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Developing mental health policy in Sweden: a policy analysis exploring how a complex societal challenge was consigned to individual citizens to solve

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ABSTRACT

Sweden, like many other countries, faces increasing problems related to mental ill-health. To address this problem the Swedish government developed a new mental health policy in 2015. This study aims to explore and analyse the development of this mental health policy. A case study was conducted. Four years were chosen. In all, 127 national and regional key documents were selected for analysis. In conducting a policy analysis it was found that structural aspects of mental health were lost when the national policy was received in regional settings, which traditionally address persons with mental ill-health. Regional policies presented interventions ranging from preventive interventions to specialized multisector care. The individuals varied from healthy persons to those with severe mental illness. Although the interventions were aimed at changing individuals, research shows mental ill-health also needs to be addressed structurally. The location of responsibility was discussed in terms of solving wicked problems using tame local solutions. The regional context lacked the power required to change societal structures, such as labour market conditions. The available solutions included individual interventions in which each individual was responsible for solving the mental ill-health challenge.

KEYWORDS

Policy analysis; mental health; national policy; local capabilities; wicked problems

Introduction

Many countries face ill-defined and complex problems related to the increase in mental ill-health (World Health Organization 2017). The negative trend has led to a rise in world and European general mental health policy agendas (World Health Organization 2013; The Joint action Mental Health and Wellbeing 2017). Children and youth are defined as an important vulnerable group in general mental health policies, largely because the investment in their health is also an investment in the future (Burstow et al. 2018). In Sweden, mental health policies until 2015 have addressed two groups: 1) persons with severe mental illness and 2) children and youth (The Ministry of Health and Social Affairs. Socialdepartementet 2012). In 2015, however, a substantially broadened mental health policy was launched to improve the capacity of the Swedish welfare system to face challenges associated with the increasing mental ill-health in the population (The Ministry of Health and Social Affairs. Socialdepartementet 2015).

The literature show that in parallel with the rise of general mental health policies numerous general mental health interventions have evolved, including school-based social work in which promotive and preventive interventions are under development (Lear 2002; Mutiso et al. 2018). Mental health interventions are also being developed to address older people's mental health

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(Machielse 2015). Another public health intervention is the education programme Mental Health First Aid (MHFA), which aspires to increase knowledge and promote more tolerant attitudes. The programme, which has a suicide prevention approach, has shown increased knowledge and preparedness in participants as fellow citizens to act in difficult situations after completing their education (Svensson, Hansson, and Stjernswärd 2015).

While some researchers study and develop interventions addressed to individuals within a care and support organization, another research field studies structural aspects of mental health issues. Concerning the latter research field, Flisher et al. (2007) explored comprehensive multisectoral approaches to break the negative cycle of poverty and mental ill-health. In a cycle, poverty in terms of economic deprivation, low education, unemployment and lack of basic amenities leads to social exclusion, high stressors, reduced access to social capital and obstetric risks. This situation can lead to mental ill-health, which may result in increased health expenditure, loss of employment, reduced productivity and social drift. And the cycle is completed. In the Swedish context Hensing (2019) reported a gender-segregated labour market in which women often choose occupations characterized by an increased risk of mental – and stress-related conditions. A systematic review (Zhou et al. 2018) describing current knowledge on policy development and challenges of global mental health identified nine domains recurring in mental health policies globally: service organizing, service provision, service quality, human resources, legislation and human rights, advocacy, administration, surveillance and research and financing and budgeting. These nine domains summarize individuals and societal structures.

Developing mental health policy to meet the increase in mental ill-health is challenging. At present, policies are formulated, implemented and reformulated to seek answers on how to reverse a negative trend. The mental health strategy in the UK concerns implementing a mental health strategy within the healthcare system (Corlett 2012). Policymakers face an intricate question: How to address a phenomenon in which there are so many multifactorial causes interacting. The current article seeks to make its contribution by addressing this issue. Knowledge developed during the policy development stage in one country (in this case Sweden) might offer valuable insights to other countries. Increased knowledge within the field of interest might be relevant to policymakers, policy implementers and individuals affected by a policy change. The purpose of the study was to explore and analyse the development of a broadened mental health policy in Sweden. Research questions posed were: What characterized the mental health policy? How was mental health problematized? How could the policy development process be understood?

The current study is part of a larger case study addressing the policy implementation process as a whole. The current study focuses on policy at the national and regional level. Implementation at a local level was addressed in another part of the study (Fjellfeldt 2020).

Analytical framework

Problematization – a way to explore a policy by contextualizing its content and meaning

In this article a post-structural approach was taken by scrutinizing the results using policy analysis according to Bacchi (2009). In the analysis model the point of departure is that a policy identifies that something needs to be changed. What is suggested by the policy indicates what needs to be done from the perspective of the policymakers. Solutions presented in policy shows how the problem is understood. Bacchi (2009) means the problematization needs to be studied rather than the problem itself. The policy analysis rests on following key propositions: we are governed through problematizations; we need to study problematizations rather than the ‘problems’ per se; and we need to problematize (interrogate) the problematizations on offer through scrutinizing the premises and effects of the problem representation they contain (Bacchi 2009 p. xxi). The analysis is deepened by posing critical questions to the policy in focus. Various layers of understanding could then be unfolded and identified. Questions guiding the analysis are: What’s the ‘problem’

represented to be? (Q1) What presuppositions or assumptions underlie the representation of the ‘problem’? (Q2) How has this representation of the ‘problem’ come about? (Q3) What is left unproblematic/Where are the silences/Can the ‘problem’ be thought about differently? (Q4) What effects are produced by this representation of the ‘problem’? (Q5) How/where has this representation of the ‘problem’ been produced, disseminated and defended? (Q6) (Bacchi 2009, p. 2) Various problematizations make different subject positions available. When a subject position is assumed, a person tends to make sense of the social world from this standpoint, including modifying behaviours and thoughts (Bacchi 2009, p. 16).

Policy development

In the policy analysis three theoretical concepts of relevance for the study were chosen to deepen and facilitate understanding. The concept travels of ideas (Czarniawska-Joerges and Sevón 1996) was applied. Fundamental when using the concept is that both transmitting and receiving persons in a process are required to make sure an idea proceeds to the next stage. Different persons involved will assign the idea with different content and meaning. Persons involved in a policymaking process are not only carriers of an idea but also interpreters and transformers. In this case the policy idea was disembedded from the original context, sent away, translated and then reembedded into a new context. When the idea is to be disseminated, the result depends not only on the essence of the idea but also on where it should be implemented and who receives it. An idea arriving at a new location is therefore never identical to the original version.

Another analytical tool applied was the ambiguity-conflict policy implementation process model (Matland 1995). The model consists of four policy implementation paradigms: 1) a low level of conflict combined with a low level of ambiguity leads to an *administrative implementation process* in which access to recourses is crucial to the development of the process. 2) A high level of conflict and a low level of ambiguity leads to a *political implementation process* in which power relationships are crucial for the development of the process. 3) A low level of conflict combined with a high level of ambiguity leads to an *experimental implementation process* in which contextual conditions are crucial to the process. The high level of ambiguity and low level of conflict results in a situation in which the outcome of the process will vary between different local contexts. 4) A high level of conflict combined with a high level of ambiguity leads to a *symbolic implementation process*. In such a situation the coalition strength on a local level is crucial to the development of the process.

Finally, the description and understanding of *wicked problems* (Rittel and Webber 1973) were applied. The term describing the complexity of problems that often have no definite shape can evolve and mutate, elude right or wrong solutions and often have many causal levels.

Research design and methods

Research design

This study was designed as a case study (Yin 2014). Case studies are appropriate when studying contemporary complex phenomena if the researcher lacks control over the process. Case studies are also useful when searching for subtle answers concerning how and why questions (Yin 2014). In this article the Swedish mental health policy constituted the case. When conducting policy analysis, policy documents are a valuable source of data. Here, the policy was developed at two organizational levels: Swedish national governance and regional response. Key documents on the national and regional level were recognized as relevant data to reveal knowledge about policy development. A period of 4 years (2015–2018) was chosen to capture subtleties during a long enough process in which national policymaking (transmitting instance) interacted with regional policymaking (receiving instance). The timeframe selected though, is specific for this study and for the Swedish situation at this point in time.

To implement the new policy *agreements* were developed and signed by two main stakeholders at the national level: The Ministry of Social Affairs and the Swedish Association of Local Authorities and Regions (SALAR) representing regional and local welfare providers (The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2015, 2016, 2017). The agreements requested regions to develop *regional action plans* in which regional needs and plans of actions were described. These agreements and regional action plans, along with two primary national documents issued at the highest political level, constitute the 127 key documents included in the present study. A mapping of the process was chosen. The selected documents were regarded as sufficient data to provide opportunities for a subtle distinction of the research questions.

To conduct the policy analysis according to the Bacchi model (2009) a document analysis was considered suitable. Interviews with key respondents could have provided information about the policy as well. However, mapping of the process was thought to enable valuable nuances to the case. The document analysis delivered an analysis rich in detail to illustrate findings within the chosen case.

Context

Within the Swedish welfare system, health care and social support are divided into two organizations with their structures and political decision-making processes: municipalities and regions. Municipalities are responsible for organizing social support and services while regions are responsible for organizing primary and specialized health care. Sweden consists of 290 municipalities and 21 regions. To retain grants associated with the new policy municipalities and regions were assigned to execute regional action plans in which social services (municipalities) and health care units (regions) jointly composed a needs assessment report and established goals for future joint efforts within the field. Involvement of user organizations was expected in the formulations of the regional action plans.

Government funding allocated to each municipality or region was calculated according to population size. Thus, there were large variations in the amount of funds each municipality and region was allocated. Consequently, high-populated municipalities and regions received more funding than low-populated municipalities and regions. Municipalities and regions were given two commissions: jointly analyse local needs and develop regional action plans. The work should be done as a collaboration between responsible stakeholders based on available national and local data, but also based on the unique experiences of professionals, users, patients and relatives.

Data material and data collection

From 2016–2019, data were identified, collected and analysed yearly. At the national level, documents consisted of the new policy and were annually issued during the implementation process about implementation strategies and an investigation assessing the implementation process from a national perspective.

At the regional level, each of the 21 regions formulated one regional action plan together with their associated municipalities in 2016, 2017 and 2018. All regional action plans were collected and analysed yearly. [Table 1](#) gives an overview of the national and regional documents collected.

Data analysis

Data analysis consisted of four consecutive stages. Content analysis (Hsieh and Shannon 2005) and policy analysis according to Bacchi (2009) were chosen to complement each other during the analytical work. First, all three types of content analysis in accordance with Hsieh and Shannon (2005) were applied. Thereafter, a policy analysis according to Bacchi (2009) was performed. This

Table 1. Overview of national and regional documents.

Document	Agent	Document character
The Ministry of Health and Social Affairs. Socialdepartementet 2015 ^a	The Ministry of Health and Social Affairs	New policy Governmental directive
The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2015 Regional Action Plans 2016 (1–34) ^a	The Ministry of Health and Social Affairs and the Swedish Association of Local Authorities and Regions (SALAR) The Swedish regions and municipalities	National document Regional documents
The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2016 Regional Action Plans 2017 (35–88) ^a	The Ministry of Health and Social Affairs and the Swedish Association of Local Authorities and Regions (SALAR) The Swedish regions and municipalities	National document Regional documents
The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2017 Regional Action Plans 2018 (89–122) ^a	The Ministry of Health and Social Affairs and the Swedish Association of Local Authorities and Regions (SALAR) The Swedish regions and municipalities	National document Regional documents
SOU 2018:90	Government Offices	Governmental investigation

^aAppendix the 122 original titles

section initially provides an overview of these consecutive stages of the data analysis process (Table 2) and the following text describes the procedure used.

Table 2. An overview of the four consecutive stages of the data analysis process

In the first stage an inductive approach dominated the analytical work for both the national and regional documents. Data were read several times and then coded into themes as part of data reduction. A conventional content analysis (Shieh and Shannon 2005) was performed. The question guiding the work was, *What characterized the policy, the national governance and the regional response?* An additional question guiding the analytical work in 2017 concerned *differences in the documents between the first (2016) and second year (2017)*. An additional question guiding the analytical work in 2018 referred to *regional descriptions of follow-up*. In the second stage the regional documents were analysed by applying summative content analysis (Hsieh and Shannon 2005). This analysis allowed to handle a large number of themes occurring in the documents and permitted quantitative comparison across themes. In the third stage *all data collected and analysed* were assembled and a directed content analysis was conducted (Hsieh and Shannon 2005). Analytical and theoretical concepts of relevance to the research questions guided the analysis to facilitate a deeper understanding of the data as described below. In the final stage results from stage three were analysed by Bacchi (2009) policy analysis. During the policy analysis, the six consecutive

Table 2. An overview of the three consecutive stages of the data analysis process.

Consecutive stages of the data analysis	Content analysis method used in 2016–2019 (Hsieh and Shannon 2005)			Policy analysis method used in 2020 (Bacchi 2009)
	Conventional	Summative	Directed	
The Ministry of Health and Social Affairs. Socialdepartementet 2015a	2016		2019	2020
The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2015 Regional Action Plans 2016	2016		2019	2020
The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2016 Regional Action Plans 2017	2017	2016	2019	2020
The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2017 Regional Action Plans 2018	2018	2017	2019	2020
SOU 2018:90	2018	2018	2019	2020
	2019		2019	2020

questions presented in the section Problematisation - a way to explore a policy by contextualizing its content and meaning, guided the final analytical work.

Validation

To validate the data (Ritchie and Lewis 2003) a panel of researchers from various research fields (public health science, implementation science, mental health science and others) was formed to discuss the preliminary results of the analyses in 2016, 2017 and 2018. The discussions were open to different interpretations of the data. From these discussions, a few changes were made in data analysis.

Limitations

One limitation of the study involves the chosen level of data collection. Focusing on the national and regional level gives access to certain aspects of developing policy. How the implementation process continued at the local level, of which several aspects of importance are revealed, is not covered in the study. To include the local the data would be overwhelming. Thus, local data were addressed in a separate study (Fjellfeldt 2020). Another limitation pertains to the length of the data collection period. Data could have been collected over a longer period to gain knowledge about long-term processes. However, the chosen period was deemed sufficient to offer an extensive, nuanced and detailed knowledge of the policy development. The time frame selected meant that the governmental investigation (SOU 2018:90) looking into the new policy could be included in the study.

Results and analysis

National and regional policy documents – a summary

The *national* 5-year (2016–2020) mental health policy document (The Ministry of Health and Social Affairs. Socialdepartementet 2015) gave regional organizations of health care and social support the task to jointly promote mental health and counteract mental ill-health among the population. The problem was described as two-fold: ‘great suffering for the individuals and their relatives’ ... ‘In addition, the social and economic costs of mental ill-health are significant’ (The Ministry of Health and Social Affairs. Socialdepartementet 2015, p. 2). Within the policy, individuals ranging from healthy (young, adult, old) persons to persons who have severe mental illness were addressed. Several vulnerable groups were mentioned. Interventions proposed varied from preventive actions to reduce unequal living conditions between different groups to treatment in specialized psychiatry.

A lack of clarity plagued the regional action plans. There were few common organizational structures available, including municipal and regional organizations addressing mental health questions at a regional level. Thus, there were no natural recipients in the municipalities and regions who could receive and process the new task. The summative analysis indicated that, at an aggregated level, the regional action plans (2016, 2017, 2018) showed that there was an even distribution between the broad group, the population as a whole, and the narrower target group of persons living with severe mental illness. However, there were large variations between how regions chose to prioritize between the groups. In some regions the broad group was exclusively prioritized, whereas in other regions the opposite occurred, i.e. the narrower group was prioritized at the expense of the broader group. Actions aimed at both a broader and narrower group were found to cover a full spectrum from promotional interventions to early intervention, and finally, to treatment and long-term support and care. Nuanced spectra developed within the regional action plans in the first years and ranged from mental wellbeing among the population as a whole to

mental wellbeing among persons who have a severe mental illness. The broadened policy seemed to have influenced perspectives that also considered the traditional target group, most appropriately expressed as holistic thinking that covered not only support and treatment but also prevention and health promotion.

A large number of vulnerable groups were numerated in the regional action plans in 2016, 2017 and 2018. Among those were adults with intellectual disabilities, people migrating, people with gambling addiction, people with vulnerable housing and minorities (e.g. Saami or Romani people). In addition, the contents of the national and regional policy documents showed a strong emphasis on the mental health of children and youth (Regional Action Plans 2016; The Ministry of Health and Social Affairs and SALAR. Socialdepartementet och SKL 2016). Initially, there were bold ambitions to address mental health in children and youth in the various regions (Regional Action Plans 2016). One recurring issue was to work in a supportive capacity to facilitate all children passing primary school grades:

Prevention and promotional work. Children and young people: approved primary school. Short-term goals and activities in 2017: improved collaboration between student health and child and adolescent psychiatry and social services. A group that needs particular attention is children skipping school. (Skånes läns gemensamma handlingsplan överenskommelsen psykisk hälsa 2016 p. 4).

Over the years, the broad definition of mental health care and support was consolidated into national and regional policies. At the end of 2018, a government investigation (SOU 2018:19) was launched on the mental health policy. The investigator of this investigation called for a long-term (10-year) mental health strategy with a clear emphasis on a public health perspective. Objectives and target structures should take their point of departure in the eight target areas that apply to the overall national work on the public health policy, including structural issues, such as housing and education, as well as individual issues, such as lifestyle. The investigation further proposed that the state should concentrate on issues (e.g. legislation, supervision, dissemination of knowledge) that only the state could perform or perform more effectively than other organizations.

The following analysis shows how the policies could be understood when applying Bacchis' (2009) policy analysis by asking the questions Q1, Q2, Q3, Q4, Q5 and Q6 as described above.

Interventions and support aimed at individuals to solve mental ill-health challenges

The national policy document described the problem as twofold: individual and societal. The national problem solution (national policy) involves addressing societal changes and providing care and support to individuals at risk of or suffering from mental ill-health. The national policy proposed preventive actions (e.g. reducing unequal living conditions between different groups). The regional problem solution (regional policies) concerns providing care and support to individuals at risk of or suffering from mental ill-health. The subjects for the policy at the regional level where the policy was translated into action were individuals who need intervention. Health care and social support organizations should provide care and support to individuals suffering from mental ill-health. In the regional action plans individuals were classified into different groups, depending on regional needs and translation of the policy. Figure 1 depicts a 'mental health intervention landscape', a large area developed in the national policy, a landscape containing support and interventions aimed at various individuals. Examples of how this landscape was translated into regional practices, given shape and content are also presented in Figure 2.

The regional and national emphasis on the mental health of children and youth could be understood as the identification of a major need. Another way of understanding the specific position of this group could be the prior governance (The Ministry of Health and Social Affairs. Socialdepartementet 2012), where children and youth were one of two prioritized groups. That meant that the standard work regarding children and youth was already started. A third way to

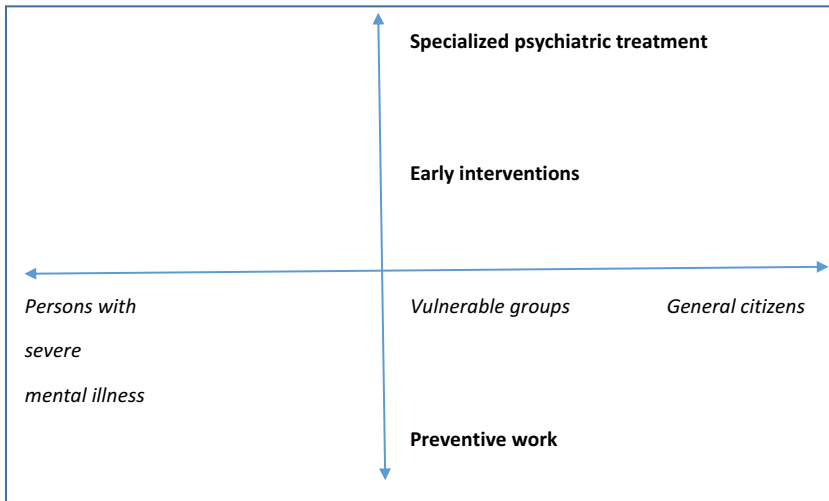


Figure 1. Mental health intervention landscape in the national policy.

	Severe mental illness	Vulnerable groups	General citizens
<i>Specialized psychiatric treatment</i>	<i>Multiprofessional teams (Skåne)</i>	<i>Addressing gambling addiction (Gävleborg)</i>	
<i>Early intervention</i>	<i>Easily accessible interventions addressing persons with addiction and psychiatric problems (Gävleborg)</i>	<i>Support NEETS (Youths Not in Employment, Education or Training) (Örebro)</i>	<i>Easily accessible information concerning support and care (Västerbotten)</i>
<i>Preventive work</i>	<i>Somatic health (Jönköping)</i>	<i>Collaborations between children and youth psychiatry and migrant health department (Västmanland)</i>	<i>Mental Health First Aid Kit (Suicide prevention) (Kalmar)</i>

Figure 2. Examples from regional action plans giving the landscape shape and content.

understand the emphasis on the new generation is to understand the Swedish case as being consistent with the ambition of other countries to invest in the new generation (Burstow et al. 2018). One part of the solution to reversing the trend of increased mental ill-health would be to prevent the young population from becoming mentally ill.

Presuppositions and assumptions underpinning the problem at the national and regional level included an understanding of mental health as an individual issue. Although the structural level was mentioned in the national policy, the emphasis was on individual interventions. Individuals owned their problem and individuals needed to change. This understanding of mental health might be explained in part by the mental health history for which individuals have always been the subject for change (Oliver 2013).

Regional settings in which the national policy was received

The new policy was launched in a care and support context where the earlier mental health policy was to be found. The former policy had previously focused on persons suffering from extensive or complex psychiatric problems as well as children and youth (The Ministry of Health and Social Affairs. Socialdepartementet 2012). In this context it was natural to focus on the needs of the individual. The holistic thinking that was evolving for persons who have severe mental illness could be understood as an effect of the preventive and promotional approach when the policy was received in the health and support organization at the regional level.

When addressing public mental health, however, the placement of the new policy in the traditional mental health context was questionable. Something else – public mental health – with a substantially broadened understanding of mental health was now the focus of attention. However, the traditional mental health setting structured to address mental ill-health was used as the starting point. Persons previously working strategically with issues associated with mental ill-health now need to develop structures for public mental health questions. The regional setting where the policy idea arrived probably influenced the problematization and solution of the problem.

The structural level – a silence

Placing the new policy in traditional regional structures, one issue left unproblematic was the structural level, which affected an individual's mental health. It has been shown that changing structural premises and conditions could make a difference in an individual's mental health. For example, in the Swedish context Hensing (2019) noted a gender-segregated labour market in which women often choose occupations characterized by an increased risk of mental – and stress-related conditions. Hensing (2019) argued that there is a need for change in an organizational and psychosocial work environment in women-dominated professions. Yet, another structural matter concerns housing. A recent mapping showed that in one Swedish municipality with about 200 000 inhabitants, 27 000 individuals live in an 'uncertain housing situation', including, for example, households not registered in the municipal population register and households moving more than once a year in the past 5 years (Föreningen för samhällsplanering 2019). Although already in 1986 the World Health Organization stated in the Ottawa charter (World Health Organization 1986) that shelter is one of the basic conditions that must be addressed when the aim is to improve health, the strategic planning of housing continued to be an issue of silence in a public mental health policy process. In research studying the relationship between poverty and mental ill-health housing was one of the main variables identified (Flisher et al. 2007). Even more, poverty itself would be another structural issue to address when the goal is to improve mental health within the population. In Sweden in 2018, 186 000 children lived in a financial situation where the family had difficulty meeting their costs (Rädda barnen 2018). The list could be long: the mental health of immigrants was addressed in the regional action plans, but no structural issues were taken up (e.g. asylum processes); the mental health of persons addicted to gaming was addressed but no structural issues were discussed (e.g. legislation on marketing methods); and the mental health of indigenous peoples was addressed but no structural issues were mentioned (e.g. minority stress). Although the national policy document addressed the structural levels, the regional policies could not address them. Regions did not have the mandate to work with structural issues such as legislation. Consequently, the structural level was lost in the regional action plans and care and support to individuals were still to be addressed. The government investigation (SOU 2018:90) once again brought attention to the structural level.

Possible effects produced by this problem representation when applying Bacchis' (2009) understanding of subject positions are that individuals assume and understand their mental ill-health as their cause, concern and responsibility. The national and regional policies make the individual as a citizen, a part of a vulnerable group or a person who has a severe mental illness, to the subjects for the policy, the subjects for change. According to their subject positions, individuals' thoughts and

behaviours in the current case could be influenced such that they blame themselves for their mental ill-health.

A comprehensive policy idea travelling through an experimental policy implementation process

The representation of the problem was produced at a national level and then disseminated through the regional organizations for health care and social support. Stakeholders at both levels agreed that mental ill-health in the population was a challenge for the individual and the community. Applying Matland's (1995) ambiguity-conflict model, the policy could be understood as an experimental policy implementation process with a low level of conflict combined with a high level of ambiguity. Stakeholders on national and regional levels agreed *that* mental health issues needed to be addressed, but the question of *how* this should be implemented remained obscure. The policy was broad enough to include almost anything that could be associated with mental health or ill-health. The high level of ambiguity and low level of conflict led to a situation in which the outcome of the process varied substantially between different local contexts. Large variations were found as to how regions chose to prioritize between the groups. In some regions the broad group of citizens was exclusively prioritized, whereas in others it was the opposite, i.e. the narrower group of persons who have severe mental illness was given the highest priority. The phenomenon could also be understood in terms of travelling ideas (Czarniawska-Joerges and Sevón 1996). Because of the broad national policy, receiving persons involved in the regional policymaking process had notable discretion to assign the regional mental health policy content and meaning adapted to the regional context. The regional action plans showed that the broad original mental health policy idea was disembedded, translated and embedded differently in all of the regional contexts according to various prerequisites and preferences.

Discussion

Positioning Sweden's mental health policy within a global mental health policy context, the national policy was largely found to address interventions directed to individuals within the care and support organizations. A few structural proposals were found but there were no associated tools to apply (e.g. legislation). When policies were developed in the regions, structural issues were lost, such as changing conditions in terms of, for example, poverty or housing (Flisher et al. 2007). Developing mental health policy in regional settings with regional capabilities for financing, the Swedish development of mental health policy took a similar position as in the UK, i.e. the mental health strategy was implemented within the existing healthcare system (Corlett 2012). In the Swedish government investigation (SOU 2018:19) launched in 2018 the investigator called for a long-term (10-year) mental health strategy with an emphasis on a public health perspective. Objectives and target structures should take their origin in the eight target areas that apply to the overall national work on the public health policy, including structural (e.g. housing and education) and individual issues (e.g. lifestyle). Not to lose sight of the structural level was underlined and could be understood as a reaction to a lost perspective during the policymaking process in which the national ambition and the regional capacity met and national policy ambitions were translated into regional capacities and traditions. A lesson learnt was that something important was lost on the way when complex societal problems were given local accessible solutions.

The Swedish example put in a global context raises the following question: Is there a difference in problematization in mental health depending on whether there are stable organizational structures built for care and support to persons living with severe mental health disorders? In Sweden (and the UK) mental health policies were implemented in well-established organizations, where there were increased awareness and competence on how to work with persons who have a mental illness. Applying the Bacchis (2009) analysis on the current policy, it was shown that the problematization

then assigns individuals the responsibility to solve the mental health challenge, and *individuals are to be changed*. In low-income and middle-income countries (Flisher et al. 2007) poverty has been identified as a primary issue to deal with to increase people's mental health. This approach puts the responsibility of mental health or ill-health of the individual on another level. Mental health would be associated with legislation, human rights, equal living conditions, etc. Societal complex queries belonging to decision-makers to deal with. In this case the perspective of *the society needs to change* to improve citizens' mental health. The problem is not the individual. Consequently, the blame should not be placed on those suffering from mental ill-health.

How could the mental ill-health challenge be addressed differently? How could a problematization from another perspective contribute to the solution of the major mental health challenge? One answer could be to consider the problem as 'wicked'. A 'wicked problem' is a term used to describe the complexity of issues that often have no definite shape, can evolve and mutate, elude right or wrong solutions and often have many causal levels (Rittel and Webber 1973). In the Nordic context Fosse, Sherriff, and Helgesen (2019) discussed how wicked problems with contesting definitions and priorities that need whole-of-government action were reduced into tame problems that required tame solutions. Their empirical example illustrated how the primary responsibility of a wicked problem was placed at local governance and the real solutions were left to the local government to handle, but that many of the solutions were to be found at other levels and even in different sectors of society. Tame solutions of wicked problems were exemplified when social inequalities were defined as lifestyle issues for marginalized groups and when solutions were individual, not structural. Based on this discussion by Fosse, Sherriff, and Helgesen (2019), the public mental health policy studied in this case could be understood as a wicked problem reduced to a tame one. Structural matters remained unaddressed and the change of individuals was considered the solution to the problem.

To admit a problem as wicked does not imply that they should be left unattended and considered as beyond the scope to address and repair because of the complexity and state of the problem. Several strategies have been elaborated (Head and Alford 2015) suggesting that there are degrees of 'wickedness' that can be understood by reference to multiple dimensions. While conclusive 'solutions' are scarce, it is possible to frame partial, provisional courses of action against wicked problems. Stating that developing mental health policies are wicked problems implies admitting they are complex. This position sheds light on the importance to work with the issue at a structural level from different perspectives and sectors.

Conclusions

When the national broad policy approach – the mental health of the population as a whole as well as of specific vulnerable groups and certain individuals – was delegated to regions, the regions were presented a wicked problem. When receiving the complex policy, agents at the regional level developed regional mental health policies due to local capability. Structural matters were excluded from being addressed as the regional level did not possess the mandate to change complex structural issues. Instead, regional mental health policies were received in organizational structures with extensive experience and skills to address individual suffering from mental illness. The translation of the broad policy approach in which structural matters could be included in a narrow regional context based on a regional mandate meant that holistic preventive aspects were reduced to solving individual problems of mental ill-health.

To improve mental health in a population structural issues need to be addressed (Hensing 2019). If change is to occur, the matter of mental health needs to be extended to concern more sectors than the health and welfare sectors. Of course, individuals who have a mental illness should receive help. However, the question needs to be also handled from a societal perspective. To address mental health within the population calls for new ways of working with mental health issues and to learn from the public health field, where broad perspectives are explored that address basic needs (e.g. housing, education, income).

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