Sweden

Helena Silfverhielm and Claes Göran Stefansson

National Board of Health and Welfare (Socialstyrelsen), S-106 30 Stockholm, Sweden,
email Helena.Silfverhielm@socialstyrelsen.se

The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributors. Please contact Shekhar Saxena (email saxenas@who.int).

With an area of 450 000 km², Sweden is one of the largest countries in Western Europe. It is 1500 km from north to south. It has nearly 9 million inhabitants (20 per km²). It is a constitutional, hereditary monarchy with a parliamentary government. Sweden is highly dependent on international trade to maintain its high productivity and good living standards. Many public services are provided by Sweden's 289 municipalities and 21 county councils. Municipal responsibilities include schools, child care and care of the elderly, as well as social support for people with a chronic mental illness. The county councils are mainly responsible for healthcare, including psychiatric care, and public transport at the regional level. Sweden is characterised by an even distribution of incomes and wealth. This is partly a result of the comparatively large role of the public sector.

The healthcare system

Sweden's healthcare system is governed through the three levels of government – central, county and municipality. Central government is responsible for legislation within the healthcare system, higher education (universities), research funding, the health insurance system, and general and directed subsidies to the counties and municipalities to help them carry out different public service measures. The 21 counties are responsible for specialised healthcare activities, which include hospitals and primary healthcare (general practitioners) and the medical professionals working there. The 290 municipalities are responsible for social services for elderly persons and those with a disability, including a mental disability. This includes not only social support but also medical nursing.

The public healthcare system is financed by taxes raised at all three levels of government. A minor part of healthcare is carried out on a private basis (mostly short-term treatment). Private care is most common in the big cities and is rare in rural regions. The management of the care and social services provided for people with mental disorders is handled by the counties and the municipalities.

In 2001 the total expenditure on medical care in Sweden was €19.1 billion, which represented 8.0% of gross domestic product (GDP). After allowing for income from patient fees and so on, the net cost to government was €12.1 billion.

Mental healthcare has achieved political prioritisation over the last 20 years, on the one hand through a national action plan for the development of healthcare and on the other by the introduction of a national mental health coordinator, combined with directed subsidies from the government for the development of mental healthcare.

Mental health services

Net expenditure on psychiatric care is €1.4 billion per year. The psychiatric treatment prevalence of adult persons is about 2–3% of the total population per year. In the bigger cities the treatment prevalence is higher (e.g. 4–5% in Stockholm).

Psychiatric care is divided between four different types of organisation: general psychiatry (for those aged 18 years or more); child and adolescent psychiatry; forensic psychiatry; and psychiatry of persons with drug misuse.

Hospital beds

In 1967 the mental hospitals were transferred from the state to the counties. At that time there were in total some 35 000 psychiatric beds (4 beds/1000 inhabitants), of which about 70% were in mental hospitals. Thereafter they began to close, and since the mid-1990s Sweden has had no beds in mental hospitals. Today there are about 4000 psychiatric beds (0.5 beds/1000 inhabitants), all of them in psychiatric wards in general hospitals (except 350 in forensic high-security hospitals).

In-patient care

The number of in-patients continues to decline. The proportion of beds occupied by persons under compulsory and forensic care was higher in 2005 than previously (Table 1). The reduction in bed numbers has been made possible through the out-patient care centres and the commitment of the municipalities to the psychiatric reforms of 1995 (see below). But there has been a re-institutionalisation. The beds in the former psychiatric hospitals have now to a certain degree been replaced by nursing homes and supported housing managed by the municipalities.

But there has been a re-institutionalisation. The beds in the former psychiatric hospitals have now to a certain degree been replaced by nursing homes and supported housing managed by the municipalities.

Social services

The social services are responsible for the care of people with a disability, which includes people with a long-term mental illness. Expenditure on social services was €13.2 billion in 2000, or 5.7% of GDP. Unfortunately it is impossible to separate costs for

https://doi.org/10.1192/S1749367600001430 Published online by Cambridge University Press

Table 1 Number of in-patients in Sweden, based on data from a single-day census

Form of care	1991		1994		1997		2005	
	Men	Women	Men	Women	Men	Women	Men	Women
Voluntary	4270	4659	3218	3396	1884	2141	2228 (total)	
Compulsory	1003	919	557	551	522	409	394	461
Forensic	731	106	677	58	699	71	809	126
Total	6004	5684	4452	4005	3105	2671	4022 (total)	

Source: National Board of Health and Welfare, Sweden (2005).

Today there are about 45 000 people with a chronic mental illness (0.7% of the total adult population) yearly in the care of social services or psychiatric care organisations. This is about a quarter of all patients in psychiatric treatment.

mental healthcare within social services from other costs. In 2002 there were some 8000 people with mental disabilities in 850 sheltered homes for whom the social services were responsible.

The social services also have responsibility for long-term care and economic support for persons with substance misuse disorders. In the year 2000 some 21 000 people aged 21 years or more were in receipt of such services, at a total cost of €406 million.

Development of psychiatric care

Community Mental Healthcare Reform, 1995

An evaluation of the sectorised organisation of psychiatric care showed, among other things, that patients with a long-term mental illness, for example those with schizophrenia, in a number of respects were not receiving satisfactory care. Their needs for medical treatment were mostly being met, but other needs (e.g. social support) were not. The responsibility for interventions regarding these needs was given to the social service agencies, with the Swedish Social Services Act of 1982. However, a parliamentary commission of 1992, the Committee on Psychiatric Care, concluded that social services were still largely inadequate and were not being provided in a satisfactory manner. Therefore, the mandate upon municipal social services was clarified through the Community Mental Healthcare Reform, which came into effect on 1 January 1995. The reform is directed towards individuals with severe and long-standing mental illness.

The aim of the reform was to take back into the local community people undergoing long-term treatment in psychiatric hospitals and nursing homes and to force social service agencies and psychiatric units to cooperate in their care for these people. The reform also clarified that social services had the primary responsibility to support anyone with a chronic mental illness in the community with housing, daily activities and rehabilitation.

Today there are about 45 000 people with a chronic mental illness (0.7% of the total adult population) yearly in the care of social services or psychiatric care organisations. This is about a quarter of all patients in psychiatric treatment.

Legislation concerning psychiatry

The Swedish Disability Act 1994 aims to provide support and services for people with disabilities of various kinds, including psychiatric disorders. The law states a number of specific forms of assistance that these people can receive, including counselling and support, personal assistance, housing with special services, contact persons and companions. The Act is 'complementary' in that it cannot entail any curtailment of assistance to which the individual is entitled under other legislation. Moreover, it is civil rights legislation, and decisions can therefore be appealed against in the administrative courts. As of 2002, 2700 persons with a mental disability were in receipt of benefits under the Disability Act.

The Healthcare Act 1982 regulates the treatment of persons in need of medical or psychiatric treatment, whether by nurses in sheltered homes within social services or by specialised psychiatric care in these homes or in clinics.

The Social Services Act 2001 obliges the municipal social services to conduct outreach activities among persons with psychiatric disabilities. Social services are also obliged to plan their assistance programmes for these people in collaboration with the psychiatric care organisation and other social bodies and organisations.

The Municipal Financial Responsibility Act 1995 makes it incumbent upon the municipalities to pay for the care of patients who, after three consecutive months of in-patient treatment by a psychiatrist, have been deemed as fully medically treated within the psychiatric in-patient system but who are still being cared for in hospital because they cannot be transferred into community-based independent living or sheltered housing. One of the aims of this municipal financial responsibility is to stimulate the development of new forms of housing within the community for people with a mental disability who have been in long-term institutional care.

Problem areas

There are three groups for whom care provision in Sweden is at present problematic:

- patients with a chronic mental illness

https://doi.org/10.1192/S1749367600001430 Published online by Cambridge University Press

- those aged 18–25 years
- those with a dual diagnosis of personality disorders and substance misuse.

Patients with a chronic mental illness

These persons belong mainly to the diagnostic categories of the psychoses and most (75–80%) have schizophrenic disorders. The Community Mental Healthcare Reform has meant that about 80% of these people live in the community, with support mostly from social services. The predominant problem is the degree of cooperation between social services and the psychiatric care organisations, which both have some responsibility for people with schizophrenia. Central government is trying to force the counties (psychiatric care) and the municipalities (social services) to create a joint organisation for the care and social support of these people. This has been legally possible since 1 July 2003.

Younger patients

The treatment prevalence of persons within psychiatric care has increased notably in recent years, mostly in out-patient services. In Stockholm county (in which one in five of the Swedish population resides) this number increased by 33% between 1997 and 2001 (from 45 000 persons to 60 000, or from 3.5% of the adult population to 4.5%). The increase is, however, most marked for people aged 18–25 years. Substance misuse is common in this group. A large part of psychiatric out-patient resources are directed to this problem but there has been no systematic effort to provide services directed to the psychiatric problems of ‘young adult’ persons. One solution would be to merge child psychiatry with adult psychiatry services. These care organisations at present mostly operate entirely independently.

People with personality disorders and substance misuse (dual diagnosis)

This category of psychiatric disorder has come to public prominence recently because of a few high-profile cases, notably one which involved the murder of Sweden’s foreign minister, Anna Lind. Investigations showed that these persons often have a long history of treatment, have had early contact with social services and from a young age have engaged in criminal behaviour. A government inquiry has been launched to investigate how medical/psychiatric treatment and social services can be better coordinated for these people.

The predominant problem is the degree of cooperation between social services and the psychiatric care organisations, which both have some responsibility for people with schizophrenia. Central government is trying to force the counties (psychiatric care) and the municipalities (social services) to create a joint organisation for the care and social support of these people.

Suicide

Sweden has traditionally had a reputation as a country with a high suicide rate, but after marked increases in the 1960s and 1970s the rate steadily fell after 1979 (Table 2). The suicide rate for 2000, 19.0 per 100,000 population aged 15 years and over, was the lowest since the current classificatory system was introduced in 1969, and Sweden is now part of the middle group among European countries. Furthermore, the age differences in suicide fatalities are, from an international perspective, relatively small. In line with the general decrease, suicide rates for both men and women fell in the 20 years up to 2001, when certain suicide rates increased from the rather low levels in 2000. Public health specialists became concerned that this increase could announce a change in trend towards rising suicide rates. Figures for 2002 published by the National Board of Health and Welfare indicate a decrease in the female suicide rate in 2001/02, accompanied by a marginal increase in the male rate.

The reduced suicide rate has not been as evident among younger groups, however; in parallel, in international comparisons, the oldest age-group has a relatively low suicide rate.

Recruitment trends

According to statistics from the National Board of Health and Welfare, in 2002 there were 1700 doctors with a specialist qualification in psychiatry. Of these, 1400 were actively engaged in healthcare. The number of new psychiatrists who had received their training in Sweden increased over the period 1996–99 but the number fell thereafter (see Figure 1).

Table 2 Numbers of suicides and suicide rates per 100 000 (men and women, aged 15 years and over), by age-group, for selected years 1980–2002

Year	15–24 years		25–44 years		45–64 years		65 years and over		Total	
	n	Rate	*n*	Rate	*n*	Rate	*n*	Rate	*n*	Rate
1980	174	15.4	805	34.4	790	42.3	468	34.4	2237	33.4
1985	158	13.5	749	31.1	664	36.6	495	34.0	2066	30.2
1990	153	13.1	638	26.2	676	35.2	513	33.6	1980	28.1
1995	131	12.1	568	23.4	663	31.3	444	28.8	1806	25.2
2000	106	10.3	416	17.1	483	21.4	375	24.5	1380	19.0
2001	110	10.6	445	18.3	601	26.3	390	25.5	1546	21.2
2002	146	13.9	418	17.2	586	25.3	335	21.8	1485	20.3

Source: Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health, 2005.

https://doi.org/10.1192/S1749367600001430 Published online by Cambridge University Press

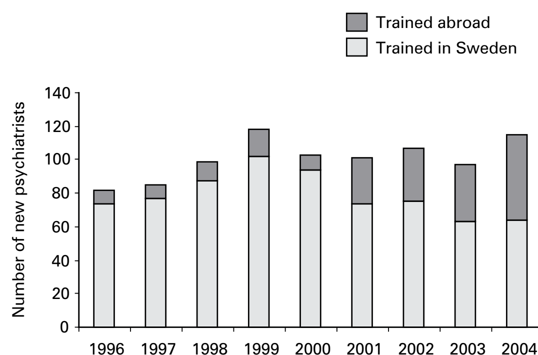

Figure 1. Total number of specialty licences in psychiatry distributed to doctors trained in Sweden or abroad, 1996–2004. Source: National Board of Health and Welfare, NPS database.

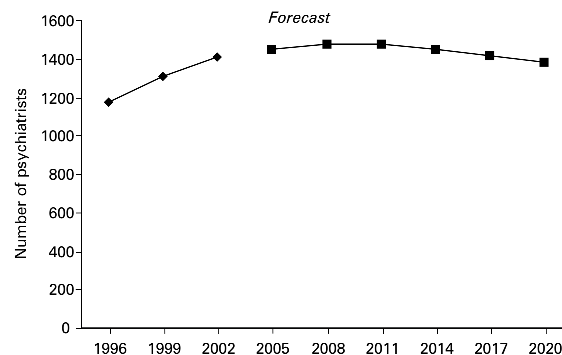

Figure 2. Total number of psychiatrists in the healthcare system, 1996–2002 and forecast for 2005–20. Source: National Board of Health and Welfare, NPS database.

The number of psychiatrists employed in the public healthcare system care is forecast to rise to 2010. Thereafter the number will be stabilised at around 1500, and then fall again so that by 2020 it is expected to be at the same level as in 2001 (Figure 2).

According to a 2004 nationwide inquiry by the National Board of Health and Welfare directed at the county councils, there was some optimism regarding their ability to recruit new professionals, not only psychiatrists but also nurses and psychologists.

COUNTRY PROFILE

Mental health in Finland

Eero Lahtinen MD PhD

Senior Medical Officer, Health Department, Health Promotion Group, Sjötullsgatan 8, Helsingfors, Finland, email eero.lahtinen@stm.fi

The recession of the 1990s, the subsequent changes in the labour market, job insecurity and persistent long-term unemployment are all part of the national context for increasing mental ill health.

The prevalence of mental illnesses in Finland generally reflects global trends, with a clear increase in the occurrence of depression and anxiety. At any time, between 4% and 9% of the population of 5.2 million suffer from major depressive disorders. Some 10–20% of the population experience depression during their lifetime. Bipolar depressive disorders affect 1–2% and schizophrenia 0.5–1.5% of the population. The prevalence of alcoholism is 4–8%.

The incidence of depression has increased over the past 15 years, in part reflecting better diagnostic practices and more widespread antidepressant treatment but also the altered living and psychosocial environment. Depression has been a growing cause of sickness absenteeism and work disability pensions – although the overall level of work disability has dropped.

Stress and burnout are common among employees, and are experienced in some form by over 50% of the workforce. The recession of the 1990s, the subsequent changes in the labour market, job insecurity and persistent long-term unemployment are all part of the national context for increasing mental ill health, although mental health trends parallel those of other countries. There is also concern about the growing extent of psychosocial problems among children and young people.

Policy, programmes and preventive work

Finland deployed the first comprehensive national suicide prevention programme between 1986 and 1996. There have since been several other national programmes to develop preventive and early intervention measures in mental health. They include the National Depression Programme, Mental Health in Primary Services, and the Meaningful Life, Early Interaction and the Effective Family programmes.

A mental health policy was initially formulated in 1993. It focused on advocacy, promotion, prevention, treatment and rehabilitation. Part of the mental health policy has been the de-institutionalisation of psychiatric care. A substance misuse policy was initially formulated in 1997.

The Ministry of Social Affairs and Health produced quality guidelines for mental health services in 2001 and is working on quality guidelines for supportive housing for people with mental health problems. The government has also adopted a Drug Policy Action Programme for 2004–07. The national Alcohol Programme was launched in 2004. Comprehensive quality guidelines for health promotion at the local level are in preparation, linked with the updating of the Primary Healthcare Act.

https://doi.org/10.1192/S1749367600001430 Published online by Cambridge University Press