Summary of Good quality, local health care. The right support for mental health (SOU 2021:6)

Starting points

In accordance with the additional terms of reference issued on 15 August 2019, in addition to previous remits, our Inquiry is to investigate the underlying conditions for developing a new form for swift and appropriate primary care interventions to treat mild mental illness, with aims including preventing exacerbation and reducing sickness absence, and to submit proposals where necessary for how this is to be effectively achieved (dir. 2019:49). This remit is based on an agreement between the Social Democratic Party, the Centre Party, the Liberal Party and the Green Party and was issued in the context of the previous proposals and assessments made by the Inquiry.

Previous reports

On 2 March 2017, the Government decided to appoint an Inquiry Chair with the remit of supporting regions, relevant government agencies and organisations in the coordinated development of modern, equitable, accessible and effective health care, focusing on primary care, on the basis of an in-depth analysis of the proposals in the report *Effective health care* (SOU 2016:2). The Inquiry chose the name *Coordinated development for good quality, local health care*.

In June 2017, the Inquiry presented its first interim report, *Good quality, local health care – a joint road map and vision* (SOU 2017:53). Based on the proposals in the interim report, in late May 2018 the

Riksdag (Swedish Parliament) reached a decision on Government Bill 2017/18:83, Styrande principer inom *hälso- och sjukvården och en förstärkt vårdgaranti* (Governing principles in health care and an enhanced health care guarantee).

In June 2018, the Inquiry presented its second interim report *Good quality, local health care – a primary care reform* (SOU 2018:39). Based on the proposals in this interim report, in December 2020 the Riksdag reached a decision on Government Bill 2019/20:164, *Inriktningen för en nära och tillgänglig vård – En primärvårdsreform* (The direction for local and accessible care – A primary care reform). Further bills based on the proposals in this second report have been announced.

In June 2019, the Inquiry submitted its third interim report *Good quality, local health care. A joint effort* (SOU 2019:29). In line with the terms of reference of the Inquiry, the report contained an account of the focus of the work and its progress. The third interim report contained an analysis of and background to the areas on which the Inquiry then submitted proposals in the main report. The third report should therefore be read alongside the proposals sections of the main report.

The Inquiry submitted its main report, *Good quality, local health care. A reform for a sustainable health care system* (SOU 2020:19) in April 2020. It contained proposals for structural changes to the health care system in its entirety, with a focus on collaboration between the two health types of authorities responsible for providing health care, , the region and the municipality. Proposals for how collaboration can be fostered at macro (regional/municipal) level, at meso (health care provision) level and at micro (individual) level were submitted. The report contained proposals for enhanced support for the patient in terms of the statutory individual plan, and proposals for how patient contracts, as a visualisation of the individual plan, can be regulated by law. Furthermore, it was proposed, in line with the remit in the terms of reference, how operations run under the Medical Practitioner (Compensation) Act (1993:1651) or the Physiotherapy (Compensation) Act (1993:1652), i.e. under the national tariff scheme, can better be integrated in the health care system of the future. Proposals on how education can be improved in primary care were submitted, together with assessments of how the role of research can be enhanced. A review of all

descriptive systems in the health care system was proposed, with the aim of facilitating the transition to good, local (i.e. integrated) health care. Finally, success factors and obstacles to the transition were highlighted. The report has been circulated for consultation and the proposals are currently being prepared by the Government Offices of Sweden.

The Inquiry's current remit

The additional terms of reference issued in August 2019 meant that the main report of the Inquiry was not to be its final report. That role will be taken by this report, which answers the questions raised in the terms of reference regarding the way primary care tackles mental illness. We wish to clearly point out that although the focus of this report is on mental illness, in its previous work the Inquiry has never made a distinction between mental health and physical health and that, indeed, we have constantly emphasised the need to take a holistic approach to people in their contact with the health care system. In a person-centred health care system, interventions derive from the individual patient's needs, and less from how the health care system has chosen to organise itself. This is the very reason why the role of primary care in the system is so important. When primary care is supplied with adequate resources and skills, it is possible to work with the whole person, based on their circumstances and in their local setting, in continuous relationships, with preventive and health-promotion interventions as well as with treatment and rehabilitation. It is important for us to emphasise that this report, and the proposals and assessments we make in it, should be read alongside the Inquiry's previous reports, and the proposals and assessments presented, therein as an indivisible whole.

The story

The cover of this final report shows Kim. You will recognise the person from the illustration of person-centred health care that we have included in our previous reports. Of course, Kim is fictional. But we think this person has a story to tell. Like many other people, Kim is affected by mental illness themselves and in the world around

them. They often feel that health care is fragmented, and sometimes that it serves the health care system's own organisational structure rather than people's real needs. They feel there is a lack of coordinated thinking and that staff-patient interaction is sometimes less than ideal. They get to see lots of different people, which makes it difficult to feel a sense of trust or confidence in the health care staff. This can make it especially difficult to bring up mental health issues or issues that impact on mental health such as risky use of alcohol, violence in close relationships or other vulnerabilities.

As in earlier phases, many of the stories we have heard in this phase of the Inquiry bring up fragmentation, scattered interventions and a system that dumps the complexities in the laps of patients and their relatives rather than providing support to ensure the best possible health outcomes based on everyone's individual circumstances. These stories have been important elements in our work, as has all the input we have received from health care employees, who often feel great frustration over lacking the structures and working methods they need to treat the large proportion of patients calling on primary care specifically to meet their mental health needs.

The proposals and assessments we present in this report focus on how primary care in Sweden's regions and municipalities is to help people suffering from mental illness and provide tools that support people's mental health. This may involve interventions from the health care service, but may also address how the health care service can act as a bridge to other provision, e.g. from civil society in the form of the voluntary sector, when one's own resources and one's usual network are too weak or insufficient.

Form and content of the report

The chapters of the report are summarised below with a focus on the proposals and assessments made. Chapters 1 and 7 contain proposals for and comments on legislation and are not summarised in greater detail here. These chapters should instead be read together with Chapter 5.

Chapter 2. The Inquiry's remit, working methods and starting points

This chapter initially sets out the background to the Inquiry's remit in line with our terms of reference and presents the report's central concepts. We describe the delimitation of the Inquiry, including specialised health care, care provided under the Social Services Act and paediatric health care in particular. Other government inquiries have remits that border our terms of reference, e.g. regarding comorbidities with substance abuse as well as the mental health of children and young people, as do government agencies, and here we set out what these are. We describe how, even in this final phase, the Inquiry has maintained an extensive dialogue with many actors, albeit partly in new forms due to the changed circumstances during the COVID-19 pandemic.

The societal context in which the remit was issued is vital to the way we approach it, as is the historic view of the body and the soul. The question of where the boundary is to be drawn between general wellbeing, reduced mental wellbeing and mental illness is highly relevant. There is a widespread view that mental illness has increased in recent decades, but opinion is divided as to the extent to which this has taken place, which groups are affected and how this change can best be described. There are also those who question whether mental illness has increased at all. We note that, particularly due to stigmatisation, there is a great need for low threshold provision with a focus on an open and unprejudiced approach to those seeking health care for mental illness. This must be ensured whether the case is subsequently to be tackled by the health care service or whether contact with the health care service leads on to other interventions. We discuss this in the context of the role of the voluntary sector and the historically important part that civil society has played in public health. We present the arguments regarding the lack of common definitions in the field of mental illness and set out the terminology used in this report and thus in designing our proposals and assessments. Finally, we set out some different target and risk groups in terms of mental illness.

Chapter 3. Conditions for mental health work in primary care

Responsibilities, historical overview and existing knowledge

This chapter as a whole describes different aspects of the conditions for primary care in working with mental health, as well as the current situation. Initially an account is provided of the breadth of actors at different levels that are involved in treating mental illness and of the responsibility that each actor has, based on their role and remit.

After a brief look back at the role of the government and the voluntary sector in this work, we then shed light on relevant existing knowledge in the field. The Inquiry finds that the coordinated work on knowledge management currently being carried out between a number of knowledge agencies and regions and municipalities is important in terms of coordinating interventions, especially in the field of mental health.

We can also confirm that several follow-ups and evaluations show that the knowledge that exists, e.g. in the National Board of Health and Welfare's national guidelines, has not been implemented to a sufficient extent. While different initiatives have been carried out and efforts made, partly via agreements between the Government and the Swedish Association of Local Authorities and Regions (SALAR), compliance remains insufficient, reflected as inadequate fulfilment of quality indicators linked to the national guidelines. A reflection from the Inquiry's side is that the existing knowledge often appears to derive from the logic and working methods of specialised psychiatry, although the majority of the patients are found in primary care. More clearly including the context of primary care in producing a knowledge base to facilitate implementation would be a success factor for the future. Within the remit of the partnership between the National Board of Health and Welfare and the knowledge management model used by the municipalities and regions as health care providers, there ought to be good opportunities for such an approach, also offering improved opportunities to incorporate municipal health care.

How the health care providers describe their mandate

The Inquiry reports on the survey we conducted on how the health care providers themselves word their mandate regarding mental illness in primary care. As far as the regions are concerned, the review highlights variation both in terms of the level of detail and specific criteria. A certain amount of variation is to be expected, as one of the intentions behind the providers designing the organisation is precisely the need to adapt to the local context and differing circumstances. However, our review shows differences that are difficult to see as being solely due to such adaptations. It is remarkable that these mandate descriptions are often at a strikingly overarching level. This provides scope for different interpretations by different suppliers, which can result in differences in care provision, even for inhabitants in the same region. These differences are also likely to impede follow-up on the part of the health care providers, making it difficult for the local population to know what they can expect from primary care.

Our review also highlights relatively wide variation in primary care in selected municipalities, illustrated by the health care that must be provided for residents in special accommodation for the elderly, and we can confirm that the health care mandate is often described in a way that does not explicitly state that it covers both physical and mental health.

In summary, we see a need for the health care providers to develop and set out clearer overarching structures and support for the way primary care operators tackle mental health.

Follow-up opportunities and remote services

In this section we illuminate the opportunities available today to systematically follow up the work of primary care on mental illness. The review confirms and underlines the need to rapidly develop more systematic and standardised documentation and follow-up of the work of primary care on mental illness, both at operator level and at regional and national level. A systematic national follow-up also requires work to improve the quality of data, partly by ensuring nationwide consistency in recording diagnoses and action taken. More systematic documentation and follow-up will offer greater

opportunities both to improve operations and for research and development of new knowledge. This is vital for effective, high-quality care.

In this context, as in previous reports, the Inquiry, highlights the need for a primary care register in some form to follow on from the National Board of Health and Welfare's ongoing mandate on the feasibility of national collection of record data from primary care. To shed more light on and learn more about the work of primary care on mental illness, we also judge it to be vital that this area is included among the indicators that are finally selected to monitor the transition to good quality, local health care. If primary care is to be the hub of the health service, it must be given the tools it needs to fulfil this role for the whole person, encompassing their mental as well as their physical health.

The chapter goes on to describe different remote services for tackling mental health, including the care advice phone line and online service 1177 Vårdguiden. Today there are different ways of providing care remotely. The forms this may take include e-health services, services over the phone or traditional treatment methods offered online. E-health solutions have special potential to provide information tailored to different target groups and at a time that suits the individual. This might be self-care advice as well as how to get in touch with the right part of the health care service for different needs. Here, 1177 Vårdguiden has a special position as the joint platform for the regions operating nationwide. The major role played by various helplines run by actors other than the regions themselves, often voluntary organisations, in tackling mental health compared with physical health should also be noted. This brings a need for clear structures for describing and running collaboration between 1177 Vårdguiden and a variety of other helplines. When developing all types of remote services, it is particularly important to embrace the opportunity of including more remote services than before, operating in new ways, while being aware of the risk of excluding people who are unable to access such services for various reasons.

Skills and development initiatives, plus sickness absence

Many professions are involved in the work of primary care on mental health to varying degrees. Primary care, with its broad mandate, is the health care level that is best placed to take a holistic view and serve as the first level of care for people's physical and psychological care needs. However, being able to do this appropriately requires certain fundamental knowledge of mental illness and treatment on the part of everyone working in primary care. There is also a need for knowledge of what different professions can contribute to tackling mental illness. This would enable the work to be organised efficiently and in line with the best available expertise, e.g. by using care managers or organising psychosocial teams. The Inquiry's dialogues have revealed challenges in terms of this knowledge, both at management and clinical level.

We therefore recognise that there is a need to improve knowledge and to carry out additional training initiatives. However, what these will look like will vary across the country, based on the local context, and there is thus a need for regional and local surveys, the results of which will enable relevant skills-boosting initiatives to be provided, both for management and leadership functions and for clinical operations.

In this chapter, we highlight that using the information provided in current national planning support (sv: Nationella planeringsstödet) , it is impossible for us to say anything regarding where in the health care system different resources may be found. In other words, we cannot say with any certainty which, and how many, professions are active in primary care in different parts of Sweden. This makes it very difficult to describe the gaps. All in all, both these factors constitute major challenges in relation to planning different training initiatives in the future and to the transition to strong primary care with the capacity to tackle both physical and mental illness.

In this chapter we also shed light on the way in which the lack of regulation of what is termed "basic psychotherapy training" creates a significant lack of clarity surrounding which skills people who have completed such training possess, which is problematic for those who are to staff primary care with skills for treating mental illness, for the patients they see and for the people with such training.

Finally, a brief account is provided of the impact of mental illness on sickness absence, and how interventions intended to reduce mental illness can be expected to affect sickness absence figures.

Chapter 4. A look at the international situation

When it comes to mental health, Sweden faces challenges similar to those faced by other countries, and our remit can be seen in a global context. Different countries are trialling different strategies to tackle these challenges. This chapter briefly outlines some international initiatives in this field and the global burden of mental illness, as well as its estimated consequences for individuals and societies. We then take a deeper look at the efforts of a couple of different countries to tackle what is termed mild mental illness, in line with the Inquiry's terms of reference to survey whether solutions for people with mild mental illness have been designed in any other country in the EU or EEA, e.g. Norway or the UK. We also shed light on Finland and its recently completed work on a mental health strategy.

In this chapter we reflect on our Swedish circumstances, with health care centres designed with broad inter-professional skills as the basis for primary care. Used properly, this means we are in a good position to benefit from the specialist skills of primary care and generalists – treating the whole individual, including their physical and psychological needs.

Our analysis is therefore that we should build further on this strength when developing the treatment of mental illness in Swedish primary care. Rather than create new, separate organisations or structures to tackle mental illness in primary care, the Inquiry judges that we should further develop, better structure and strengthen the work of existing primary care operations on mental health.

At the same time, we judge that there are important lessons to be learned from the work of the UK and Norway in creating clear structures to support patients and employees alike. These structures should incorporate accessibility, assessment and treatment, and be linked to requirements regarding continuous monitoring and constant improvements. Similarly, Finland's recently conducted work on a ten-year strategy can serve as inspiration for Sweden's upcoming work on strategy.

Chapter 5. The fundamental mission of primary care

Proposed legislative amendment

The Inquiry proposes that the fundamental mission of primary care (Sv: Primärvårdens grunduppdrag) make it clear that primary care is responsible for care in the realms of both physical and mental health. Chapter 13 a, Section 1, paragraph 1 of the Health and Medical Services Act (2017:30) HSL on the fundamental mission of primary care is to be worded such that within the remit of operations that constitute primary care, regions and municipalities are to particularly provide the health care services required to meet common *physical and mental* health care needs.

Reasons for the Inquiry's proposal

The current health care system came about in a context different to that of today, when common health care needs differed from those that are common today. The role of mental illness has historically been overlooked in health care and in the debate as a whole. When health care was discussed and planned, precedence was given to somatic care in various forms. Today there is a greater focus on mental health, but although financial investment, mandates and inquiries have increasingly identified and drawn attention to mental illness, the investments that have been made have largely not included primary care.

It is key to the very definition of primary care that its mandate is not limited in terms of the kinds of illness it treats. The majority of patients suffering from mental illness are already found in primary care, in line with the intentions of the National Board of Health and Welfare's national guidelines in this area, among other things. Our overviews in Chapters 2 and 3 show, however, that health care services for mental health needs, and monitoring of these, are not provided in equally structured forms as health care services for physical health care needs. It should therefore be made clear in the fundamental mission of primary care that primary care is responsible for both physical and mental health.

Government efforts in the field of psychiatry, mental illness and mental health have comprised and largely continue to comprise

targeted government grants, national coordinators and agreements between the Government and health care providers represented by SALAR. Regulation has been used as a form of Government governance in this area to a lesser extent. However, legislation and other regulations will create national consistency, a long-term approach and clarity. The regulation of the fundamental mission of primary care recently decided upon is one example of standardisation being applied to create consistency and so facilitate more equitable health care. This regulation and an amended definition of primary care and other changes constitute important steps in the transition in health care and the reform of primary care. According to the Inquiry, the work already commenced on legislative amendments to HSL to boost primary care should also be applied and developed with the aim of addressing mental illness.

In the Inquiry's dialogues it has been asserted that it would be easier were there clear support in legislation for organising and planning primary care to take into account the need to tackle mental illness. This is seen as supporting the functions that are to plan, organise and resource health care, specifically primary care.

Chapter 6. The organisation of primary care

The right support for mental health

In this chapter we present the Inquiry's assessments (distinct from the Inquiry's proposals, in the sense of proposed legislative regulation) of how primary care should work with mental health based on the surveys and analyses in Chapters 2, 3 and 4 and the proposed legislative amendment in Chapter 5. We set out these assessments under three different headings: *The way in*, *Organisation of primary care initiatives* and *Cooperation and collaboration*. We bring these three areas together under one umbrella – "The right support for mental health". The model comprises a number of principles and working methods that, in combination, are intended to improve the reception and treatment of the individual and better meet needs at population level. Together, the Inquiry's assessments contribute to improvements in tackling mental illness in primary care, covering psychiatric conditions and

also mental ill-health. The assessments are intended to be based on a person-centred perspective and principles for stepped care.

The basic idea is that in cases of mental illness (patient's perspective), i.e. suspicions of psychiatric conditions (health care perspective), primary care is usually the way into health care. This is where a first assessment is made, support for self-care is given and, if indicated, treatment is provided, either at primary care level or via contact with and referral to another part of the health care system. In cases where criteria for a psychiatric condition are not met, interventions to reduce the functional impact of mental ill-health may need to be offered, sometimes by primary care, other times via structured collaboration with other actors, such as occupational health care, student health care or the voluntary sector.

In our assessments, we show best practice from organisations and initiatives with which we have been in contact in different phases of the Inquiry's work. The examples we highlight have been selected because they demonstrate working methods and methods in which evidence is available based on the current state of knowledge, or where interventions have been linked to ongoing research or own structured follow-up.

In addition to these examples, during the course of the work we have received a large number of examples of interventions made in different parts of the system to meet the mental illness needs that individual health care providers, operations, professions and organisations encounter day to day. We report these in Appendix 6, in no particular order and in the knowledge that the degree of evidence for these interventions varies.

We once again remind readers that the assessments we make in this chapter must be seen as cohesive with the proposals the Inquiry has submitted in earlier reports, both in terms of the role of primary care as the foundation of the health care system, with a particular mandate to ensure coordination and to promote health, and in terms of a joined-up health care system. We once more wish to emphasise the importance of conditions being in place in primary care for staff to adopt a relational approach, with long-lasting, continuous contacts, both with individuals and with and in their communities. This fosters trusting relationships and a sense of confidence, opening up an opportunity to reduce the stigma that often prevents

people from raising mental health problems in their contact with the health care service.

Prerequisites for "The right support for mental health"

Attaining an integrated working method in line with the intention of the model "The right support for mental health" requires an infrastructure that facilitates and supports the system in making such changes. This concerns a number of areas: patient engagement, training and skills supply, research and development, adequate and evidence-based knowledge support and financing. We therefore also make a number of assessments regarding how such conditions can be created.

To conclude, we present an opportunity for development work in the form of geographical model areas for implementing "The right mental health support". Here we particularly highlight the opportunity to conduct (and the benefit of) simultaneous accompanying research on such an introduction in a limited local context.

Finally ...

This final part of the Inquiry's remit has in many ways been felt to be one of the most important. There are so many aspects to highlight in the field of mental health and mental illness, but the one that has dominated the most is the vulnerability and the suffering that affects many people with mental illness. Our awareness that we do not possess the knowledge of the best way of engaging with and treating many people in this field and the fact that the knowledge we have is incomplete and unevenly implemented are also crucial factors. There are major challenges, and sometimes failures, on the part of health care in engaging with the people behind the statistics, e.g. regarding suicidality, sickness absence or the high rates of somatic sickness and mortality in many patients with comorbid mental health problems.

Therefore this remit has felt particularly meaningful, especially because we found ourselves carrying it out during an ongoing pandemic. It is, as yet, too early to state what effects the pandemic has had on mental health, but in the aftermath it will be important to

monitor and tackle the impacts that fears of the effects of everything from long periods in intensive care to general social worry and impact on daily life will have had.

As always, we would like to give our greatest thanks to everyone who has been involved in our work, contributed views and input, given us an insight into their work and their organisation and set aside time to talk to us. We would particularly like to thank patient/user organisations, people with their own experiences and health care workers who have contributed to this work despite often difficult circumstances during the ongoing pandemic.

We conclude by reiterating the globally accepted principle "No health without mental health".