Sweden

General Information

Sweden is a country with an approximate area of 450 thousand sq. km. (UNO, 2001). Its population is 8.886 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 17% (UNO, 2004), and the proportion of population above the age of 60 years is 23% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a high income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 8.7%. The per capita total expenditure on health is 2270 international $, and the per capita government expenditure on health is 1935 international $ (WHO, 2004).

The main language(s) used in the country is (are) Swedish. The largest ethnic group(s) is (are) European. The largest religious group(s) is (are) Evangelical Lutheran.

The life expectancy at birth is 78 years for males and 82.6 years for females (WHO, 2004). The healthy life expectancy at birth is 72 years for males and 75 years for females (WHO, 2004).

Epidemiology

There is substantial epidemiological data on mental illnesses in Sweden in internationally accessible literature. No attempt was made to include this information here.

Mental Health Resources

Mental Health Policy

A mental health policy is absent.

Substance Abuse Policy

A substance abuse policy is absent.

National Mental Health Programme

A national mental health programme is absent.

Mental health care reforms directed towards individuals suffering from severe and long-standing mental illness was initiated in 1995. Sweden has a comprehensive national suicide prevention programme.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is absent.

Mental Health Legislation

The fundamental legislation for psychiatric health and sickness are the Health and Illness Act (HSL), the Compulsory Psychiatric Care Act (LPT) and the Forensic Psychiatric Care Act (LRV). Guidance is also provided by the 1991 UN Resolution, supported by Sweden, concerning the principles for the protection of the mentally ill. The latest legislations are the Law on Compulsory Care and the Law on Forensic Psychiatry Care. The Swedish National Board on Forensic Medicine is responsible for the assessment of offenders with mental illness. Treatment is carried out in special wards within the civil psychiatric hospitals in each county or in special forensic psychiatric hospitals.

The latest legislation was enacted in 2000.

Mental Health Financing

There are budget allocations for mental health.

The country spends 11% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family and private insurances.

The Municipal Financial Responsibility Act makes it incumbent upon the municipalities to pay for the care of patients who have to remain in hospitals because of lack of community services. As a part of the Mental Health Reform (1995), the counties themselves receive a state subsidy in order to ease the transition from life in an institution to living in the community. In addition, there were specified subsidies for provision of case managers, severely mentally ill drug abusers, family programmes and for supporting user associations. Community services now account for about 15% of the budget of psychiatric care organizations.

The country has disability benefits for persons with mental disorders. The objective of the Swedish Disability Act and Assistance Compensation Act is to provide comprehensive and equal benefits to patients with physical or mental illness. Under these laws the individual is allowed counselling, personal assistance, housing with special services, contact people and companions. The municipalities are obligated to conduct outreach care facilities including rehabilitation for the elderly and disabled. The Municipal Financial Responsibility Act makes it compulsory for the municipalities to pay for the treatment of patients, who after 3 consecutive months of inpatient care are deemed treated but still require hospital care as they are not able to lead independent lives within a community care system. Disability benefits are reaching between 10-30% of those who need them, but the proportion is likely to rise as case management becomes more frequent.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level.

Regular training of primary care professionals is not carried out in the field of mental health. There are some local and regional training programmes.

There are community care facilities for patients with mental disorders. Community care is primarily carried out by social services. As a result of the 1995 reforms, approximately 4000 patients and 400 rehabilitation programmes were transferred from psychiatric care organizations to municipal social services. Furthermore, nearly 900 projects related to employment and rehabilitation were financed with state subsidies and about 300 educational

projects directed towards the staff of the social services were launched. There are, however, regional variations in services. Day care facilities are currently available for about 50% of those in need. Mobile teams are operational in more than 50% of the catchment areas.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	6
Psychiatric beds in mental hospitals per 10 000 population	
Psychiatric beds in general hospitals per 10 000 population	6
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	20
Number of neurosurgeons per 100 000 population	1
Number of psychiatric nurses per 100 000 population	32
Number of neurologists per 100 000 population	4
Number of psychologists per 100 000 population	76
Number of social workers per 100 000 population	

In Sweden, there has been sectorization, where the psychiatric service unit of a particular catchment area was responsible for comprehensive psychiatric care of the whole population belonging to that area. However, a referral is not required for contacting specialized services. There has been a reduction of inpatient beds (by almost 85% over a 25 year period starting in 1962) and an increase in community based treatment. Most of the stand-alone mental hospitals have closed. Regional differences in resources for care, methods of care and use of care have been noted. There are, specially in the northern part of Sweden, long distances between the municipalities, and as it is sparsely populated it is hard to fund the adequate resources needed. Individual care plans are drafted in consultation with patients and their relatives. Other than psychiatrists, the number of other mental health professionals, seem to be adequate. Most are employed by the municipalities. Sub-specialization in forensic and geriatric psychiatry is possible.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention and rehabilitation. NGOs play an important part in suicide prevention programmes. Increased user influence through well-informed and participating patients and relatives is an important development. Under the mental health reform movement of 1995, financial support was provided for user and carer organizations and these were able to launch about 170 projects.

Information Gathering System

There is mental health reporting system in the country. Reports of county council for inpatient care is available.

The country has data collection system or epidemiological study on mental health.

As required by the mental health reform, approximately 85% of the municipalities have conducted surveys to identify people with mental disabilities living in their communities and the needs these persons have for social assistance.

Programmes for Special Population

The country has specific programmes for mental health for elderly and children. There is a Swedish National Programme to develop suicide prevention with the objectives: to decrease the number of successful and unsuccessful suicide attempts; early detection and management of high risk cases; public education on management of suicide both by laymen and professional staff. There is also a National Council for Suicide Prevention.

Specialized sub-systems exist for child, adolescent and forensic (there are six regional forensic hospitals) patients. Mobile teams are providing outreach, health care, food and other services for the homeless.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Carbidopa is available in combination with levodopa (200 mg).

Other Information

In 1967, the responsibility of care was shifted from the state to the counties. The 1970s saw the creation and reorganization of community centres in catchment areas and promulgation of the National Board on Health and Welfare's policies concerning deinstitutionalization, development of out-patient care, intersectoral collaboration and involvement of families in services development. In 1992, a parliamentary commission reported that much more needed to be done and the Mental Health Care Reform of 1995 provided the required mandate to municipal social services for providing mental health care.

Additional Sources of Information

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