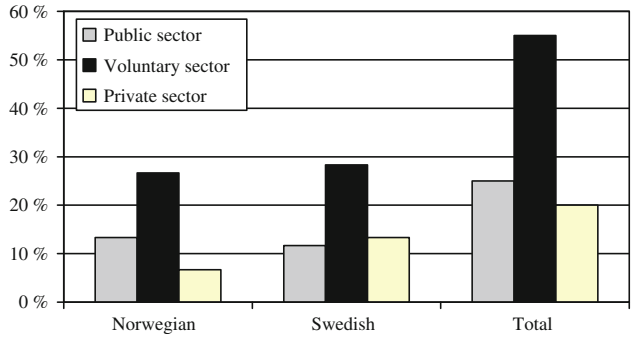

Fig. 1 Origin of Internet-based mental health services in Norway and Sweden

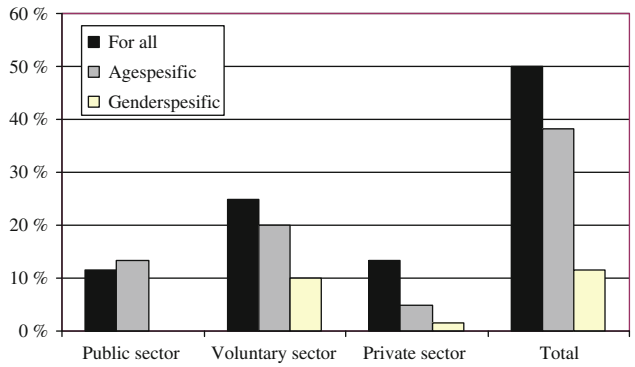

Fig. 2 Main target groups of Internet-based mental health services in Norway and Sweden

Who are the Target Groups?

Half of the sites specified no target groups and were open to everyone. Many sites offered some kind of medical assistance and addressed the general public. Some sites indirectly specified the target groups and addressed people interested in certain topics. A second group of services limited the target group according to age, addressing users between 10 and 30 years of age. Gender represented a third target group. Figure 2 illustrates the distribution of criteria established by data comparison (see above).

This comparison shows that the private sector orients mostly toward open access services. The public sector seems slightly more interested in operating sites for young people and less interested in running gender-specific services. Services from the voluntary sector seem most diverse.

Who Answers the E-mails?

Unmasking counselor qualifications were difficult, and data was missing in five services. However, we were able to identify four different categories of respondents to the other sites.

- *Professionals*. Some websites identified them as experts, while others published names, education, and photographs. The professionals were doctors, nurses, psychologists, family therapists, social workers, priests, and sexologists.
- *Laypeople*. These respondents had no professional education in mental health but had often achieved some sort of training.
- *Service-users*. These services were staffed by people whose personal experience was relevant to the services. They based their answers mainly on that personal experience.
- *Mixed* (i.e., a combination of professionals and service-users).

The distribution between the language groups was fairly similar. Comparing information about the counselors qualifications with the information about the services' origin yielded the following data distribution (Fig. 3).

Figure 3 shows that Internet-based services from both the public and private sectors are staffed mainly by professionals with "expert" knowledge, while services from the voluntary sector drew upon more diverse staff and different sources of knowledge (e.g., personal experience).

What are the Major Themes Under Which Counselling is Sought?

Internet-based mental health services in Norwegian and Swedish cover most aspects of life (i.e., pregnancy, birth, growing up, going to school, forming an identity and building self-confidence, enjoying your body and its appearance and (dys)functions, creating affectionate relationships with others, finding a lover, having sex, drinking

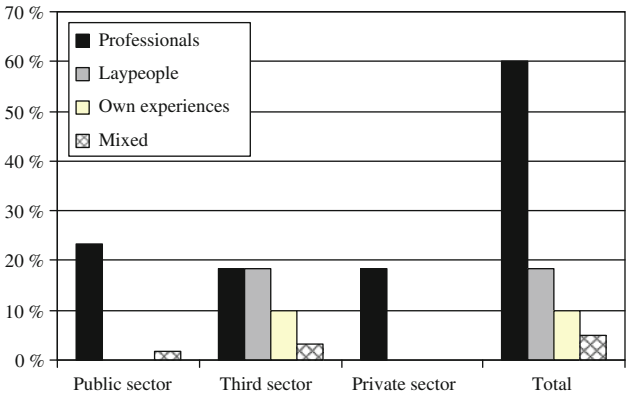

Fig. 3 Qualifications of the counsellors in Internet-based mental health services in Norway and Sweden

alcohol, trying to stop smoking, being a parent, being ill or having a medical problem, having experiences of violence, abuse and harassment of some kind, going to work, finding meaning in life, experiencing life's ups and downs, enjoying human rights, the experiences of suicide and death). Variation is the most substantial characteristic of the topics of interest. Based on a thorough examination of content, we divided the websites into eight different categories. Although not fully mutually exclusive, these categories summarize the main tendencies regarding major themes.

- *Emotional, cognitive and/or relational problems*. Ten services (six Norwegian and four Swedish) addressed human phenomena related to emotional, cognitive, and/or relational challenges in life. This category includes sites focusing on individual challenges (e.g., anxiety, depression, obsessive thoughts, eating disorders, feeling blue, restlessness, and inner tensions) but also on challenges that emerge in family life, including services offered to children in families where one or both parents had mental disorders and children who had lost close family members to suicide. E-mail respondents who sought services in this category varied greatly.
- *Gender, identity, and relationships*. Ten services offered services for these topics. Only two sites in this category were run by public authorities—one in each country—and both sites offered services, mostly to young people, regarding questions about health, relationships, family, love, and sexuality. With one exception, all of the other sites were owned and operated by organisations in the voluntary sector, and two sites—one in each country—directed their attention mainly towards homo-, bi-, and transsexual people, offering support, guidance, and help for these groups in various ways. E-mail respondents to both sites were people with personal experience in the area. Two sites, also one in each country, were exclusively for women, and offered information and guidance concerning women's problems and rights regarding self-confidence, self-esteem, abortion, bullying, oppression, and sexual harassment; answers were provide by other women. Generally, questions regarding body, health, sex, contraception, and sexual functions in general were addressed in two of the sample sites, while two Norwegian sites offered information and counselling on questions regarding pregnancy, abortion, birth, and infants. Another site, privately owned and operated, was exclusively for men.
- *Addiction and abuse*. Eight sites (five Swedish and three Norwegian) offered information, counselling, and help for people struggling with some kind of addiction and/or abuse to steroids, tobacco, alcohol, gambling, and/or drugs. This category includes services for children of parents with addiction problems. Four fit into the voluntary sector and four fit into the public sector; all showed variation regarding e-mail respondents.
- *Growing up*. Eight services (four Norwegian and four Swedish) focused on different aspects of childhood, adolescence, and being young. They offered various modes of information, consultation, and counselling for young people, parents, and professionals. Some sites were initiated on the basis of the UN convention on the Rights of the Child; others focused mainly on information and e-mail counselling about different aspects of young life. Two sites focused on different aspects of parenthood and one had a geographical origin and offered young people the opportunity to ask adults about anything regarding young people in this region.
- *Help and psychotherapy*. Most services sought to provide help, so it is difficult to establish a separate category for this purpose. Some services expressed their goal of helping people with mental health problems more openly. Seven services were put together in this category (two Norwegian and five Swedish); with one exception, their e-mail respondents were professionals. The services varied in profile and content.
- *Health information and medical counselling*. Six services, (three Norwegian and four Swedish) offered health information and medical counselling by doctors and nurses. Most offered information and advice regarding illness and disease, including psychiatric disorders and mental illnesses. One focused exclusively on disease-related pain and the consequences of such pain, including depression, sadness, and anxiety.
- *Violence, incest, and sexual abuse*. Six sites (one Norwegian and five Swedish) addressed issues concerning violence, incest, and sexual abuse; all of them were delivered by the voluntary sector. Both the Norwegian and Swedish samples yielded e-mail services for people encountering incest and sexual abuse. Sweden also had a service for women who had been exposed to violence, threats, harassments, and sexual abuse in close relationships. One websites was translated into eleven different languages, emphasizing the multicultural aspects of this topic. One Swedish site focused exclusively on violence, harassment, and abuse towards homo-, bi-, or transsexual persons; another focused on living conditions for victims of crime.
- *Work and study*. Four sites (two Norwegian and two Swedish) addressed living conditions at work or school, or explored the consequences of work conditions. Two sites offered information and advice regarding the work

environment (e.g., work-related health problems rooted in bullying at work). One site addressed health and living conditions for pupils at school; another offered support and counselling for soldiers who had worked on UN peace-keeping missions abroad.

Figure 4 illustrates the distribution achieved by comparing major themes and site origin.

While comparing services in Norway and Sweden, we identified sites with similar profiles. Some sites seem to have a "twin brother or sister" in the other country. Our sample contains at least eight different "twins," revealing a pattern of "necessary" Internet-based mental health services. Twin services addressed questions about "growing up" (2 pairs of twins); "gender, identity, and relations to others" (3 pairs of twins); "violence, incest, and sexual abuse" (1 pair of twins); and "health information and medical assistance" (1 pair of twins).

We also identified country-based differences. One obvious distinction involved the difference between numbers and variations of services in the category of "violence, incest, and sexual abuse". The services that focused on steroids and gambling constituted another difference. In both cases, the Swedish sites were more comprehensive. On the other hand, Norwegian services focusing on children of parents with either mental health problems or drug problems were more numerous and seemed more varied.

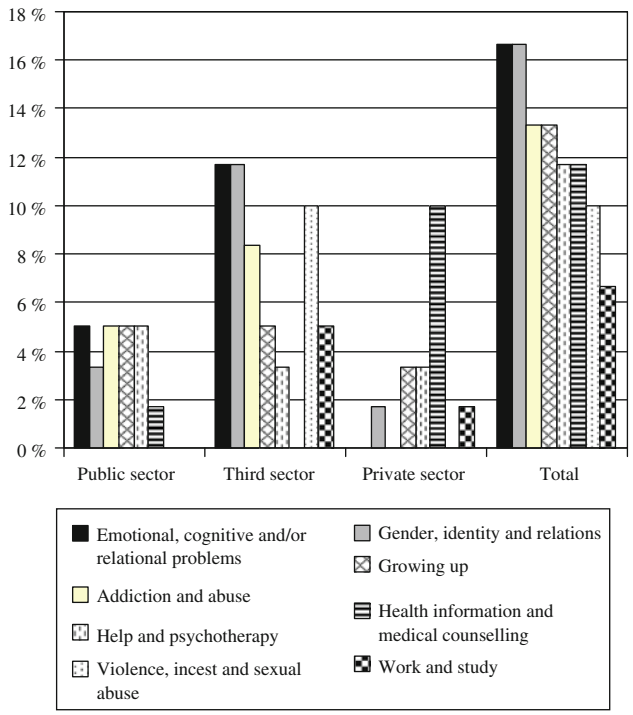

Fig. 4 Major themes under which counselling is sought in Internet-based mental health services in Norway and Sweden

We identified a small but interesting difference concerning secrecy. A majority of the websites provides no information on this matter, but four sites offered instructions on how to hide all traces from their visit, and two sites included an easily visible panic button on their home pages. Users who pressed this button were automatically redirected to a TV program and Google, respectively. Both websites were Swedish and both focused sexuality and identity.

Discussion

A majority of the Norwegian and Swedish language Internet-based mental health services are delivered by voluntary organisations and are partly financed by public authorities. The content of each site varies but they cover most aspects of human life. Although such sites commonly direct their services toward people between 10 and 30 years of age, more than half of the sites in this study target no specific group. Our identification of twin sites allowed us to determine a pattern of "necessary" services in both countries, thus illustrating the weight society ascribes to reaching out and finding new ways to connect with the upcoming generation. This characteristic seems especially important in the public sector. In public and privately run services, the users get answers from professionals, whereas services in the voluntary sector hire a mix of professionals, laypeople, and/or service-users as respondents. This article discusses the consequences that arise from the delivery and policies of Internet-based mental health services.

Changes in the Delivery of Mental Health Services

In both Norway and Sweden, public authorities own, finance, and deliver traditional mental health services almost exclusively. However, our study determined that voluntary organizations deliver many of those services. How should this be interpreted and what are the possible consequences? Here, we offer three possible explanations.

Bottom-up Perspective

Our results illustrate a sort of bottom-up perspective wherein voluntary organisations intercept new needs in the population, particularly within groups of people who are excluded from the community. Research emphasising the important role of Internet-based services in rural areas may strengthen this focus (Farrell and McKinnon 2003; Griffiths and Christensen 2007; Meyer et al. 2005; Proudfoot 2004). Some organizations clearly emphasize the democratic aspect of their services, and they use information gleaned from their service-users to reinforce these perspectives in society. In many ways, the services amplify

marginalized people. However, it is possible to turn this argument upside down. Internet services might reduce the potential for social unrest by offering individuals an opportunity to share experiences and individualize their troubles. Accordingly, it possible to view the e-mail services as a way of eliminating critical voices and silencing oppressed people. On one hand, Internet-based mental health services may reinforce the voices of the citizens and strengthen our democracies; on the other, they may further marginalize oppressed people by rendering important experiences invisible.

Alternative Mental Health Services

Alternatively, it is possible to view this development in light of the particular history of the mental health field, and also view it as a sign of distrust in conventional public mental health services. Service-user organisations have independently developed more suitable services according to their needs. The Internet offers increased user-control over interventions, and some researchers understand this as a form of user-empowerment (Griffiths et al. 2006; Recupero and Rainey 2006; Ybarra and Eaton 2005). Such reasoning makes it difficult to view Internet-based services unambiguously as supplements to traditional services (Fukkink and Hermanns 2009). The new services also engender possible criticism towards established services, thus providing an alternative service to people who seek another kind of help.

New Public Management

Finally, our results may illustrate how the New Public Management provides modern health policies and generates more project-based funding for the traditional social service model in the Nordic welfare states (Matties 2006). Most services within the voluntary sectors are financed partially by the public support. However, government is cautious about taking full responsibility for new services, thus reducing public responsibility. Therefore, e-mail services could reinforce the ideology behind self-help movements and consumerism or strengthen the individualisation of mental health and reduce public responsibility.

A Modern Confessional

Internet-based services provide individual narratives about life challenges. Most services are anonymous, with no face-to-face meetings, and they often attract young people. A few services operate in a high degree of secrecy. Earlier research showed that anonymity makes it easier to discuss embarrassing concerns and uncomfortable topics (Przeworski and Newman 2006). Users attach a high premium to such characteristics (Griffiths et al. 2006; Kummervold et al. 2002; Richards 2009; Umefjord et al. 2003). Indeed, Internet-based mental health services cover most aspects of life and focus on topics that are commonly experienced by most people in Norway and Sweden.

What drives this secrecy and need for anonymity? One obvious answer is danger. If someone has experienced violence and abuse, risking further injury by seeking help creates an understandable need for secrecy. Others simple need for privacy. Anonymity in services regarding gender, identity, and relationships likely reflects the need for privacy in children, adolescents, and young people. The right to privacy likely relates to the United Nations' Convention of the Rights of the Child. This argument is related closely to the concepts of embarrassment and sense of decency and also to human's need maintain social identity and personal dignity.

At the same time, the question of privacy seems culture-specific, blurring the borders that surround these unwritten rules. Thus, the need for privacy links to the concept of stigmatization and may contribute to social exclusion and discrimination. The World Health Organisation (WHO) addressed this issue in their World Health Report 2001, recommending that all countries launch public awareness and education campaigns about mental health to reduce stigma and discrimination and more closely align mental and physical health care (WHO 2001). Secrecy thrives on a lack of knowledge.

The French philosopher Michel Foucault offers an interesting analysis of the catholic confessional (Foucault 1980; Taylor 2009), arguing that confession contributes to social control in societies and maintains the order of social discourse. This perspective suggests the possibility of viewing Internet e-mail services as a modern confessional (i.e., a place where we create and maintain narratives of our lives, develop authoritative interpretations of normality and life challenges, and participate in activities that mould our identities and govern our souls (Rose 1999)).

Differences among e-mail respondents are particularly interesting because they imply possible differences in understandings of mental health. Some people resist reducing life challenges to medical disease (Givens et al. 2007), rejecting the "medicalization" of everyday life (Conrad and Schneider 1992). Some Internet-based services support the demedicalization of everyday life and often include service-users as counsellors. Thus, Internet services may offer alternatives to the public mental health services and to professional health knowledge.

Methodological Considerations

The selection of keywords affects the question of validity in this study and requires critical examination. Keywords identify relevant information in an inclusive and precise way, narrowing the sample and making the research results

more manageable. One may argue that keywords are too precise, limiting the sample in ways that exclude relevant information. Although the keywords may have limited application in the findings of the present study unwantedly, such limitations were opposed by expanding snowball sampling (see above). It is nearly impossible to obtain an accurate count of websites, and we cannot guarantee that we didn't overlook some relevant services. However, new sites appear constantly, and others disappear (Heinlen et al. 2003). One year after the sampling process, one website and one e-mail service had closed down; others were still operating. Consequently, our results are best understood as a snapshot of the situation in 2009.

Furthermore, keywords help determine which phenomena we are investigating; this is particularly interesting in the mental health field. After selecting "depression" as a keyword, De Wattignar and Read (2009) identified a major influence by the pharmaceutical industry regarding the funding of the websites. Although we expected to find the same tendencies in this study, we were surprised by the limited influence of the pharmaceutical industry. However, such influence can be indirect and difficult to trace, and for this reason we acknowledge the possibility that industry could play a more important role in this sample. The choice of keywords may yield different results. "Depression" is a clinical term that relates closely to the medical model. Our study suggests that private funding is much more frequent in themes related to medical counselling. "Mental health" is not unambiguously related to the medical model, possibly explaining some of the variation observed in our results, and also increasing interest in different discourses about mental health.

Because the categorisation "major themes under which counselling is sought" is not fully and mutually exclusive, categories may overlap to some extent, possibly reflecting methodological weakness related to the analysis process and the demand for internal homogeneity and external heterogeneity (Patton 2002). On the other hand, it might be understood in light of the previous conceptual discussion, emphasizing the differences between a narrow and a broad concept of mental health.

Conclusion

Internet-based mental health services in Norway and Sweden are characterised by a variety of major themes under which people seek counselling. More than half of the services investigated here were distributed by the voluntary sector and targeted towards young people. Professionals answered the questions in 60% of all services. These characteristics may indicate a shift in the delivery of mental health services in both countries, possibly reinforcing the service-user perspective. Internet-based services might also exert pressure on the individualization of social problems and the medicalization of everyday life. Either way, it seems evident that this development will affect the understanding of mental health and mental health services.

Finally, one might ask if this study applies to Internet service providers outside the Scandinavian context. Because service delivery can differ substantially between countries, it is very difficult to generalize the findings of this study. Nonetheless, we wish to address two issues in a wider context. WHO (Herrman et al. 2005) emphasizes the importance of developing a broad concept of mental health; emphasizing the variations in this study strongly supports the concept of openness. Some might interpret the present study as emphasizing the liberating potential of Internet-based services. Our findings suggest a slow shift in power from professionals to service-users, from expert-based knowledge toward experience-based knowledge. Consequently, our study may highlight an additional and important source for the developing understanding of mental health in a public health perspective (Herrman et al. 2005).

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Conflict of Interest From 2005 to 2008 the first author was a member of the board of one of the services examined in this study. Although experience initially inspired the current project, it did not affect the research and is not considered e a conflict of interest. No other conflicts of interest are identified.

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