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An Individual Enabling and Support model for return to work among persons with affective disorders-evaluation and implementation of a new model

An Individual Enabling and Support model for return to work among persons with affective disorders-evaluation and implementation of a new model

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LUND UNIVERSITY

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Abstract

The thesis aims to evaluate an advanced supported employment model, the Individual Enabling and Support (IES), in terms of employment and health-related outcomes among people on long-term sick leave due to affective disorders and who are unemployed. A further aim is to investigate and develop greater knowledge of the IES model and the process involved as perceived by the participants, and of the barriers and facilitators related to the implementation process in a traditional vocational rehabilitation (TVR) context. The thesis’ design is based on a single-blinded, parallel randomized controlled trial in a mental healthcare setting. The aims of the four studies are to investigate: the return-to-work needs at baseline (Study I), the effectiveness of IES as compared to TVR on employment rate at 12 months (Study II), the perceived process (Study III), and the implementation challenges of introducing IES in a TVR context (Study IV). The results in Study I showed inverse relationships between depression severity and empowerment and quality of life scores; the odds for belonging to the group with moderate to high depression severity decreased with higher empowerment and quality of life scores. Furthermore, the results showed that the participants had been on sick leave and unemployed for an average of 4 years and a majority reported not receiving RTW support. The RCT (Study II) results revealed that the primary outcome of employment rate at 12 months were in favour of the IES group as compared to the TVR group, 42.4% vs 4%, a difference of 38% (p=0.001) with a medium effect size of 0.44. Secondary outcomes showed a decrease in depression severity in favour of the IES group. Within group analysis between baseline and 12 months also showed increased quality of life in the IES group, but not in the TVR group. In Study III Enabling strategies were combined and used together with supported employment principles to support individual RTW, as illustrated by five cases. The theme Enabling engagement in RTW also showed how the continuous person-centered support from the employment specialists helped to increase the participants’ self-confidence and RTW self-efficacy. Furthermore, the participants learnt new work-related coping strategies and behaviours. The findings in Study IV showed that the IES model could be implemented in the TVR context, owing to perceived model advantage and perceptions that people with affective disorders are in need of RTW support. Barriers were also found due to divergent opinions of the model fit of IES in the TVR context, lack of time for leadership engagement and collaboration difficulties with employment services due to their regulations. The results from this thesis add to the knowledge about the effectiveness of advanced supported employment for people with affective disorders, about the qualities of the IES model and how it may be delivered in a TVR context.

Key words Return to work, Supported Employment, affective disorders, depression, implementation, mental healthcare service

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To Manne and Håkan

Content

Content 10
Acknowledgement 13
Abbreviations 15
List of publications 16
Preface 17
Introduction 19
Setting the scene 20
Background 23
Health and occupation 23
Work 24
Occupational engagement and quality of life 25
Empowerment 26
Affective disorders 28
Work, sick leave and unemployment among people with affective disorders 29
Factors influencing RTW 30
Two approaches of RTW support 32
Traditional vocational rehabilitation 32
The Individual Enabling and Support model 34
Implementation challenges 36
Rationale 38
Thesis aim and specific aims 41
Study I 41
Study II 41
Study III 42
Study IV 42
Material and methods 43
Study context 44

Procedure....44
Inclusion criteria and recruitment of participants....46
Randomization....48
Intervention groups....51
Selection of participants in Study III....53
Selection of participants in Study IV....53
Data collection....54
Studies I and II....54
Study III....57
Study IV....58
Data analysis....59
Study I....59
Study II....60
Study III....60
Study IV....61
Ethical considerations....61
Results....63
Effectiveness of the IES intervention....63
Empowerment and quality of life....68
Enabling engagement in return to work....69
Self-confidence and motivation....70
Faith in own abilities....70
Enhancing thinking and behavioural strategies....71
Balancing occupation in relation to family....71
Implementation of the IES model....72
Discussion....75
Advanced Supported Employment for people with affective disorders....75
Health-related aspects in the RTW process....78
The role of empowerment....80
Enabling strategies influence engagement in the RTW process....82
Turning the IES model into practice....85
Methodological considerations....88
Studies I-II....89
Studies III-IV....90
Conclusions....92
Implications for further research....93

Summary in Swedish/Svensk sammanfattning 95
Bakgrund..95
Aktivitetsengagemang, livskvalitet och egenmakt 97
Traditionell arbetsrehabilitering och Individual Enabling and Support modellen 100
Syfte och metod...101
Resultat...103
Konklusion 104

References 107

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Abbreviations

RTW	Return to Work
IES	Individual Enabling and Support
IPS	Individual Placement and Support
SE	Supported Employment
ES	Employment Specialist
CMD	Common Mental Disorders
SMI	Severe Mental Illness
CBT	Cognitive Behavioural Therapy
MI	Motivational Interviewing
WHO	World Health Organization
SIA	Social Insurance Agency
PES	Public Employment Service
REHSAM	Rehabilitering och Samordning
SOU	Statens Offentliga Utredningar

List of publications

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Preface

Since I wrote my undergraduate thesis about motivation for work, and accomplished my occupational therapy field work in a vocational rehabilitation centre, my major interest in rehabilitation has been on how to support people to return to work (RTW). I first came in contact with Supported Employment (SE) when I was working in a RTW project for people with severe mental illness (SMI) where we successfully supported people into employment. After completion of that project I continued working with people on sick leave due to long-term pain and/or mental disorders, conducting assessments of work ability and supporting them to find a passage back to work. I have experienced many challenges in this work; however, I have also collaborated with many professionals who indeed have shared my interest in RTW issues and recognized the RTW support as important. When I later, in 2011, got the opportunity to work as a project administrator for a RTW intervention named the Individual Enabling and Support, this matched my intention to further deepen my knowledge in the area and to return to the method of SE.

Introduction

Occupational therapy and occupational science focus on enabling people's engagement in the occupations that they want and need to perform in order to promote health and well-being (Townsend, 2013). This professional scope is based on the philosophical assumption that people are occupational beings who need to be occupied to maintain or increase health (Mosey, 1981). To study what people do and accomplish, can thus enhance an understanding of the perceived meaning in their lives when they engage in occupations. It has been suggested that there is a reciprocal process of occupational engagement in meaningful and favoured occupations and a person's identity that is closely related to subjective well-being (Christiansen, 1999). In this thesis the focus is on how to enable people, who are on long-term sick leave due to affective disorders, to return to work (RTW). Affective disorders encompass depression and bipolar disorder, which both includes episodes of depression, and work is understood as full-time or part-time paid employment in competitive work settings. Work is important for health and well-being, particularly in societies where work is highly valued both as an identity and as an economic resource, as it facilitates participation in the community (Blank, Harries, & Reynolds, 2015; Eklund, Hansson, & Ahlqvist, 2004; Halliday, Coveney, & Henderson, 2015; Waddell, Burton, & Kendall, 2008).

On the other hand, not being able to work, or not having the opportunity, is shown to negatively impact health and well-being (Jefferis et al., 2011). Affective disorders are highly prevalent both internationally and in Sweden and constitute a major cause for long-term sick leave, generating difficulties for those affected to RTW (Vingård, 2015). Even though a majority of people with mental disorders do RTW after medical treatment, a significant number of those afflicted find themselves in prolonged sick leave periods thus risking health deterioration, unemployment and difficulties in regaining a worker role (Holmgren & Ivanoff, 2004; Jefferis et al., 2011; Försäkringskassan, 2015). Experiencing mental disorders and long-term sick leave can impact on the person's psychosocial functioning and identity, from someone who has been active and engaged in everyday life, into having a more passive and sick role identity (Godard, Grondin, Baruch, &

Lafleur, 2011, Millward, Lutte, & Purvis, 2005). This can in turn impact on the person's self-efficacy for RTW and empowerment to act according to own desired goals (Andersén, Larsson, Lytsy, Kristiansson, & Anderzén, 2015; Bejerholm & Björkman, 2011; Millward et al. 2005). Importantly, there are factors on several levels that influence the RTW process, not only those pertaining to the individual, but also those related to the stakeholders who are involved in the RTW process, unemployment status and organizational structures (de Vries, Fishta, Weikert, Sanchez, & Wegewitz, 2017; SOU, 2011; Waddell et al., 2008). It is thus essential to have both the individual and the context where the RTW support is provided, in focus when investigating how working life can be achieved for people with affective disorders who want to re-engage in work.

Setting the scene

International research and reports about RTW support has been updated and intensified with increasing sick leave numbers during the last decades (Joyce et al., 2015; Organization for Economic Cooperation and Development, 2014; SOU, 2011; WHO, 2015). Return-to-work as a concept can be defined both as a process, the individual's way back to work, and as an outcome measure, returning to employment or achieving employment if unemployed (Ekberg, 2015; Hees, Nieuwenhuijsen, Koeter, Bültmann, & Schene, 2012; Young et al., 2005). Mental disorders and musculoskeletal pain are the two most frequent reasons for long-term (>60 days) sick leave in Europe and in Sweden (Organization for Economic Cooperation and Development, 2014). Rates of sick leave are currently high in Sweden, but not increasing among people with mental disorders., The duration of sickness absences have however been prolonged, with the consequence that people are absent from work longer periods (Försäkringskassan, 2017). Costs for sick leave were rapidly rising towards the end of the 1990s, due mostly then to the large organizational downsizing among employers such as those in the welfare sector (SCB, 2004). Official reports show that people who were unemployed at the beginning of 1990 were still unemployed and on sick leave at the end of that decade (SCB, 2004).

The government has since then introduced national reforms and regulations in the social insurance system to create control and a balance between benefit costs and the work principle, i.e. people need to have opportunities for work, and are expected to work from a societal point of view and thereby economically support themselves (Junestav, 2007;

Försäkringskassan, 2015). The rehabilitation chain was established in 2008 as a comprehensive reorganization of sick leave management in the social insurance system which included regular assessments of work ability. (Socialdepartementet, 2007). In spite of the reforms, the cost for sickness absenteeism due to mental disorders remains high (Organization for Economic Cooperation and Development, 2014).

In the Swedish national guidelines for treatment of depression, RTW or education are emphasized as being important goals, but no research evidence exists on RTW interventions for this target group (Audhoe, Hoving, Sluiter, & Frings-Dresen, 2010; Furlan et al., 2012; Joyce et al., 2015; Karen Nieuwenhuijsen et al., 2014; SOU, 2011). Directives about how to perform support for RTW have thus not been specified (Socialstyrelsen, 2017c). The fact that people with affective disorders receive medical treatment and symptom levels decrease does not constitute sufficient prerequisites for acquiring employment (Henderson, Harvey, Øverland, Mykletun, & Hotopf, 2011; Lauber & Bowen, 2010). Many people with affective disorders are thus not engaged in work and are consequently excluded from the labour market. It has been reported that this group of people are in need of more support in order to be able to RTW than is provided at present (Adler et al., 2006; Lauber & Bowen, 2010) and there is a need of research into how to design that RTW support (Henderson et al., 2011; SOU, 2011).

The national research campaign, REHSAM, was initiated in 2009 in line with the introduction of a rehabilitation guarantee in primary and mental healthcare, to facilitate research on RTW interventions for people with common mental disorders (CMD) and/or musculoskeletal pain. The focus in this thesis, which is based on one of the projects in the national campaign, concerns the evaluation of the Individual Enabling and Support model; an advanced supported employment (SE) approach for people with affective disorders. The model is based on the evidence-based supported employment of Individual Placement and Support (IPS), an approach developed to support people with severe mental illness (SMI), foremost schizophrenia, to gain employment (Bejerholm, Areberg, Hofgren, Sandlund, & Rinaldi, 2015; Bond, Drake, & Becker, 2008; Burns et al., 2007; Modini, Tan, et al., 2016). The IPS approach is effective concerning employment outcomes, increased occupational engagement and quality of life and is recommended in the Swedish national guidelines for psychosocial rehabilitation for people with schizophrenia or other psychosis (Socialstyrelsen, 2011; Socialstyrelsen, 2017a). The model is integrated in the mental healthcare services, and together with a person-centred support, they appear to be essential components for employment success, as has been reported in

research from various countries (Modini, Tan, et al., 2016). However, implementation studies of the evidence-based SE have in a Swedish context highlighted challenges for introducing such integrated RTW support in a traditional vocational rehabilitation (TVR) context and a sectored welfare structure, due to several stakeholders having distinct organizational frames and with differing perspectives of RTW support (Bejerholm, Larsson, & Hofgren, 2011; Bergmark, Bejerholm, & Markström, 2016; Hasson, Andersson, & Bejerholm, 2011). A major point of interest in this thesis is whether an advanced SE approach focussing on enabling features could also benefit the group of unemployed people on sick leave due to affective disorders, in terms of employment achievements in comparison to support with TVR. Another focus is to identify important implementation components when introducing integrated RTW support in a TVR context.

Background

Health and occupation

A holistic and salutogenic perspective of health has been described as encompassing a process, including physical, mental, social and spiritual aspects (Eriksson, 2015). This description has a dynamic approach to health, including the assumption that people can influence the determinants of health in the surrounding environment (Eriksson, 2015). The holistic and dynamic expression is present in the World Health Organization's (WHO) definition of health promotion, where health is viewed as a resource that is essential for individuals to be able to live their lives, in contrast to the view that health is a state that individuals need to reach and accomplish (WHO, 2004). The health concept is even more elaborated in the definition of mental health according to the WHO, described as ; "…a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2004). This definition entails a self-development process and an occupational focus where well-being concerns occupational engagement, individual resources and participation as a citizen in society.

Occupation has been defined as what an individual does and is occupied with in time and space (Zemke, 2004) and the meaning an individual gives to that occupation. Occupations can be classified as work, play and activities of daily living (Kielhofner, 2008) and they can be described as being based on different activities. There is a well-known assumption in occupational therapy that individuals need to have a balance between work, play, rest and sleep to live a healthy life (Wilcock, 2015). Occupational science and therapy research have an interest in people's occupational patterns and how they perceive the occupations they perform in relation to well-being (Kielhofner, 2008). Wilcock (2015) describes that there is an interaction between what people do and how they respond to their own occupational performance that is linked to different health aspects. Among these, the meaning people experience in occupational performance is

understood as important for health and well-being (Wilcock, 2015). To perform occupations can also be used as a mean to reach a goal, thus allowing people to develop and reflect on their capacity and own value, which can initiate a change process (Kielhofner, 2008). Engaging in occupational performance is thus a process where people can gain experience of accomplishments and in this sense achieve control of their resources and limitations, in an interaction between the person, the environment and the occupation (Kielhofner, 2008). Enabling occupational engagement is established as a core competence in the profession of occupational therapy (Townsend, 2013). Providing opportunities for engaging in occupations is also underlined in the literature, referring to a societal and occupational justice perspective (Townsend, 2013). This means promoting access to participation and inclusion in society in occupations that people favour as meaningful and important (Durocher, Gibson, & Rappolt, 2014; Stadnyk, 2010). The perspective of this thesis thus follows these core assumptions and knowledge from occupational therapy and occupational science.

Work

Despite the fact that a number of factors in a work environment can have a negative impact on working people's health, the opposite has also been widely reported. Work is a source of personal development of capacities and competence, meaningfulness and personal well-being (Eklund et al., 2004; Modini, Joyce, et al., 2016). Work generates a social status and is a way of contributing to the community, at least in societies where paid work and a worker role are culturally highly valued (Waddel & Burton, 2006). Work and having a job is described as reducing depression and anxiety, promoting recovery and mental health and providing opportunities for feelings of belonging (Baker & Procter, 2014; Blank et al., 2015; Dunn, Wewiorski, & Rogers, 2008; Modini, Joyce, et al., 2016; Provencher, Gregg, Mead, & Mueser, 2002). Employment also provides an opportunity for re-gaining a worker role among people with mental disorders (Lexén, Hofgren, & Bejerholm, 2013a), which can positively influence other life roles (Modini, Joyce, et al., 2016). Moreover, work is reported to be a way of building social relationships, which can protect from ill-health (Leufstadius, Eklund, & Erlandsson, 2009). Mental healthcare consumers have described work as giving life a sense of purpose, structure and hope (Fossey & Harvey, 2010). These aspects have in turn positively impacted on the ability to maintain

employment. Work has been shown to be an essential occupational field where finding self-managing coping strategies for various work stresses were important for being able to cope with work from day to day and essential for understanding one's own needs and prerequisites (Fossey & Harvey, 2010).

Occupational engagement and quality of life

Occupational engagement and quality of life are two different ways of addressing aspects of health. While occupational engagement pertains to what people do, where and when and how they perceive meaning or not in their engagement, quality of life is an objective way of measuring the subjective perception of people's overall satisfaction with various life domains, such as their work status, private economy, relationship with family and friends and leisure activities (Bejerholm & Eklund, 2006c; Priebe, Huxley, Knight, & Evans, 1999). Well-being on the other hand, is the personal experience of one's own health (Medin, 2000). Quality of life measures are often used to capture the changes in an individual's life satisfaction prior to and after an intervention. Both quality of life and occupational engagement have shown to be important in a RTW process (Areberg & Bejerholm, 2013). More specifically, occupational engagement can be described as people's involvement in occupations throughout the day and throughout the lifespan and could in this sense be seen as a process (Morris & Cox, 2017). Occupational engagement is influenced by internal values and external environmental factors, essentially, when people engage in what they deem meaningful occupations, engagement can lead to increased well-being (Bejerholm & Eklund, 2007; Stewart, Fischer, Hirji, & Davis, 2016). For people with SMI who have participated in supported employment, having daily routines and a high level of occupational engagement at home and in the community, was associated with empowerment, and in particular with self-efficacy (Bejerholm & Björkman, 2011). Work motivation, among those from the same group, has been found to be associated to occupational engagement (SMI) (Bejerholm & Areberg, 2014).

Measurement of occupational engagement pertains to the extent to which a person engages in daily occupations and participates in the surrounding environment and can be understood and visualized through a time-use perspective (Bejerholm, Hansson, & Eklund, 2006). This can provide a picture of the individuals' psychosocial functioning in everyday life and

indicates whether there is a balance between active and restful activities, whether the occupations are meaningful, and whether occupations are performed in various environments and includes social interaction (Bejerholm et al., 2006). Time-use diaries allow for documentation of occupations, environments and reflections about daily routines of occupations, and how they unfold over the day. Occupational engagement is a way for understanding and operationalizing the link to mental health and is thus an aspect important for unemployed people with affective disorders on long-term sick leave and who want to RTW. Time use assessed occupational engagement has not, however, been commonly studied in the target group.

Quality of life has been more often researched in relation to depression severity and has generally shown to have a negative association (IsHak et al., 2012; Kuehner & Buerger, 2005; Mascha, Koeter, Bockting, Schene, & Group, 2010; Pan, Chung, Chen, Hsiung, & Rao, 2011). It is, however, significant that even when depression severity decreases, many people still report low quality of life (Angermeyer, Holzinger, Matschinger, & Stengler-Wenzke, 2002; Mascha et al., 2010; Skärsäter, Baigi, & Haglund, 2006). This could be due to being unemployed, and to factors pertaining to psychosocial domains. Social support and self-esteem were found to be strong determinants of quality of life when measured among a group of people four weeks after depression treatment (Kuehner & Buerger, 2005). Furthermore, when people with SMI participated in SE, a positive effect on overall quality of life in the domains of work, financial situation, and social interaction with friends, was reported (Areberg & Bejerholm, 2013). Moreover, having a work place and social support predicted quality of life in people on sick leave due to depression (Pan et al., 2012). Other predictive factors for quality of life in the latter study pertained to the opportunity to engage in occupations perceived as favourable, together with the opportunity to develop a sense of competence and mastery (Pan et al., 2012).

Empowerment

Empowerment is another health-related factor that is closely linked with motivation for engaging in occupations, and for people's self-efficacy in own abilities (Corrigan, 2004; Zimmerman & Warschausky, 1998). In this sense empowerment makes a difference in terms of how people view their future opportunities. Empowerment has several dimensions; a personal

psychological, an organizational and a community dimension (Zimmerman & Warschausky, 1998). The personal dimension in focus here is defined as having control over one's life and being able to make decisions in areas such as work and social relationships (Corrigan, 2004). It also refers to a person's awareness of external hindrances and opportunities when trying to achieve life goals (Zimmerman & Warschausky, 1998). Empowerment has been studied in psychiatric rehabilitation in terms of the promotion of consumer service influence (Corrigan, 2004). Even though empowerment has not been studied to a great extent regarding people with affective disorders, one study found that depression severity was associated with social withdrawal, discrimination and alienation, objective empowerment on a personal level (Brohan, Gauci, Sartorius, Thornicroft, & Group, 2011).

Work according to empowerment values in a mental healthcare perspective, entails having more of a health-related approach as opposed to an illness-related and medical approach, and supporting personal control and decision-making (Zimmerman & Warschausky, 1998) so that people on long-term sick leave can re-gain their worker role and receive access to RTW support, which is in line with a person-centred support (Modini, Tan, et al., 2016). One of the identified five areas of intervention in the Empowerment Scale is self-efficacy (Rogers, Chamberlin, Ellison, & Crean, 1997). This is thus closely related to empowerment, and pertains to the individual's psychological dimension and is highly relevant in RTW research (Andersén et al., 2015; Lagerveld, Blonk, Brenninkmeijer, & Schaufeli, 2010; Løvvik, Øverland, Hysing, Broadbent, & Reme, 2014). It has been asserted that self-efficacy is a predictor of RTW, while low self-efficacy can negatively impact duration of sick leave (Andersén et al., 2015; Volker, Zijlstra-Vlasveld, Brouwers, van Lomwel, & van der Feltz-Cornelis, 2015). Self-efficacy as a concept was developed by Bandura (1977) in the field of social psychology constituting a person's belief in his/her own ability to accomplish an action or activity. Self-efficacy is, in the Model of Human Occupation (Kielhofner, 2008), termed personal causation, or one's sense of competence, and is described as part of the volitional dimension of a person comprising values and interests. Understanding people's motivation for doing occupations thus includes an understanding of their interest in doing the occupation, the value they give to that occupation and if they believe that they have the competence and ability to perform the occupation (Kielhofner, 2008). In this sense, people influence their occupational engagement and behaviour change by their thoughts and feelings in interaction with the response they receive from the environment (Bandura, 1977; Kielhofner, 2008).

Affective disorders

Affective disorders per se; are the umbrella term for the psychiatric diseases of depression, bipolar disorder and anxiety disorder (WHO, 1993). Much of the RTW research embraces the concept of common mental disorders (CMD), which includes generalized anxiety disorder, social anxiety disorder, a combination of anxiety and depression, depressive episodes, panic disorder, obsessive-compulsive disorders, phobias and post-traumatic stress syndrome (WHO, 2004, Vingård, 2015). Exhaustion disorder is usually included when referring to CMD in Sweden (Vingård, 2015). CMD is used in this text when referring to some of the previous RTW research (Reme, Grasdal, Løvvik, Lie, & Øverland, 2015).

The study participants in this thesis are people with depression and bipolar disorder and the term affective disorders (and depression) will be used when referring to them. The rationale for using diagnoses as inclusion criteria was based on previous research of the evidence-based supported employment model for people with foremost schizophrenia or other psychoses (Bond et al., 2008; Modini, Tan, et al., 2016). It has been proposed that adjustments to the work support in the supported employment approach could be made to better suit people with affective disorders, being as support needs could differ concerning for example, initiation of work return (Bejerholm & Areberg, 2014). Depression severity and length of depressive episodes in bipolar disorder have shown to affect work ability and employment status to a greater extent than in manic episodes (Gilbert & Marwaha, 2013; Tse, Chan, Ng, & Yatham, 2014), which is the basis for their inclusion. Furthermore, somatic and psychiatric comorbidity is common in people with affective disorders which can also have a negative impact on rehabilitation and RTW (Holma, Holma, Melartin, Rytsälä, & Isometsä, 2012; Linder, Ekholm, Jansen, Lundh, & Ekholm, 2009, Zimmerman et al., 2010). The common denominators for the study participants is their long-term sick leave (>1year) due to affective disorders and unemployment status.

Having defined, psychiatric disability entails having major difficulties in performing daily activities in important life areas such as housing, work and education, leisure and social relations (SOU, 2006). This definition is not diagnosis-specific but the most common diagnoses included are psychoses, personality disorders and severe affective disorders (SOU, 2006). The term severe mental illness also refers to longstanding difficulties in psychosocial functioning (<50 on Global Assessment of Functioning scale) and a long duration of mental healthcare service use (>2years) and is commonly

associated with schizophrenia, other psychoses and affective disorders (Ruggeri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). The term severe mental illness will mostly be used when describing evidence-based supported employment. People having severe affective disorders with elements of psychoses, are not included in this study.

Work, sick leave and unemployment among people with affective disorders

Depression severity and recurrent depression prolong time on sick leave and negatively affect an individual's work ability, psychosocial functioning, cognition, work motivation and ability to engage in daily activities (Adler et al., 2006; Baker & Procter, 2014; Beck et al., 2011; Lagerveld et al., 2010). Cognitive dysfunctions could pertain to attention deficits and difficulties in processing information (Godard et al., 2011). Impairments in psychosocial functioning, for example making relationships work out well, performing home and work activities have also been reported, and those impairments had further a negative impact on the perception of quality of life domains (Godard et al., 2011; Lauber & Bowen, 2010). Depressive episodes were shown to particularly impact on work functioning in people with bipolar disorders, thereby affecting the amount of days off work and presenteeism (Gilbert & Marwaha, 2013). Furthermore, psychiatric comorbidity and several depressive episodes among people with bipolar disorder, prolong unemployment periods (Zimmerman et al., 2010). In qualitative studies, people with depression have described a difficulty to be productive at work and working slower, because of low mood and fatigue (Bertilsson, Petersson, Östlund, Waern, & Hensing, 2013) and having experiences of work-related stress (Sallis & Birkin, 2014).

People with mental disorders have generally longer sick leave duration than people suffering from somatic diseases (Försäkringskassan, 2017), and typically people with affective disorders are reported to return to work to a lesser degree than, for example, people with adjustment or anxiety disorders (Lidwall, 2015). They also appear to have an unstable employment status (Lerner & Henke, 2008) with job turnover and productivity loss (Lerner et al., 2004). Women were on sick leave due to depressive episodes to a larger extent than men in Sweden in 2017 (Försäkringskassan, 2017). At the same time, sick leave rates due to mental disorders in men are increasing. It is common for people with depressive episodes and bipolar disorder to experience relapses (Socialstyrelsen, 2017c), thus leading to periods of

absence from work one time period after the other, and having to rely on welfare benefits to a high degree (Henderson et al., 2011; Försäkringskassan, 2013). A decrease in work functioning due to previous sick leave could make it difficult for a person to initiate planning actions for job seeking because of low self-efficacy in future work and fear of RTW, which in turn could lead to an ambivalence about working (Andersén et al., 2015; Lagerveld et al., 2010; Lauber & Bowen, 2010).

Furthermore, people with affective disorders who are unemployed are in a particularly vulnerable position as there is no work place to return to and no employer support (Andersen, Nielsen, & Brinkmann, 2012; Lammerts et al., 2015; Olesen, Butterworth, Leach, Kelaher, & Pirkis, 2013). The number of people on long-term sick leave and unemployment has earlier been estimated to 17% in Sweden, however, estimating the number of people having affective disorders and unemployment or benefits, is difficult due to insufficient information (Försäkringskassan, 2013; Vingård, 2015). Unemployment has been reported as being associated with a risk for having a depressive episode (Jefferis et al., 2011). Working people with depression became unemployed five times more often at a 6-month follow-up compared to people with rheumatoid arthritis and healthy working people (Lerner et al., 2004). The authors of this longitudinal study also found an increased risk for becoming unemployed after 6 months, when participants had reported depression at the baseline measure (Jefferis et al., 2011). These results indicate the existence of a negative spiral of experiencing depression and later becoming unemployed, which has previously been reported (Lerner et al., 2004), as well as the risk for unemployment leading to poor mental health (Jefferis et al., 2011; Waddel & Burton, 2006). Furthermore, psychiatric comorbidity and several depressive episodes among people with bipolar disorder, has been shown to prolong unemployment periods (Zimmerman et al., 2010).

Factors influencing RTW

Several factors have been examined and shown to have an influence of RTW. In this previous research it is concluded that due to difficulties in psychosocial functioning and disengagement in everyday activities, supporting people with affective disorders in their RTW appear to be important in many cases (Adler et al., 2006; Hees, Koeter, & Schene, 2013; Lauber & Bowen, 2010; SOU, 2011). Apart from loss of work identity and working routines on the personal level (Lee & Kielhofner, 2010; Millward et al., 2005), factors such as sick leave duration (Riihimäki, Vuorilehto, &

Isometsä, 2015), age (de Vries et al., 2017; Lammerts et al., 2015; Waghorn & Chant, 2006), gender and depression severity (Banerjee, Chatterji, & Lahiri, 2014) can negatively impede the return to work process. However, depression severity and duration were shown not to be associated with RTW in a longitudinal study by Lammerts and colleagues (2015), as opposed to other study results (Banerjee et al., 2014; Riihimäki et al., 2015). In a longitudinal study of people with depression, an association was found between a decrease in depression severity and work functioning just as experiencing positive work outcomes decreased depression severity (Hees, Koeter, et al., 2013). This is in line with results showing that work engagement can have a positive influence on depression and anxiety (Modini, Joyce, et al., 2016). How people perceive their possibilities to RTW and if they believe in their own abilities to accomplish work performance have a strong influence on actual RTW (de Vries, Hees, Koeter, Lagerveld, & Schene, 2014; Ekbladh, Haglund, & Thorell, 2004; Lagerveld et al., 2010; Løvvik et al., 2014). Self-efficacy is stated to be a predictor of RTW, and low self-efficacy can negatively impact duration of sick leave (Andersén et al., 2015; Volker et al., 2015). Also, difficulties in learning coping strategies and avoidance of RTW (Baker & Procter, 2014), unemployment and household income , can have a negative impact, while having support from the home environment (Lammerts et al., 2015) and having a better self-rated health (Nielsen et al., 2012) are positive for RTW.

Other factors influencing RTW might pertain to the workplace and comprise adequate adaptations at work and social support from colleagues and the manager (de Vries, Koeter, Nabitz, Hees, & Schene, 2012; Lexén, Hofgren, & Bejerholm, 2013b). Having social support in terms of understanding colleagues and to be able to feel safe in the work environment may enhance RTW (de Vries et al., 2014). Furthermore, insufficient collaboration between healthcare and other stakeholders and too little attention to the RTW perspective in the mental healthcare service showed to negatively influence RTW (de Vries et al., 2014). Disempowerment in the contact with employment agencies and inability to make decisions about one's own rehabilitation has been reported and those negative experiences impeded the RTW process (Hillborg, Svensson, & Danermark, 2010).

Two approaches of RTW support

Current vocational rehabilitation is in a national and international context, often based on a stepwise approach following the underlying assumption that people on sick leave due to mental disorders need to practice their functional abilities and increase their work ability before they can return to work (Corrigan, 2001; Henderson et al., 2011). This stepwise approach to vocational rehabilitation, where people need to be assessed as being prepared enough for returning to work, has been referred to as a "train then place" model (Corrigan, 2001). It is guided by the biomedical perspective of the human being where successful symptom reduction and regaining of functions are prerequisites for returning to work (Henderson et al., 2011).

Conversely, supported employment is a person-centred and recovery-oriented service developed through the consumer and empowerment movement, highlighting the importance of letting personal preferences direct the RTW process (Slade, 2010). SE in this respect is based on a holistic health perspective, where an individual can suffer from a mental disorder but still have mental health and thereby still have access to own resources (Keyes, 2005; Slade, 2010). In this approach the individual, the employment specialist and stakeholders, including the employers, work together for a sustainable work return by integrating RTW support in mental healthcare (Drake, 2013). This method is referred to as a "place then train" approach, where job seeking starts early on in the intervention as opposed to the stepwise design, and no pre-vocational activities or practising is required before the job seeking process can start (Corrigan, 2001).

Traditional vocational rehabilitation

TVR denotes services that "-helps someone with a health problem to stay at, return to or remain in work" (Waddell et al., 2008). *Traditional* includes services typically provided from several autonomous organizations included in a sectored welfare context, in Sweden constituting of mental healthcare, employers, the Social Insurance Agency (SIA), the Public Employment Service (PES) and the municipalities. The responsibilities for TVR overlap to a certain degree, and authority collaboration is regulated concerning RTW support (SOU, 2011). This is reported to be a challenge because of distinct authority regulations and differing perspectives on RTW (Ekberg, 2015; Eriksson, Engström, Starrin, & Janson, 2008). Medical therapy and treatment are typically viewed as preconditions for vocational services,

performed in the mental healthcare sector (Henderson et al., 2011). Vocational services in turn, are provided by the PES, by offering vocational training and internship placements and the municipalities provide more sheltered vocational practise (Insp. för Socialförsäkringen, 2010).

Work ability could be described as a relative concept that can be seen in relation to the particular work a person is going to perform or, more generally, in relation to any work (Tengland, 2011). For people who are unemployed and do not have a work place to relate to, work ability is seen in relation to any work. Work ability is, however, also integrated in the social insurance system as being the object assessed in the sick leave process and in relation to insurance benefit. The current TVR follows the rehabilitation chain that entails regular assessments of an individual's work ability during the first 12 months (Socialdepartementet, 2007). An employed person's work ability is assessed in relation to his/her own working tasks or other tasks at the work place the first 90 days on sick leave and after 180 days work ability is assessed in relation to the whole labour market until day 364. The availability of suitable work is not considered at this stage in the assessment. Unemployed people on sick leave are assessed in their work ability in relation to the whole labour market from the first day of their sick leave. If people become unemployed during a sick leave period they are recommended to register to the PES. TVR for unemployed people on long-term sick leave is performed in an enhanced collaboration between officials at the SIA and the employment service together with treatment staff from the mental healthcare service. There is a strong tradition in TVR to use internships for practising the individual work ability or to participate in work introduction groups if sick leave and unemployment have been prolonged before taking the next step to find an employment (Arbetsförmedlingen, 2018). Various pre-vocational and pre-educational activities and training are provided by the employment agencies or by their contracted rehabilitation actors.

A gap in terms of work support between mental healthcare and vocational services has been reported when providing a stepwise approach to RTW, where unemployed people on long-term sick leave have not had the same access to RTW support as others (Burström, Nylen, Clayton, & Whitehead, 2011; Eriksson et al., 2008; Lerner & Henke, 2008) or access to support came late in their sick leave (Melén, 2005), which still appears to be the case (Johansson, 2011). The risk for being caught between different authority regulations, and not accessing RTW support has been confirmed in official reports (Försäkringskassan, 2016). This indicates that it is important to develop and evaluate new integrated approaches to RTW

support that could close the gap between mental healthcare and vocational services (Joyce et al., 2015).

The Individual Enabling and Support model

The evidence-based supported employment model, as presented above, integrates RTW support with mental healthcare services in a person-centred approach, thus differing from the TVR (Corrigan, 2001; Henderson et al., 2011; Modini, Tan, et al., 2016). The TVR typically uses a stepwise assessment of work ability, following regulated time limits and often several stakeholders are involved in the RTW support and coordination can be challenging. Person-centred support is, on the other hand, provided by one person, the employment specialist (ES), who coordinates the network (stakeholders, family, others) around the individual in accordance with each person's needs (Bejerholm et al., 2015; Bond et al., 2008; Burns et al., 2007). A person-centred service means that the ES and the person form a partnership in the RTW support where the person is highly involved in decisions, planning and goal-setting (McCormack & McCance, 2006). This methodology is in accordance with the holistic health perspective, where the person's resources are highlighted together with an empowering approach (Slade, 2010). The individual's preferences are in focus and job seeking starts early in the process (Drake, 2013). The enabling part of the approach, in the IES model is constituted by motivational, cognitive as well as time-use strategies. These enabling strategies are applied at the beginning of the RTW process and thereafter integrated with the SE principles, so that particular attention is given to the initiation of the RTW process in order to meet the needs of people with affective disorders (Bejerholm, 2016).

Previous research results have shown that more depressive symptoms are related to lower work motivation among people who entered a supported employment intervention (Areberg & Bejerholm, 2013). Low self-confidence is common in people with depression and is connected to personal causation and motivation (Kielhofner, 2008). In addition, long-term sick leave and depression negatively impact faith in one's own ability to RTW and accomplish work (Løvvik et al., 2014). The use of motivational strategies is to enable the person's motivation for change in relation to work and to enhance the initiation of the RTW process (Hettema, Steele, & Miller, 2005). It is also used as a method for involving the person to take an active role in the planning of the RTW (Miller, 2002). Motivational interviewing is in line with a person-centred service and a way of denoting the ambivalence for change (Miller, 2002)

Cognitive Behavioural Therapy (CBT) is recommended in the National guidelines for treatment of depression and anxiety as being an evidence-based treatment (Socialstyrelsen, 2010; Socialstyrelsen, 2017c) and cognitive strategies and MI have been proved to be a useful combination of methods in the treatment of depression (Flynn, 2011) and bipolar disorder (Jones et al., 2011). Furthermore, cognitive strategies combined with work place interventions have shown positive results in RTW for self-employed people with mental health problems due to anxiety or depression (Blonk, Brenninkmeijer, Lagerveld, & Houtman, 2006). In the current IES methodology, cognitive strategies are used to enable more functional and realistic thinking about the person's ability to work with the purpose of reinforcing work identity and keeping track of the individual working goal by using tools from behavioural activation methods (Hellerstein et al., 2015). For example, the method of "trap-and-trac" is used to identify and recognize unhelpful behaviour, with the intention of enabling behaviour change (Addis, 2004). One way to generate behaviour change is by strengthening faith in the individual's own abilities, defined as self-efficacy (Bandura, 1977). The enabling strategies also include learning coping strategies, for example, how to handle social interaction in a job seeking process or at work.

As both depression per se and long-term sick leave affect a major part of an individual's life domains (Baker & Procter, 2014; Beck et al., 2011), it is important to attend to time-use strategies in everyday life related to work to elucidate the individual's occupational engagement. Loosing motivation and routines have been described as a hindrance for how to engage in everyday activities during depression (Baker & Procter, 2014). A changed occupational pattern and loss of energy negatively impacted on the individual's initiation of daily activities and ability to sustain in an activity. Time-use methods could enhance participants' possibilities of finding a more balanced way of occupational engagement in relation to family and daily activities (Christiansen, 2005).

The evidence-based supported employment model was shown in a randomized controlled study in Sweden, to be more than three times as effective compared to TVR in terms of employment outcome and the participants gained employment five times quicker (Bejerholm et al., 2015). The person-centred support has shown in particular to have an empowering effect on the individual in the RTW, where the person can start to have confidence in his/her own abilities and have control and act on his/her vocational goals (Bejerholm & Björkman, 2011). Moreover, the contact with employers has also been shown to be facilitated with this support (Areberg, Björkman, & Bejerholm, 2013). Furthermore, health-related

outcomes, such as quality of life and occupational engagement, increased among the supported employment participants and they also scored higher on the empowerment scale (Areberg & Bejerholm, 2013).

Implementation challenges

The provision of evidence-based interventions has been stated as an essential goal for all healthcare services today (Tansella & Thornicroft, 2009), but it is not clear how new models are to become routine work in the services and new interventions become practice (Durlak & DuPre, 2008). Implementation research of evidence-based interventions in healthcare and the challenges that might be brought has thus been prioritized by governments and authorities (Moore et al., 2015). Using fidelity ratings, by assessing if the intervention is performed as intended, is one way of measuring implementation (Becker, Swanson, Bond, & Merrens, 2008). High fidelity ratings when evaluating evidence-based SE are said to be related to the RTW intervention (Bond, Drake, & Becker, 2012) and implementation outcomes (Markström, Svensson, Bergmark, Hansson, & Bejerholm, 2017), and as such it is also important to study fidelity together with critical components linked to the implementation context (Damschroder et al., 2009; Durlak & DuPre, 2008). Implementation research has been reported as still being rare in mental healthcare and more studies on how to turn evidence into practice in complex healthcare services have been encouraged (Campbell et al., 2007; Moore et al., 2015; Tansella & Thornicroft, 2009). Providing evidence-based interventions is a matter of quality for the service users in healthcare (Campbell et al., 2007), and it is thus essential to evaluate factors of importance when introducing the IES model in mental healthcare and in collaboration with other welfare actors.

There are several studies that report implementation hindrances potentially occurring at different levels in an organization; the individual, team or organizational levels, and in differing phases (Damschroder et al., 2009; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Meyers, Durlak, & Wandersman, 2012). A number of critical steps and components have been recommended for attending to in the process, of which some can have a compensatory effect (Fixsen, Naoom, Blase, & Friedman, 2005; Meyers et al., 2012). A thorough planning of the implementation, education and continuous training and supervision of the providers has been emphasized, as is the leadership (Fixsen et al., 2005; Markström et al., 2017). The intervention itself and its complexity can also affect the uptake

of knowledge, just as the relative advantage of the intervention compared to other models provided and its compatibility to existing ideology also need attention (Bhattacharyya, Reeves, & Zwarenstein, 2009; Durlak & DuPre, 2008). The recruitment of so called champions, people who are very knowledgeable about the intervention and its implementation, is crucial, as well as the engagement of opinion leaders or key persons in the team driving the implementation (Damschroder et al., 2009).

When evaluating evidence-based supported employment in several Swedish municipalities; established networking, a flexible approach to the intervention and creative collaboration between mental healthcare services, the municipality and employment agencies was reported as enhancing the implementation in some local contexts (Bergmark et al., 2016; Markström et al., 2017). However, the implementation failed in terms of sustainability where networking and collaboration did not work out well and local financing of the intervention was lacking. Implementation of evidence-based supported employment has also been reported as being difficult to establish in a sectored welfare context (Bejerholm et al., 2011; Bergmark et al., 2016; Hasson et al., 2011). Different perspectives among welfare authorities and employment specialists of how to best support RTW, hindered the implementation, while the integration with mental healthcare services was sufficient (Bejerholm et al., 2011).

The meta-theoretical Consolidated Framework of Implementation Research (CFIR) has been proposed as a guiding tool in the planning and evaluation of implementation outcomes (Damschroder et al., 2009). This framework allows for the analysis of different factors, which affect the introduction of a model within the implementation context studied. The framework comprises five domains; the intervention characteristics, the inner and outer setting, the individual characteristics and the process (Damschroder et al., 2009). Each domain has several sub-components and together they encompass a broad spectrum of critical implementation components, such as: relative advantage, adaptability, networks and communication, leadership engagement and compatibility or model fit within a system. This framework appeared to be particularly suitable as a guiding tool in the implementation study in this thesis due to its comprehensive nature and the outer setting domain containing the component of cosmopolitanism, i.e. collaboration between the host organization and other organizations, which is an essential component in a RTW process.

The IES model, comprising an advanced SE approach is a new integrated RTW support, which was introduced in the TVR structure in this research project. Merging the two approaches of IES and TVR could generate an implementation challenge as has been referred to previously (Bejerholm et

al., 2011). It is thus essential to investigate and identify important factors when implementing a novel SE approach in the mental healthcare service for people with affective disorders in the TVR context.

Rationale

It has not as yet been clarified whether advanced supported employment is an effective way for RTW for people with affective disorders (Reme et al., 2015, Hellström et al. 2017). Previous research has been focussed on symptom reduction and self-management of affective disorders in favour of studying integrated RTW support in mental healthcare service and very few studies have included RTW as an outcome (Ejeby et al., 2014; Joyce et al., 2015; SOU, 2011). Considering the research reporting that people with affective disorders are in need of RTW support and that there is a research gap regarding evidence-based RTW models for this target group, it appears important to evaluate advanced and new interventions. Previous research of RTW interventions, of which some combined treatment and work place interventions, has shown promising results, as has depression prevention at the workplace (Hees, de Vries, Koeter, & Schene, 2013; Modini, Joyce, et al., 2016; Reme et al., 2015; SOU, 2011). Integrated CBT and work support based on supported employment has also been reported to be effective in terms of increasing work participation among people on sick leave due to anxiety or depression in Norway (Reme et al., 2015). Another study showed the opposite result however, when providing modified supported employment for people recently diagnosed with depression and anxiety (Hellström et al. 2017). Given these inconclusive results, it is essential to evaluate the effectiveness of the IES model in terms of employment outcomes being as it has not been performed among people with affective disorders previously in Sweden. It is also important to describe and study the target group in terms of health-related factors because people with affective disorders who are unemployed constitute an exposed group in relation to vocational services and opportunities for employment.

Furthermore, how to support people with affective disorders to increase their RTW self-efficacy has not been extensively investigated and thus there is a need for more knowledge and explanations of important mechanisms that can facilitate the RTW in this respect. Obtaining information of a qualitative nature about aspects of complex trials is essential for the understanding of the constituents of new effective methods (Campbell et al., 2007). Finally, integrating RTW support in mental healthcare, and

coordinating this support in a TVR context, has been reported to meet implementation challenges (Bejerholm et al., 2011). Implementation issues and important components in such a process thus need further attention. In these respects this thesis adds to the knowledge of the effectiveness of advanced supported employment models for people with affective disorders, how the IES model is provided and perceived, and how it may be delivered in a TVR context.

Thesis aim and specific aims

The overarching aim of this thesis was to evaluate an advanced supported employment model, the Individual Enabling and Support, for people with affective disorders who are unemployed, in order to gain greater knowledge of the model's effectiveness and qualities. This included a special focus on return-to-work needs in this target group, the enabling strategies which have been added to the evidence-based supported employment model and implementation components.

The specific aims were:

Study I

The aim of Study I was to examine the relationships between depression severity and the health related factors of empowerment, quality of life, occupational engagement and work aspiration. Included in the aim was also to study and describe the target group, people on long-term sick leave due to affective disorders who are unemployed, according to sociodemographic and clinical characteristics.

Study II

The aim of Study II was to evaluate the effectiveness of the Individual Enabling and Support model in comparison to traditional vocational rehabilitation regarding the primary vocational outcome of employment rate, and the secondary vocational outcomes of internship, pre-vocational training and education. In addition the aim was also to investigate the number of worked weeks, hours per week and total working hours. Health related secondary outcomes were evaluated for depression severity and quality of life.

Study III

The aim of Study III was to illustrate the model and process of the Individual Enabling and Support approach in terms of content and direction of the participant's RTW processes. This also included illustrating important characteristics that influenced the processes of the five cases.

Study IV

The aim of Study IV was to investigate important characteristics in the implementation of the Individual Enabling and Support model according to the Consolidated Framework of Implementation Research. This included examining how important components could facilitate or hinder an implementation process of the model in a traditional vocational rehabilitation context, in order to understand what measures need to be taken for implementation.

Material and methods

The research context of this thesis entailed a RCT design, following the Consort guidelines for non-pharmacological interventions (Moher, 2012). Furthermore, cross-sectional and case-study designs were used (Yin, 2014).

An overview is presented in Table 1.

Table1: An overview of study design, participants, data collection and analyses

Study	Study design	Participants	Data collection	Data analyses
Study I Association	Cross-sectional	Participants with affective disorders recruited in mental healthcare, n=61	*MADRS-S, MANSA, ES, POES, Work aspiration (WRI), ASRS, KEDS, Audit, GAF	Descriptive and correlation statistics, logistic regression analyses
Study II Effectiveness in terms of employment	Randomized Controlled Trial	Participants with affective disorder recruited in mental healthcare, n=61	Employment status, internship, education, prevocational act/training, weeks and hours working, MADRS-S MANSA	Student's independent t-test, Mann-Whitney U-test, Pearson χ^2 or Fischer's exact test, Wilcoxon Signed-Rank test or Mc Nemar's test, Cramer's phi or Cohen's d
Study III IES model and process	Multiple case study	Purposeful sample, 5 participants and 2 Empl. Spec., n=7	Semi-structured interviews, SE-profile and plan, text material	Content analysis, within- and across-case analyses
Study IV Implementation	Embedded case study	Purposeful sample, key informants,n=19	Semi-structured interviews, text material, meeting protocols	Directed content analysis, Consolidated Framework of Implementation Research

*MADRS-S; the Montgomery-Åsberg Depression Self Rating Scale, MANSA; the Manchester Short Assessment of Quality of Life Scale, ES; Swedish version of Empowerment Scale, POES; Profiles of Occupational Engagement in people with Severe mental illness, Working life aspiration item (WRS) Worker Role Self-Assessment Scale, ASRS; Adult Attention Deficit and Hyperactivity Disorder Self Report Scales, KEDS; Karolinska Exhaustion Disorder Scale, AUDIT; the Alcohol Use Disorders Identification Test, GAF; Global Assessment of Functioning Scale

Study context

The current research project was conducted at four mental healthcare service units in the County Council of Skåne in southern Sweden between the years 2012-2014. The participants were recruited in geographically diverse mental healthcare services covering 16 municipalities with a population range of 18 000 - 41 000 inhabitants, and in total approximately 120 000 inhabitants. The selection of mental healthcare service units was determined by the research project steering committee (see below), based on the services providing outpatient treatment for people with affective disorders, a representation of rural and urban areas and the notification that no other research project was ongoing when the project started.

The mental healthcare services provided with one or two multidisciplinary teams responsible for people with affective disorders. The teams consisted of medical doctors, nurses, psychologists, social workers, occupational therapists and physiotherapists as well as administrators. Individual treatment was the most frequently provided for of treatment, but treatment in groups also occurred. The Social Insurance Agencies had different geographical catchment areas serving a number of the mental healthcare service units, while the local Public Employment Services were most often locally situated comprising small to large offices. The research project was financially supported by REHSAM, Forte and Region Skåne.

Procedure

The IES model was developed on the basis of the evidence-based supported employment model of Individual Placement and Support, by the principle investigator (PI) of the research project, in collaboration with a clinical psychologist. The thesis author was recruited in 2011 and had responsibility of organizing and conducting information meetings in the mental healthcare units and the SIA and PES offices, coordinating information about the research project and organizing the recruitment of participants. The employment specialists, the professionals performing the RTW support, were recruited for the project on a time-limited basis of 2 years. Three employment specialists were needed, having a case load of approximately 20 participants each when the aim was to include 120 participants in the project. However, 63 participants were randomized for the intervention, following that two employment specialists were employed. One of them was an occupational therapist by profession and one was a former case worker at the Public Employment Service. They were trained in

supported employment methodology and specifically in the IES model in a three-week period by a cognitive behaviour therapy (CBT) psychologist, a certified motivational interviewer, an occupational therapist and an employment specialist. They were then continuously supervised throughout the project by the CBT psychologist and by two experienced employment specialists. The training of the IES model concerned techniques for motivational interviewing, cognitive behavioural strategies in relation to job seeking and work performance as well as time use assessments and strategies for balancing everyday life. Tools and instruments pertaining to the methods were introduced and tested during these three weeks. The training also consisted of background information of the principles of evidence-based supported employment and previous research. Case examples were studied and discussed with experienced employment specialists, who also gave advice in practical matters of the SE principles, for instance building employer networks. Two research assistants were employed to collect data by means of assessments and self-reported measurements by the participants. They were both occupational therapists by profession with experience of working with the target group and using instruments and they received training in the specific instruments used in the data collection.

The research project was run at the local level by a research steering committee from the County Council of Skåne, in which a project leader, head and strategic planner from the healthcare, SIA and PES were part. The PI together with a collaborating senior researcher met with the strategic planner and heads of the County Council mental healthcare services, SIA and PES to establish contact and inform about the research project. A project administrator (the thesis author) continued together with the researchers, to provide information to the mental healthcare service units, SIA and PES offices prior to the start of the participant recruitment. Firstly, the four first line managers of the mental healthcare service units were informed and thereafter two or three staff meetings were performed at each unit. Secondly, four first line managers from the PES offices were informed about the research project and thereafter the staff attended scheduled information meetings. Within the SIA organization, the head from the southern district in Sweden was assigned first and then first line managers covering the mental healthcare services' catchment areas were informed as well as the staff at the SIA offices.

Inclusion criteria and recruitment of participants

The main criteria for participant inclusion in the research project and thus in the four studies were: having an affective disorder, defined in accordance with ICD-10 (WHO, 1993) and diagnosed by a psychiatrist at one of the mental healthcare services; including depressive episode (F.32), recurrent depression (F.33, F.33.1), bipolar disorder (F.31, F.30) including depressive episode. Further inclusion criteria were: age, 18-63 years, expressing a desire for employment, being able to communicate in Swedish since instruments were written and interviews were held in Swedish, having been unemployed during the previous year, attending an information meeting at the mental healthcare centre and receiving treatment at the mental healthcare service. The exclusion criteria were: having a severe alcohol or drug abuse and having a somatic illness or disability that could intervene with the experimental factor, the IES model.

Participants were recruited at the four mental healthcare services during an 18 month time-period. Regular information meetings were held by the project administrator, where persons interested in participating could attend together with staff from the mental healthcare service, a relative or a friend, if desired. Information about the time and place for the meetings and the project was announced in the waiting room at the centres by posters and brochures as well as on a web-site. Information was provided about the nature of the project, the IES intervention, when interviews would take place and the randomization procedure into two groups and related study design at every meeting. Information about ethical considerations, the voluntary basis for participation and informed consent was also provided. The meeting attendees who had an interest in participating in the study project could either decide to complete the informed consent form afterwards or return for the next meeting after consideration. There was also the possibility of contacting the project administrator by telephone or e-mail. Individual information meetings were provided if necessary. Information about the IES project could also be given by staff at the mental healthcare services. Introduction letters were sent from two of the mental healthcare services to persons with affective disorders receiving medical, psychological or other treatment at that centre in order to be able to access prospective participants. Sending these information letters could not be prioritized from the other two mental healthcare centres. Furthermore, advertisements with information about the IES project and how to contact the project administrator were published in a free, daily newspaper, as an attempt to reach more people in the target group receiving treatment in the mental healthcare services.

The people who expressed a desire to participate in the study and who submitted the written informed consent were contacted by a research assistant to meet for the baseline interview. Interview dates were agreed upon by the participant and the research assistant. If the participants needed to postpone a date or the participants were difficult to get in contact with, the research assistant telephoned or e-mailed three further times and re-scheduled. If, however, participants had not come to the interview after three appointments, they were not enrolled in the study trial. Fourteen persons decided not to attend the baseline interview due to uncertainty about wanting to gain employment or not and about engaging in the study project. Two participants were excluded after having attended baseline interview in accordance with the exclusion criteria. One of them disclosed having multiple sclerosis and being a regular user of an electric powered wheelchair and the other had a diagnosis of obsessive compulsive disorder and thus did not fulfil the diagnosis inclusion criteria. This person had not been fully aware of the diagnosis but referred to feeling depressed. The final sample consisted of 61 participants. Socio-demographical, clinical and vocational characteristics of the participants are shown in Table 2.

Table 2: Baseline characteristics of study participants (*n*=61)

Socio-demographics	**N(%)**
Female/male	44 (72)/17 (28)
Age in years, mean (SD)	41 (10)
Civil status	
Married/not married or divorced	20 (33)/30 (49) or 11 (18)
Cohabiting/living alone (n=60)	30 (49)/30 (50)
Have children, yes/no	37 (61)/24 (39)
Educational level	
Comprehensive school	9 (15)
6th form college	33 (54)
College/university	19 (31)
Country of origin (Sweden)	56 (92)
Clinical characteristics	N (%)
Depression/bipolar disorder	42 (69)/19 (31)
Illness episodes, mean (SD) (n=47)	6 (9)
Hospital admission, mean (SD) (n=59)	2 (5)
Comorbidity	Median (min–max)
ASRS1 (inattention) (n=61)	20 (1–31), cut off score <17 and >24
ASRS2 (hyperactivity) (n=61)	15 (2–29), cut off score <17 and >24
AUDIT (alcohol use) (n=61)	2 (0–10), cut off score >6 (women) and >8 (men)
KEDS (exhaustion) (n=61)	26 (9–49), cut off score >19
GAF (functioning) (n=55)	59 (42–77)
Somatic disease yes/no (n=42)	23 / 19
Income and benefit characteristics	N (%)
Income in Euros, mean (SD) (n=50)	EUR 1032 (456)
Sick leave	29 (47)
Welfare benefit	41 (70)
Other	19 (30)

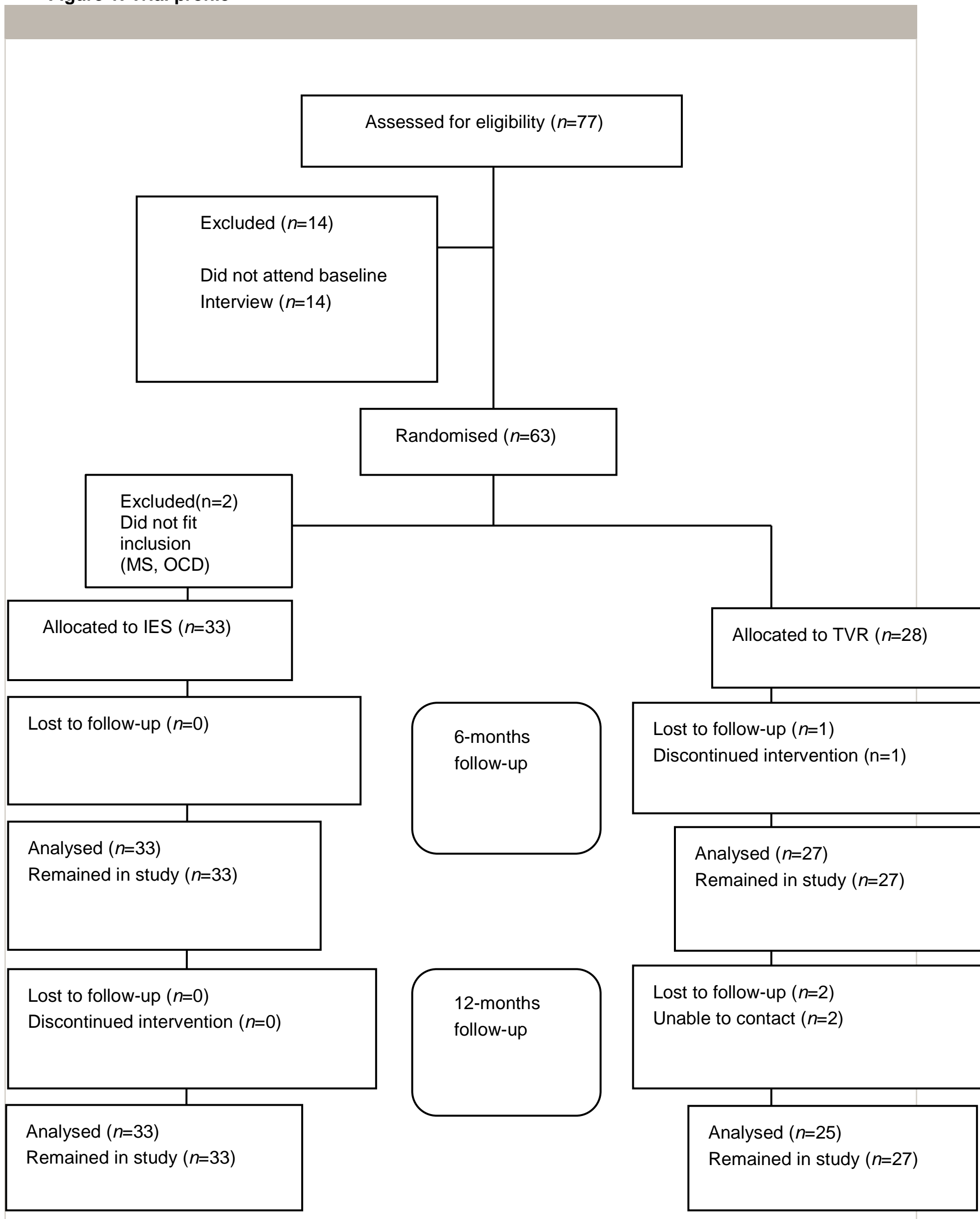
Randomization

The cross-sectional study and the randomized controlled trial included all participants (n=61). The power calculation of the randomized controlled trial was based on previous studies comparing employment rate differences in people with severe mental illness participating in supported employment (Bejerholm et al., 2015; Burns et al., 2007; Cook et al., 2005; Drake et al., 1999). In order to detect a medium effect of employment rate, when the alpha was set to 0.05 with a power of 0.80 (Cohen, 1988), the sample size was estimated to between 11 to 42 participants in each group. Based on a

recent conducted study of supported employment, 60 participants in each group were estimated to be sufficient when the risk for attrition was attended to. The final number of participants recruited was 77, of whom 63 attended the baseline interview and were randomized to either the IES group or the control group.

The randomization was performed by an independent researcher who did not have any contact with the participants and was not involved in the intervention. A software programme was used for the randomization process, in which the allocation to either group was performed according to block sizes of eight numbers each time (Dallal, 2015). Participant distribution of the groups was moderately uneven, which is explained by the block sizes originally being estimated to include 120 participants. Thirty-three participants were assigned to the IES group, and 28 to the TVR group. The researchers had no knowledge of the participants' identities or group allocation. The group allocation could not, however, be blinded for the professionals performing the intervention. No participant was lost to follow-up interviews in the IES group. In the TVR group, one participant was lost to follow-up at 6 months and two more were lost to the follow-up at 12 months. Analysis of differences between participants lost to follow-up or not within the TVR group did not reveal any significant results. Trial profile is illustrated in Figure 1.

Figure 1: Trial profile



Intervention groups

IES

The IES intervention was performed by the two employment specialists with a case load of 16 and 17 participants respectively. The employment specialists were located at two mental healthcare services each from start but later shared the responsibility in the largest service to even out the number of participants to support. The participants in the IES group received RTW support from the employment specialist who coordinated and worked together with the participant and the mental healthcare service, PES, SIA, family and employers, in accordance with the ten IES principles. The first and second principles are added to the already existing principles of evidence-based supported employment and correspond to the enabling part of the support. The first principle concerns how to deal with the change and progress in coping strategies and the second relates to time-use strategies that can assist work. The IES support starts with the first two principles but is later integrated with the other principles as an overarching support and not following any particular order. Accordingly following principles guided the employment specialists:

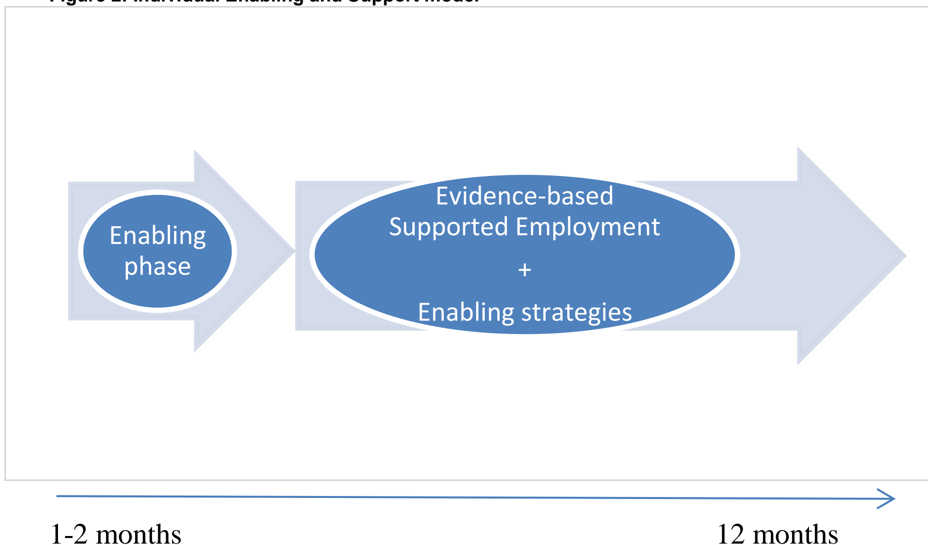
1. Handling change and developing cognitive strategies
2. Having a time use pattern that supports work
3. Eligibility according to participant's own choice to work, i.e. work ability assessment is not necessary prior to entering the intervention
4. Job seeking is based on participant's interests, values and preferences
5. The primary goal of the support is competitive employment
6. Integration of IES in the mental healthcare
7. The job seeking process starts early in the intervention
8. On-and off-work site support and accommodation are continuous
9. Authority guidance and counselling of economic benefit
10. Continuous recruitment and networking with presumptive employers

(Bejerholm, 2016; Drake, 2013)

Meetings between the employment specialist and the participant were initially conducted either at the mental healthcare service or in a public place, for example at a café or library. Support was provided regularly in accordance to the participants' personal needs and preferences. The IES model can be described as comprising the enabling phase where motivational, cognitive and time-use strategies are mobilized, and the participants' career profile and plan are completed. Secondly, the supported employment phase starts with job seeking and the enabling strategies are

integrated with the supported employment. As an approximation, the first phase last for 1-2 months. This phase involve a duration of support, approximated, to 1 hour per week. Job seeking lasts until employment is achieved in the second phase, and work support lasts as long as there is a need for this, with a time requirement of 20-30 minutes per week. The IES model is shown in Figure 2.

Figure 2: Individual Enabling and Support model



TVR

Participants in the TVR group had different types of support during the intervention time period, from the mental healthcare service, the PES and SIA services and the municipality. The services included treatment and medical rehabilitation, prevocational activities and training according to social or unemployment insurance regulations. In order to provide a picture of intensity and duration of the TVR support, an approximation is described. The support followed the stepwise approach concerning work ability assessments and increasing work ability, first in mental healthcare, which was approximated to 1 hour per week. Next, work ability assessments were performed by the SIA service or by both SIA and PES services in an enhanced collaboration. If work ability was assessed as being less than 50% the participants were recommended vocational training in the municipality, approximated to between 5-20 hours per week where support was accessible

during this time. Prevocational training and education were also provided in the enhanced collaboration of SIA and PES, at 10-20 hours per week. The last step involved internship placements, at 20-40 hours per week. These internships could lead to employment.

Selection of participants in Study III

The participants for study III were selected in two steps and in accordance with the study aim of illustrating the IES model and process from several perspectives in a multiple-case design. Firstly, participants from the IES group, who had participated for 12 months, were considered. Secondly, five participants were selected according to a replication logic (Yin, 2014), based on the assumption that the participants could be supported in increasing faith in their own ability to return to work by using the IES model. Moreover, diversity was considered in terms of education level, work experience, employment status after 12 months, family situation, employment specialist and length of sick leave period, in order to achieve rich data. The participants were selected and contacted with support from the employment specialists. The interviews took place either at the mental healthcare service unit or at a work place, according to the participant's preference. Furthermore, the two project employment specialists participated as interviewees.

Selection of participants in Study IV

The aim in study IV was to investigate the implementation of the IES model and participants were selected according to the purpose to illustrate this process from several perspectives and thus various levels of the organizations involved in the project (Berg, 2012). In a first step, relevant organizations were identified, i.e. the four mental healthcare service units, the county council administration, current social insurance agencies and local public employment services. In a second phase, key informants from various levels in the above organizations were selected. The selection aimed to include key informants who had been involved in decisions about the implementation and/or who had been working in the IES intervention. An introduction letter describing the aim of the interview and the voluntary commitment in the study was sent to prospective participants prior to contact via telephone or e-mail. Six key informants could not be reached for an interview or disagreed to participate due to job turnover in several of the

organizations during the project. A total of 19 key informants were included and informed consent was collected from them all. Thus, the head of mental healthcare, employment specialists, first line managers in the mental healthcare services, staff including opinion leaders in the mental healthcare services, strategic planner and project leader from the County Council , first line managers and handling officers from SIA and PES were selected.

Data collection

Studies I and II

Data was collected for Study I and II by using several instruments at three points in time, at baseline (Study I and II), at 6 and at 12 months (Study II), between the years 2012 - 2014. Data on gaining employment or starting education, internship or pre-vocational training was collected every third month by the research assistants.

Montgomery and Åsberg Depression Self-rating Scale (MADRS-S)

The Montgomery and Åsberg Depression Self-rating Scale, MADRS-S was used for measuring depression severity. The instrument consists of nine self-rating questions (mood, sleep, appetite, feeling of unease, concentration, emotional involvement, initiatives, pessimism and zest for life) and is psychometrically sound (Montgomery & Asberg, 1979). Every question is graded from 1-6 and the sum score ranges from 0 to 54 points. Scores ranging between 0-12 points indicate no or very light depression, scores ranging between 13-19 indicate light depression, 20-34 points indicate moderate depression and >35 points, severe depression.

Empowerment Scale

The Empowerment Scale (Rogers et al., 1997) is reported to have good psychometrical properties. The Swedish version was used in this study. Following statements are addressed in five subscales; self-efficacy/self-esteem, power/powerlessness, community activism, righteous anger, optimism/control over the future. The respondents rate on a scale in accordance with 'strongly agree=1' to 'strongly disagree=4'. Sum score is calculated and ranges between 28 to 112 points where a higher score equals with a higher notion of empowerment.

Working life aspiration

To assess respondent's individual aspiration to work, one item from the Worker Role Self-Assessment Scale was used. In this item the respondent's belief in a future working life is addressed, which has been reported to be a predictor of such aspiration (Ekbladh et al., 2004).

Profiles of Occupational Engagement in people with severe mental illness (POES)

Occupational engagement was measured by POES, which has shown good psychometric properties and is described as a generic instrument and as such is not diagnosis specific (Bejerholm et al., 2006; Bejerholm & Lundgren-Nilsson, 2015). POES was, however, developed among people with schizophrenia and thus Cronbach's alpha was calculated for the target group in this thesis, resulting in α=0.923. Despite a sound alpha, there was a tendency for ceiling effect in some items as the ratings exceeded 20% for 'continuously engaged'. The instrument comprises two parts, first a time-use diary for a 24-hour period, which is self-administered by the respondent and focuses occupations, the social and geographical environment as well as reflections about the performed occupations. Secondly, the time-use diary is objectively assessed in relation to nine items on a four point scale. These address balance of daily rhythm of activity and rest, the variety and range of occupations, time spent in various social and geographical environments, dealing with social interplay, and reflections on occupational experience, perception of meaningful occupations, routines and initiations of activities (Bejerholm et al., 2006). The sum score ranges between 9-36 points, where a higher score relates to a higher occupational engagement.

The Manchester Short Assessment of Quality of Life (MANSA)

To collect data on subjective quality of life, the Swedish version of MANSA was employed. It is psychometrically tested with good result (Bjorkman & Svensson, 2005; Priebe et al., 1999). MANSA includes 12 items about an individual's perceived satisfaction with various life domains. These are rated on a 7-point scale: '1=could not be worse', to'7=could not be better'. Sum score is calculated to 12-84 points. The domains of the instrument refer to satisfaction on life as a whole, private economy, friends and family relations, leisure activities, living conditions, physical and mental health, safety, sexual life and fellow residents.

Global Assessment of Functioning Scale

Psychosocial functioning was measured using the GAF instrument. GAF is commonly used clinically and is psychometrically sound (Pedersen & Karterud, 2012). The instrument combines symptoms and functioning with a score referring to psychological, social and occupational functioning. The scores range from 1 to 100, where a higher score indicates fewer symptoms and a better psychosocial functioning. The trained research assistants conducted this assessment.

Sociodemographic, clinical and comorbidity characteristics

A questionnaire was developed for Studies I-II, including sociodemographic and clinical characteristics and three instruments on comorbidity were used. Mental health diagnosis was determined by the participant's medical doctor and validated in medical records. The questionnaire included variables such as age, gender, education, civil status, mental health service, illness episodes, vocational status and income.

The Alcohol Use Disorders Identification Test (AUDIT) was used as a self-report of use and misuse of alcohol (ref). The measure instrument consists of ten questions with scores ranging between 0-4 points. The sum score is between 0 and 40. As reported by Bergman and Källmén (Bergman & Källmén, 2002), cut off scores are set as hazardous use >6 for women and >8 for men. The instrument is tested for good internal reliability and test-retest results.

To screen for attention and hyperactivity disorders, the Swedish version of Adult Attention Deficit and Hyperactivity Disorder Self Report Scale was used (Konstenius et al., 2015). This instrument comprises 18 items relating to symptom frequency with a score between 0-4 points. Highest sum score is 72. Symptoms of inattention are measured in nine questions and the other nine refer to hyperactivity. ADHD is indicated to be unlikely if sum score is <17, while a sum score >24 in either subscale indicates a probability of ADHD (Konstenius et al., 2015).

Karolinska Exhaustion Scale was an instrument used to screen for exhaustion disorder (Besèr et al., 2014). The instrument consists of nine questions referring to concentration, memory, physical and mental stamina, sleep, recovery, hypersensitivity to sensory impression, demands experience and irritation/anger. The scale ranges between 0-6 with a sum score of 54 points. A cut off score is reported to 19 points as for discriminating between absence or presence of exhaustion disorder (Besèr et al., 2014).

Study III

A semi-structured interview protocol was created and used, in combination with intervention documents and memos, in order to answer the study's research questions. The questions aimed at capturing the areas of perceptions of the IES intervention, process and received support. The questions to the employment specialists focused on support strategies in relation to the participants and reflections on the IES processes. The interviews were performed by the thesis author and took approximately 60 minutes each. Intervention documents comprised the SE Profile and SE Plan as well as documentation from the enabling phase, such as protocols from MI and CBT strategies and time-use diaries. Memos consisted of notes taken during the employment specialist's supervision sessions. The SE Profile targeted the participant's work experience and preferences, education, family and resources and the SE Plan is a document of work goals and sub goals, activities needed to attain goals, resources and hindrances of goal attainment. Time for work documentation consisted of time-use diaries from past, present and future, and these were used to set realistic time-use goals to accommodate a working life. MI documents included a motivation-to-work ruler, pros and cons of a working life and decisions taken for making a change or not as well as documentation of participant's faith in own ability to work. CBT-strategy documents included behavior change plan and focused on areas for change, plans for how to attain change in that area and identification of matters triggering avoidance of activity and finding alternative coping strategies. The interviews and the documents together represented detailed data of the participants' IES processes. Data material used in Study III is presented in Table 3.

Table 3: Data material used in Study III

Document	Description
Transcribed interviews	Interviews with participants and employment specialists.
Memos	Notes taken during supervision sessions.
SE profile (Career profile)	Information about education, work experience, interests, resources, family, mental health disclosure, work preferences
SE Plan (Job development plan)	Work goal setting, sub-goals, resources/hindrances, activity to reach goal.
Time use-diary: Covering activities, environment and personal factors, change plan	Past, present and future time-use diaries are recorded. Discrepancy between diaries is analysed to set realistic time-use goals in relation to work.
MI strategies: Motivation to work ruler, Decisional balance exercise, change plan	Pros and cons of working or not working, faith in own ability to work, pros and cons of making a change or not.
CBT strategies: Behaviour change plan, “trap and trac”, circumstance and consequence	Setting change area/behaviour, reason for change, steps needed to accomplish change, identification of situation-based triggers leading to avoidance pattern – identification of alternative coping (trap and trac).

Study IV

Study IV addressed the implementation process of IES and data was collected throughout the study project. Data consisted of protocol documentation of start-up meetings and steering committee meetings, as well as memos and semi-structured interviews with key informants from mental healthcare services, county council representatives, social insurance agencies, employment services and employment specialists together with fidelity ratings at 6 and 12 months. Text and memos from meetings included decisions taken during project planning and reflections of the implementation and collaboration process from the research group. An interview guide for the semi-structured interviews was prepared following the Consolidated Framework of Implementation Research (CFIR) as a guiding model to target critical areas in an implementation. It aimed to

capture following domains: intervention components, outer setting, including other collaborative organizations, inner setting referring to norms and values of staff, changing climate and leadership, characteristics of the individuals and the implementation process itself. Nineteen key informants were interviewed. The questions were slightly modified depending on which organization the key informant represented as not all informants had been equally involved. The interviews were performed by the thesis author during the last 6 months of the research project and each lasted between 40 and 75 minutes. Fidelity measures were performed by means of the Supported Employment Fidelity Scale (SEFS) (Bond, Becker, Drake, & Vogler, 1997) by the PI. The instrument consists of 25 questions referring to the areas of organization, staff and service. Three questions were added to the instrument in order to cover the IES service. All items are rated on a 5-point scale and the sum score ranges between 25-125 points (Becker et al., 2008). A sum score of <73 refers to 'not IPS supported employment', 74-99 refers to a 'fair fidelity', 100-114 reflects 'good fidelity' and a sum score of 115-125 refers to 'exemplary fidelity'.

Data analysis

Various methods were used for data analyses depending on study design and level of measurement. Quantitative analyses were performed using IBM SPSS software, version 22 and SAS statistical software, version 9.2. Significance level was set at $p<0.05$.

Study I

For the presentation of the sociodemographic and clinical data, descriptive statistics were applied and non-parametric statistics were used for ordinal data. Correlations were tested between depression severity and health related psychosocial variables by means of Spearman's rank correlation test. To control for differences between depression and bipolar disorder groups, Mann-Whitney U-test was used. Multiple logistic regression analysis was applied for associations between the dependent variable of depression severity and the independent variables of empowerment, quality of life, aspiration for work and occupational engagement. Depression severity was dichotomized to no or light depression and moderate to severe depression based on the median value of

the group. Multicollinearity was calculated according to a variance inflation factor score (VIF) and multicollinearity was assumed if VIF was >5.

Study II

In study II the groups of IES and TVR were compared according to various variables. For normally distributed interval data Student's independent t-test was used, Mann-Whitney U test was used for ordinal data and Pearson $\chi 2$-test/Ficher's exact test were applied for nominal data. Within group differences were calculated by means of Mc Nemar's test for nominal data and Wilcoxon signed-rank test for ordinal data. For the binominal proportion of having employment or not, confidence intervals were presented (95%) and calculated according to a small sample size by an exact confidence interval test (Chan & Zhang, 1999). Calculations of worked hours/week, hours and weeks in total were conducted; mean differences were bootstrapped due to a skewed distribution and the small sample size. Missing data on hours and weeks were imputed with zero. Cohen's D was used for calculating effect sizes of means. Effect sizes of proportions of employment, education, internship and prevocational rates, Cramer's Phi were applied (Cohen, 1988).

Sensitivity analysis was performed for missing follow-up data for employment rate, applying a best (employed) and worst (unemployed) scenario (Kazdin, 2010). Adjustments for potential confounders at 12 months were controlled for using logistic regression models. The independent variables age, gender, diagnosis, work experience, age at first contact with mental healthcare service and alcohol use were included. Time to employment was calculated by means of Kaplan-Meier survival analyses, and differences between groups regarding time to employment was analysed according to Cox proportional hazard regression model.

Study III

Data was analysed in a stepwise manner. The audiotaped interviews were listened to several times thereafter the transcriptions were read repeatedly case by case. Interviews with employment specialists added information to the five cases throughout this process. Information from the SE Profile and Plan, enabling documents and memos were also analysed to give further details of the IES processes. Within-case analyses (Yin, 2014) were conducted, first by drawing flowcharts of case processes and referring to the

various strategies used and time line for the support. Following that, each case report was created and described. Cross-case analysis was performed using all data to identify similarities in case profiles of perceived support and influences of the return-to-work processes. Inductive content analysis inspired by Graneheim and Lundman (2004) was applied to condensate the material to codes and categories. These were finally consolidated into an overarching theme.

Study IV

Interviews and text material were analysed using a directed content analysis where codes and categories follow the concepts of CFIR constructs (Hsieh & Shannon, 2005). The first author started the coding process with the crude material and then the co-researchers all reviewed the coding and adjustments were made in an iterative process. To validate the emerging findings, the last author had the role of reviewing the analysis process as a whole. After finishing the coding process, a summary of the whole implementation process was created based on all material and described in a chronological order.

To add more detail to the overarching implementation process, the embedded sub-units (the four mental healthcare services), were analyzed in two steps. Firstly, by making a synthesis of important constructs of CFIR for each unit, and secondly, by comparing the units with respect to construct value, i.e. addressing the constructs as being a facilitator or a hindrance. This was achieved by applying an overall rating approach as inspired by Damschroeder (2013). The rating was adapted to consist of two distinguishing criteria where each construct was assessed as having either a positive or a negative impact on the implementation. To discriminate between the predominantly positive or negative influence, concrete examples and explicit descriptions of whether a component supported the implementation or not, was needed from a majority of the interviewees.

Ethical considerations

All procedures in the thesis project followed the ethical standards of the Committee on Human Experimentation and the Helsinki Declaration of 1975, as revised in 1983. The studies included were approved by the regional ethical board at Lund University, Lund, Sweden (Dnr 2011-544)

and the RCT trial was registered as Trial Number Register ISRCTN93470551. The principles of informed consent and voluntary participation were followed, and all participants received both written and oral information about the IES intervention, the research design and confidentiality, in order to enhance informed decisions of participation. All participants were clearly informed about that they could withdraw from the participation at any time during the intervention and that withdrawal would not have any consequences for their rehabilitation or further RTW support. In Studies III and IV, the participants and key informants gave their permission to record the interviews and when presenting the cases in Study III, pseudonyms were used, to assure anonymity. The results from Studies I and II were presented on a group level to assure anonymity. All data material was stored in a locked cabinet.

Information meetings were held at the mental healthcare services twice a month. To assure information equity, checklists were used and the same information was given at each setting and each time. Informed consent could either be handed in at one of those meetings or be sent by post. The participants could reach the project administrator by phone or e-mail if they had any further questions. Informed consent from key informants in Study IV, were collected in connection with the interview. Precautions were taken during data collection in Studies I-II, where the research assistant gave support if participants needed this, and offered breaks and coffee/tea.

Results

The major aim in this thesis was to evaluate the effectiveness of an advanced SE model, the Individual Enabling and Support, in comparison to the regular TVR. The result indicates that the IES model is effective for gaining employment for the participants on long-term sick leave due to affective disorders who are unemployed (Study II). Moreover, the results showed the significance of taking health-related factors into account, such as empowerment and quality of life, in relation to depression severity (Study I). A service gap between mental healthcare and vocational services was also identified, which was reflected in an average of four years since the previous employment for the participants and that a majority of them reported no RTW support at baseline despite long-term sick leave (Study I). The person-centred support and the enabling strategies were shown to enhance the opportunities for the participants to increase their self-confidence and faith in their own abilities to RTW, and to engage in their RTW process (Study III). Finally, it was shown that the IES model could be implemented in the TVR context as the model was perceived as having advantages and the need for RTW support for people with affective disorders was recognized in the mental healthcare service. Both facilitating and hindering components were, however, identified (Study IV).

Effectiveness of the IES intervention

The two samples in the randomized controlled trial were compared regarding the primary outcome of employment or not at 12 months. Secondary outcomes concerned internship, prevocational training and education as well as depression severity and quality of life at 6 and 12 months. The number of weeks working, hours per week and total working hours were also calculated, as well as a comparison of income between groups and time to employment. No participant were lost to follow-up in the IES group (baseline n=33, 12 months n=33), while in the TVR group 1 participant was lost to follow-up at 6 months and another two were lost to

12 month follow-up (baseline *n*=28, 6 months *n*=27, 12 months *n*=25). There were no detected differences regarding baseline characteristics between participants who were analyzed and those who were lost to follow-up.

At the 12 month follow-up 42.4% of the IES group were competitively employed compared to 4% in the TVR group, a difference of 38% (p=0.001) and with an effect size of 0.44 (Cramer's Phi effect size, small=0.10, medium=0.30, large=0.50). At 6 months there was no difference between groups in employment rate. However, within group differences regarding employment or not from baseline to 12 months (*n*=33, *p*=0.000) as well as from 6 to 12 months (*n*=33, *p*=0.004), were shown for the IES group. The TVR group did not show such within group differences. Furthermore, no significantly confounding variables were found in the regression model that could predict employment rate when controlling for age, sex, work history, diagnosis, alcohol use and age at first contact with mental healthcare. Intention to treat analyses for participants lost to follow-up, showed significant differences between groups when best scenario was applied (employment: *p*=0.024, chi2=5.77, effect size=0.31) and worst scenario was applied (no employment: p=0.001, chi2=10.95, effect size=0.45). Interventions group differences for vocational outcome are presented in Table 4.

Tabel 4. Interventions group differences in vocational outcome rates at 12-month follow-up (n=58)

12-months	Group (n)	Rate (n)	95% CI	Diff.	95% CI	Sign (χ^2/df)
Employment	IES (33)	42.4 (14)	24.2-57.6	0.38	0.12-0.55	0.000 (10.95/1)
	TVR (25)	4 (1)	0-12			
Internship	IES (33)	39.4(13)	24.2-57.6	0.19	-0.07-0.42	0.11 (2.5/1)
	TVR (25)	20(5)	0-36			
Education	IES (33)	15.2(5)	3-27.3	0.19	-0.07-0.42	0.167 (1.91/1)
	TVR (25)	4(1)	0-12			
Pre-vocational training	IES (33)	3(1)	0-9.1	-0.36	-0.58-0.15	0.000 (12.65/1)
	TVR (25)	40(10)	20-60			

There were no significant differences between groups at 6 or 12 months for the secondary outcomes internship and education, however in the IES group, 12 participants had internship at 6 months and four participants in the TVR group had internship at this point in time. Concerning pre-vocational training and activities there were significant differences at 6 months (*p*=0.000, chi2=15, effect size=-0.50) and at 12 months (*p*=0.000, chi2=12.65, effect size=-0.47). The TVR group was more involved in pre-vocational training than the IES group. When calculating the number of working hours per week for those who were in employment, there was a difference between groups at 6 months. Participants in the IES group worked more hours (n=4, m=38) than the group of TVR (n=4, m=20). At 12

months, the IES group worked more hours per week, more weeks and more total hours, than the TVR group in internships and employment. There was also a significant difference between groups for the number of days to gaining employment at 12 months, where the IES group gained employment earlier (316 days) than the TVR group (344 days). Further, net income increased in the IES group as compared to the TVR group. At baseline there was no difference between groups, but at 6 months a significant difference was detected and at 12 months there was a mean difference of 517 (Euro) between groups (95% CI=251-783, t=3.90, p=0.000).

There was no difference between groups at baseline or 6-month follow-up in terms of depression severity. At 12-month follow-up, there was a significant difference in favour of the IES group compared to the TVR group. Within group differences were also shown for the IES group, depression severity significantly decreased from moderate to mild depression between the baseline measures and follow-up at 6 and 12 months, which was not the case for the TVR group. This latter group remained on a depression severity level of moderate depression at 12 months follow-up. Similarly, quality of life scores increased within the IES group between baseline and follow-ups, but not in the TVR group. As shown in Table 5, there was no significant difference between groups at 12 months concerning quality of life, but a significant difference was shown for psychosocial functioning in favour of the IES group. Psychosocial functioning was measured by the means of GAF. The results concerning differences between group on quality of life and psychosocial functioning were added to this thesis and not reported in Study II.

Table 5: Description and comparison of health-related variables between intervention groups at baseline and 12 months (*n*=61).

	Characteristics	IES		TVR		Sign
		Median (min-max)	Mean (SD)	Median (min-max	Mean (SD)	
	Depression severity					
Baseline (n=61)	MADRS-S	22 (11-39)	21.4 (6.8)	23.3 (3-42)	24.1 (8.8)	0.13
12 months (n=56)	MADRS-S	15 (1-37)	16 (9.9)	20 (3-42)	22 (10.2)	0.03
	Quality of Life					
Baseline (n=61)	MANSA	47 (22-62)	46.4 (8.6)	46 (27-63)	45.7 (10.0)	0.65
12 months (n=56)	MANSA	52 (38-76)	53.3 (9.9)	47 (24-67)	47.6 (11.7)	0.091
	Psychosoc. functioning					
Baseline (n=61)	GAF	59 (45-75)	59.4 (5.9)	58 (42-77)	59.1 (8.9)	0.690
12 months (n=56)	GAF	68 (40-96)	68.2 (14.16)	60 (45-90)	61.2 (11.63)	0.038

Empowerment and quality of life

The health-related and psychosocial factors of occupational engagement, empowerment, work aspiration and quality of life, were studied in relation to depression severity in the first study which had a cross-sectional design (n=61). These psychosocial factors have previously shown to be of importance in a RTW process for people with SMI. The results from the correlational and regression analyses showed a significant negative correlation between depression severity and the investigated variables of empowerment and quality of life. There was no statistically significant association between occupational engagement or working aspiration and depression severity. In the logistic regression model, it was shown that the odds for having moderate to severe depression decreased with higher levels of empowerment and quality of life.

Tabel 6. Results of logistic regression with depression severity as dependent variable (*n*=61)

	β	S.E.	Wald	P-value	Odds ratio	95 % CI
Empowerment (n=60)	-0.109	0.049	4.897	0.027	0.90	0.81-0.99
Quality of life	-0.115	0.048	5.705	0.017	0.89	0.81-0.98

The results from the descriptive statistic showed that the average period of time since being employed was more than 4 years and a majority of the participants did not have any RTW support, thus indicating a long time gap between services in mental healthcare and vocational services. Furthermore, a majority of the participants were female, co-habituated and had children. The average age was 41 years and the average age for the first contact with the mental healthcare service was 28 years. Sixty-nine percent of the participants had a diagnosis of depression while 31 percent reported bipolar disorder. Twenty-nine participants of the whole group reported no to light depression severity, while 32 participants reported moderate to severe depression. Nineteen percent self-reported somatic comorbidity. Socio-demographical and clinical characteristics in terms of comorbidity are presented further in Table2 and mental healthcare services and vocational status are presented in Table 7.

Table 7: Baseline mental healthcare service and vocational status (*n*=61)

Mental healthcare service	N (%)
Medication (n=57)	51 (90)
Counselling (n=58)	46 (79)
Cognitive behavioral therapy (n=55)	21 (38)
Psychiatric dynamic therapy (n=51)	6 (12)
Physical therapy (n=55)	14 (25)
Occupational therapy (n=52)	8 (15)
Work history	
Work experience yes/no	58 (95)/3(5)
Years since last employment, mean (SD) (n=55)	4.4 (3.1)
Vocational status (n=60)	
No prevocational intervention	35 (57)
Prevocational intervention, Social Insurance Agency and Public Employment Service*	15 (25)
Prevocational intervention at day centre	3 (5)
Supported Employment at PES*	2 (3)
Education / Internship	2 (3) / 1 (2)

Enabling engagement in return to work

The IES model was illustrated in five cases by describing the enabling strategies used (content) and how each participant's RTW process developed during the intervention (direction). The descriptions of the cases presented how motivational, cognitive and time-use strategies can be combined with supported employment principles and provided by the employment specialist in a way to promote the participants engagement in their RTW process and develop work-related coping strategies. The combination of strategies supported the participants in re-gaining confidence in RTW after long time periods of sick leave and unemployment. They all started out with low self-confidence and low faith in work return. Motivational strategies in combination with the SE Plan supported the participants to set work-related goals and to recognize any needs for change. It also gave the opportunity to weigh the pros and cons of an employment in relation to their own decision to RTW. The participants' resources and skills were emphasized in accordance with the SE Profile, and perceived work hindrances were identified. This in turn paved the way for

practising new work-related behaviour and coping strategies. Identification of time-use and daily routines enabled the participants to find regular habits that could promote a working life.

The theme of the cross-case findings was phrased *Enabling engagement in return to work* and comprised four categories related to the characteristics in the IES model that had influenced the RTW process, as perceived by the participants and employment specialists. The categories were; *Self-confidence and motivation, Faith in own abilities, Enhancing thinking and behavioural strategies* and *Balancing occupations in relation to family*.

Self-confidence and motivation

The first category involved a general perception that the continuous support from the employment specialist, particularly after setbacks, was of great importance for the participants to be able to move on and identify their own work goals. The participants emphasized that they experienced the relationship with the employment specialist as being equal, which enhanced their conversation. By emphasizing previous work experience and related resources in a motivational dialogue the participants started to believe in their abilities to RTW and were encouraged to start seeking jobs. The method of motivational interviewing was experienced as a way to become conscious of changes that were needed to be initiated which in turn planted a seed of hope. Some participants also reflected of the importance of having the opportunity to weigh pros and cons of working. By discussing the inner motivation for work the participants appeared to strengthen their self-confidence and commitment to work.

Faith in own abilities

The next category was a description of how mistrust in own abilities could hinder participants from taking a first step towards work. Mistrust related, for example, to the person’s own work skills, ability to perform a job seeking interview, to handle interpersonal communication or to be able to learn new coping strategies. The enabling phase gave opportunities for breaking behavioural or activity patterns of avoidance because of mistrust, by doing activities in various social contexts, and thus some participants received positive response about their capabilities and dared to visit social arenas outside the home. The employment specialists also continued to

emphasize the participants' resources and connected them to concrete working goals to increase faith in own abilities. The participants were challenged to talk about fears of work and hindering factors for starting work and found solutions for how the support could be tailored to counteract these concerns.

Enhancing thinking and behavioural strategies

Practising work-related coping strategies was described as a new experience for the participants. The strategies could include how to cope with social interaction, and work-related stress and demands as well as questions from colleagues. Four of the participants expressed that they had gained an awareness of how to use various coping strategies in a work context which made them feel more confident. They were now able to modify their thinking and behaviour when needed in relation to, for example social interaction with colleagues. Behaviour for specific situations was also practised, for example job seeking interviews. This practising appeared to be important as the participants often evaluated themselves negatively and needed positive responses on their acting. By accomplishing coping strategies the participants appeared to be able to move on in a favoured direction and became determined to either apply for a job without support from the employment specialist or to maintain contact with an employer.

Balancing occupation in relation to family

It was apparent for some of the participants that focus on RTW could be impeded due to a strained family and social life. Job seeking might need to be postponed when a socially vulnerable situation occurs. The importance of a person-centred support was emphasized as important in such situations, where continuity in the support was attended to and daily routines and structure were needed to be considered. The individualized support contributed to a trustful relationship between the participant and the employment specialist. This category also pertained to how occupations and routines in families develop and adapt to the fact that one person is not working outside the home but instead takes an overall responsibility for the family's everyday life. A great change thus occurs that affects the whole family when that person becomes employed. Involving the family in the RTW process was thus essential for some of the participants.

Implementation of the IES model

Guided by the CFIR framework in the implementation study, both facilitating and hindering components for the implementation of the IES model were revealed in the findings. The most facilitating component of the implementation pertained to intervention characteristics, other important components belonged to the inner and outer setting and the process. The domain of characteristics of individuals did not reveal any components. Fidelity ratings corresponded to good fidelity regarding delivery of supported employment and the enabling phase, which indicated that the IES model could be implemented in the context of TVR. An overview of essential implementation components is seen in Table 8.

Table 8: Facilitating and hindering components in the implementation of the IES model

CFIR	
	Facilitating components
Process	Meetings involving all organizational levels and dialogues about model fit Successful recruitment of opinion leaders
Intervention characteristics	Employment specialist's competence of labour market and psychiatry Appropriate support for the target group; people with affective disorders are in need of RTW support Person-centered, continuous and not time limited support
Inner setting	Employment specialists built constructive relationships and functioning teams with engaged staff members in the mental healthcare units Opinion leaders enhanced collaboration at the mental healthcare units which was important for the ongoing intervention
Outer setting	Fruitful collaboration was developed in some of the PES and SIA services
	Hindering components
Process	Large geographic area and many organizations involved made the implementation complex Difficulty engaging opinion leader in one of the mental healthcare units Major reorganizations delayed the implementation
Intervention characteristics	Staff members in the mental healthcare units had divergent opinions about the IES model fit in their organization Informants from the PES slightly questioned the model advantage of the IES
Inner setting	Leadership engagement; lack of time made engagement of first line managers difficult Difficulty for the employment specialist to integrate in the existing mental healthcare teams Responsibility, commission and financing of RTW support perceived as unclear, related to vague guidelines for vocational services and organizational boarders for responsibility
Outer setting	Collaboration with PES and their subcontractors Differing perspectives of RTW provision, where internships and vocational training were proposed from the PES according to regulations

A foundation for further collaboration was built in the planning phase of the implementation, by conducting various meetings at every organizational level where important decisions for the implementation were taken. In a dialogue with the first line managers and later all staff members at the mental healthcare units, a presentation of the characteristics of the IES model was conducted and the model fit within the TVR context was discussed. It was clear during this phase that there was a consensus in each of the units of the need for RTW support for the target group. Top level and first line managers as well as several members of the staff in the mental healthcare services described the model as a missing piece between healthcare and vocational rehabilitation, which was important for the acceptance of the IES in the start of the implementation process. The recruitment of opinion leaders was also successful in most of the units and continuous feedback was described as facilitating the process. The hindering components, which made the implementation complex, during the planning phase, were related to the large geographical area and the many organizations involved, as well as the major reorganizations in two of the units.

The relative advantage of the IES model, one of the components in the intervention characteristics, was related to the broad competence of the employment specialists, in both the labour market and psychiatry fields. The support was perceived as being appropriate for the target group, people with affective disorders who wants to RTW. First line managers and staff at the social insurance agencies mostly had a positive attitude to the model. Another model advantage concerned the person-centred and continuous support. Hindering components in this domain pertained to divergent opinions about the IES model fit in the mental healthcare organization and that informants from the PES doubted the advantage of the IES model and its fit in the prevailing welfare context.

Most components, both facilitating and hindering, were linked to the inner setting domain. One important component was that the employment specialists built constructive relationships and functioning teams with engaged staff members in the mental healthcare units, as it was shown to be difficult to integrate the employment specialists in the team service. One reason for this was seen to be the confidential nature of the team work and that work issues were not discussed in that forum. Another component concerned opinion leaders, who enhanced collaboration at the mental healthcare units, and this was important for the ongoing intervention. However, hindering components related to lack of time for the first line managers to fully engage in the IES implementation when the intervention

was running. It was also revealed that the responsibility for and the commissioning and financing of RTW support were perceived as being unclear, both from the mental healthcare and PES informants. Vague guidelines for vocational services and responsibility between the organizations were emphasized as complicating the implementation of an integrated model and the managers declared that RTW support was not the duty of the mental healthcare services.

As regards the outer setting domain, the findings showed that the employment specialists created fruitful collaboration with some local PES and SIA services, as some of the staff approved of the IES model. On the other hand, collaboration with PES was also a hindering component, partly due to several subcontracted actors that the PES use for delivering prevocational services, which complicated the implementation, and partly because of different perspectives of RTW support and design. Prevocational training and internships are the common stepwise way of providing RTW support in accordance with TVR, which contrasts with the IES principles.

Discussion

Advanced Supported Employment for people with affective disorders

The first evidence for the effectiveness of the IES model is shown. The enabling model of supported employment appeared to suit the RTW needs of people with affective disorders. In spite of the participants having been treated in the mental healthcare services and on sick leave and unemployed for on average four years (Study I), 42.2% gained competitive employment, worked more hours per week and in total, and had larger incomes at 12 months as compared to those who participated in TVR. Furthermore, their depressive symptoms significantly decreased at the same time as their quality of life increased within the IES-group. No such within group changes were detected for those in the TVR-group, of whom only 4% entered the employment market. Accordingly, it seems warranted that the mental healthcare service and other rehabilitation actors and services in TVR need to focus on RTW, together, and integrate their services in a person-centred approach. This shift in focus is critical but nevertheless the encouraging results of the IES need to be replicated in larger trials and in other contexts. In conclusion, the studies in this thesis have together contributed to a robust understanding of the need (Study I), effectiveness (Study II), and nature (Study III) of a novel RTW approach, and knowledge of how it may be delivered in complex organisations (Study IV). The results and findings are discussed in relation to relevant literature.

To our knowledge, this is the first study in Sweden, to investigate a SE approach specifically designed to meet the needs for people with affective disorders in mental healthcare services who want to RTW. The integrated and person-centred support of the IES model has shown to be effective for gaining employment. These results provide support for an earlier trial in Norway where CBT was combined with SE (Reme et al., 2015). People with depression and anxiety disorders benefitted from work-focused CBT group sessions conducted by psychologist and SE delivery as being conducted by employment specialists in that trial. The inclusion in that trial

concerned participants both with and without employment, thus the outcome concerned gaining or remaining in employment which was addressed at 12- and 18-month follow-up (Reme et al., 2015). The results showed that the participant group which had been on long-term sick leave and was unemployed, as in the current study II, was shown to benefit the most from this advanced SE model. In addition, depression severity decreased and quality of life increased from baseline to follow-up (Reme et al., 2015). The Swedish and Norwegian trials thus reveal similar results and forward the importance of providing SE and integrating CBT strategies (Study III) or combining it with CBT group sessions (Reme et al., 2015). Another RCT trial from Denmark focussed on people with recently diagnosed depression or anxiety disorder and compared a modified SE model with usual care and vocational services (Hellström et al., 2017). In this trial no significant differences were found between groups regarding employment, days to RTW or health-related factors at follow-up after 2 years. The authors discuss that central SE principles of integrating the service with mental healthcare services and providing with systematic job development in contact with employers, were not possible due to how mental healthcare services were organized (Hellström et al., 2017). Not being able to follow these critical ingredients in SE could help to explain the non-findings in this superiority RCT trial. Based on these Scandinavian findings on the effectiveness of SE for persons with affective disorders, it is critical to provide a combination of effective interventions, to integrate RTW support in healthcare and to deliver it as an overall RTW strategy. This solution could counteract long-term sick leave for people with affective disorders and other CMD (Joyce et al., 2015; Modini, Tan, et al., 2016; SOU, 2011). Furthermore, another study showed that combining single interventions of adjuvant occupational therapy and mental healthcare routine service revealed positive results regarding time until RTW for people with depression (Hees, de Vries, Koeter, & Schene, 2012). To sum up, the evidence for advanced models of SE for people with affective disorders are still in their early stages and thus the results concerning their effectiveness are as yet inconclusive. This could depend on the fidelity to the SE model of integrating vocational rehabilitation with healthcare and of meeting the support needs of people with affective disorders (Hellerstein et al., 2015). However, unemployed people on long-term sick leave seem to benefit from this type of SE models.

As discussed earlier in relation to the Danish trial, the SE principle of a systematic recruitment of employers and building relationships and networks with employers was challenged. As stated above, due to organizational circumstances, the participants, needed to apply for jobs by

themselves through ordinary job seeking channels and were not supported at the work site in their transition to work (Hellström et al., 2017). This SE principle of job development and employer contacts is important to consider for the group of people who have no employer to return or relate to (Drake RE, 2013). The elements of job seeking and taking contact with new employers were shown to be hindering factors for the participants, as shown in study III, and are in line with previous research (Hellerstein et al., 2015; Pfeifer & Strunk, 2016). Subsequently the employment specialists have an important role to play regarding job development and of building quality contact with employers (Lexén, Emmelin, & Bejerholm, 2016). In a Dutch study of an advanced RTW intervention for unemployed people with CMD, the support was provided by a team consisting of a RTW coordinator and a labour expert early after sick-listing and in accordance with the Dutch social insurance regulations (Lammerts, Schaafsma, Bonefaas-Groenewoud, van Mechelen, & Anema, 2016). After initial support including mapping of work hindrances, providing job advices and establishing a RTW action plan, the participants were referred to another vocational service agency to start their job seeking. This intervention was not found to be better than regular occupational healthcare and did not show any significant health-related differences (Lammerts et al., 2016). Notably, the RTW support was provided by a variety of professionals and services. Even though the participants received support in their job seeking process, the RTW support was not integrated with the healthcare and it was provided by another person in another organization and not by members in the team. Having the same person to relate to, the employment specialist, and having a continuous support over time was essential for the participants in the present project, as shown in study III. The significance of building a supportive and trustful relationship with the SE participants has previously been reported in qualitative research to be of great importance for the persons receiving the RTW support (Areberg et al., 2013; Johnson et al., 2009). Providing with this type of continuity of person-centred support is also a way of bridging the gap between the mental healthcare and vocational services (Henderson et al., 2011).

As shown in study I, the participants seemed to be a disadvantaged group in relation to having access to RTW support in today's TVR context. This is particularly serious for this target group which has also been reported to have an unstable work position at the labour market with job turnover and job loss as common patterns (Lerner et al., 2004). In addition, affective disorders often appear with relapses that can have a negative impact on psychosocial functioning and make RTW more difficult (Adler et al., 2006). However, added results from measures of psychosocial functioning showed

that the IES-group had significantly higher scores on the GAF measures than the TVR-group at 12 months, which indicate better psychosocial functioning. Furthermore, the contributory fact that unemployment means having no employer to relate to, can lead to this target group risk entering into a vicious and ongoing circle of being stuck in the RTW process. A significant number of participants in the TVR group stayed in pre-vocational training during the follow-up period (Study II). This thesis contributes with increased knowledge and understanding of how RTW support could be provided to mitigate such negative RTW circles.

Health-related aspects in the RTW process

Both psychiatric and somatic comorbidity was common among the participants (Study I, II) thus leading to a majority of them having several healthcare contacts. This could complicate information transactions between healthcare services in different settings and make it difficult to achieve an overall picture of support needs for a RTW. It has been previously reported that setting diagnoses for depression and elucidating somatic and other comorbidity is a complex matter which could in turn complicate the identification of rehabilitation and support needs (Linder et al., 2009).

In the attempt to study the RTW and support needs in study I, it was evident that the participants' quality of life played a central role for their mental health. The results showed that quality of life were negatively associated with depression severity and that increasing levels of quality of life can have an impact on depression severity, which provides support for previous research (Kuehner & Buerger, 2005; Pan et al., 2011). Quality of life is reported to be important to address in a RTW context as it mirrors the individual's overall subjective satisfaction of various life domains, and satisfaction with employment status is one of these important domains (Pan et al., 2012). Quality of life, as stated above, may remain at a low level for people with depression in spite of successful medical treatment and the reduction of depression symptoms (Godard et al., 2011). A low level of quality of life could in this sense be a consequence of being unemployed, isolated, having remaining psychosocial difficulties and of being in an occupational deprived situation, which in turn could have an impact on self-confidence and RTW self-efficacy (Andersen et al., 2012; Nielsen et al., 2012). Quality of life increased significantly as a consequence of participating in IES (Study II) in line with the results of persons with SMI participating in SE (Areberg & Bejerholm, 2013). In another study on

people with depression, having a workplace and social support actually predicted quality of life (Pan et al., 2011). This highlights the importance of focussing on having a holistic perspective on mental health and quality of life in the provision of RTW support and of involving important others in a RTW context to help counteract reported isolation, low self-efficacy and the avoidance of activities (Study III) when having depression (Brohan et al., 2011). At the 12 month follow-up a majority of the participants had reached employment, education or internship, which meant that they had an occupational and social arena to relate to. Having a workplace to attend generates a feeling of belonging (Blank et al., 2015) and is described as reducing depression and anxiety (Modini, Joyce, et al., 2016), thus having an effect on health and well-being (Pan et al., 2011). It has also been found as a place for creating a positive self-identity, and for feeling capable of doing an occupation that is favoured (Blank et al., 2015). In line with this, the enabling strategies used in IES also nurtured self-efficacy; the belief of that RTW was possible (Study III).

No association was found between the level of occupational engagement and depression severity in study I. Some participants, as described in the time-use diaries (Study III), appeared to live a rather active life with their families and were engaged in household chores, some were also engaged in leisure activities. Others were described as being isolated, mostly those who did not co-habitat and they reported less engagement in occupations. This may indicate that this group of people had sufficient medical treatment and rehabilitation from the mental healthcare service, but not sufficient RTW support to be able to gain employment. Measurements of occupational engagement by means of POES are however developed for people with SMI (Bejerholm et al., 2006), and the results may reflect that the instrument could not capture the whole picture of occupational engagement in this target group. A ceiling effect was revealed as reported in study I. However, discussions about time use, of how to make room for work and orchestrate everyday occupations is key in order to support mental health and mitigate stress and anxiety. Such time use discussion strategies formed one part of the enabling strategies in the IES model (Study III). When the RTW support is lacking there is a risk for health deterioration and disempowerment for individuals who want to RTW. As introduced in the thesis, work may provide with mental health and well-being but should according to the results (Study II, III) attend the RTW needs, of enabling the motivational, cognitive and time use strategies in combination with a steady focus on employment in favour of lengthy prevocational training and assessments.

The role of empowerment

The result in study I showed a significant association between depression severity and empowerment, indicating that an increase in empowerment could decrease depression severity. This direction of results is further demonstrated through the findings of the impact on enabling and SE strategies on self-efficacy in Study III. These results are in line with previous research that showed depression and anxiety to be predictors of lower self-efficacy in women on sick leave due to either long-term pain or mental disorders (Andersén et al., 2015). Disempowering RTW situations can foster more depressive thoughts and a pessimistic view of a future working life as well as negative impact on self-efficacy for work (Hillborg et al., 2010) and empowerment issues are thus important to address in a RTW context (Bejerholm & Björkman, 2011). There is not only a need for access to RTW support, the support also requires that people are recognized as capable persons who need to be involved in the decisions of their own RTW process, and to feel more empowered. Previous research reveals that incongruent demands, misunderstandings and insufficient support, had a disempowering effect on people with mental disorders participating in vocational services (Hillborg et al., 2010). This disempowering effect can further establish the sick role (Agner, 2017). People are expected to follow the pre-determined route of the traditional rehabilitation chain where the support is guided by a medical and disability perspective (train-place) (Corrigan, 2001). When RTW pathways are decided in advance, people with mental disorders thus have little opportunity to decide and control their own plan to engage in employment (Corrigan, 2004). Furthermore, when people are having negative RTW expectations during sick leave, this may influence negative illness perceptions (Løvvik et al., 2014). In a study investigating this phenomenon a comparison showed that the group with negative RTW expectations experienced less control and more concerns about the illness and what the consequences would be for their personal, family and social life, than people having a positive RTW expectation. This might have been the case for the participants in TVR in study II. It was evident that they did not develop their role as a worker (4% in competitive employment) and remained at the same depression severity level as they were at the beginning of the trial.

When evaluating the overall empowerment scores among participants in the IES intervention in a RCT study, empowerment and specifically the self-efficacy domain, was found to increase at follow-up (Porter & Bejerholm, 2018). Even though the RTW context ought to be an active and health-related course towards re-gaining a worker role, the medical perspective

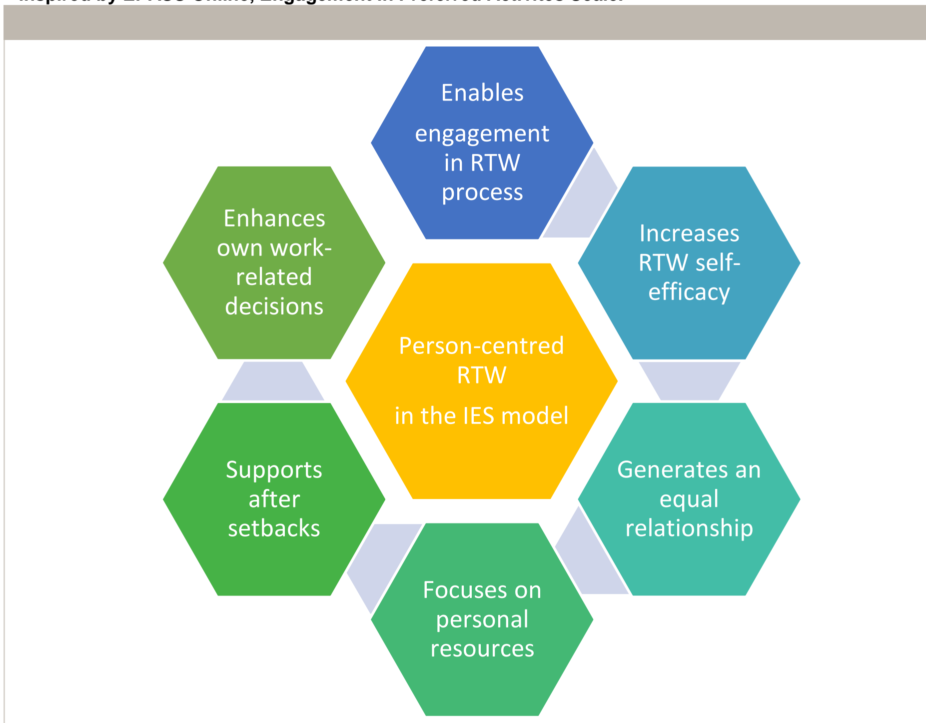
leaves its mark in this process. Empowerment principles have been discussed to not being in line with the medical perspective of healthcare, indicating potential difficulties for incorporating them in such contexts (Agner, 2017), which is also shown in previous SE research in relation to the Swedish welfare system (Bejerholm et al., 2011).

The case study in the present thesis (Study III) revealed that the five participants (cases) did not need or wish to have on-worksite support, which is in contrast to the findings in a case study on SE support among persons with SMI (Lexén et al., 2013b). Work place accommodations were shown in that study to be important regarding the ability for learning new work tasks and working independently (Lexén et al., 2013b). The participants in the present study instead had off-worksite support by the use of phone calls and text messages. This type of support has previously been shown to indirectly lead to work accommodation for people with SMI, as the ES provided counselling by phone (Lexén et al., 2013b). Furthermore, in the present case study, the participants had practised cognitive coping strategies for work stresses in advance and then the ES supported by phone by reminding them of strategies to use. Work-place interventions have been recommended for successful and early RTW for people on sick leave due to CMD (Joyce et al., 2015) but a recent systematic review showed low to moderate effect of time until RTW after work-place interventions among those with mental disorders, but no effect on job tenure (van Vilsteren et al., 2015). The interventions regarded changes at the work-place, accommodations and adaptations of work environment (van Vilsteren et al., 2015). Further research on work place interventions included as an overarching strategy for RTW seems warranted. The reasons for not wishing to have at-work site support could vary but one of them might pertain to stigma. The majority of the IES participants had extensive work experience prior to their sick leave period (Study I), and may perceive a disclosure of an affective disorder to the employer as being stigmatizing. Perceived stigma and self-stigma are associated with depression severity and people with either depression or bipolar disorder reported more self-stigma when being unemployed compared to people in the same group who had an employment (Brohan et al., 2011). Factors pertaining to lower stigma scores consisted of employment, education, social contact and empowerment (Brohan et al., 2011). Stigma is not as extensively researched in people with affective disorders as it has been among people with SMI, but it still appears to be relevant to attend to in a RTW context.

Enabling strategies influence engagement in the RTW process

The findings in Study III illustrated how the employment specialists provided a combination of motivational, cognitive and time-use strategies with SE principles that was described as stimulating the participants' engagement in their RTW process. This study was a way of examining the mechanisms of the IES model concerning content and process direction. Using motivational interviewing questions and work sheets were strategies that initiated the enabling process of IES. The support was found to promote the participants' engagement in their RTW planning and the participants experienced that the support had an influence on their self-confidence and motivation. Motivational interviewing is a way to analyse the ambivalence for change, to direct questions on advantages and disadvantages for making a behaviour change (Miller, 2002). This can in turn help people to become aware of their own wishes and thereby enhance goal-setting. Motivational interviewing thus emphasizes a person-centred and an empowerment approach, where the participants' own choice and decisions are in focus (Miller, 2002). Person-centredness emphasizes the participant's values and preferences, an equal relationship between the support person and the participant and a process approach (McCormack & McCane, 2006). It could be one way to counteract RTW services that put too much weight on the medical perspective and to turn a sick-role into a more engaged role and make opportunities for own decisions. A person-centred RTW approach is illustrated in Figure 3, as an elaboration of the findings in Study III.

Figure 3: Illustration of the IES model as a person-centred RTW support. The illustration is inspired by EPASS Online, Engagement in Preferred Activites Scale.



(EPASS, 2018)

Self-efficacy was not measured per se in the studies, but is one of the domains in the Empowerment Scale (Rogers et al., 1997), as measured in Study I, where a relationship between depression severity and empowerment was shown. Participating in IES, as described in Study III, revealed that the participants received the opportunity to practice their job seeking skills and work abilities at a work place, thereby developing a stronger self-efficacy. By engaging in occupations people may strengthen their capacities, develop interests and increase their self-efficacy/personal causation, which can in turn impact on their motivation to continue being engaged in occupations (Kielhofner, 2008). This development of an occupational role is important as it is widely recognized that self-efficacy is an essential aspect in the RTW process (Andersén et al., 2018; Lagerveld et al., 2010; K. Nieuwenhuijsen, Noordik, van Dijk, & van der Klink, 2013). Self-efficacy has generally been seen to decrease in relation to long-term sick leave and the number of sick leave periods (Sommer, Thomsen, & Labriola, 2013) thus making RTW more difficult.

The application of CBT for affective disorders is an evidence-based method and recommended in the National guidelines for treatment of depression and anxiety (Socialstyrelsen, 2017c). Positive results on symptom reduction and increasing coping strategies have been shown (Joyce et al., 2015; Rose, Perz, & Harris, 2012). Using CBT in a work-related context is not evidence-based to the same extent. However, some RCTs and longitudinal studies have found work-focused CBT to promote gaining employment and for individuals to better cope with work demands and work stress (Naidu, Giblin, Burke, & Madan, 2015). To note, CBT treatment did not constitute a part of the IES model but cognitive strategies were integrated with the support service and delivered by the employment specialist with supervision from a psychologist. The participants described benefits of learning new thinking and behaviour strategies, both in relation to the job seeking process and to work demands. To learn these cognitive oriented coping strategies in relation to work was expressed as a new experience. Previous research suggests that work-focused cognitive strategies could enhance the opportunities to use adaptive strategies to counteract ruminative thinking (Pfeifer & Strunk, 2016), as long-term unemployment could worsen depressive symptoms such as rumination, which in turn can impact with a negative attitude towards opportunities and self-confidence.

All participants in the multiple case study initially described low self-confidence and no faith in own abilities to work. This could lead to avoidance of job seeking activities as a way of avoiding further job seeking failures (Pfeifer & Strunk, 2016). By providing opportunities to discuss goal-setting and achievements earlier on in the enabling planning phase of IES, the participants' behavioural patterns of avoidance could be broken and the engagement in new occupations could be initiated. This kind of behaviour and occupational change was also shown in an earlier study where work-focused behavioural activation was used for unemployed people with depression (Hellerstein et al., 2015). This is important as maladaptive coping strategies have been reported to sustain difficulties to RTW despite depression symptoms having been reduced (Hellerstein et al., 2015). The participants in Study III also emphasized the importance of having support after setbacks in the job seeking process. The person-centred support in IES in combination with their own ability to learn and use coping strategies most likely enhanced their ability to cope with setbacks and start a new process towards work. In an earlier study, cognitive and behavioural skills predicted the opportunity for receiving a job offer, while job seeking self-efficacy did not (Pfeifer & Strunk, 2016)., job seeking skills were also perceived as increasing, as illustrated in Study III, which gives some

evidence for providing cognitive strategies in the RTW support. Furthermore, the results in the RCT (Study II), on the IES intervention's effect on depression, support this research assumption.

The application of time-use strategies aimed at identifying how the participants engaged in occupations during the daytimes and if that occupational pattern supported a life with employment. As described in the sociodemographic results in Study I and in the cases (Study III), participants were mostly engaged in home and/or family occupations but avoided social contexts. Using time use diaries and discussing necessary changes of the occupational pattern, which goes hand in hand with the motivational and cognitive strategies, supported the participants in starting to find regular habits that could promote a working life. Finding ways to leave room for and include employment, part- or full-time, is important in terms of sustainability of employment, the risk of job loss and the worker role. In fact, Study II showed that the amount of weeks worked, an outcome of sustainability, was higher among the IES participants, with a large effect size. Thus, perhaps the time use strategies in combination with the ongoing support principle in SE may have contributed to the longer working hours per week and in total. Furthermore, a need to reorganize responsibility and performance of household chores in the family context was revealed in Study III, to make room for employment. Previous qualitative research has shown that people with depression and anxiety to a lesser extent engage in meaningful occupations outside work in order to be able to manage the work situation and perform better at work (Bertilsson et al., 2013; Sallis & Birkin, 2014). Such occupational pattern could in the long term diminish mental health and increase the risk for sick leave. A need to focus on strategies for managing everyday tasks after severe setbacks was illustrated by the cases in Study III, where job seeking could not be prioritized for some time, thus supporting the provision of time use strategies for laying a foundation for work-life balance (Christiansen, 2005).

Turning the IES model into practice

The facilitating and hindering components for implementation of the IES model were examined in Study IV to gain a picture of essential components for implementing an integrated RTW model in a sectored welfare structure such as the TVR context. As reflected in the results in Studies II and III, the IES model could be implemented in the mental healthcare service, but some components that hindered the implementation were also revealed in the findings.

Many of the important planning steps, assessments of needs and preparation of a supportive implementation environment were achieved in the first phase prior to launching the IES model in practice in the mental healthcare services. The planning phase is emphasized as being essential in implementation research (Bergmark et al., 2016; Fixsen, Blase, Naoom, & Wallace, 2009; Meyers et al., 2012). A major positive attitude to the IES model and a perception of a need for RTW support for the target group of people with affective disorders in the mental healthcare services supported the acceptance of the IES model. This was significant as an implementation could be delayed or even prevented without the acceptance of an intervention among the involved staff and could generate difficulties for the feasibility (Powell, Proctor, & Glass, 2014; Proctor et al., 2011). The acceptance and the fact that the IES model was perceived as having advantages in relation to other RTW models thus facilitated the implementation.

Resistant attitudes to the model fit, a component in intervention characteristics, mainly belonged to the perception that providing RTW support was not a commission for the mental healthcare services. Work is described as an essential goal in the national guidelines for treatment of depression (Socialstyrelsen, 2017c) and the healthcare services are obliged to collaborate with other organizations regarding RTW issues. The guidelines were however referred to by the informants as being ambiguous and difficult to interpret in regard to organizational responsibility between mental healthcare and vocational services. There was a need to set boundaries between professionals, where medical skills and mental health treatment competence were prioritized before RTW knowledge. This might reflect the fact that healthcare staff work according to healthcare regulations to accomplish their duties of service provision and medical treatment is at present emphasized in guidelines and directives. It could also reflect the organizational climate of being a learning organization. This was discussed in previous research of implementation in mental healthcare, suggesting that a climate where staff is regularly updated in new interventions and methods, could make implementation easier (Brooks, Pilgrim, & Rogers, 2011). Too much routinization in work practice may impede willingness to change and accept new interventions (Brooks et al., 2011). It has been suggested that behaviour change at the individual level is important for implementation (Damschroder et al., 2009; Godin, Bélanger-Gravel, Eccles, & Grimshaw, 2008; Nilsen, Roback, Broström, & Ellström, 2012) and if staff members are prepared to change their working routines, implementation might be facilitated.

The component of patient needs and resources, in the outer setting domain, showed examples of inter-organizational communication and collaboration that worked well, where much was due to trustful relationships between the employment specialists and the PES's first line managers and handling officers, having a positive attitude to the model. However, as shown in previous studies of IPS, collaboration could also be impeded (Bejerholm et al., 2011). Implementation became complicated and delayed because of regulations in the TVR context concerning the stepwise approach to RTW. Participants were remitted to pre-vocational training and internships, instead of starting the job seeking process early in line with the IES principles. The TVR structure for RTW support could be described as reflecting an opinion about how RTW support could best be designed (Corrigan, 2001), which involves assumptions from the medical perspective that people with mental disorders need to practice their abilities in more sheltered environments before they can start a job seeking process (Henderson et al., 2011). It is however also important to take into consideration that while the vocational services in PES are regulated according to agreements mostly politically directed, mental healthcare services are recommended to work according to EBP (Socialstyrelsen, 2017c). It could be assumed that EBPs do not have the same legitimacy in politically directed organizations and subsequently receive less attention than in healthcare. Furthermore, Study IV showed that participants were remitted to the PES offices' sub-contractors for pre-vocational training, which made their pathway to employment even longer and the implementation more difficult. Even though fruitful collaboration in local contexts makes implementation work, it has been suggested that politically directed policies are needed if integrated interventions are to be implemented to a larger extent in sectored welfare structures (Bergmark et al., 2016).

The findings also showed that integrating the employment specialists in the existing mental healthcare teams, was difficult to achieve, which corroborates the findings from an implementation study of IPS in a Swedish context, where the implementation was carried out in the municipalities (Bergmark et al. 2016). This hindering factor in Study IV was compensated for by the employment specialists collaborating successfully with other engaged staff and building functional teams around the participant. The employment specialists adapted to the various contexts and found creative collaboration within the mental healthcare services. Moreover, opinion leaders who engaged in the implementation process were important for the completion of the implementation. The recruitment of interested and committed individuals has a great influence on implementation as there is a

need for people who are determined to make a change and who are unaffected by the resistance of others (Damschroeder, 2009, Brooks et al., 2011). Implementation at the organizational and individual level thus appears to concern social processes where the building of relationships with first line managers and staff in the involved organizations can enhance the implementation process (Brooks et al., 2011). The findings in study IV about the leadership engagement of the first line managers showed that there was a lack of time for engaging during the process, even though they were engaged at the start of the implementation. Previous research suggests that first line managers play a crucial role as their commitment to an implementation can impact on the process (Brooks et al., 2011, Markström et al., 2017). It was found in a previous study about guideline implementation in mental healthcare that the staff recognized the first line manager as having the responsibility for spreading the information of new interventions, indicating an expectation of top-down information and updating (Sandström, Willman, Svensson & Borglin, 2014). Resistance to new interventions from first line managers has been found to prevent the implementation process (Brooks et al., 2011). It thus appears as if first line managers have an important role to play in the implementation of new interventions, however, they are probably also in need of implementation management support on the organizational level.

Methodological considerations

This thesis project comprised a RCT trial design, a cross-sectional, and two separate case-studies, thus combining quantitative and qualitative research designs to provide with different perspectives of the evaluation of the IES model. Associations and effectiveness were calculated in the quantitative studies, and the case-studies provided a greater understanding of the IES model and support and implementation issues.

Studies I-II

The RCT study basically demonstrated robust results, with few drop-outs and no baseline variables that predicted the employment outcome. The procedure followed the Consort guidelines for conducting non-pharmaceutical interventions (Moher, Hopewell, Schulz, Montori, Gøtzsche, Devereaux & Altman, 2012). The randomization appeared to be successful with minimal risk for selection bias, which increases the likelihood that the outcomes could be explained by the intervention. Inclusion and exclusion criteria were applied and two participants needed to be excluded in accordance with these. The number of participants that were aimed for was, however, not achieved and this may have influenced the power in the RCT study. The recommended sample size was 11 to 42 when power was set to 0.80 at 0.05 as alpha value. The intention of recruiting 60 participants in each group was based on an earlier study of IPS in Sweden recruiting 120 participants, having an attrition rate of 30%. This was not achieved, however, having 30 participants in each group has been reported to be sufficient for a pilot RCT based on power calculations from the Swedish study of the effectiveness of IPS (Bejerholm et al., 2015). Moreover, with a dichotomous outcome of measuring employment or not, as in Study II, 21 participants are sufficient for showing effect sizes of 0.40 (Chan, 2003). In addition, the result is in line with a larger trial of an adapted SE intervention for people with CMD, where sub-analyses showed positive results for long-term unemployed (Reme et al., 2015).

The participants in Studies I-II were recruited from four different mental healthcare services, including one large and three small to medium-sized towns in the south of Sweden. All participants received treatment from the mental healthcare services and were recruited from that environment. Recruitment from primary healthcare settings were not performed which could have had an influence on the diversity of the sample, as there may be people on long-term sick leave due to affective disorders receiving mental healthcare treatment in that type of healthcare environment and they were thus not reached (Kazdin, 2010). Information meetings about the IES intervention were conducted every third week for one year in the mental healthcare services. This long period of time provided the opportunity for recruiting as many participants as intended, however this was not achieved, as discussed above. It might have been the case that people with very poor mental health declined to attend the information meetings and they were thus not reached. A majority of the participants in Studies I and II were female, which may reflect the proportion of those on sick leave on a population level regarding affective disorders. There was, however, no

ethnic diversity among the participants. This could be seen as a limitation but could be due to low mental health literacy or that many people do not seek help (Bhugra & Mastrogianni, 2003).

All instruments used in the studies had been psychometrically tested and should provide valid and reliable data. The research assistants were trained in using all the instruments and they were experienced in performing assessments and interviews. There is one limitation regarding the measurement of occupational engagement, using the POES instrument, where a small ceiling effect was found. POES was constructed for people with foremost schizophrenia, but it has been proposed that the instrument needs to be tested and further developed for other target groups (Bejerholm & Lundgren-Nilsson, 2015). Despite the ceiling effect for this target group, POES has been found to be psychometrically sound (Bejerholm & Eklund, 2006a). Logistic regression analyses in Study I was deemed most appropriate as the data was ordinal in nature. Using a cross-sectional design (Study I) does not allow for cause and effect inferences. However, this design is appropriate when exploring a field where little research has been carried out. This was the case when addressing empowerment and depression severity as well as quality of life, occupational engagement and work aspiration in a RTW context for the target group. Generalizations should be made with caution as the external validity is restricted to unemployed people with affective disorders on long-term sick leave receiving mental healthcare in Sweden and the sample size was rather small.

Studies III-IV

The two case studies, one multiple-case and one embedded case-study, both followed the method guidelines of Yin (2014) and study protocols were used for both studies. Case-studies can add to the understanding of the mechanisms in a complex phenomenon, rather than showing generalizable findings and can be used to add knowledge about for example, individual people or processes by striving to answer the questions of how and why (Yin, 2014). The participants in Study III were purposively selected for the interviews, both to bring diversity to the cases and to select participants who were prepared to share their experience of participating in the IES intervention. In addition, the employment specialists were interviewed. The implementation process was in focus in Study IV, which was feasible as the process was limited in time, 2011-2014. Nineteen interviews were performed with purposively selected key informants working in either of the organizations involved in the implementation. It could be perceived as a

limitation that first line managers from the mental healthcare, the SIA and the PES services discontinued their employments and they could not be reached at the time for interviews. This was the same for some staff members in the mental healthcare services. All organizations were, however, represented by the key informants.

The trustworthiness of Studies III and IV were attended to in several ways, first by the use of several data sources, which allows for a variation in perspectives and gives detail to the findings (Berg, 2012). Several documents, protocols and memos were used to validate the cases described apart from interviews. Further, trustworthiness was strived for in the analysis processes where all authors were involved in interpreting the multiple cases and the case of the implementation process. The multiple cases were first analyzed as within cases and then across cases. The several steps in these analyses were conducted in accordance with a study protocol and described thoroughly. It could be argued that the cross-case analysis was not fully inductive as the interview questions targeted the strategies used in the enabling phase of the intervention. However, new codes and categories were allowed to emerge in the analysis, as described by Hsieh and Shannon (2005). Also, the enabling phase was in focus as described in the aim of Study III. To strengthen the findings, theoretical concepts in the discussion of the multiple cases were used as suggested by Yin (2014). This can make a theoretical generalization, or transferability, possible. Many studies show that the theoretical concepts of self-efficacy or personal causation are highly relevant on a general basis in RTW support. A theoretical framework, the Consolidated Framework of Implementation Research, was used in Study IV. CFIR consists of identified important implementation components from various healthcare contexts and was used both for constructing the semi-structured interview guide and for the analyses as a way of strengthening the credibility of the study (Lincoln, 1985). Furthermore, the context in which the implementation was conducted, the mental healthcare context and the collaboration with the SIA and the PES, was described.

Conclusions

Following conclusions are drawn from the study results.

The Individual Enabling and Support model was effective as a RTW support in terms of employment outcome, decreased depression severity and increased quality of life, for people on sick leave due to affective disorders who are unemployed.

RTW support according to IES is a way to achieve employment at a faster speed than RTW support according to the TVR, with the opportunity to rise the own income rate and re-gain a worker role.

There is a time and service gap between mental healthcare and vocational services which could worsen depression severity in unemployed people on long-term sick leave. This group of people need to have access to RTW support.

Empowerment and quality of life are related to depression severity, indicating that these health-related aspects are important in the RTW support, and need to be attended to, in order to reverse the negative spiral of long-term work disengagement into taking own decisions and gaining more control of the RTW process.

The enabling approach, with motivational, cognitive and time-use strategies in combination with the evidence-based supported employment, appeared to meet the needs of this target group, who wanted to RTW. The strategies facilitated the participant's goal setting and motivation for work, and they became more engaged in the RTW process and increased self-efficacy for RTW.

The enabling approach also appears to work well in a combination with the evidence-based supported employment principles as a way of providing a holistic, empowerment and person-centred perspective in the RTW process.

A person-centred, continuous and respectful support from the employment specialists were key factors for the participants to continue to strive for their employment goal particularly after setbacks.

The integration of RTW issues in the mental healthcare needs to be prioritized. The employment specialist was able to coordinate and collaborate with the various stakeholders involved as a way of closing the gap between the mental healthcare and vocational services.

The IES model was implemented in the TVR context due to careful planning, and positive perceptions and attitudes to the IES model which influenced the acceptance of it. The employment specialists were able to work according to the IES principles to a great extent but it was clear that engagement of first line managers was important for the implementation.

Hindering factors for implementation pertained to the perception of unclear guidelines concerning organizational boarders for vocational services and inter-organizational collaboration was partly difficult. RTW support is the responsibility of several stakeholders in the TVR and integrated RTW models need to be more attended to in the mental healthcare context to better benefit the service-users.

Implications for further research

To corroborate the results from the RCT trial of the effectiveness of the IES model, larger studies in the mental healthcare service is warranted to contribute to more evidence for the intervention concerning people with affective disorders.

Larger studies would also be warranted in primary healthcare as a great number of people receive treatment for affective disorders in that healthcare context. Person-centred RTW support by employment specialists could be beneficial for the target group in primary healthcare as well.

There is a need for longitudinal studies where follow-up is conducted after 2-3 years to evaluate work sustainability after acquiring employment with the support of the IES model. There is also a need to further study how the RTW support can be developed at the work place and how to collaborate with employers.

The motivational, cognitive and time use strategies in the enabling phase need further attention to answer questions about how these methods could be elaborated to meet all the different needs that people on long-term sick leave due to affective disorders have. CBT-strategies that are work-related were shown to be important in this thesis and could be further developed concerning social relationships and communication at a work place. Further studies could also be conducted on the use of enabling strategies for other target groups on long-term sick leave, for example people with long-term pain.

Integrated RTW interventions need to be further studied in mental healthcare. How can employment specialists be integrated in the organization as a profession responsible for RTW issues and how can implementation of integrated RTW interventions become further enhanced? Could researchers and clinicians have a closer collaboration to facilitate implementation of new interventions?

There is a need to further explore empowerment processes among people with affective disorders and the meaning it has in a RTW process. There is also a need to study occupational engagement during long-term sick leave in the target group to explore occupational patterns and how these can hinder or facilitate a RTW. This is also important in relation how long-term sick leave can be avoided and early RTW can be facilitated.

Summary in Swedish/Svensk sammanfattning

Bakgrund

Både i Sverige och internationellt är sjukskrivningarna höga p.g.a. psykisk ohälsa. Psykisk ohälsa tillsammans med muskuloskeletal smärta är de vanligaste orsakerna till långvarig sjukskrivning (>60 dagar). Med stigande och långvariga sjukskrivningar har forskningen också ökat kring frågeställningen hur stödet för återgång i arbete ska se ut. Återgång i arbete kan ses som en process, individens väg tillbaka till ett arbete, men det kan också fungera som ett utfallsmått i forskning och på så sätt visa ifall återgång i arbete uppnåddes eller inte efter en intervention. För personer som inte har en anställning handlar utfallsmåttet om att faktiskt bli anställd. Långa sjukskrivningar är negativt både för personerna som är drabbade och för samhällsekonomin. I Sverige har sjukskrivningarna för psykisk ohälsa ökat under flera år men enligt en aktuell rapport från Försäkringskassan, har ökning av sjukskrivningarna p.g.a. psykisk ohälsa stannat upp men däremot blir sjukskrivningarna längre. Att sjukskrivningsökningen har stannat upp beror troligen på att staten under många år reformerat sjukförsäkringen vid flera olika tillfällen och tillfört ekonomiska medel till landsting och kommuner för att förbättra arbetet med, och samordningen av, sjukskrivningar. Rehabiliteringsgarantins införande gjorde exempelvis att många personer fick tillgång till evidensbaserad rehabilitering inom primärvården gällande långvarig smärta eller psykisk ohälsa som omfattade depression, ångestsyndrom och utmattningssyndrom. Vid utvärderingen av denna garanti visades att många personer hade höjt livskvaliteten och på det sättet ökat sin hälsa men någon effekt på återgång i arbete visades inte. Vad gäller de nationella riktlinjerna för vård vid depression och ångestsyndrom, påpekas att arbete och studier är ett viktigt mål på individnivå men eftersom det inte finns några interventioner med evidens för återgång i arbete, finns följdriktigt inte heller några riktlinjer för den typen av intervention. Snarare har det påpekats i både forskning och rapporter att bristen på evidens för

återgång i arbete för personer med depression är allvarlig och att mer forskning kring interventioner behövs. Det har också konstaterats att gruppen personer med psykisk ohälsa såsom depression och ångestsyndrom är i behov av mer stöd för att komma tillbaka till arbete än vad de faktiskt får idag. I linje med rehabiliteringsgarantin initierades en forskningssatsning på interventioner för återgång i arbete och minskning av sjukskrivningar 2009, vid namn Rehsam, rehabilitering och samordning. Denna avhandling är en del av denna satsning, ett av forskningsprojekten, där en typ av intervention för återgång i arbete utvärderas för personer med affektiva sjukdomar, såsom depression och bipolär sjukdom. Modellen heter Individual Enabling and Support (IES) och är en utveckling av den evidensbaserade modellen för stöd till arbete (Supported Employment), Individual Placement and Support (IPS) för personer med svår psykisk ohälsa såsom schizofreni eller andra psykossjukdomar. IPS har visat sig vara effektiv för återgång i arbete, d.v.s. bli anställd, eftersom det till största delen handlar om personer som inte har någon anställning sedan tidigare. I den här evidensbaserade modellen integreras stödet till arbete i psykiatrin genom att stödpersonen, som kallas arbetsspecialist, har sin hemvist på den psykiatriska mottagningen och jobbar tillsammans med det stödteam som finns kring individen. Arbetsspecialisten samordnar alla insatser som har med arbetsåtergång att göra utifrån en persons önskemål och intressen och är den stödperson som kontinuerligt finns till hands. Denna typ av person-centrerat stöd för återgång i arbete och att arbetsfrågorna integreras i psykiatriarbetet tycks vara viktiga komponenter för att återgång i arbete ska lyckas.

Att integrera frågor kring återgång i arbete inom det psykiatriska behandlingsarbetet är dock inte självklart. Tidigare studier av evidensbaserat stöd till arbete visar att det kan vara svårt att införa den typen av integrering i en s.k. traditionell arbetsrehabiliteringsstruktur där välfärdsorganisationerna som är inblandade i arbetsrehabilitering, är sektoriserade och arbetar efter sina regler och lagar för återgång i arbete. Även om samverkan mellan organisationer är reglerad kan det ändå vara svårt att utföra den i praktiken. Det finns således flera utmaningar i att införa en integrerad modell i den rådande strukturen för psykiatrisk behandling och stöd till arbete som fortsatt behöver undersökas för att öka kunskapen om möjligheterna till implementering. Det huvudsakliga intresset i denna avhandling är dels att undersöka ifall IES modellen är en effektiv modell för arbetsåtergång för personer med affektiv sjukdom och dels att undersöka vilka väsentliga faktorer som kan ha betydelse för en implementering av den här typen av modell i öppenvårdspsykiatri.

Den här avhandlingen har skrivits inom Institutionen för Hälsovetenskaper med inriktning mot arbetsterapi och baseras därför på grundläggande antaganden och inriktningar inom dessa områden. En utgångspunkt för den här avhandlingen är synen på psykisk hälsa såsom den beskrivs av Världshälsoorganisationen, som ett tillstånd av välbefinnande där individer kan upptäcka sin egen potential och klara av att hantera livets olika påfrestningar som normalt förekommer men också att kunna arbeta och bidra till det samhälle där hon lever (WHO, 2004). Den här beskrivningen stämmer väl överens med arbetsterapeutisk kunskap och forskning. Ett grundläggande antagande i arbetsterapi gäller synen på människan som en varelse som är i behov av att engagera sig i olika aktiviteter för att må bra. Det här antagandet har historiskt sett alltid funnits med i arbetsterapi och utgör mycket av drivkraften kring forskningen om aktiviteter och dess betydelse för människor samt för hur arbetsterapi-interventioner utformas. Arbetsterapeuter arbetar till stor del med att möjliggöra aktiviteter för personer som av olika anledningar inte kan eller har möjlighet att utföra de aktiviteter som de vill och behöver göra. Det här är viktigt eftersom forskning visar att det finns ett samband mellan vad personer gör och deras hälsa, vilket bl. a. inbegriper vilken mening personer tillägnar olika aktiviteter och hur de upplever den respons de får från den omgivande miljön vid aktivitetsutförande (Wilcock, 2015). Det finns också en koppling mellan vad personer gör och hur de uppfattar sin identitet (Cristiansen, 2010). Inom arbetsterapi används aktiviteter också som ett terapeutiskt medel för att möjliggöra för personer att nå till de mål som de har, vilket är ett sätt för personen att bli medvetna om egna resurser och förmågor. När det gäller aktiviteten arbete, visar det sig att det har stor betydelse för subjektivt välmående att ha ett arbete, kanske framför allt i kulturer där lönearbete är av stor betydelse i samhället och utgör en stor del av människors identitet. I sådana samhällen kan det därför bli ett lidande för människor som inte har ett arbete p.g.a. sjukdom och som har små möjligheter att återgå i arbete. Den här avhandlingen har ett fokus på återgång i arbete och hur denna återgång kan möjliggöras med hjälp av IES modellen, för att människor som är långtidssjukskrivna p.g.a. affektiva sjukdomar och som inte har någon anställning ska kunna återgå i arbete.

Aktivitetsengagemang, livskvalitet och egenmakt

I tidigare forskning om evidensbaserat stöd till arbete har det visats att aktivitetsengagemang, livskvalitet och egenmakt är faktorer som har betydelse för personerna som deltar i stödet till arbete.

Aktivitetsengagemang innebär att mäta i vilken utsträckning personer är engagerade i aktiviteter över tid, vilken typ av aktiviteter som personer är engagerade i, hur dessa aktiviteter upplevs och ifall de utförs i olika kontexter, exempelvis i hemmiljön men också ute i samhället. Att mäta aktivitetsengagemang är ett sätt att undersöka och förstå hur engagemanget är kopplat till hälsa. För personer med svår psykisk ohälsa som genomgick evidensbaserat stöd till arbete, visade en studie att ett ökat aktivitetsengagemang med dagliga rutiner både hemma och i samhället samvarierade med egenmakt (Bejerholm & Björkman, 2011). I samma grupp har det också visats att motivation till arbete samvarierar med aktivitetsengagemang (Bejerholm & Areberg, 2014). Det tycks således väsentligt att undersöka aktivitetsengagemang när arbetsåtergång studeras, särskilt eftersom affektiva sjukdomar med fokus på depression, ofta påverkar i riktningen att personer som är drabbade blir mindre benägna att engagera sig och initiera olika aktiviteter och kanske t.o.m. att isolera sig.

Att undersöka livskvalitet är ett sätt att få kunskap om personers egen uppfattning av den egna hälsan i förhållande till flera olika livsdomäner som exempelvis arbetsliv, fysisk och psykisk hälsa, privatekonomi och sociala relationer. Livskvalitet mäts ofta före och efter en intervention för att se ifall interventionen haft effekt på självskattad hälsa. Livskvalitet samvariear negativt med grad av depression, d.v.s. livskvaliteten är lägre när graden av depression är högre. För personer med svår psykisk sjukdom ökade livskvaliteten i domänerna arbete, ekonomi och sociala relationer efter att de deltagit i evidensbaserat stöd till arbete. Hos personer med depression har livskvalitet kopplats till möjligheter att delta i aktiviteter som upplevs meningsfulla och önskvärda samt till möjligheten att utveckla sin egen kompetens och hanteringsförmåga (Pan et al., 2012).

Motivation och tilltron till sin egen förmåga att kunna utföra olika aktiviteter hänger nära samman med egenmakt. Egenmakt är viktig för alla personer i förhållande till synen på de egna framtidsutsikterna och vad det finns för möjligheter att påverka dessa. På individnivå handlar egenmakt om att kunna fatta beslut i olika livsval som exempelvis kan handla om arbete eller personliga relationer. Det handlar också om en medvetenhet och kunskap om hur olika förutsättningar i samhället kan möjliggöra eller hindra att personer kan nå de mål som de själva sätter upp. Egenmakt har också visat sig viktigt inom stödet för återgång i arbete eftersom det sätter fokus på ett mer hälsorelaterat perspektiv som bygger på att alla personer har resurser som gör att de kan komma vidare till sina egna uppsatta mål ifall förutsättningarna finns. Att arbeta med ett perspektiv på egenmakt innebär bl.a. att ge personer möjlighet att stärka sin egen tilltro på egna förmågor. Ifall detta inte tillgodoses när det gäller exempelvis bemötande från olika

aktörer i en arbetsrehabilitering, har det visat sig att personer upplever minskad egenmakt och större svårigheter att faktiskt återgå i arbete (Hillborg, 2010).

När det gäller personer med affektiv sjukdom visar forskning att både arbetsförmåga, psykosociala funktioner, kognition, motivation och förmågan att engagera sig i dagliga aktiviteter kan bli nedsatt (Adler et al., 2006, Baker & Procter, 2014, Beck et al., 2011, Lagerveld et al., 2010). De depressiva perioderna för personer med bipolär sjukdom har visat sig påverka mest i förhållande till arbete och sjukskrivningar, mer än de maniska perioderna (Gilbert & Marwaha, 2013). Förhållandevis har personer med affektiva sjukdomar långa sjukskrivningar och riskerar därmed att ha en osäker plats på arbetsmarknaden, att förlora arbetet p.g.a. svårigheter att upprätthålla sin arbetsförmåga och p.g.a. återkommande depressiva perioder har rapporterats (Lauber & Bowen, 2010). Att inte ha ett arbete att relatera till och ingen arbetsgivare som stödjer personen under en lång sjukskrivningsperiod, försvårar arbetsåtergången. Dessutom har arbetslöshet i sig visat sig relatera till högre risk för depression (Jefferis et al., 2011).

Det finns ett stort antal faktorer som kan påverka återgången i arbete och dessa kan röra både individnivån, arbetsgivare och olika aktörer i samhället som är inblandade i arbetsrehabilitering. Några viktiga faktorer handlar om att personer som är långtidssjukskrivna kan förlora sin arbetsidentitet vilket i sin tur påverkar hur personen ser på sina möjligheter och på sin förmåga att klara av att komma tillbaka till arbete (de Vries et al., 2014, Lagerveld et al., 2010, Ekbladh, Haglund & Thorell, 2004). Andra faktorer som studerats och som visat sig påverka återgång i arbete handlar om längden på sjukskrivning (Riihimäki et al., 2015), ålder (de Vries, 2017,), könstillhörighet och grad av depression (Banerjee et al. 2014). Samtidigt har forskning visat att när personer deltar i arbete under en återgångsprocess så minskar graden av depression (Hees et al. 2013, Modini et al., 2016). När personer skattar den egna hälsan som bra, ökar möjligheten för återgång i arbete precis som stöd från den egna familjen ökar möjligheten (Lammerts et al., 2015, Nielsen et al., 2012). Att socialt stöd för återgång i arbete är positivt gäller också stödet från kollegor och chef på själva arbetsplatsen (de Vries et al., 2012, Lexén, Hofgren & Bejerholm, 2013). Det har visat sig att det är viktigt för personer att känna sig trygga på arbetsplatsen för att arbetsåtergången ska lyckas (de Vries et al., 2014).

Traditionell arbetsrehabilitering och Individual Enabling and Support modellen

I litteraturen om evidensbaserat stöd för återgång i arbete beskrivs att det går att urskilja två olika perspektiv på stöd till arbete (Corrigan, 2001). Det första perspektivet benämns som ”place-train” och handlar om just evidensbaserat stöd där personer får stöd till arbete genom att tillämpa principen att börja söka arbete tidigt i processen utan att först genomgå arbetsförmågebedömningar och stegvis arbetsträning i olika arbetsliknande sammanhang. Det andra perspektivet benämns i sin tur ”train-place”, d.v.s. arbetsträning tillämpas i flera steg innan personen kan påbörja en anställning. Det senare perspektivet tillämpas oftast inom den traditionella arbetsrehabiliteringen både internationellt och i Sverige och kan ses som en följd av ett medicinskt perspektiv där sjukdom först ska behandlas och symtom ska minskas innan en person är redo att börja arbeta. Inom forskningen om personer med svår psykisk sjukdom kontrasteras ofta dessa perspektiv för att lyfta nyttan med att bygga stödet för återgång i arbete på människors egen upplevelse av återhämtning i ett person-centrerat stöd där egenmakt är en viktig komponent.

I benämningen traditionell arbetsrehabilitering menas den kedja av aktörer som på olika sätt arbetar med att stödja personer i att behålla, eller återgå i arbete (Waddell et al., 2008). I Sverige utgörs dessa aktörer av öppenpsykiatrin (hälso- och sjukvården), arbetsgivare, Försäkringskassan, Arbetsförmedlingen (vid arbetslöshet) och kommunen. Aktörerna har alla ett ansvar för arbetsrehabiliteringen och deras områden överlappar varandra men det är samtidigt inte helt tydligt var gränserna går för när någon aktör börjar och en annan slutar ge stöd (Ekberg, 2015). Det finns dock samverkansavtal som reglerar aktörernas samverkan men dessa är inte alltid är enkla att överföra i praktiken. Återkommande bedömningar av personers arbetsförmåga görs inom ramen för den s.k. rehabiliteringskedjan. Personer som har en arbetsgivare bedöms i relation till det arbete som tidigare utförts eller liknande arbetsuppgifter medan personer som inte har en arbetsgivare bedöms i relation till vilket arbete som helst som finns på arbetsmarknaden. Inom den traditionella arbetsrehabiliteringen tillämpas ofta praktik på olika arbeten som ett sätt att komma närmare en anställning och för att träna arbetsförmågor. Det finns också tillgång till olika kurser och utbildningar.

I IES modellen tillämpas principerna från evidensbaserat stöd för återgång i arbete, tillsammans med strategier från motiverande samtal, kognitiv beteendeterapi och strategier för s.k. tid-för-arbete. Dessa strategier har lagts till som en utveckling av evidensbaserat stöd till arbete för att på ett bättre sätt kunna möte de behov som personer med affektiva sjukdomar

kan ha vad gäller att återgå i arbete. Motiverande strategier tillämpas för att förbereda personer för en förändring, sätta igång processen för återgång i arbete och för att personen ska utgår från sina egna önskemål vad gäller planeringen för arbetsåtergång. Kognitiva strategier används för att personer ska bli medvetna om olika tankar och beteenden som kan stödja eller hindra dem från att komma vidare till ett arbete, och att hitta olika hanteringsstrategier som kan tillämpas i olika arbetssituationer eller när personen söker ett arbete. Ett sätt att stimulera beteendeförändring är att personer får möjlighet att öka sin tilltro till de egna förmågorna. Strategier för att hitta utrymme för arbete tillämpas också, som ett sätt att hitta bra rutiner och engagemang i olika aktiviteter för att personer ska våga återgå i arbete efter en lång period av sjukskrivning. Dessa s.k. möjliggörande strategier kombineras och integreras sedan med principerna för evidensbaserat stöd till arbete som utgörs av: personer är behöriga att delta i stödet ifall man vill arbete, d.v.s. det behövs ingen bedömning av arbetsförmåga i förväg, tidigt i processen påbörjas sökandet efter arbete, arbetssökandet baseras på personen önskemål och intressen, målet är konkurrensutsatt anställning, IES integreras i öppenpsykiatrin, stör på arbetsplatsen pågår så länge som personen själv upplever att det behövs, samordning av Försäkringskassan och Arbetsförmedling där personen får information om ekonomiska ersättningar kring sjukskrivningen, uppbyggnad av arbetsgivarnätverk och upprättande av goda relationer med arbetsgivare.

Syfte och metod

Det övergripande syftet med den här avhandlingen var att utvärdera en nyutvecklad modell för återgång i arbete för personer med affektiva sjukdomar som också är arbetslösa, avseende modellens effektivitet och dess innehåll. Det fanns ett särskilt fokus på vilka behov personer med affektiv sjukdom har vad gäller återgång i arbete, hur strategierna som utvecklats för modellen tillämpades och vilka väsentliga implementeringskomponenter som kunde identifieras.

Avhandlingen hade en randomiserad kontrollerad studiedesign där IES modellen jämfördes med traditionell arbetsrehabilitering. I avhandlingens delstudier användes även tvärsnittsdesign och fall-studiedesign.

Personerna som deltog i studien var personer som var långtidssjukskrivna p.g.a. affektiv sjukdom; depressiv period, återkommande depression, bipolär sjukdom med depressiv period, och som var arbetslösa. Det slutgiltiga antalet deltagare var 61 (IES=33, traditionell arbetsrehabilitering=28). De

hade alla tillgång till behandling inom den öppenpsykiatriska vården där IES modellen prövades. I Studie I undersöktes samvariationen mellan de hälsorelaterade faktorerna egenmakt, livskvalitet, arbetsmotivation, aktivitetsengagemang och grad av depression, i Studie II utvärderades effekten av IES modellen avseende återgång i arbete, d.v.s. anställning eller inte, i en jämförelse mellan gruppen som deltagit i IES och gruppen som haft tillgång till traditionell arbetsrehabilitering. Mätningar gjordes vid baslinjen, 6 och 12 månader. Även förändring i grad av depression och livskvalitet utvärderades, inkomstförändring samt antal timmar och veckor som personerna hade arbetat och hur lång tid det tog att få en anställning. I Studie III undersöktes själva IES modellen och dess kvaliteter genom en illustration av arbetsåtergångsprocessen för fem olika fall. Slutligen i Studie IV undersöktes vilka viktiga implementeringskomponenter som kunde identifieras i införandet av IES modellen i den traditionella arbetsrehabiliteringskontexten.

Studiekontext

Interventionen av IES modellen genomfördes vid fyra olika öppenpsykiatriska mottagningar på orter av medelstor storlek i södra Sverige. Mottagningarna var organiserade i multidisciplinära team för personer med affektiv sjukdom och bestod av läkare, sjuksköterskor, psykologer, kuratorer, arbetsterapeuter och fysioterapeuter. Teamen var dock inte samordnade runt personer med affektiv sjukdom på så sätt att de arbetade tillsammans med personerna, utan de flesta i behandlingspersonalen träffade personerna enskilt. Samarbete genomfördes också med chefer och personal på lokala Arbetsförmedlingskontor och kontor för Försäkringskassan, vilka var spridda på olika orter beroende på organisation och upptagningsområde. Två arbetsspecialister rekryterades för att genomföra IES modellen och de genomgick utbildning i evidensbaserat stöd till arbete och kontinuerlig handledning av psykolog och erfarna arbetsspecialister under interventionstiden. Två forskningsassistenter anställdes för att genomföra datainsamlingen. Organisatoriskt sett fanns det en styrgrupp inom regionen där den huvudansvariga forskaren och avhandlingens författare deltog på möten. Avhandlingens författare arbetade till en början i projektet som projektadministratör med ansvar för information och kommunikation mellan alla berörda parter i projektet.

Då detta arbete var en randomiserad kontrollerad studie följdes de riktlinjer som är uppsatta av Consort-gruppen för RCT-studier, med ett registrerat studienummer, ISRCTN93470551. Studien har också godkänts av Etiknämnden vid Lunds Universitet, (Dnr 2011-544). Datainsamling för de olika delstudierna skedde på flera olika sätt. I Studie I och II användes ett

flertal instrument varav alla var psykometriskt utvärderade och forskningsassistenterna insamlade också uppgifter var tredje månad angående arbetsutfall. All data som var på ordinalskalenivå analyserades i stort med icke-parametrisk statistik och kvotdata analyserades med parametrisk. I studie III genomfördes semi-strukturerade intervjuer med fem deltagare i IES interventionen och i Studie IV med nyckelpersoner från implementeringsprocessen. Intervjuer gjordes dessutom med de två arbetsspecialisterna i båda dessa studier. Dessutom användes i studie III arbetsdokument från interventionen och minnesanteckningar och i studie IV användes dokument från mötesprotokoll och daganteckningar från planeringen och genomförandet av IES interventionen. All data i Studie III och IV analyserades med innehållsanalys samt fall-analys.

Resultat

Eftersom ett huvudsyfte med den här avhandlingen var att utvärdera effekten av IES modellen avseende arbetsåtergång, presenteras resultatet från denna RCT-studie först, följt av Studie I, III och IV.

Då utfallet mättes efter 12 månader, avseende arbete på den öppna arbetsmarknaden, hade 42.4% av deltagarna i IES anställning, medan 4% av deltagarna i traditionell arbetsrehabilitering hade anställning. Det var en skillnad på 38% och en effektstorlek på 0.44 (Cramer's Phi effektstorlek; liten=0.10, medel=0.30, stor =0.50). Denna skillnad var statistiskt signifikant. Resultaten visade också att betydligt fler deltagare i traditionell arbetsrehabilitering var i praktik vid 12 månader jämfört med IES-gruppen. Vid 12 månader arbetade deltagarna i IES-gruppen fler timmar, fler timmar per vecka och antal veckor än gruppen från traditionell arbetsrehabilitering. IES-gruppen hade också en större inkomst, en lägre grad av depression och högre livskvalitet jämfört med kontrollgruppen. Vad gäller psykosociala färdigheter fanns också en statistiskt signifikant skillnad till IES-gruppens fördel vid 12 månader.

I Studie I visades att det fanns en negativ samvariation mellan egenmakt, livskvalitet och grad av depression, oddsen för att tillhöra gruppen med svårare depression minskade med ökad egenmakt och livskvalitet. Ingen samvariation hittades mellan motivation till arbete, aktivitetsengagemang och grad av depression. Studie I visade också det var mer än 4 år sedan deltagarna senast hade haft ett arbete, i medeltal på gruppnivå, och att 95% av gruppen hade arbetserfarenhet samt att majoriteten inte deltog i någon arbetsrehabilitering vid baslinjemätningen.

I Studie III undersöktes IES modellens innehåll och process med hjälp av fem deltagare i en fall-studie. I fallen illustrerades hur de olika principerna för användning av kognitiva och motiverande strategier och tid-för-arbete kombinerades med principerna för stöd till arbete i ett person-centrerat stöd till arbete. Deltagarna beskrev att stödet hjälpte dem att öka sitt självförtroende och sin tilltro till att de skulle klara av att återgår i arbete igen. Deltagarna beskrev också hur de lärde sig arbetsrelaterade hanteringsstrategier för att klara av jobbintervjuer eller olika arbetssituationer framför allt då det gällde social interaktion.

I Studie IV framkom olika komponenter utifrån ett teoretiskt ramverk implementering, som hade betydelse för implementeringsprocessen, d.v.s. införandet av IES modellen i de öppenpsykiatriska mottagningarna och i samarbetet med Försäkringskassan och Arbetsförmedlingen. Implementeringen gick att genomföra på de olika mottagningarna till synes mycket p.g.a. att IES modellen uppfattades ha många fördelar i jämförelse med andra modeller och att det fanns en utbredd uppfattning om att personer med affektiv sjukdom är i behov av mer stöd vad gäller återgång i arbete än vad som är fallet. Dessa uppfattningar gjorde att IES modellen accepterades, vilket är viktigt i början av en implementering. Det fanns också betänkligheter vad gällde passformen för IES modellen i den traditionella arbetsrehabiliteringskontexten, ifall modellen passade in och ifall arbetsspecialisterna skulle vara med på team-konferenser. Dessutom var det svårt för mottagningscheferna att tidsmässigt prioritera IES projektet och det uppstod långa processer i återgången till arbete p.g.a. att deltagarna många gånger behövde följa den traditionella vägen till arbete med praktikplatser som anvisades.

Konklusion

Sammanfattningsvis visar den här avhandlingen den första evidensen i Sverige för att den här typen av utvecklad modell, stöd till arbete, fungerar för att stödja personer med affektiva sjukdomar tillbaka till arbete. Studieresultaten är i linje med en liknande studie från Norge där den evidensbaserade modellen stöd till arbete också var utvecklad för att bättre möta behoven för personer med depression och ångestsyndrom, och där resultaten visade att framför allt personerna som var långtidssjukskrivna kom tillbaka till arbete. Avhandlingen visar också att det tycks behövas ett personcentrerat stöd för återgång i arbete för den här målgruppen och att gruppen kan ha stor nytta av att erbjudas metoder från motiverande samtal, kognitiva och tidsanvändningsstrategier som är kopplade till arbete för att

öka självförtroendet och tilltron till att kunna komma tillbaka till arbete. Avslutningsvis tillför den här avhandlingen också kunskap om olika implementeringskomponenter som är av vikt för införande av den här typen av integrerat stöd till arbete i öppenpsykiatrin, där det finns möjligheter men också utmaningar för införandet av IES modellen.

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