Chapter 5

Integrating mental health and employment services in Sweden

This chapter discusses the effectiveness of the mental health system in providing adequate treatment to persons with common mental disorders, subsequently looking at the resource capacity in primary health care services, treatment options and the accessibility of specialist mental health care services. It then reviews the recent policy initiatives to improve co-ordination between the mental health and the employment system and the extent to which rehabilitation services are offered in an integrated way.

Most persons with mild mental illness can recover well, provided they receive appropriate on-going treatment and support. Adequate treatment can enable persons with mental disorders to lead fulfilling lives as well as increase their chances to stay in, or return to, work. This in turn, can lift the very high burden of mental disorders on the individual and the economy. Yet, lack of treatment of mental health disorders remains one of the biggest barriers to achieving both good clinical and employment outcomes.

Additionally, the limited attention given to employment in the treatment process minimises the chances of gaining or returning to work. In Sweden, the interface between the employment and the health sector has improved over the past few years mainly due to the government's plan to cut down the very high sickness absence rates in the country. But actions need to go beyond this short-term objective. Poor co-ordination both within the mental health system and between mental health services and employment services continues to be a major obstacle for effective rehabilitation and recovery.

Treatment, access and utilisation of mental health services

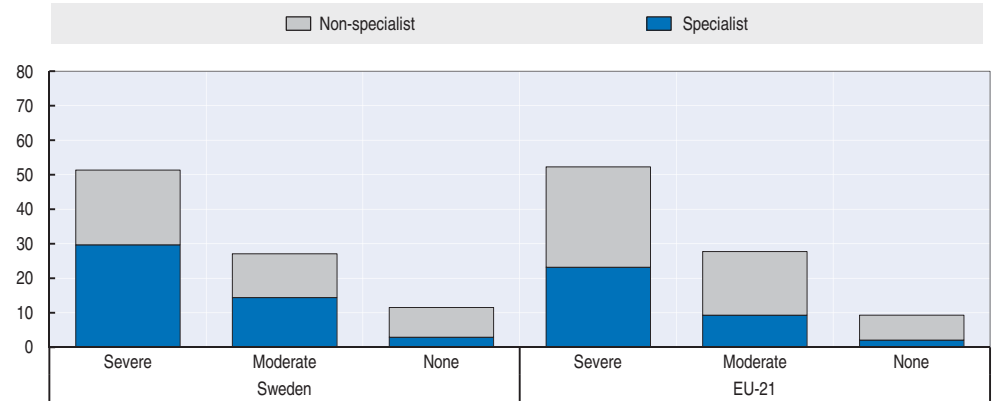
The treatment gap for mental disorders is large

Most people who are severely mentally ill are likely to be known to the mental health service or have had some earlier contact with the mental health system. Survey-based evidence on the current use of mental health care (drawing on the Eurobarometer), however, suggests that under-treatment is large: some 50% of those with a severe mental disorder and over 70% of those with a moderate mental disorder do not receive any treatment for their illness (Figure 5.1). This suggests a large unmet potential need for mental health services in Sweden, as in other OECD countries. Moreover, treatment is often only given by a general practitioner, not involving any specialist, thereby lowering the chances for the patient to receive adequate treatment in line with minimum treatment guidelines. In an international comparison it appears though that Swedes are more likely than people in other countries to receive treatment by a specialist health care professional such as a psychiatrist.

The under-treatment of persons with moderate mental disorders in Sweden, as in other OECD countries, remains a big challenge. This is likely to have negative consequences for the individual and the society. If left untreated, milder disorders may transform into serious ones over time affecting an individual's chances of functioning as well as increasing their risk of resorting to sickness and disability benefits that generate a huge cost to the economy.

Figure 5.1. **Under-treatment is potentially very large**

Proportion of people being treated by a specialist or non-specialist, by severity of their mental disorder, mid-2000s



Source: OECD calculations based on the Eurobarometer, 2010.

The current potential of reducing the treatment gap in primary care is weak

Many psychiatric disorders are either preventable or manageable through proper prevention or primary care interventions. Better management of these chronic conditions in primary care settings can reduce exacerbation and costly hospitalisation. In addition, discrimination and stigma are reduced because people with mental disorders are treated in the same way as people with other conditions (WHO, 2008).

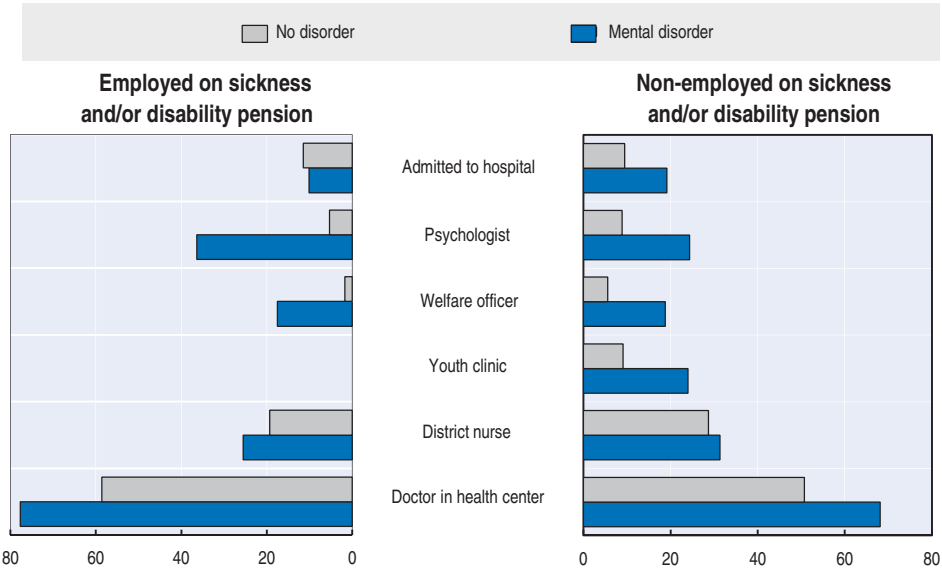
In Sweden, according to the Health Act, the responsibility for patients with mild to moderate mental health problems lies with the primary care sector, as with patients with physical health problems who do not require hospitalisation. On the other hand, patients with severe mental health problems are referred on to specialised psychiatric care in hospitals. Unlike in other OECD countries, GPs are not the main gatekeepers into specialist mental health care and services. In most of the Swedish counties, it is possible to bypass primary care and access specialist services directly.

The latest survey on public health shows that, a substantial proportion of persons with an identified mental disorder have contact with their doctors in the health centres. Persons with a mental disorder have significantly more contact with their GP than with any other profession (Figure 5.2). For example, some 70% to 80% of those on sick leave and disability benefits are in contact with their doctor in primary health care.

This represents a substantial opportunity for early identification of mental disorders, treatment of common mental disorders, as well as paying attention to the mental health needs of people with physical health problems. High over-representation of those on sick leave in particular lends to improving mental health services in primary health care units as they are at a high risk of leaving the labour market if no medical treatment is offered.

Figure 5.2. **Primary care has a main role to play in treatment of mental illness**

Share of persons who visited a doctor, by type of practitioner, labour force status and mental disorder



Source: Swedish Health Interview Survey, 2009-11.

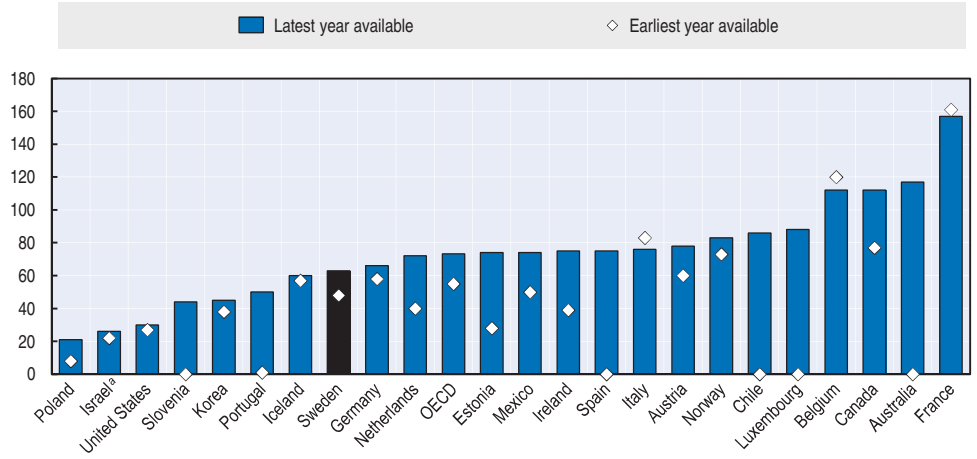
Despite these potential benefits of providing mental health services in the primary care setting, Swedish GPs, as in other OECD countries, are often unable to fully understand and treat their patients' mental health concerns. This is partly due to time constraints and a lack of psychiatric training, leaving the physician unable to address much beyond the patient's physical complaint.[1]

An adequate and well-trained health workforce in primary health care settings is a prerequisite for quality front-line services. Currently, although the bulk of the burden of treating persons with mild mental disorders falls on physicians, the workforce in the primary care sector is relatively small to respond to such needs. Indeed, the density of GPs per 1 000 inhabitants lags behind the OECD average (Figure 5.3). The relatively low number of GPs is

likely to undermine the effectiveness of prevention, diagnosis and treatment of illness and may further exacerbate the delay in receiving treatment. Lack of access to treatment and long waiting times has a number of repercussions on the welfare system. For example, according to Engblom *et al.,* (2011), a majority (63%) of the GPs certified unnecessarily long sick leave periods at least once a month due to waiting times for investigations or medical treatments. One third did this due to lack of access to cognitive behavioural therapy for patients. Another third did so due to lack of other adequate treatment or care providers.

Figure 5.3. **Sweden has fewer GPs than most other OECD countries**

Density of general practitioners, earliest and latest year available, per 100 000 population



Note: OECD is an unweighted average of the countries in the chart.

a. Information on data for Israel: http://dx.doi.org/10.1787/888932315602.

Source: OECD Health Care Quality Indicators Data 2012 *(www.oecd.org/health/healthdata).*

Lacking data on treatment in out-patient clinics mean that evaluations on how effective primary health care performs in dealing with mental health problems are largely missing. Available indicators by the Swedish National Health and Welfare Board provide some indication on efficiency.[2] The indicator "avoidable inpatient medical care for people with a psychiatric diagnosis" reflects the quality of outpatient care, such as primary care and preventive public health efforts, for certain specific conditions. The assumption is that unnecessary hospitalisations can be avoided if patients with the selected conditions receive proper outpatient medical care.

According to the report on Quality and Efficiency in Swedish Health care in 2010, the percentage of avoidable admissions was considerably higher among people who had been treated for psychiatric diagnoses. Among the reasons may be that the medical condition was detected later or treatment took longer. But it could also mean that patients were not good at complying with their regimens.

In an effort to support doctors in primary care units in dealing with psychiatric disorders, the NBHW has issued clinical guidelines for depression and schizophrenia. It also recommends evidence-based psychological treatment options for such disorders. Among all the treatments, cognitive behavioural therapy (CBT) is ranked highly in the case of all mild and moderately serious states of mood and anxiety disorders. However, most GPs have inadequate training for giving CBT and thus accessing this service from primary care is difficult and can involve long waiting times. New cost-effective ways are sought of improving access to CBT in Sweden which might remedy the situation (Box 5.1).

Box 5.1. **Innovative practice for delivering cognitive behavioural therapy for mild and moderate mental disorders**

A number of scientific evaluations have shown that CBT is an effective treatment for both panic disorder and depressions as well as effective in increasing persons return to work provided it is delivered through trained experts. In response to the lack of psychologists and psychotherapists that use CBT methods, Internet-based CBT has been developed, in which the patient undergoes an Internet-based self-help programme and has contact with a therapist by email.

Results so far show promising results. For instance, a randomised clinical trial of 104 patients with panic disorder compared the effectiveness of Internet-based CBT and group CBT within a regular healthcare service. The study shows that both treatments worked very well and that there was no significant difference between them, either immediately after treatment or at a six-month follow-up. Analyses of the results for the treatment of depression show that Internet-based CBT is most effective if it is administered as early as possible. Patients with a higher severity of depression and/or a history of more frequent depressive episodes benefited less well from the Internet treatment. Internet treatment had also superior cost-effectiveness ratios in relation to group treatment both at post-treatment and follow-up (Bergström *et al.,* 2010).

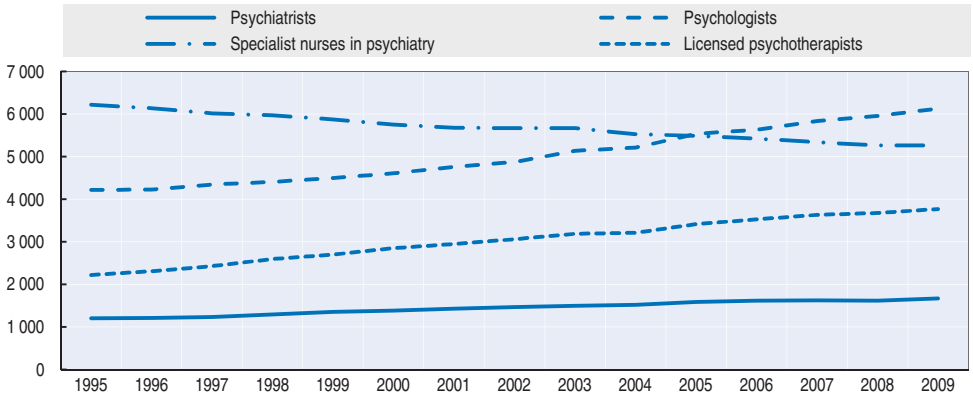
Overall supply of specialist mental health staff is insufficient

Similar to the primary sector, Sweden is facing considerable shortages in specialised personnel, especially in the area of clinical psychology and other specialist staff well placed to deliver adequate treatment.

Figure 5.4 presents the overall picture of specialist staff in psychiatry. The number of psychiatrists has been systematically lower than that of any other specialist staff category. During the period 1995-2009, the availability of psychiatric nurses has declined steadily while the number of licensed psychotherapists and psychologists has been rising. Nevertheless, by international standards, the availability of psychiatrists (as measured by the density of psychiatrists per 100 000 inhabitants) in Sweden is above the OECD average. On average, there are around 20 psychiatrists available per 100 000 inhabitants. But there are significant variations regarding the distribution of psychiatrists between the counties and regions. According to the national health report on psychiatric care, the number of psychiatrists per 100 000 inhabitants is too low (NBHW, 2010).

Figure 5.4. **The number of non-medical specialists is increasing while there are fewer specialist nurses**

Employees in psychiatry for health sector by occupation



Note: Includes all persons working in the private and public health care sector.

Source: NBHW (2010), *Psykiatrisk Vard – ett steg på vägen* (Psychiatric Treatment – A Step on the Way), National Board of Health and Welfare, Stockholm.

In some regions, with a shortage of salaried psychiatrists, county councils are forced to employ psychiatrists, either independently working doctors or supplied by private medical staffing companies as "rent-a-doctor" at relatively exorbitant rates. As such, the system has become much more expensive for the public, and discontinuous, so that patients tend to meet a new doctor at each return visit with little follow-up. In effect, there is a vicious circle whereby psychiatric clinics function badly because of a doctor shortage and rented doctor discontinuity, while the resulting stressful

working conditions serve to discourage young doctors from choosing psychiatry as a profession.

There is a growing concern about the financial untenability of such a solution. According to the New Action Plan on Mental Health, the government plans to increase the number of training places in the psychology programme and create research posts in psychiatry.

Patients seeking treatment can also directly make contact with outpatient clinics in the private sector that are affiliated to the public health care system at reduced costs.[3] With regards to psychologists, psychiatrists and psychotherapists, there are also private practices without affiliation to the public system. This, however, is a more expensive alternative and unaffordable for many patients.

Though having access to a psychiatrist in the government-funded part of the private sector can facilitate faster access to treatment, such psychiatrists are relatively few, and almost exclusively concentrated in the larger cities. Anecdotal evidence suggests that with the current tendency towards the privatisation of health care, a restrictive policy within the county councils has made it difficult or impossible for doctors working on their own (regardless of speciality), to be registered as private practitioners within the national health system. This may further exacerbate lack of treatment among patients with lower socio-economic backgrounds who cannot afford to purchase treatment in the private sector.

The current two-tier system of GPs and specialists in the public and the private sector is problematic particularly for persons with mild mental disorders who appear to be functional in daily lives despite having a disorder, yet live in states of suffering which demand expert and time consuming treatment. Many of these patients are not favoured by public psychiatry as they would simply not qualify as "sick enough" and instead be advised to seek expensive private help.

The health and employment interface

Traditionally, as in most other OECD countries, focus on employment matters in the mental health system has been very limited. But this in Sweden is changing. The health care sector has now an increased responsibility as a partner, who is obliged to be more actively involved in the sick listing and rehabilitation process. Yet, work and employment are not yet seen as a primary goal or a means of treatment by the mental health system.

The following section reviews some of the major policy initiatives undertaken in the last few years to better align objectives and services to achieve better socio-economic outcomes for persons with mental health problems.

Policies addressing employment in the mental health system are developing slowly

In the mental health sector, the importance of work or the adverse consequences of being out of work have been recognised in two main ways. First, the latest national strategy for mental health *(2009-11) – From Vision to Action* – aimed at strengthening psychiatric care – highlights that the "work-first" principle also applies for persons with mental health problems.[4] Accordingly, the plan calls for greater attention to work and occupational therapy in municipalities.

Second, the National Board of Health and Welfare has taken a number of initiatives mainly in accordance with the government's overarching goal of reducing sickness absence. Consequently, as mentioned earlier, the board published diagnostic-based sickness absence guidelines for GPs issuing sickness certificates. It also recommends the Individual Placement and Support (IPS) model for persons with schizophrenia or schizophrenia spectrum disorders and indeed, a number of IPS pilots across Sweden are currently in place. Evidence indicates that IPS-supported employment is a more effective approach for helping people with psychiatric disorders to find and maintain competitive employment than traditional, stepwise approaches to vocational rehabilitation.

These initiatives represent an important step but there is a need for more focused action to include work as a means to achieve better clinical and employment outcomes. For example, though the Action plan emphasises work as part of a holistic treatment strategy, it does not provide direction as to who is responsible for what nor does it include clear tangible objectives in regards to employment. Similarly, in spite of collecting substantial information on evidence based treatment, the NBHW does little dissemination and promotion of work in its guidelines.

Financial incentives for health and medical care

More recently, collaboration between the employment and the health sector is reinforced through financial co-operation, specifically targeting those with mental health problems. The Ministry of Health and Social Affairs recently introduced a *Rehabilitation Guarantee* for people on sick leave or at risk of longer-term leave as a result of long-standing psychological problems such as anxiety, depression or stress, whereby county councils are receiving direct payment from the SSIA for each medical intervention. The guarantee offers rehabilitation measures in the form of cognitive behavioural therapy (CBT) and interpersonal psychotherapy for a relatively short period. Those working with CBT must be qualified, and assessment and treatment can take place either individually

or in groups. The Rehabilitation Guaranty includes such medical treatments which have proven beneficial in the process of returning to work.

The outcomes of the Rehabilitation Guarantee have improved over time due to improved local implementation process and the development of interventions, but there still seem to be significant weaknesses in the scheme. Two cohorts were followed-up; one in 2009 and another in 2010 to examine the effects of the Rehabilitation Guarantee on sickness absence and health. According to the evaluation by Karolinska Institute, the pattern of sick leave was similar regardless of whether a person obtained therapy via the Rehabilitation Guarantee or not. However, results from the 2010 cohort showed a statistically significant difference between the treatment group and the reference group in terms of the proportion that was granted disability pension. The latter had an approximately 170 percentages higher risk of receiving a disability pension. Individuals who received rehabilitation covered by the guarantee also experienced improvements in their mental and physical health and their ability to work during the follow-up period (Karolinska Institutet, 2011a and 2011b).

The full potential of the scheme is however, yet to be harvested. According to the authors, several factors undermine the effectiveness of the scheme. For instance, it is argued that six sessions are too few in the context of rehabilitation. Another concern is the high early dropout rate before the treatment ends. For example, data from one county council (Skåne) indicate that roughly 34% of those who had started the programme terminated treatment within six rehabilitation sessions. Furthermore, authors found that early drop-out and the low number of patients at many units (less than five patients per year) in general made it financially unviable for primary care units to deliver "highly qualified" rehabilitation service. This in turn affected motivation to develop the guarantee within the unit as well as to maintain specialist competence.[5]

In theory, extra funding provided by the SSIA for the health sector to boost psychological treatment indicates a concrete step towards integrating treatment and mental health. However, the success of the scheme is also dependent on the ability of the health sector to provide a sufficient number of staff with competence to deliver specialist therapies. The Rehabilitation Guarantee currently faces immense challenges as there is a lack of people with adequate training in CBT (as discussed above). There is a definite need for new recruitment of people with those skills, but funding is still lacking.

Divided responsibility for rehabilitation can hinder rapid return to work

Persons with psychological disorders often suffer from a combination of medical, social and work-related problems and therefore are in need of a comprehensive rehabilitation approach to facilitate early recovery and successful return to work.[6] As such, co-operation in rehabilitation between different actors is imperative. However, the existing institutional structure of a split level of governance of health and social services means that it is difficult to provide co-ordinated and good quality care for people with mental health problems.

Responsibility for providing health care and social services to people suffering from mental illness is divided between the government and the municipal and county councils. The municipalities running social services bear primary responsibility for the provision of housing and occupational therapy to people with mental health problems. Psychiatric treatment, on the other hand, is part of health and medical care of the county councils.

Currently, there is a lack of formal mechanisms for co-operation between the national, the regional and the local level and thus integration of health and employment services remains a big challenge for both health and social services. Too often, rehabilitation measures do not reach their intended target or lead to undesired effects since it is not clear who will pay for rehabilitation; intervention is often coming too late due to the conflicting priorities of different actors.

For some time, Sweden has been trying to tackle this issue by enticing co-operation through pooling together funding under the 2004 Act on Financial Co-ordination and Rehabilitation Measures, which allowed different institutions in the rehabilitation field to form local associations for financial co-ordination.[7] This co-operation involves the SSIA, health and medical services, the social services and the PES. Under the Act, the parties are required to contribute in equal amounts but contributions are not earmarked for interventions coming under any one party's sphere of responsibility. So far, a total of 80 co-ordination associations representing some 200 municipalities have been established. The main target group for financial co-ordination would in general include those who need integrated efforts *i.e.* long-term unemployed, long-term sick leave recipients and young persons. Activities under these associations usually related to occupational and labour market measures, socio-medical and preventative and promotional measures.

Though, practice in different associations vary, the model hinges upon multidisciplinary teams, consisting of physicians, psychologists, social workers and employment officers who provide the above stated services. By

way of example, DELTA – one of the earliest and long-running co-operations in the region of Gothenburg – offers co-ordinated services to clients in need of rehabilitation. The main objective of early and co-ordinated rehabilitation programmes under DELTA are *i)* social medical activities included in a treatment plan to shorten patient treatment, *ii)* occupational activities to speed up return to work, and *iii)* preventative activities aiming to prevent sickness absence and social exclusion (Box 5.2 for more details).

Evaluations of such co-operation models are limited. DELTA is the only collaborative model that has been systematically evaluated over time. Most of the studies show mixed results and very few of them have evaluated the impact of co-operation on return to work. Ahgren *et al.* (2009), report that users perceive services as well integrated and adapted to their needs. Results from a follow-up study in 2005 also showed that interventions under DELTA had a positive impact on finding employment. Some eight out of ten formerly unemployed were able to maintain gainful employment, while two out of three were no longer sick-listed (Wollberg, 2006).

Other evaluations, however, are more critical. Andersson *et al.* (2011), for instance, argue that among all the different types of approaches, pooling of budgets is the most complex and demanding model of collaboration in vocational rehabilitation. Lack of employer involvement in facilitating return to work is a major obstacle to better outcomes. Furthermore, a more recent study showed that, the recent changes in the sick leave process *i.e.* work capacity assessments at three and six months periods have led to a more narrow time perspective which puts higher demands on purposeful co-operation between relevant actors in the processes of rehabilitation and return-to-work (Ståhl *et al.,* 2011).

The approach to generate co-operation through pooling of budgets has had some positive impact on providing integrated rehabilitation services, but has a number of drawbacks. One major issue is that financial co-ordination is solely voluntary. This does not guarantee sustained collaboration in the long-run nor effective follow-up of individuals who need the greatest support. Secondly, though the principle idea of offering services through "one-stop-shop" like models (such as the model offered by DELTA) are desirable, many of the initiatives are free-standing projects as opposed to forming an integral part of an authority's regular operations. As such, a more systematic national or municipal-led approach is required to provide uniform services.

Box 5.2. **Innovative model of co-operation between the employment and the health sector**

DELTA was launched in 2007 in Hisingen, as one of the six areas hosting pilot projects on financial co-ordination involving the social insurance authorities, the health and medical care services and the social services. The pilot intended to support individuals and cut costs arising in connection with absence from work due to illness, unemployment and other welfare benefits.

Just over 25 activities have been carried out within DELTA since its inception in 1997. Current activities can be categorised under three main headings: *i)* preventative and promotional activities, *ii)* socio-medical activities and *iii)* occupation activities.

Working methods and activities

Preventative and promotional activities are targeted at preventing absences due to illness and tackling social exclusion. Working methods include interviews and discussions with clients; theme based sessions, group activities as well as dissemination of information and education.

The main aim of the socio-medical activities is to reduce waiting times and shorten patient treatment and speed up return to work. Measures are conducted by inter-professional teams in primary health care centres and the treatments on offer are adapted to the needs of the clients. All activities offer early intervention with the aim to cutting down rate of absence from work due to illness.

Occupational measures are orientated towards attaining employment. One example of the occupational activity is the labour market Plaza. The plaza operates as a one-stop-shop providing a range of services for clients who previously were shunted from one authority to another.

Collaborative primary health care centres are open to anyone in need of inter-professional interventions. There are also special initiatives targeted at young persons with mental health problems (mainly those who have not finished high school education) registered with the PES or those in receipt of social assistance.

Each client has a joint action plan which is designed jointly by the different authorities. A number of hours per week are set aside to discuss and agree on issues relating to individuals cases.

DELTA based activity is assigned a project co-ordinator, a number of project assistants and a steering committee. Project co-ordinators are usually recruited and paid from one of the collaborating authorities, *e.g.* SSIA, PES, etc.

Other ways of ensuring co-operation should be sought to give each actor, or government level, the right (financial) incentive to act in a way that improves outcomes – including employment outcomes – overall and not only within the area of responsibility of the respective actor. An alternative approach of integrating health and employment objectives is through

building employment capacity within the health sector and *vice versa*. One interesting example is the pilot *Individual Access to Psychological Therapies* (IAPT) in the United Kingdom, whereby co-location of Employment Advisers' with clinical teams has been successfully exploited to advocate an early intervention approach to job retention support. Employment Advisers are part of the IAPT service provision and play a key role in contributing to multi-disciplinary delivery. This duality of approach has been critical to the success of the pilot, as close working with IAPT colleagues in the Primary Care team ensured that service users had their employment and their mental health needs met at the same time and by the same team.

Conclusion and recommendations

As in other OECD countries, mental disorders are under-treated in Sweden. Less than a third of those who suffer from a mild mental disorder and around a half of those with a severe mental disorder receive treatment which is critical for fostering early recovery and facilitating early return to work.

GPs in the primary care setting frequently encounter mild mental disorders. Up to 80-90% of those on sick leave with mental disorders are in contact with their GP. But Swedish GPs in primary care have insufficient training and resources to deal with prevailing mental health issues among their patients. Primary mental health care is only now beginning to expand as a result of recent initiatives to provide psychological therapies, but these efforts are likely to be insufficient in closing the large treatment gap. Better training is needed for GPs for them to deliver short-term cognitive behavioural therapy. Similarly, more resources need to be diverted to train and recruit psychiatrists and psychologists to meet the growing demand of psychotherapy treatment.

The interface between the employment and the mental health sector has improved in the past few years in the context of reducing the huge number of persons on sickness and disability benefits. That said, Sweden still lags behind in promoting employment issues in the mental health system. Too few people who use mental health services are supported to achieve their employment aspirations. On the one hand, increasing co-operation between the mental health system and the sickness insurance through the Rehabilitation Guarantee should be praised but initial results are still disappointing. On the other hand, co-operation between the PES, SSIA and the mental health service in terms of rehabilitation measures, which is critical in facilitating early return to work, is inadequate. Current approaches

of pooling budgets to integrate rehabilitation measures have not delivered the desired outcomes.

Strengthen capacity of the mental health system

- *Increase capacity in primary care to better identify and treat persons with mental disorders.* Give mandatory training to GPs on CBT as well as refresher courses on identifying mental health problems for those who have been in practice for a long time. At the same time, increase the number of psychotherapists and psychiatrists working in primary health care units whereby GPs can make quick and easy referrals within the same health practice. In addition, NBHW should develop indicators using the patient register dataset to monitor the effectiveness of diagnosing and treating moderate mental disorders in the primary care sector.
- *Increasing resources to train more psychotherapists, psychiatrists and special psychiatric nurses.* One way of achieving this could be to offer higher salaries to attract more persons in this profession.

Improve integration between health and employment policy

- *National Action plan on mental health should include employment outcomes.* Include common agreed goals and measures on employment into the Action Plan on mental health with systematic follow-up and monitoring of goals. This would foster the notion that work is a key element in treatment of mental illness.
- *Disseminate and promote evidence-based treatment for return to work.* In addition to providing evidence-based guidelines on treatment, NBHW should promote treatment that is effective for return to work among GPs and other mental health professions. The board should also disseminate good practice co-operation models between local employment and health services.
- *Build-in outcome-based payments in the Rehabilitation Guarantee.* Consider a move towards an outcome-based funding model which could facilitate innovation and change in the current Rehabilitation Guarantee. Fees should be paid on the number of beneficiaries of sickness benefit treated by the health care sector.
- *Integrate vocational and clinical services*. Integration of vocational and clinical services is key to higher employment of persons with mental disorders. Integration other than pooling of funds can be achieved in several ways. One approach is that the health system

builds vocational capacity within its own realm- as is done in England where the IAPT model is funded by the National Health Service. Alternatively, the employment services or the SSIA can build clinical capacity by hiring mental health specialists.

Notes

1. A three month psychiatry rotation after medical finals is mandatory within the two-year housemanship period leading to basic medical qualification. Qualified doctors embarking on the 5-6 year specialist training to become GPs (in Sweden general practice is considered a speciality), are currently not legally obliged to complete a further rotation within psychiatry. It is however legally necessary to prove sufficient knowledge of psychiatry to the supervisor. Thus, current praxis considers it highly desirable that trainee GPs gain at least four months of additional psychiatric experience during specialist training, mainly in out-patient units, unless they can prove to their supervisor that they have previously acquired this competence.
2. A total of 15 national indicators have been prepared for the follow-up of the health care (psychiatric) inputs and 12 national indicators for social service inputs for persons with mental impairment. These indicators mostly cover population suffering from severe mental illnesses.
3. Specialist doctors registered with the public system are reimbursed by the state medical system known as the National Tariff for Medical Specialists (*nationella läkarvårdstaxan).*
4. Four priority areas include; children and young people, access to work for people with psychiatric diseases or disabilities, the development of evidence and skills and quality development. A large number of decisions regarding assignments have been made in these areas.
5. A health care clinic receives a start-up fee to start up patient treatment, but the clinic receives little or no compensation from the county council if there is an early drop-out of treatment.
6. Rehabilitation is a collective term for interventions of a medical, social, psychological and occupational character aimed at restoring an individual's ability to function, work and lead a normal life.
7. Between 1993 and 2003, there were a number of initiatives for improving inter-organisational co-operation in rehabilitation. These experiments resulted in a new legislation in 2003.

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