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SUSANN PORTER
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Critical factors for the return-to-work process

Perspectives of individuals with mental health problems, vocational rehabilitation professionals, and employers

This thesis has examined the critical factors in the return-to-work (RTW) process from the perspective of individuals with mental health problems, vocational rehabilitation professionals and employers. The results showed the critical importance of providing individuals with hope and power, the need for professionals to have positive attitudes, beliefs and behaviours that support the RTW-process. Furthermore, the results showed the importance of employing a holistic perspective and integrating mental health with vocational services. When these enabling factors were provided, individuals increased their empowerment and decreased their depressive symptoms. Vocational rehabilitation professionals need to increase their mental health literacy since they have a critical role toward both the individual and employers. Employers also need to increase their mental health literacy and other actors in the RTW-process need to improve their understanding of the employer's situation and provide them with necessary support.

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Susann Porter

LUND
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Perspectives of individuals with mental health problems, vocational rehabilitation professionals, and employers

Abstract

Introduction: Mental health problems are a major concern among todays working age population. This is experienced by individuals as personal suffering and a loss of income, and by society overall as a financial burden regarding sick leave, healthcare costs and a loss of productivity of individuals outside the labour market. When an individual is in the return-to-work (RTW) process, they often need support from both vocational rehabilitation professionals and employers. Insufficent support can present a barrier for a successful RTW-outcome.

Aims: *Study I*: To explore which factors are of critical importance for individuals with affective disorders in their RTW-process, and to explore the impact of two vocational approaches, Traditional Vocational Rehabilitation (TVR), and Individual Enabling and Support (IES), on the service users' experiences of the RTW-process. *Study II:* To evaluate the effect of the IES and TVR approaches on empowerment and depression severity after 12-months of intervention. *Study III:* To explore the mental health literacy of vocational rehabilitation professionals and their perceptions of employers in the RTW-process. *Study IV:* To examine employers' beliefs, knowledge and strategies used in providing support to employees with mental health problems.

Methods: Studies I and II were based on the same parallel randomized controlled trial (RCT) (*n*=61) of individuals with affective disorders participating in either TVR or IES**.** *Study I* was a qualitative study using content analysis. Participants (*n*=16), purposely sampled from the RCT, had undergone TVR (*n*=8) or IES (*n*=8) interventions over the preceding 12-months. *Study II* was a quantitative study including all 61 RCT participants (TVR *n*=28 and IES *n*=33). *Studies III and IV* both applied the grounded theory methodology, with S*tudy III* including (*n*=22) vocational rehabilitation professionals, and S*tudy IV* (*n*=24) employers.

Results: In S*tudy I* three themes of importance in the RTW-process emerged: To experience hope and power, Professionals positive attitudes, belief and behaviour, and Employing a holistic persepctive and integrating health and vocational service. In *Study II* a statistically significant difference was found between TVR and IES where the IES participants showed an increase in empowerment and a decrease of depression which was not seen among the TVR participants. In *Study III* three categories emerged regarding the vocational rehabilitation professionals: Holding a position of power in the RTW-process, Viewing and believing in individuals' work ability plays a central role, and Recognizing employer's role as a key factor for realizing employment. In *Study IV,* two categories emerged: Comprehending mental health problems is complex, and Lacking established conditions to support work.

Conclusion: From the perspective of individuals with affective disorders the results highligted the importance of the IES approach i.e. having an Employment Specialist working together with the individual in a person-centered manner, and integrating vocational services with health services towards the goal of competitive employment. When doing so, the result showed increased empowerment and decreased depression. It is therefore critical to increase the mental health literacy among both vocational rehabilitation professionals and employers. Such knowledge may strengthen collaboration between them and close time and service gaps that exist among welfare organisations involved in the RTW-process.

Key words: employment, mental health problems, return-to-work, RTW support, vocational rehabilitation

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MADE IN SWEDEN

To Emma, Oskar and Mark

"To dare is to lose one's footing momentarily.
Not to dare is to lose oneself".

Søren Kierkegaard

Content

Acknowledgement

As I reach the conclusion of this PhD journey there are numerous people I would like to thank.

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My sincere gratitude goes to all the participants who have taken part in the four thesis studies and shared their experiences. You have all contributed to important research in the mental health field and I will do my very best to use the results to contribute to an improved return-to-work process.

To my doctoral colleagues, some who have finished their PhD journey by now, but who I have known for years: Suzanne Johanson, you have been so kind to me. You let me share your office when I started in the group, helped me understand the mental health field and listened at times when I doubted myself and my ability. Your support has been very important, thank you. Jenny Hultqvist, you have been a rock to lean on throughout the journey, beginning when we took our Master's degrees. I love our morning conversations and how you are happy for every little step I take, thank you for all your advice and support. Kristy Lund, you have been my room neighbour over these three years. You have helped me to understand grounded theory and you have remembered to celebrate my milestones, including a mountain summit, thank you. To both Suzanne and Kristy, I would also like to say a special thank you for taking your time to be my opponents during my kappa seminar. Pia Hovbrant, you are so talented, a kind and frank person, giving me advice and always providing good interesting conversation and making me laugh, when I really needed it, thank you. Ulrika Liljeholm, you are so generous and supporting, I am so glad I have had to opportunity to get to know you. Bodil, thank you for your good and friendly Danish spirit, you can do this too. To Patrik, you are so clever and kind, with amazing computer skills, thank you for helping me when I most needed it. I promise you the view from the top is worth all the hard work.

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Abbreviations

CA	Complementary Actor
ICD-10	International Classification of Diseases 10th Edition
IDI	In Depth Interview
IES	Individual Enabling and Support
IPS	Individual Placement and Support
ITT	Intention to Treat
MHS	Mental Health Service
OHS	Occupational Health Service
PC	Primary Care
PES	Public Employment Service
RCT	Randomized Controlled Trial
RTW	Return-To-Work
SIA	Social Insurance Agency
TVR	Traditional Vocational Rehabilitation
WHO	World Health Organization

Definitions used in this thesis

Affective disorder	An umbrella term including depression and bipolar disorders (WHO, 1993).
Empowerment	Empowerment is referred to as the level of control, choice and influence the user of the mental health service has over events in their lives (WHO, 2010).
CONSORT guidelines	Consolidated Standard of Reporting Trials contains a checklist and a flow diagram, established to improve the quality of reporting Randomized Controlled Trials (RCT) (Moher et al., 2010).
CHIME framwork	The CHIME framwork consists of five recovery-oriented components: Connectedness, Hope and Optimism about the future, Identity, Meaning in Life, and Empowerment (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).
Mental health literacy	"…knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking." (Jorm et al., 1997, p. 182).
Mental Health	"… state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community." (WHO, 2018, p. 1).
Mental health problems	The term mental health problems is used interchangeably in this thesis referring to mental health condition, illness, disability, disorder, issues, including diagnosed and undiagnosed conditions.
Recovery	The term recovery in relation to mental health has two meanings: clinical recovery and personal recovery. Personal recovery is a process of changing one's feelings, attitudes, values and goals to live a satisfying, hopeful and contributing life even with limitation due to an illness (Anthony, 1993). Clinical recovery is achieved when the mental illness has reached full remission (Slade, 2009a).
Return-to-work	The return-to-work (RTW) process refers to the process an individual with mental health problems follows when returning to, and remaining at work (Ekberg, Eklund, & Hensing, 2015; Waddell et al., 2008, Young et al., 2005).

List of publications

This thesis comprises the following papers:

I. Porter, S., Lexén, A., Johanson, S., & Bejerholm, U. (2018). Critical factors for the return-to-work process among people with affective disorders: Voices from two vocational approaches. *Work*, 60(2), 221-234.

II. Porter, S., & Bejerholm, U. (2018). The effect of individual enabling and support on empowerment and depression severity in persons with affective disorders: Outcome of a randomized control trial. *Nordic Journal of Psychiatry*, 72(4), 259-267.

III. Porter, S., Lexén, A., & Bejerholm, U. (2019). Mental health literacy among vocational rehabilitation professionals and their perception of employers in the return-to-work process. *Journal of Vocational Rehabilitation,* 50(2), 157-169.

IV. Porter, S., Lexén, A., & Bejerholm, U. (2019). Employers' beliefs, knowledge and strategies used in providing support to employees with mental health problems. *Journal of Vocational Rehabilitation*, 51(3). In press.

Preface

I grew up in Norrbotten, in the north of Sweden, in an environment where my parents gave me freedom to explore who I was and what I wanted to become later in life, both as a person and professionally. Ever since I was 15 years old, I have in one way or the other worked with people who suffer from different illnesses or have had accidents that have influenced their life. During my younger years in a summer job and later as an occupational therapist. During these years I have met so many people with different physical disabilities but also those who suffer from mental health problems. All of them facing a variety of challenges in their lives, and in need of support from others in order to be able to live a life with quality.

I have learned during my own career, that without support and people who believe in you, it does not matter how hard you work, and how much you want to achieve something, your goal might still be unattainable. However, with the right support and with people who do believe in your ability, empowering you and seeing your potential, you can achieve the most extraordinary thing, you can receive a PhD.

I have had the privilege of researching the RTW-process from multiple perspectives, those of individuals with mental health problems, vocational rehabilitation professionals and employers. I believe the results of this thesis can improve our understanding of the RTW-process and can contribute to improving this process for individuals with mental health problems.

Context of this thesis

This thesis focuses on Health Science, specializing in mental health. It has been carried out at the Department of Health Sciences/Mental Health, Activity and Participation research group at Lund University, Sweden. This research group is part of the Swedish national network: Center for Evidence-based Psychosocial Interventions (Center för Evidensbaserade Psykosociala Insatser CEPI).

Prior to entering my doctoral studies, I received a Bachelor's degree in occupational therapy in 2001, and a Master's degree in Medical Science in 2014, with the focus on working environment and health.

During my years as a doctoral student, I have participated in several seminars both with other doctoral students with a background as occupational therapists, and interdisciplinary seminars such as those within CEPI. I have also, as part of my doctoral studies, participated in compulsory courses, and there participated in different research contexts. It has been a privilege and a challenge to take part in other research environments, and to have the opportunity to discuss my specific research field. The seminars have given me the opportunity to reflect on and explain my research, return to the literature and learn more, put questions to other more experienced colleagues and also listen to my own voice and to learn to trust myself and the skills I possess. These opportunities to meet with other researchers, and the knowledge I have gained during these years, have been part of my journey to complete my thesis work. I am very grateful for the opportunity to have taken part in these different research contexts.

Project context

In the research context of developing knowledge about critical return-to-work (RTW) factors, it has been crucial not only to reflect on the perspectives of individuals with mental health problems but also the perspectives of those vocational rehabilitation professionals and employers involved in the process. Studies I and II took place within the research context of REHSAM (Rehabilitation in collaboration). The aims were to evaluate rehabilitation methods that would help individuals of working age regain their working capacity and to RTW after sick leave and unemployment. The project was carried out between 2010 and 2015, following the agreement on the rehabilitation guarantee amongst the Swedish municipalities.

The Individual Enabling and Support (IES) project within Studies I and II was initiated due to a lack of research on evidence-based vocational rehabilitation methods in RTW for individuals with affective disorders and who were unemployed. The research had instead been focused on clinical recovery, seen as a reduction of mental health symptoms in the mental health service setting, separated from the vocational rehabilitation (Joyce et al., 2016). This focus was shown to lead to time and service gaps between different actors thus prolonging the RTW-process in this Traditional Vocational Rehabilitation (TVR) chain (Bejerholm, Areberg, Hofgren, Sandlund, & Rinaldi, 2015; Johanson, Markström, & Bejerholm, 2017). Individual Enabling and Support (IES) was developed as an alternative to this stepwise TVR approach. IES is based on the individual's personal recovery goals connected to employment (Bejerholm, 2016). The method is a modification of the evidence-based supported employment approach Individual Placement and Support (IPS), originally developed for individuals with psychosis (Bejerholm et al., 2015). IES integrates motivational, cognitive and time use strategies to better support the needs of individuals with affective disorders. The overall aim of the IES project was to study the effectiveness in terms of employment rate of the IES approach compared to TVR (Bejerholm, Larsson, & Johanson, 2017). Studies I and II in this thesis compare the participants' perception of the RTW-process using the IES and TVR approach, and the effectiveness in terms of both clinical and personal recovery. It was evident in Studies I and II that there was a service and knowledge gap in the RTW-process in the TVR approach for individuals with mental health problems. It

was thus important in Studies III and IV to explore the mental health literacy of vocational rehabilitation professionals and employers.

Studies III and IV were part of a project called Support to Employers from Rehabilitation Actors about Mental health (SEAM) funded by the Social Insurance Agency (SIA). The overall aim was to increase knowledge of the support employers need in assisting individuals with mental health problems in the RTW-process, and when recruiting and employing individuals with mental health problems. The aim was also to develop, implement and evaluate an intervention for providing the employer with adequate support for addressing mental ill health at work (Försäkringskassan, 2018). The aims connected to this thesis were to explore the mental health literacy of vocational rehabilitation professionals and their perceptions of employers in the RTW-process, and to explore employers' beliefs, knowledge and strategies used in providing support to employees with mental health problems.

Introduction

Mental health and mental health problems

Mental health affects individuals of all ages (Allen, Balfour, Bell, & Marmot, 2014; WHO, 2017; SOU, 2018), as various environmental, social and economic stressors influence mental health throughout the different stages in life (Allen et al., 2014). Mental health has been defined by the World Health Organizations (WHO) as:

> "… a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community." (WHO, 2018, p. 1).

Various terms are used in the literature when referring to mental health problems. Mental illness, for example, (SOU, 2018) is a term often used by psychiatric and psychological services placing the emphasis on the underlying illness (Mental health foundation, 2018). Common mental disorders (CMD), is defined by the WHO as including both depression and anxiety disorders (WHO, 2017). Mental health disorders is another term that can refer to both diagnosed and undiagnosed conditions as the Organisation for Economic Co-operation and Development (OECD) specified in the report *Sick on the Job*. In their report a mental disorder:

> "…is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems. The broader terms mental ill-health, mental illness and mental health problems are used interchangeably and refer to mental disorders defined in this way but also includes psychological distress i.e. symptoms or conditions that do not reach the clinical threshold of a diagnosis within the classification systems (so called sub-threshold conditions)." (OECD, 2012, p. 11).

The term mental health problems, used in Studies III and IV in this thesis, corresponds to the OECD definition (OECD, 2012) i.e. an umbrella term ranging from mental disorders such as depression and anxiety which are highly prevalent, to conditions such as psychosis which are less common. Diagnosed and undiagnosed conditions are included in Studies III and IV, whilst in Studies I and II only individuals diagnosed with affective disorders (WHO, 1993) participated.

Mental health problems lead to negative consequences for both the individual and the society. They contribute to individual suffering and financial losses (OECD, 2012; Folkhälsomyndigheten, 2019; Försäkringskassan, 2017). The major cost for society is linked to the fact that mental health problems often start early in life and are recurrent (OECD, 2012; Folkhälsomyndigheten, 2019; Marcus, Yasamy, van Ommeren, Chisholm, & Saxena, 2012). Mental health problems can lead to functional limitations manifested as difficulties performing everyday activities, which for some individuals can lead to life-long suffering (Socialstyrelsen, 2017). Individuals can for example, lack energy, have decreased cognition, and have difficulties with concentration, but can themselves try to find strategies to compensate for these difficulties through working longer hours, taking on less demanding tasks, and avoiding breaks (Danielsson, Elf, & Hensing, 2019). Individuals with mental health problems are also at a greater risk of dying prematurely due to unattended physical health problems (WHO, 2015). Mental health problems, such as anxiety and depression, can also be a normal and temporary reaction to life events (Socialstyrelsen, 2017; SOU, 2018).

General public health in Sweden can be regarded as good with increased life expectancy and a reduced difference in average life expectancy between the genders. This development is, however, different for mental health problems, where the prevalence has increased over the past 20 years (SOU, 2018). Mental health problems are the major cause of sick leave among individuals of working age, (Försäkringskassan, 2017; OECD, 2013), with the longest sick leave periods and the lowest returning to work rate (Försäkringskassan, 2017).

There are several factors that increase the risk of mental health problems including a low educational level, being in a state of unemployment, and gender, with women at a higher risk than men (Folkhälsomyndigheten, 2019; SOU, 2018). Women are 2.5 times more likely to take sick leave for mental health problems than men (Försäkringskassan, 2017). A government demand to reduce costs in the welfare system appears to exacerbate mental health problems in the population and increase this inequality (Folkhälsomyndigheten, 2019). There is also a higher prevalence of mental health problems among those who are foreign born, have a disability or are homo- or bisexual (Folkhälsomyndigheten, 2019).

Childhood experiences affect the mental health of individuals as adults, with low socioeconomic status being a key aspect (Folkhälsomyndigheten, 2019). Children between 10 to 15 years of age from families with a low socioeconomic status have a 2.5 times higher prevalence of anxiety or depression (Allen et al., 2014). If parents have had mental health problems, if there has been a suicide among the parents or the child has moved frequently are also factors that can lead to a greater risk of mental health problems as an adult (Folkhälsomyndigheten, 2019). This highlights

the importance of early support for work on prevention in families and schools (Allen et al., 2014; Folkhälsomyndigheten, 2019).

Allen et al states;

> "At every stage in the life course, vulnerability and exposure to harmful processes or stressors can be disruptive, which is why any public mental health intervention needs to take a life course approach. A life course approach implies that institutions such as kindergarten, preschools, schools, universities and colleges, employers all need to be involved for building healthier and happier societies. This needs national policies but local actions" (Allen et al., 2014, p.394).

A long-term strategic work is thus required within all parts of society to meet the growth in mental health problems among the Swedish population (SOU, 2018).

Affective disorders

Affective disorders, or mood disorders as they are also termed (WHO, 1993), include depression that is estimated to affect approximately 350 million individuals globally (Marcus et al., 2012). Depression is the largest single cause of disability worldwide (WHO, 2015) and in particular among women (Försäkringskassan, 2017; WHO, 2015), who have the longest sick leave periods (OECD, 2013). Depression often starts in younger years and is frequently recurrent (OECD 2012) leading to a substantial financial cost for society (Chisholm et al., 2016). In Studies I and II, the definition of affective disorders includes individuals with both depression (F32, F33, and F33,1), and bipolar disorders (F30, F31) in accordance with the International Classification of Diseases ICD-10 (WHO, 1993). Both of these diagnoses are included as the depressive episodes for an individual with bipolar disorder can be more disabling for work performance than the manic periods (Gilbert & Marwaha, 2013; Godard, Grondin, Baruch, & Lafleur, 2011).

Depression can be divided into different levels depending on the severity, amount and duration of symptoms (Socialstyrelsen, 2017; WHO, 1993, WHO, 2016). In summary when having depression, the individual suffers from a decline in mood, energy and activity. His/her enjoyment of life, concentration and interest is reduced, and tiredness is common. Furthermore, appetite is diminished, sleep is disturbed, self-confidence and self-esteem are reduced, and worthlessness and guilt are present. The individual's mood can vary between days, regardless of the circumstances. The depression level depends on the number and severity of symptoms and can be mild, moderate or severe. Mild depression comprises usually two or three of the symptoms named above and causes the individuals to generally feel distressed but often able to continue most activities of daily life. When suffering from moderate depression, four or more of the above symptoms are present and the

individual can have severe difficulties performing activities. When suffering from severe depression, several of the above symptoms are present and cause the individual severe distress, loss of self-esteem and feelings of guilt and worthlessness. Suicidal thoughts and acts are common (WHO, 2016).

Depressive symptoms have a negative impact on daily life and work (Adler et al., 2006; Johanson & Bejerholm, 2016; Joyce et al., 2016; Lerner & Henke, 2008; Marcus et al., 2012). Despite this impact, individuals with depression and bipolar disorders, have received little attention in research regarding the evaluation of effective vocational rehabilitation approaches. This is in contrast to RTW research for individuals with severe mental illness such as psychosis, where there is extensive research and evidence (Bond, Drake, & Becker, 2012; Burns et al., 2007; Modini et al., 2016a). Joyce et al., (2016) showed in a meta-review that no effective RTW intervention exists to support employment for individuals with depression (Joyce et al., 2016), even though work can contribute to recovery by providing a sense of autonomy, well-being, reduced depression and increased social status (Modini et al., 2016b). In practice, there are also time and service gaps between the mental health care and vocational rehabilitation actors including employers (Lexén, Hansson, Bejerholm. In press). This lack of effective vocational approaches can hinder the RTW-process and reduce the chance of a successful outcome, leading to a feeling of hopelessness and an increase in symptoms (Modini et al., 2016a). Individuals with affective disorders are a vulnerable group in this respect, and their experience and need for support in their RTW-process has neither been evaluated nor fully understood (Joyce et al., 2016). In Studies I and II, affective disorders and depression are used correspondingly referring to the individuals meeting the inclusion criteria according to ICD-10 (WHO, 1993).

Employment, unemployment and sick leave

Work is defined in this thesis as competitive employment in mainstream settings at a regular market salary and also as employment with subsidies to compensate for limitations due to mental health problems. Employers in Sweden can receive compensation from the government in the form of a wage subsidy, which is a labour market strategy to enable work for an employee with functional limitations. In the studies that form this thesis, the author has made a distinction between these two forms of salary when meaningful for the specific aims.

There are several benefits to having a job (OECD, 2012). It is not only financially beneficial for the individuals concerned but has also shown to be of importance for their identity and how they are perceived by themselves and others. Work can also contribute to recovery by improving mental health, breaking isolation, providing

structure for the day and providing routines (Cameron, Sadlo, Hart, & Walker, 2016). This is contrary to being unemployed which has shown to negatively impact mental health (OECD, 2012; Modini et al., 2016b; SOU, 2018). Regaining a working role positively affects the everyday life of individuals with mental health problems (Lexen, Hofgren, & Bejerholm, 2013a). Employment is also vital in gaining a sense of purpose, for social contacts, and status (Cameron et al., 2016; Vornholt, Uitdewilligen, & Nijhuis, 2013). Work provides daily structures and can provide a distraction from psychiatric symptoms (Lexén, Hofgren, & Bejerholm, 2013a). A work identity is an important part of who we are, and how we are perceived by others. Being on sick leave excludes the individual with mental health problems from vital routines linked to work, leading to feelings of isolation and loneliness (Cameron et al., 2016). The longer the time that individuals are not part of the labour market the harder it can be to return to employment (Arbetslöshetsrapporten, 2018; Waddell, Burton, & Kendall, 2008).

Evans & Repper (2000), described work as;

> "…one of the most important routes (within a capitalist society) for achieving a positive community presence and a valued status within society" (Evans & Repper, 2000, p. 15).

The overall employment rate in Sweden in 2017 was 82% among those of working age (18-64 years old), which constituted the highest employment rate in the European Union (EU). The employment rate for men stood at 83.3% and for women at 79.8%. More frequent sick leave and a longer time in education are the main reasons for women being outside the labour market to a greater extent. Even though Sweden has a high employment rate, approximately 6% of the working age population remained unemployed 2017 (Arbetslöshetsrapporten, 2018).

Individuals with mental health problems can struggle to maintain their employment (OECD, 2013) as the tasks performed in modern work situations rely increasingly on mental resilience, which can be difficult for employees with these problems to carry out (OECD, 2012). Another concern is that workers with mental health problems are more likely to have employment that does not match their skills. They are also more likely to have jobs with both a high level of psychological demand and a low level of decision autonomy, a combination that can lead to unhealthy work-related stress (Cameron et al., 2016; OECD, 2012). Women are more affected than men by work-related mental health problems such as stress, reflecting a gender pattern in society as a whole. Professions with a large proportion of employees with mental health problems are the health care professions, teachers, nursery nurses, psychologists and social secretaries (SOU, 2018).

The return-to-work process

The RTW-process refers to the process an individual with mental health problems follows when returning to, and remaining at work (Ekberg, Eklund, & Hensing, 2015; Waddell et al., 2008). RTW can also be defined as an outcome (Ekberg, 2015, Young et al., 2005). Vocational rehabilitation professionals are those who are involved in the RTW-process of individuals with mental health problems (Waddell et al., 2008). There is a wide range of actors and organizations in Sweden (Table I) who are involved; the Social Insurance Agency (SIA), Public Employment Service (PES), Primary Care (PC), Occupational Health Service (OHS), Mental Health Services (MHS), and employers (SOU, 2011). Depending on the services provided by the MHS and the local municipal authority, individuals might also have access to professionals working in accordance with the Individual Placement and Support (IPS) approach (Bejerholm, Larsson, & Hofgren, 2011). Complementary Actors (CA) working on behalf of PES may also form part of the RTW support.

Table I

Swedish RTW authorities, and organizations included in Study III (*n*=7)	Abbrevation
Complementary Actor	CA
Individual Placement and Support	IPS
Medical Health Service	MHS
Occupational Health Service	OHS
Primary Care	PC
Public Employment Service	PES
Social Insurance Agency	SIA

The different actors in the RTW-process have different regulations dictated by their organizations (Bejerholm et al., 2015; Bejerholm et al., 2011; Ekberg et al., 2015; Hasson, Andersson, & Bejerholm, 2011), and approved through political decisions.

The outcome of the effectiveness of employment for an individual with mental health problems is significantly linked to the quality of the support given in the RTW-process (Bejerholm et al., 2017), which has also been reported by the service users (Johanson et al., 2017). An individual's work capacity can be viewed as a dynamic interaction between the individual and the surrounding physical and social context (Ekberg et al., 2015), in which the RTW-support forms one important part (Bejerholm et al., 2017).

Two different RTW approaches have been studied in this thesis, which are available for individuals with mental health problems; Traditional Vocational Rehabilitation (TVR) and Supported Employment. The outcome of employment is dependent on several factors where the support factor is one of these. Other predictors of

employment have been found, these include: female gender, being under 25 years old, having had previous sustainable employment, university education, and no psychological symptoms during childhood (Joensuu et al., 2018).

The train-then-place paradigm

Two rehabilitation paradigms have emerged to guide professionals working with individuals with mental health problems, the train-then-place model and the place then-train model (Corrigan, 2001). TVR is a rehabilitation approach that is delivered stepwise where the individual can gain better health in a safe and pre-vocational environment (train-then-place) before being ready to cope in a real work situation (Corrigan, 2001). From the perspective of recovery, TVR focuses primarily on clinical recovery, i.e. focusing on reducing symptoms of the illness before entering the RTW-process (Anthony, 1993). This generally entails service users in TVR receiving care and treatment for long periods of time, without any connection to a work situation (Bejerholm et al., 2017). Negative attitudes such as a disbelief that individuals with mental health problems would be allocated work have shown to be prevalent among professionals in MHS (Hansson, Jormfeldt, Svedberg, & Svensson, 2013). A successful outcome of real work requires the supporting professionals to have a broad knowledge and belief in the individual's ability to resume working life (Bejerholm et al., 2017). Research has, however, shown that the vocational rehabilitation professional can lack understanding, empathy, and belief, which can constitute a significant barrier for successful RTW for these individuals (Lammerts, Schaafsma, Bonefaas-Groenewoud, van Mechelen, & Anema, 2016). More knowledge is thus needed about the vocational rehabilitation professionals' own perspectives and experiences of supporting individuals with mental health problems to gain and maintain work.

Medical doctors in Sweden are responsible for the medical certificate and the underlying assessment of an individual's symptoms and limitations in relation to work (Försäkringskassan, 2017). The focus in the RTW-process is thus primarily on treating the symptoms, not necessarily with a RTW focus (Ekberg et al., 2015). The right to receive financial compensation, such as sick leave benefit, is regulated in the Social Insurance System. The sick leave certificate is thus based on this medical perspective (Ekberg et al., 2015) and can be granted if the individual's work ability is reduced (Ekberg et al., 2015; Försäkringskassan, 2017).

The place-then-train paradigm

Supported Employment is a personal recovery approach intervention which provides personal-oriented support to individuals with functional limitations (Bejerholm & Roe, 2018). Supported Employment does not require prior work

training for the individual with mental health problems. Instead training and support are provided when the individual has started work (place-then-train) (Corrigan, 2001). Individual Placement and Support (IPS) is an evidence-based Supported Employment approach designed specifically for individuals with severe mental health problems (e.g. psychosis, schizophrenia). The approach has proven to be the most effective for gaining competitive employment for these individuals (Bond, Drake, & Becker, 2008; Burns et al., 2007; Drake, Bond, & Becker, 2012; Kinoshita et al., 2013; Modini et al., 2016a). IPS is built on the place-then-train model (Corrigan & McCracken, 2005), where individuals are rapidly placed in competitive employment with additional support and adaptations to meet their needs (Corrigan, 2001). The IPS uses 8 principles, shown in Table II, numbered 3-10. Individual Enabling and Support (IES) is a Supported Employment approach that builds on the IPS but with an addition of two extra principles to better meet the needs of individuals with affective disorders. The IES is further described under the method section on page 40. Both IPS and IES acknowledge a good cooperation with employers for a successful RTW. An important principle is thus to also provide support to the employer as part of the RTW of individuals with mental health problems (Lexén, Emmelin, & Bejerholm, 2016).

Table II. The 10 principles of Individual Enabling and Support (IES)

Principle	Explanation
1. Motivational and cognitive strategies are mobilized.	Motivational strategies to prepare and cope with changes, and CBT strategies to handle avoidance behaviour and negative thoughts.
2. Time for work i.e. synchronize lifestyle with working life.	Find a balance between work, rest and family life.
3. Eligibility based on client choice	No prevocational training or assessment of the participnats work ability is needed. The core feature is the desire and motivation to work.
4. Job search based on personal preferences	The job development and RTW-support is based on the participants' interests, resources and needs.
5. Benefit counselling (SIA/PES) at an early stage	The SIA/PES services are integrated in the RTW-process to consult with participants on how the RTW affects their financial situation.
6. Competitive employment as a primary goal	Competitive work is the goal that matches the participants' skills and work ability.
7. Integration of IES with mental health treatment	The mental health service is integrated in the RTW-process to support the participant's mental health.
8. Rapid job search	Introduces participants to the labour market in an early stage of the RTW-process. This shows belief from the Employment Specialist in participant's ability to work.
9. Ongoing RTW and workplace support, and work accommondation as needed for both client and employer.	The support is not time limited but ususally decreases gradually.
10. Systematic recruitment and quality engagement with employers	Building quality relationships with employers is important as well as addressing their support needs. Regular contact with employer in general is critical in order to know when suitable work is coming up.

(Bejerholm, 2016)

The employers' role in the RTW-process

Employers are an important actor in the RTW-process in Sweden and are legally responsible for the physical and psychosocial work environment of their employees (Ahlberg, 2018, Ericson, 2019). This entails preventing, adapting to and supporting their employees, and ensuring they do not get injured or ill due to their work environment (Ekberg et al., 2015; Waddell et al., 2008). Despite this important role and legal responsibility employers can lack knowledge related to mental health problems (Jansson & Gunnarsson, 2018; Lexén et al., In press). Employers are vital for gaining and maintaining employment in the RTW-process (Lexén et al., In press; Lexén et al., 2016). A study carried out in Australia on the competence of supervisors supporting employees with mental health problems in their RTW-process, showed a need for supervisors to enhance their skills in several areas specifically; training in conflict management, increased communications skills and knowledge of their legal obligations (Johnston et al., 2015). Improved knowledge through education and direct contact with individuals with mental health problems

has shown to lead to more positive attitudes and a reduction in stigma (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012).

In the hiring process, employers can be concerned about hiring an individual with mental health problems due to apprehensions regarding work performance, mental health symptoms, medication side effects, and how the individuals would fit with other employees (Burke et al., 2013). Research on supported employment has shown that the support given by the Employment Specialist to employers, reduces apprehension and enhances the likelihood of appointing an individual with mental health problems (Bejerholm et al., 2015; Johanson et al., 2017; Lexén et al., 2016). Employers perceived the Employment Specialist as taking responsibility and providing trust, and working as an expert in resolving problems that arise (Gustafsson, Peralta, & Danermark, 2013; Lexén et al., 2016).

When an employer needs support for work accommodation, the RTW professionals should provide that support (Slade, 2009b). With appropriate work accommodation based on the employee's needs, for example allowing work from home when needed (Jansson & Gunnarsson, 2018), flexible schedule, modified job duties, or social support such as supporting an employee on how to interact with co-workers (Lexén, Hofgren, & Bejerholm, 2013b), employees can be at least as productive as those without mental health problems (Janson & Gunnarsson, 2018). Furthermore, interventions that can increase the employee's control such as self-selection of shifts, stress reduction and RTW-programs that comprise CBT and include problem-focused strategies, were associated with improvements of mental health (Joyce et al., 2016). With that said, working proactively has shown to be the most cost effective for employers (Waddell et al., 2008).

According to the IPS supported employment principle, it is vital for vocational rehabilitation professionals to systematically develop a collaborative relationship with employers and provide them with adequate support in order to open up their workplaces for individuals with mental health problems (Lexén et al., 2016). This thesis aims to highlight which critical factors are important for such a collaborative process of providing RTW-support for the target group.

Recovery

The term recovery in relation to mental health has two meanings, clinical recovery and personal recovery. Anthony (1993) describes personal recovery as a;

> "…deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery

> involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effect of mental illness" (Anthony, 1993, p. 527).

Personal recovery is an ongoing process during a person's life, a way of living a meaningful life and of having social roles despite the presence of mental health symptoms (Slade, 2009c). Clinical recovery is on the other hand considered as being achieved when the mental illness has reached a full remission (Slade, 2009c).

Mental health research has mainly focused on symptom reduction in healthcare settings, detached from the work setting and vocational outcomes (Joyce et al., 2016). Finding work is an important goal for many individuals with mental health problems and can be vital in their recovery (Dickson & Taylor, 2012; Joyce et al., 2016; Modini et al., 2016b), as work can give the individual an important and meaningful role, and provide normality in everyday life (Cameron et al., 2016; Gammelgaard et al., 2017). Few individuals with mental health problems are, however, provided with the opportunity to achieve their personal recovery goals such as work, and they are currently the group that are furthest away from the labour market (Folkhälsomyndigheten, 2019; OECD, 2013; SOU, 2018).

It has been shown in a literature review that recovery-oriented services working according to the Supported Employment approach have a positive impact on the individuals' personal recovery (Bejerholm & Roe, 2018), and significantly increase the probability of gaining work (Bejerholm et al., 2015; Bejerholm et al., 2017; Modini et al., 2016a). Supported employment has also shown to aid recovery as the intervention decreases depressive symptoms, increases self-esteem and helps to develop a positive attitude despite mental health problems (Areberg & Bejerholm, 2013; Gammelgaard et al., 2017). It is important for the individual in the personal recovery process to have a positive identity, other than that of being an individual with mental health problems (Slade, 2009c). Being employed can provide such a positive identity (Gammelgaard et al., 2017).

The individual's recovery goals should be supported by professionals (Slade, 2009a), this is however not always the case. To achieve this in the clinical recovery setting, professionals need to change focus from being the only expert on the individual's mental health problems, to instead encouraging their clients to take on an active role in their own recovery process (Slade, 2009c). The Employment Specialist offers support, works collaboratively and is attentive to the individual's needs and abilities (Gammelgaard et al., 2017). This work alliance with participants is, according to individuals participating in IPS, vital in their recovery process (Areberg, Björkman, & Bejerholm, 2013).

The CHIME framework of personal recovery, is the result of a review of 97 studies on components of importance in personal recovery for individuals with mental

health problems (Leamy et al., 2011). The result contains the following five components;

- **C**onnectedness
- **H**ope and optimism about the future
- **I**dentity
- **M**eaning in life
- **E**mpowerment

The five components have been given the following meanings; *Connectedness* includes relationships, support from others and being part of the community. *Hope and optimism about the future* is related to belief in the possibility of recovery, motivation to change, hope-inspiring relationships, positive thinking, valuing success, and having dreams and aspirations. *Identity* includes rebuilding or refining a positive sense of identity and overcoming stigma. *Meaning in life* encompasses quality of life, meaningful life, social roles, goals and rebuilding life. *Empowerment* includes personal responsibility, control over one's life, and focus upon strengths. The CHIME personal recovery framework has shown good validity when measuring recovery (Bird et al., 2014). The five components of this framework could be identified among participants in a qualitative study where the IPS approach and subsequent employment positively impacted personal recovery in the form of reduced depressive symptoms (Gammelgaard et al., 2017).

Empowerment

Empowerment has a strong connection with personal recovery (Slade, 2009c), and in a mental health context refers to the choice, influence and control the mental health user exercises over events in his/her life (WHO, 2010). As early as 1978, the declaration of Alma-Ata (WHO, 1978), from the WHO stated;

> "People have the right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO, 1978, p. 1).

Becoming empowered is critical for the personal recovery journey according to user experiences (Leamy et al., 2011). Individuals with mental health problems have, however, historically been excluded from decision making about their own mental health services. This disempowerment of mental health users occurs across all social levels and societies, work and social activities. Powerlessness through absence of influence or control can lead to reduced health outcomes (WHO, 2010), and consequently prevent personal recovery. Conversely, empowerment can lead to enhanced possibilities of recovery, as seen through quality of life, engagement in

daily activities, and in community life (Bejerholm & Björkman, 2011), increased emotional well-being, independence, and coping strategies (WHO, 2010).

Having control in one's working life is fundamental. Joyce et al. (2016) has shown in a meta-review that if employees' control increases, their wellbeing can increase and protect against anxiety and depression (Joyce et al., 2016). These results are in line with earlier research showing that empowerment can be promoted by interventions that have a high consumer involvement in decision-making (Slade, 2009c). Empowerment and quality of life positively impacted depression severity in an IES supported employment context (Johanson & Bejerholm, 2016). This was also shown to be true for the group with severe mental disorders (Bejerholm & Areberg, 2014; Bejerholm & Björkman, 2011). In addition to the scientific evidence of the relationship between empowerment and depression symptoms, higher levels of empowerment are also related to reduced experiences of being stigmatized in connection to society (Bejerholm & Björkman, 2011).

As described earlier, mental health problems are a major concern today (OECD 2012), it is thus vital to also empower society to be better equipped to support individuals with mental health problems (Jorm, 2012). In order to gain a greater understanding of the prerequisites for empowerment and control in the RTW-process, and to study whether in fact IES supported employment impacts empowerment, and thus depression, it is important to understand this on an individual level. It is, at the same time, important to explore which RTW-factors are critical on a societal level for RTW professionals and employers.

Attitudinal barriers in the RTW-process

Stigma could be another barrier to an effective RTW (Baker & Procter, 2014; Cameron et al., 2016). Stigma can be divided into public stigma meaning discrimination and prejudice from the public towards individuals with mental health problems, and self-stigma (internalized stigma) experienced as internalizing these public views of mental health problems, leaving the individuals with reduced self-esteem and self-efficacy (Corrigan & Watson, 2002). Negative attitudes towards individuals with mental illness among the general public are described in the literature as one of the major barriers for employment (Alonso et al., 2009). Stigma, seen as the belief that individuals with mental health problems are dangerous, has shown from a literature review to be common, although lower among those with higher education (Jorm, Reavley, & Ross, 2012).

Furthermore, mental health professionals and employers can also have negative attitudes towards individuals with mental health problems (Hansson, Stjernsward, & Svensson, 2014; Krupa, Kirsh, Cockburn, & Gewurtz, 2009), where employers

can lack willingness to employ (Audhoe, Nieuwenhuijsen, Hoving, Sluiter, & Frings-Dresen, 2018; Burke et al., 2013; Dickson & Taylor, 2012) due to a lack of mental health literacy and a lack of support from vocational rehabilitation professionals (Lexén et al., In press). A systematic review has showed that employers rated an individual with mental health problems as less employable than an applicant with a physical disability. An individual with previous experience of depression was also less likely to be recommended for a job compared to someone with a physical disability (Brohan et al., 2012).

Regarding the workplace, a cross-sectional study (*n*=834) revealed 62.5% experienced or anticipated discrimination in the workplace among individuals with major depressive disorders (Brouwers et al., 2016). The psychosocial work environment, i.e. support from employers and good relationships with colleagues, is an important aspect of promoting recovery. However, the attitude to mental health problems in the workplace is described by employees as surrounded by secrecy with an absence of support offered when suffering from mental health problems (Moll, 2014). It is thus vital for an individual with mental health problems to be accepted at the workplace if employment is to be sustainable (Vornholt et al., 2013). Nevertheless, employers who had previous experiences of hiring individuals with mental health problems had less apprehension about hiring someone again with the same condition (Brohan et al., 2012).

Vocational rehabilitation professionals may present another attitudinal barrier in the RTW-process. Research has revealed that they can perceive individuals with mental health problems as having a deficient capacity to work (Dickson & Taylor, 2012). The individual can be perceived by vocational professionals as having difficulties with time management, work demands, and emotions (Bejerholm et al., 2011; Bertilsson, Löve, Ahlborg Jr, & Hensing, 2015; Hasson et al., 2011).

The individuals with mental health problems can themselves also be a barrier to their own recovery as self-stigma has shown to prevent individuals with mental health problems seeking help (Barney, Griffiths, Jorm, & Christensen, 2006; Clement et al., 2015). In relation to the RTW-process, individuals themselves could also lack belief in their own ability to work (Audhoe et al., 2018; Brohan et al., 2012; Vingård, 2015). Anticipation of discrimination has also shown to prevent individuals from even applying for a job (Brohan et al., 2012; Brouwers et al., 2016). This expectation of discrimination hinders the individual's recovery as stated by Slade:

> "The experience (and anticipation) of discrimination blights the lives of many people with mental illness" (Slade, 2009b, p.370).

Mental health literacy

Possessing appropriate mental health literacy is of great importance for all actors in the RTW-process (Furnham & Swami, 2018; Jorm et al., 2012). This requirement encompasses the individuals with mental health problems (Danielsson et al., 2019), vocational rehabilitation professionals, employers, and the wider public in order to prevent, recognise and manage mental health problems (Jorm et al., 1997). Mental health literacy has been defined by Jorm et al (1997) as;

> "…knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking" (Jorm et al., 1997 p. 182).

Mental health literacy has been studied in different contexts and with different focus over the years. Jorm et al. (1997) stated that if individuals are to recognize mental disorders early and seek help, mental health literacy among the general public needs to be increased (Jorm et al., 1997). Possessing mental health literacy enables the recognition and responses to early signs of mental health illness and can thus facilitate early intervention and improve the prospect of a positive outcome (Kelly, Jorm, & Wright, 2007).

Employers are, as previously mentioned, responsible for their employees work environment (Ahlberg, 2018, Ericson, 2019). Research has, however, shown that they can lack knowledge of mental health problems (Lexén et al., 2016). Deficient mental health literacy has also shown to be prevalent among vocational rehabilitation professionals, as they do not always understand the symptoms of the mental health problems and lack belief in the prospects of the individual holding a competitive job (Lexén et al., In press).

A study of mental health professionals and the general public, comparing recognition of symptoms of mental health problems and feeling of social distance, showed that whilst professionals could recognize signs of mental health problems to a higher degree than the general public, no difference could be seen among the social distance both groups felt (Nordt, Rössler, & Lauber, 2006). Furthermore, research on the general public's ability to recognise depression showed that their ability to recognise symptoms of depression, did not differ between those who had their own experiences and those without. However, a gender difference was observed and significantly more women (36%) than men (21%), could identify depression (Dahlberg, Waern, & Runeson, 2008). Age has also shown to be a factor with younger individuals better able to recognize depression than those over 70 years old (Farrer, Leach, Griffiths, Christensen, & Jorm, 2008).

Mental health first aid is an education developed to increase mental health literacy and covers several areas such as knowledge about different diagnoses and symptoms, suicidal thoughts, acute stress reaction, panic attacks and acute psychotic behaviour. The course also covers co-morbidity with substance use disorders (Kitchener & Jorm, 2002). A RCT of mental health first aid training among employees (n=301) conducted in Australia showed the education's benefits as better confidence in providing help to others with mental health problems, enhancing the likelihood of being able to advise individuals to get professional help, and a decrease in stigmatizing attitudes. The results also showed a significant improvement of the participants' own mental health (Kitchener & Jorm, 2004).

In this thesis, mental health literacy is an essential concept for the understanding of the knowledge, beliefs, attitudes and strategies used, by important actors in the rehabilitation chain that may impact on the individuals' RTW-processes. Such an understanding is a precondition for improvement of the RTW-process. The four studies in this thesis contribute to closing the knowledge gaps in the RTW-process in Sweden, by presenting critical factors concerning; the individual's needs, how the RTW-process affects them, and the mental health literacy of the vocational rehabilitation professionals and employers involved.

Rationale

Mental health problems are the leading cause of sick leave among individuals of working age (Försäkringskassan, 2017) and depression is the most common of those mental health problems, (Marcus et al., 2012; WHO, 2015). RTW interventions focus mainly on decreasing the symptoms of mental health problems and on increasing work ability, however, with limited connection to the employer and the workplace (Bejerholm et al., 2017; Joyce et al., 2016). There is also little collaboration between the RTW actors in the commonly used TVR approach, with no authority taking overall responsibility for the individuals' progress and employment goals (Bejerholm et al., 2011). A Public Health Authority report on social inequalities and mental health, stated that individuals with mental health problems are a marginalised group and that their sick leave and employment situation exacerbates this difficult life situation (Folkhälsomyndigheten, 2019). There is a lack of knowledge about the critical factors that individuals with affective disorders perceive as vital to a successful RTW in relation to both the IES and the TVR intervention (Johanson et al., 2017). Similarly, how the IES supported employment approach affects the sense of empowerment and depression severity of individuals with affective disorders in comparison to the traditional stepwise RTW-process, has not been explored in the scientific literature. Knowledge is also lacking about the mental health literacy among both vocational rehabilitation professionals

and employers who form critical roles in the RTW-process for those affected by mental health problems.

Individuals with mental health problems are the largest group receiving sick leave benefit, and they are less likely to ever return to work (Folkhälsomyndigheten, 2019). A more comprehensive understanding is thus of great importance for developing knowledge that can enlighten all actors in the RTW-process, including the individuals themselves, vocational rehabilitation professionals, and employers. Knowledge about which critical factors are valued as significant, and effective for all actors in the RTW-process could improve the mental health literacy of those involved and increase the likelihood of a positive outcome. This could also close the knowledge, time and service gaps between different actors in the process.

Thesis aim and specific aims

The overarching aim of this thesis was to increase the knowledge of critical factors for individuals with mental health problems in their RTW-process. These factors are explored through the perspectives of the individuals, and the mental health literacy of vocational rehabilitation professionals and employers.

The specific aims:

Study I

To develop an understanding of the perspectives and experiences of individuals with affective disorders of critical factors they believe hinder or facilitate them during the RTW-process. A further aim was to obtain their perspectives on two vocational approaches; IES supported employment and TVR services, and to discern the possible impact the two different vocational approaches have on the service users' experiences.

Study II

To examine the effectiveness of IES versus TVR on empowerment and depression severity after 12-months intervention among individuals with affective disorders. A further aim was to evaluate the longitudinal changes of empowerment and depression severity within each intervention group, and the correlation between empowerment and depression across the measurement time points.

Study III

To develop an understanding of the mental health literacy of vocational rehabilitation professionals concerning individuals with mental health problems in the RTW-process. A further aim was to develop an understanding of the professionals' perception of employers in the RTW-process.

Study IV

To explore employers' beliefs and knowledge regarding mental health problems, and to explore employers' strategies in supporting employees with mental health problems.

Method

This thesis included three qualitative, and one quantitative study shown in Table III. Content analysis (Graneheim & Lundman, 2004) was used in Study 1, and grounded theory (Charmaz, 2014) was used in Studies III and IV. In Study II a RCT design was applied following the CONSORT (Consolidated Standards of Reporting Trials) guide for non-pharmacological interventions (Moher et al., 2010).

Table III. Overview of the four studies in this thesis.

Study	Study design	Participants	Data collection	Data analysis	Manuscript status
I	Qualitative, Content analysis method	Individuals in MHS with affective disorders: *n*=16	In-depth-interviews	Manifest and latent content analysis Within and across analysis	(Porter, Lexén, Johanson, & Bejerholm, 2018)
II	Quantative, Randomised controlled trial	Individuals in MHS with affective disorders IES *n*=33 TVR *n*=28	Questionnaires: Empowerment Scale MADRS-S ASRS AUDIT KEDS	Mann-Whitney U-test Wilcoxon sign rank test ITT Primary data	(Porter & Bejerholm, 2018)
III	Qualitative, Grounded theory	Vocational rehabiliation professionals *n*=22	Interviews with open ended questions	Initial sampling Theoretical sampling Focus coding Axial coding Theoretical coding Memo writing	(Porter, Lexén, & Bejerholm, 2019)
IV	Qualitative, Grounded theory	Employers with staff responsibilities *n*=24	Interviews with open ended questions	Initial sampling Theoretical sampling Focus coding Axial coding Theoretical coding Memo writing	(Porter, Lexén, & Bejerholm, 2019, In press)

Interventions

Individual Enabling and Support

The Individual Enabling and Support (IES) intervention was developed from supported employment for individuals with psychosis (Table II, numbers 1-10), but was augmented to better fit the support needs in relation to RTW of individuals with affective disorders (Bejerholm, 2016). The IES intervention was designed by a supported employment researcher with support from a clinical psychologist. Previous research and clinical findings emphasized the need for an enabling support in order to mobilise motivation (Areberg, et al., 2013) as depressive symptoms can affect motivation to work (Bejerholm & Areberg, 2014). Cognitive Behavioural Therapy (CBT) strategies were also integrated in the IES support to enable RTW and mitigate avoidance behaviours. CBT is recommended in the national guidelines in Sweden for treatment of individuals with depression and anxiety (Socialstyrelsen, 2017). A balanced time use, as opposed to a stressful life, has previously shown to be related to mental health and engagement in daily life, including work (Bejerholm, 2016, Bejerholm & Eklund, 2007). This knowledge contributed to additional principles on motivation and cognitive strategies, and time use planning being added to the original eight principles (Table II number 1-2).

An Employment Specialist is the key professional and has an important role in IES in terms of providing person-centred support, integrated with MHS and other welfare actors, and facilitating competitive employment and contact with the labour market, according to the IES principles (Bejerholm, 2016; Bejerholm et al., 2017; Johanson et al., 2017). The Employment Specialist creates a work alliance with the participant meaning he/she is highly involved in their own RTW-process, such as decision-making, goal setting, and the planning of the interventions based on personal needs (Areberg, Björkman, & Bejerholm, 2013, Bejerholm, 2016, Johanson et al., 2017).

The role of the Employment Specialist required a holistic perspective corresponding to the 10 IES principles. The Employment Specialist had undergone a three-week period of training consisting of; cognitive strategies deriving from CBT, taught by a psychologist, motivational interviewing techniques from a certified motivational interviewer, time-to-work strategies from an occupational therapist, and training in supported employment from three Employment Specialists. Throughout the intervention this knowledge and the strategies were reinforced through face-to-face supervision.

The IES intervention comprises several phases. The enabling phase of IES concerns mobilising motivation and cognitive strategies, as well as introducing a work-life balance that supports mental health. These strategies are integrated into the

completion of a career profile and plan lasting for approximately 1 to 2 months for 1 to 2 hours each week. In the next phase the vocational plan is translated into job seeking activities and lasts until employment is gained and the enabling strategies are then realised in a workplace setting usually with off-worksite support from the IES network. This phase continues for as long as necessary and comprises about 20 minutes a week (Bejerholm et al., 2017; Bejerholm, 2016).

Since IES has been developed as a person-centred service, the work alliance and a power neutral relationship between the participant and the Employment Specialist is fundamental in the IES. Work thus begins with the participant and Employment Specialist getting to know each other, often in a public place such as a library or coffee shop. This is done so that the participant can feel: that the intervention takes place in the community, that the relationship is equal, and the participant is in focus and in control of the intervention. It is the participant's interest, preferences, resources and health needs that guide the intervention. As indicated above, the Employment Specialist guides the participant through the enabling phase and provides support for RTW such as a work plan, finding a workplace, employment interview, support at work and if needed workplace adaptations, follow-up talks, and employer interviews and support. The Employment Specialist is the key professional who performs and coordinates the interventions based on the participant's needs and health, and with the other RTW actors including employers (Bejerholm, 2016; Bejerholm et al., 2017). The intervention lasted for 12-months in Studies I and II.

Process evaluation forms an essential part of designing and testing complex interventions (Moore et al., 2015). Complex interventions are defined as interventions that comprise several interaction components (Craig et al., 2013). For process evaluation of the IES intervention the Supported Employment Fidelity Scale was used at 6 and 12-months (Becker, Swanson, Bond, & Merrens, 2008). The scale focuses on the assessment areas of staff, organization and services with 28 implementation question areas and was used together with three additional areas corresponding to the enabling strategies. The response to each question is estimated on a five-point scale where the criteria are carefully described. For example, the response is rated at five (highest) if the first contact with an employer takes place within one month (Bejerholm, 2016).

Traditional Vocational Rehabilitation

In Sweden, TVR is regulated by the unemployment social security system and the social benefit system linked to SIA and PES, with a number of different professionals in several settings and organizations involved (Table I). The authorities and organizations regulate the service, which is delivered in several assessment steps. In order to illustrate the different stages in the TVR process and

their duration, an estimation is made as follows. The first step includes reducing symptoms and increasing work ability at the MHS (about 1 hour a week). The individuals' work ability is then assessed by SIA and/or PES (about 10-20 hours a week). Step three is regulated by law at about 5-20 hours each week and comprises pre-vocational activities arranged by the local municipal authority. The individual is encouraged to enter step three if his/her work capacity is not sufficient. The final step is vocational training in an internship placement (about 20-40 hours a week), which can lead to employment through PES (Bejerholm et al., 2017).

The various authorities and organizations have different obligations in the RTW-process. MHS are responsible for the medical rehabilitation. The employers are responsible for the vocational rehabilitation and to help the employee regain and maintain work ability. They also have an obligation to make a rehabilitation plan that includes the actions taken to support the employee in RTW-process. The role of SIA is to assess the work ability and decide if sick leave benefit can be granted or not, mainly based on the medical certificate **(**Försäkringskassan, 2019a). To be able to receive benefit for sickness absence, the individual needs to have a reduced work ability assessed at different points during the sickness absence period (Försäkringskassan, 2019b). SIA is also responsible to initiate status meetings with the different actors involved if considered necessary. The individuals themselves are obligated to participate in the RTW-process in order to be granted sick leave benefit (Försäkringskassan, 2019a). Time and service gaps are a reality in TVR due to a lack of collaboration between the different authorities and organizations (Bejerholm et al., 2015; Bejerholm et al., 2017; Vingård, 2015).

Study I

Design and participants

This qualitative study sought to explore critical factors in the RTW-process for individuals with affective disorders, who had participated in IES or TVR for 12-months. The participants were recruited from a randomized control trial (RCT) (Bejerholm et al., 2017) designed to evaluate the effectiveness of IES and TVR on the outcome employment rate (RTW) at 12-months follow-up. The trial period was December 2011 - December 2014 (Bejerholm et al., 2017).

Participants were recruited for the RCT (Bejerholm et al., 2017) from four geographically diverse outpatient settings in the county of Scania in southern Sweden. They were recruited in a number of different ways: advertisement in the daily paper, information on the project web page, and leaflets in the outpatient units' waiting rooms. Research information meetings were also held twice a month at each

location where information on the inclusion criteria, ethical issues, interventions, RCT design, and randomization were provided. Information could also be received individually. Participants fulfilling the following criteria were eligible for the interventions: 1) diagnosed with a depression episode (F32), recurrent depression (F33.0, F33.1), bipolar disorder (F30, F31) including depressive episodes. Diagnoses were set by the team psychiatrist according to the International Classification of Diseases 10th edition (WHO, 1993). Further inclusion criteria were: 2) aged 18-63 years, 3) ability to communicate in Swedish, 4) unemployed for the preceding year, 5) interested in becoming employed. The exclusion criteria were severe substance abuse, somatic illness or physical disability that could affect participation and vocational outcome.

The participants in Study I had taken part in an IES or TVR intervention for 12-months. Thirty-one individuals were purposively selected by the two Employment Specialists from the 63 participants in the RCT (Figure I). Diversity was sought in terms of age, gender, handling officer (TVR) and Employment Specialist (IES), as well as outpatient unit. Of the 31 who were invited to participate, 16 accepted, with eight participants from IES, and eight from TVR. All the participants had some experiences of TVR, including the IES group who had those experiences prior to entering IES. The demographic and clinical characteristics of the participants in Study I are shown in Table IV.

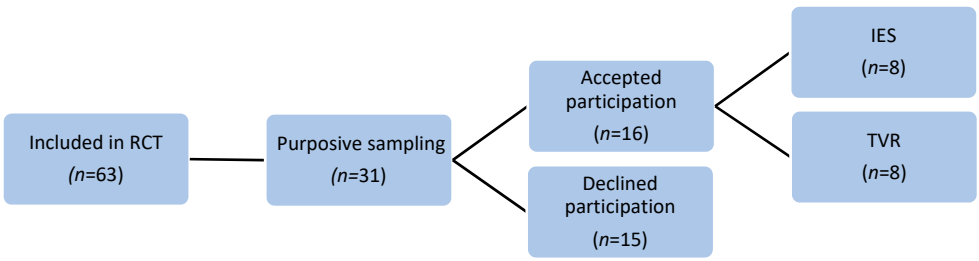

Figure I. Recruitment process of Study I

Table IV. Demographic and clinical characteristics of participants in Study I (*n*=16)

Characteristics		*n*
Sex		
	Female	10
	Male	6
Age in years		
	Mean, SD (range)	39.3, 12.5 (22-58)
Country of origin		
	Sweden	14
	France/Vietnam	1/1
Civil status		
	Married/not married	5/8
	Divorced	3
Living situation		
	Cohabiting/living alone	9/7
Have children yes/no (*n*=13)		8/5
Educational level		
	Middle school	2
	Upper secondary school	6
	College/university	8
Occupational status		
	Employment	5
	Internship	3
	Mainstream education	2
	Prevocational training/activity	6
Years of unemployment prior to study		
	Mean	4.4
Clinical diagnosis		
	Depression (female/male)	11(5/6)
	Bipolar (female/male)	5(5/0)
Age in years at first contact with psychiatry		
	Mean (range)	28 (12-49)

Data collection

The data collection for Study I took place between January and July 2014 and used the In-Depth Interview (IDI) method. The IDIs are performed on a small number of participants using open ended questions, where binary yes or no questions should be avoided. The method allows prompting questions if needed i.e. *Can you give me an example? Can you elaborate on that?* (Boyce & Neale, 2006). The method is ideal for evaluating and exploring the perceptions of participants in an intervention process and is useful when the researcher seeks detailed information about behaviours and thoughts on a deeper level (Boyce & Neale, 2006; Patton, 2015). Trustful interaction, focus and concentration is required between the interviewer and participant in order to obtain suitable data. During the interview, the interviewer

should make sure the participant is comfortable, show interest in what they are saying, and not reveal any personal opinions. Generalisation is not possible due to the small sample size, and absence of methods for random sampling (Boyce & Neale, 2006).

The questions used were developed by UB (Ulrika Bejerholm) and concerned a) work identity and motivation*: How do you perceive yourself in relation to work? Does anyone or anything hinder you from applying for a job/to work? Can you describe your aspiration to work?,* b) the social environment in terms of family, and vocational rehabilitation professionals: *Can you talk about the support you experience from others in your RTW-process?,* c) welfare authorities and the organizations involved: *Can you describe how welfare actors support your aspiration to work?* Supplementary probing questions were also asked if needed, for example: *Could you elaborate on that idea? Can you give me an example?* All the interviews were conducted by AL (Annika Lexén), who is a skilled interviewer with substantial experience of working with individuals with affective disorders. There was no previous connection between AL and the participants, and AL had not previously had a role in the research team. The interview questions were tested on two occasions prior to the present study and discussed between AL and UB in relation to the aims of the study. The interviews, which lasted for about one hour, took place at the participants' outpatient unit or in their home, and were digitally recorded with their consent. The data material was kept on an USB drive and stored securely at Lund University with access limited to the researchers involved in the project.

Data analysis

An independent administrative assistant transcribed all the interview material. An independent research assistant and UB first analysed the material using content manifest analysis method in order to stay close to the spoken material (Table V). Meaning units i.e. sentences, and words that comprised characteristics related to each other, and that corresponded to the study aim, were identified and tabulated. The next step was the coding of the meaning units, i.e. labelling and condensing while retaining the core of the words. The development of codes was a collaborative process between the authors. When the codes were formulated, they were compared, read and re-read. Similar codes formed categories and sub-categories, where both positive and negative responses could be applicable to the same category. This marked the completion of the manifest part of the analysis according to Graneheim & Lundman (2004). In the final stage a theme was created, which represents the latent content, i.e. the underlying meaning when the meaning units, codes and categories have been condensed (Graneheim & Lundman, 2004).

Table V. Example of the analysis process

Meaning units	Codes	Categories
When you have a mental health problem, then people think that you are crazy and go and murder people.	Stigma and lack of knowledge can be present regarding mental health problems.	Prejudice and lack of knowledge about mental health problems
It feels like I almost don't care anymore, being stuck in the system. Which has been quite a lot for me to handle, just to keep the very destructive thoughts away, like those of hopelessness.	Traditional systems with wage-subsidies and work assessment lead to a more difficult struggle for the individual.	Traditional system is unable to help individuals.

Text verification was performed by the thesis author SP (Susann Porter) to ensure credibility following the transcription by replaying the audio conversation files and validating against the transcribed interview material. This supplementary step was taken to confirm whether the transcribed interviews were sufficiently accurate (Kvale, 2008). In order to respond to the secondary aim concerning experiences of the two RTW approaches, within and across analysis were performed i.e. analyses were also made within each group, and between groups (Ayres, Kavanaugh, & Knafl, 2003).

Study II

Design and participants

Individuals with affective disorders who participated in either IES or TVR for a duration of 12-months were included. In addition to the inclusion criteria for Study I, the participants in Study II had been unemployed for the preceding year (Bejerholm et al., 2017).

In Study II it was hypothesised that the perception of IES participants of empowerment would increase and their depressive symptoms would decrease and that there would be a difference between the IES and TVR groups at 12-months. Study II was part of a parallel RCT trial with the primary focus concerning the outcome of employment rate at 12-months (Bejerholm et al., 2017). There were 77 participants who were assessed for eligibility. Of those, 14 had not attended the baseline interview and were thus not included. The remaining 63 participants were randomized to IES *(n*=35) and TVR (*n*=28). The uneven distribution can be explained by an initial estimation of 120 participants in the block-size randomization plan. The categorization was masked until after randomization. Two participants, who were randomized to IES, were excluded as they did not fit the inclusion criteria (IES *n*=33). The study thus had a total of 61 participants. The study period for each individual was 12-months and the RCT began in December 2011

and ended two and a half years later (Bejerholm et al., 2017). The RCT followed the CONSORT guidelines for non-pharmacological interventions (Figure II). CONSORT was developed to improve the quality in the reporting of RCT studies (Moher et al., 2010).

Sample size and blinding

The significance level was set at 0.05 with 0.80 power, which required a sample size of 11 to 42 participants per group (Cook et al., 2005; Drake et al., 1999; Lehman et al., 2002). RCT groups of 60 individuals per group were considered to have a sufficient size allowing for an attrition rate of 30%, a rate in line with previous research on individuals with psychosis, where a loss to follow-up was 28% (Bejerholm et al., 2015). The power calculation in the RCT project was made on the primary outcome of the RCT, the employment rate at 12-months (Bejerholm et al., 2017). The results revealed a mean difference between intervention groups of 38%, with a moderate effect size. A power calculation was not made on empowerment and depression severity relevant for Study II.

One large catchment area was initially targeted for effectively facilitating logistics and recruitment. A decision was later made by the division of MHS and the project steering committee to select four geographically varied medium-sized cities and outpatient teams instead. The reason for this decision was that other projects had started since the planning of the present trial. Additional sites could not be included due to logistical difficulties with IES delivery. Randomization

The randomization was performed by an independent researcher at Lund University who did not have any involvement in the distribution of the interventions or the recruitment process. The randomization plan had a block size of eight allocation numbers at a time (Dallal, 2015). A confirmation letter was sent to participants with details on the intervention to which they were allocated. The trial was single blinded, i.e. the researchers did not have prior knowledge about the allocation of the participants or their identity, and all data was coded. The allocation status could not, however, be blinded for participants or those delivering the interventions.

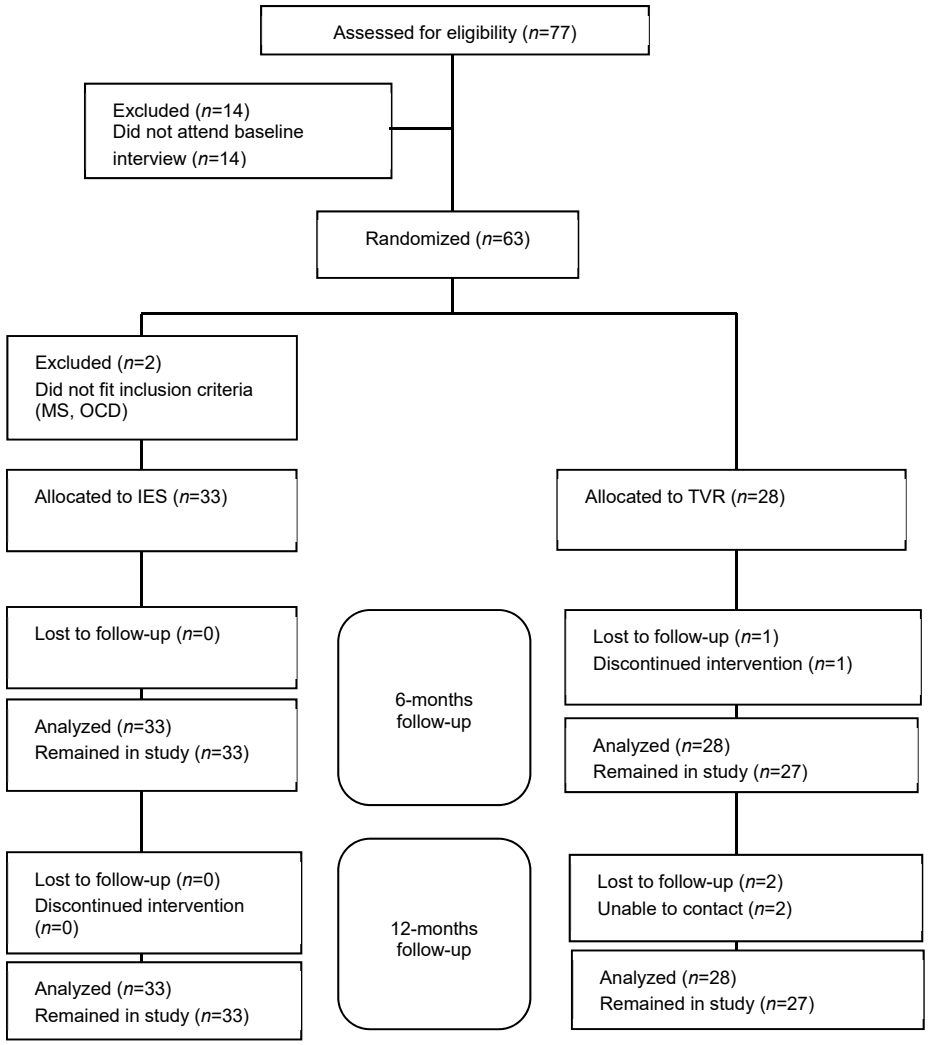

Figure II. Trial profile.

Baseline characteristics

A questionnaire comprising clinical and sociodemographic characteristics was developed and applied, including age, gender, civil status, education and occupational status (Table VI). The participants' psychiatrist determined the mental health diagnosis. There were three additional instruments used in Study II, which were used for baseline comorbidity screening on exhaustion, attention disorder, and alcohol misuse among the participants:

The Adult ADHD Self-Report Scale (ASRS)

The self-reported screening tool ASRS addresses adult attention and hyperactivity disorder. The ASRS consist of 18 items distributed equally into two groups; inattention and hyperactivity-impulsivity. Individuals grade themselves on a 5-point rating scale (0-4). The sum scores ranges from 0-72 where a score of more than 24 points indicates a higher chance for ADHD (Kessler et al., 2005).

The Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT is an assessment instrument addressing hazardous drinking habits (Saunders, Aasland, Babor, De la Fuente, & Grant, 1993). It consists of 10 questions and scores are given between 0 and 4, with a maximum sum score of 40. The cut-off score for hazardous drinking is set at >6 for women and >8 for men (Babor & Robaina, 2016). The Swedish version of AUDIT has shown to have both satisfactory internal and test-retest reliability (Bergman & Källmén, 2002).

The Karolinska Exhaustion Disorder Scale (KEDS)

The KEDS is a self-rated screening tool for assessment of symptoms of stress and exhaustion. The 9 items address concentration, memory, physical stamina, mental stamina, recovery, sleep, hypersensitivity to sensory impressions, experience of demands, and irritation/anger. Each item has a 7-point scale (0-6) with a maximum score off 54 points. A cut-off score of ≥19 points distinguishes the presence of exhaustion disorder (Besèr et al., 2014).

Data collection corresponding to the study aims

There were two instruments corresponding to the study aims concerning empowerment and depression severity that were used in collecting data at baseline (T1), 6-months (T2), and at 12-months (T3).

The Empowerment Scale

Empowerment was measured using the Empowerment Scale (Rogers, Chamberlin, Ellison, & Crean, 1997). The Empowerment Scale includes 28 statements and five subscales: Self-esteem/self-efficacy, power/powerlessness, community activism and autonomy, optimism and control over the future, and righteous anger. The question responses were graded from 1 (strongly agree) to 4 (strongly disagree), with a range of 28-112 points. A higher score indicated a greater perception of empowerment. The Empowerment Scale has showed a high internal consistency (Rogers, Ralph, & Salzer, 2010). The Swedish version of the Empowerment Scale has also presented satisfactory reliability in relation to internal consistency (Hansson & Björkman, 2005). Cronbach's alpha values in the present study were satisfactory: T1=0.792, T2: 0.872, and T3=0.872.

Montgomery-Åsberg Depression Self Rating Scale (MADRS-S)

Depression was assessed by the self-rated MADRS-S scale (Montgomery & Asberg, 1979). The scale includes 9 items: mood, feelings of unease, sleep, appetite, ability to concentrate, initiative, motivational involvement, pessimism, and zest for life. Each item is rated on a 7-point scale (0-6). The sum score ranges from 0 to 54 points and is categorised as no or hardly any depression (0-12), less severe depression (13-19), moderate depression (20-34), and severe depression (≥35). MADRS-S has satisfactory construct validity, internal consistency, and sensitivity to change (Fantino & Moore, 2009). Cronbach's alpha values were satisfactory: T1=0.839, T2= 0.888, and T3=0.907.

Statistical methods

Sociodemographic and clinical variables were evaluated using the Chi2-test. Continuous variables were evaluated using the Student t-test. In order to investigate the differences between the IES and TVR interventions, the Mann-Whitney U-test was applied at TI, T2 and T3. Empowerment and depression severity between measuring points within the two intervention groups, were analysed using the Wilcoxon signed rank test. Effect size, coefficients of variation (*r*) were calculated for non-parametric data (Fritz, Morris, & Richler, 2012), and interpreted using Cohen's criteria (0.10=small, 0.30=medium, 0.50 large), (Cohen, 1988). Spearman's rank test (r_s) was applied for correlation statistics. Values were measured, and 1 or -1 indicated a perfect correlation, while zero indicated no correlation. The principle of Intention-To-Treat (ITT) was used (Kirkwood & Sterne, 2010; Moher et al., 2010). The main analysis was based on the ITT (Moher et al., 2010), though analysis was also made using primary data. The application of ITT strategy has been used in order to preserve randomization in a randomised control trial. All participants remain in the group they were originally allocated to regardless of whether they received the treatment or not (Moher et al., 2010). For missing data, the imputation principles of the last observation carried forward (LOCF), or the next observation carried backwards (NOCB) where applied (Fielding, Maclennan, Cook, & Ramsay, 2008). Supplementary analyses on primary data, i.e. prior to imputations, were performed. A binary logistic regression was applied to investigate if the empowerment and depression scores affected the RTW outcome, that is, employment or not, at 12-months. The dichotomous variable of RTW was the dependent variable, and empowerment and depression were the independent variables. Statistical analyses were performed using SPSS version 23 (SPSS Inc., SPSS Armonk, NY. Released 2015 for Windows) A two-tailed p-value of <0.05 indicated statistical significance.

Table VI. Baseline sociodemographic and clinical characteristics of participants in Study II (*n*=61)

Characteristics		IES (*n*=33)	TVR (*n*=28)	Total (*n*=61)
Age in years				
	Mean (min-max)	38 (21-63)	44 (20-60)	41(20-63)
Sex				
	Women	22	22	44
	Men	11	6	17
Ethnicity				
	Swedish	31	25	56
	Other*	2	3	5
Civil status				
	Married	9	11	20
	Not married/divorced	18/6	12/5	30/11
Living situation				
	Cohabiting with partner or other	18	17	35
Have children				
	Yes/no	18/15	19/9	27/34
Diagnosis (ICD-10)				
	Depression (F32-F33)	21	21	42
	Bipolar (F30-F31)	12	7	19
Age in years at first contact with psychiatry				
	Mean (min-max)	26.3 (8-53)	29.5 (14-49)	27.8 (8-53)
Educational level (yr)				
	Middle school	6	3	9
	Upper secondary	16	17	33
	College/university	11	8	19
Work history (yr)				
	Work experience	31	27	58
Years since last employment				
	Mean	4.5	4.4	4.4

*France *n*=1, Vietnam *n*=1, Denmark *n*=2, South Korea *n*=1

Study III

Participants

Eligible participants were vocational rehabilitation professionals, referred to as both vocational rehabilitation professionals, and professionals in this thesis. They worked within CA, IPS, MHS, OHS, PC, PES, and SIA (Table I), which are the various organizations and authorities providing RTW support to individuals with mental health problems. Furthermore, they had experience of interactions with employers in the RTW-process. To clarify, both CA and IPS can be complementary actors working with individuals with mental health problems at PES. They often have, however, two different RTW perspectives as the CA generally apply the train-then-

place model, while the IPS generally apply the place-then-train model. Both these vocational rehabilitation professionals were included in order to achieve diversity among the different actors in the RTW-process.

Table VII. Socio-demographic characteristics of the vocational rehabilitation professional in Study III (n=22)

Characteristics		*n*
Sex		
	Female	18
	Male	4
Age in years		
	Mean (range)	47.1 (31-66)
Educational level in years		
	Upper secondary school	3
	University/college	19
Work experience in years		
	Mean(range)	19.9 (3-38)
Duration of work experience within vocational rehabilitation in years		
	Mean (range)	15.7 (3-23)
Type of authority/organization		
	Complementary Actors	2
	Individual Placement and Support	2
	Mental Health Service	2
	Occupational Health Service	3
	Primary Care	3
	Publice Employment Service	4
	Social Insurance Agency	6

Design, data collection and analysis

Grounded theory was applied to guide the data collection (Charmaz, 2014). This method was chosen as previous research in this field is limited. To gain an understanding of the RTW-process from the perspective of vocational rehabilitation professionals, a conceptual model was sought. A constructive approach to grounded theory aims to theorize the empirical data, whilst recognizing that the theory is an interpretation and depends on the researchers' views. It is a bottom-up approach which strengthens the method as researchers continuously engage with the data through analytical questions (Charmaz, 2014).

The recruitment area was the county of Scania in southern Sweden. Prior to starting the study, two pilot interviews were performed resulting in minor revisions to the interview guide. Twenty-two vocational rehabilitation professionals from 7 different settings met the inclusion criteria (Table VII). All of these were asked to participate in the study and all consented. The participants consisted of 4 men and 18 women with a mean age of 47 years (range 31-66).

A contact person from each recruitment field, i.e. authority or organization, forwarded information about potential participants, who were interested in the study, to the research team. These potential participants were then contacted by telephone or by email and provided with information about the study. Additional information was given at the time of the interview, both verbally and in written form. Informed consent was obtained from all the participants. The interviews were performed at the participants' workplaces with a duration between 30 and 90 minutes. The interviews were all recorded digitally with the consent of the participants.

Initial sampling was applied to select the first two participants in relation to the aims and the study criteria (Charmaz, 2014). The interviews were then transcribed verbatim and analysed using incident-by-incident initial coding by abstracting the transcribed text and using labels (Table VIII). The aim was to locate action in each section of the data, and to form a link between the collected data and the developing tentative theory in order to understand the data (Charmaz, 2014). The next step was theoretical sampling, which involves continuing the data collection through seeking to explain and elaborate the tentative categories and specifying relationships between categories in order to create an analytical meaning (Charmaz, 2014). Theoretical sampling was applied to guide the remaining data collection which entailed the inclusion of a diversity of professionals working in the RTW-process, e.g. different ages and genders, from a variety of authorities and organisations, and with different work experiences. Theoretical sampling helps to develop the emerging categories, and to elaborate and refine the established categories. (Charmaz, 2014). By using theoretical sampling, the participants were thus gradually included, and the data collection and the analysis process were performed simultaneously in an iterative process.

The research team (AL, UB and Maria Emmelin (ME)) developed the interview guide with an emphasis on questions exploring experiences of mental health problems and the RTW-process. Introductory questions focused on asking the participants to describe themselves and their motivation to work in the chosen area. Further questions were: *What experience do you have of meeting employers as part of the RTW-process? Can you tell me about a situation, where you had contact with an employer, that you remember as being positive/negative? What is your view of individuals with mental health problems and their ability to work?* When using theoretical sampling, in grounded theory, the researcher can add modified questions, which in this study covered experiences of mental health problems, support strategies and the professionals' experiences of the employers' support needs. Gradually, more specific questions were also added as part of the theoretical sampling process. This procedure of feeding initial results back into the data collection, and adding questions that could be modified or more specific and that needed to be explored, is vital in grounded theory (Charmaz, 2014).

The new question areas of interest were personal skills, experiences of mental health problems, attitudes and support strategies, and experiences of employers' support needs. Theoretical sampling was considered to be concluded i.e. theoretical saturation, when no new theoretical insight occurred in relation to the emerged categories. *Focus coding* was the next step i.e. the most frequent and important initial codes were used to categorise the data. The authors then proceeded to the *axial coding*, meaning connecting the categories and the sub-categories to each other. Axial coding gives the coding coherence to the developing analysis. *Theoretical coding* was the last step i.e. connecting the categories to give an understandable analytical explanation. Memo writing was used during the whole analysis process, allowing the authors to reflect on the analysis process, validate and categorise codes, and as in the last step making connections among the categories. Results that were a contrast to the main result, i.e. negative cases, were also included (Charmaz, 2014). The research team included three occupational therapists and a researcher with a background as a social worker.

Table VIII. Example of the initial analysis

Interview text	Initial coding
I can understand that it's very difficult for you, but this is how the regulations are set and I have to follow those rules.	Must follow the regulation set up.
It can be as though the employers want a high wage-subsidy and an individual that has a 100% work ability.	High wage-subsidy and 100% work ability.

The interviews were conducted by AL and UB. The initial coding was performed by AL, UB and ME. Text verification was performed by SP against all the digitally recorded interviews. The remainder of the analysis process was performed by the whole research team (AL, UB, ME, SP). Open Code 4.01 software was used throughout the data analysis process.

Study IV

Participants

The eligible participants for Study IV comprised employers with responsibility for staff, and with or without experience of employees with mental health problems (Table IX). The aim was to include a variety of employers from both the public and the private sectors.

Table IX Socio-demographic characteristic of the employers participating in Study IV (*n*=24).

Characteristics	*n*
Sex	
Female	14
Male	10
Age in years	
Mean (range)	49.2 (39-62)
Education level in years	
• Middle school	1
• Upper secondary school	5
• University/college	18
Type of authority/organization	
• Education institutions	5
• Manufacturing	3
• Healthcare	4
• Installation, operation and maintenance	1
• Hotel or restaurant	1
• Sales, purchasing and marketing	4
• Information technology	2
• Construction	1
• Police	1
• Administration, economy and law	1
• Politics/Government	1

Design, data collection and analysis

A grounded theory approach was applied to guide the data collection and began in 2015 with an originally estimated completion during 2016. However, due to the aims of the present study, the perspective of a politician was also sought as their perceptive as an employer (and policy-making actor) was of interest. An additional interview was therefore performed during the autumn of 2018 by SP. The final interview did not change the prior results. The authors followed the same data collection and analysis processes as described in Study III when applying grounded theory, starting with the initial sampling (Table X) of two participants, promptly transcribing the interviews, analysing the data material and then moving on to

theoretical sampling (Charmaz, 2014).The researchers contacted a total of 25 potential employers either by telephone or email, provided them with information regarding the study. If they agreed to proceed, more detailed information regarding the study were given in both verbal and written form. One potential participant declined due to being new as an employer. The interviews were digitally recorded and lasted between 40 to 90 minutes. The interview guide contained open-ended questions and was developed by the research team (AL, UB and ME) in relation to the study aims. Two pilot interviews were performed, and minor changes were made. The interview opened with questions like: *Tell me about yourself and why you do what you do today? How many years of work experience do you have? How many employees are you responsible for? How many years have you worked as an employer? What do mental health problems mean to you? What are your experiences of mental health problems?*

In the next phase of the interview, participants were asked to read and reflect on two pre-written vignettes. These can be used in qualitative research in order to improve the validity through a better framing of the research areas that are to be investigated (Jenkins, Bloor, Fischer, Berney, & Neale, 2010). The first vignette related to the time employers devoted to supporting employees with mental health problems. The second vignette related to employers' difficulties helping and supporting an employee with mental health problems. The following questions were asked to stimulate reflection: *Can you tell me about an employee who has had mental health problems at your workplace and how that was handled? Can you tell me about a case that worked well/worked less well? Have you received support from vocational rehabilitation actors when hiring or having an employee returning after sick leave? If so, can you tell me about the support you received?* As previously explained, additional question areas were added as part of the theoretical sampling approach. The questions in this study addressed the experiences of hiring employees with mental health problems, the recruitment process, and the sourcing of applicants.

Table X. Example of the initial analysis

Interview text	Initial coding
He has been given work tasks that are different from his colleagues, meaning he can do more independent work that suits him better.	Adapting the work to the employees' needs.
For instance, we had a person who worked with finances and who became depressed and stopped doing those tasks and when doing them, did a very bad job.	Mental health problems affects the work ability.

The interviews were conducted by AL and UB. The initial coding (except for the last interview) was performed by AL, UB and ME. SP conducted the final interview and conducted the initial coding for that interview, together with performing text

verification against all the digital recordings. Focus coding, developing of categories and sub-categories and memo writing was undertaken by all the authors.

Ethical considerations

All four studies in this thesis were conducted in accordance with the ethical guidelines of the Declaration of Helsinki (WHO, 2001). The studies were approved by the Regional Ethical Review Board in Lund, Sweden. Studies I-II were approved in 2011 (Dnr 2011-544) and Studies III-IV in 2015 (Dnr 2015/90).

The World Medical Association developed the ethical principles in order to provide guidance for researchers when performing medical research on humans. The principles underline the researcher's responsibility and duty to guard the health of the participants. The well-being of the participants should be prioritized before the interest of science. The ethical principles state that research on humans should only be conducted by researchers who are qualified in the field. Participants should be informed of the study, that participation is voluntary, and that they can withdraw their participation at any time. Before the study begins the participants should give their informed consent to participate (WHO, 2001).

All the participants in Studies I-IV were given both written and oral information about the study prior to the interviews. The participants who consented to participate in the study, gave their written consent together with permission for digital recording of the interview. All participants (Studies I-IV) were guaranteed confidentiality and the right to end their participation without having to give a motive. The analysis material was stored on a USB drive, securely kept in a locked cupboard at Lund University, with access limited to the researchers involved in the study. The transcribed interviews did not include names of the participants, workplaces or location information. After the participation in the IES was completed (Studies I-II), those participants who needed it were allocated back to the TVR with the support of the Employment Specialist. The researchers who conducted the interviews were all experienced occupational therapists with extensive experience of carrying out interviews.

In relation to the ethical principles of research on humans, the study was motivated as the individuals with mental health problems are a large group in society who would benefit from an improved RTW-process to aid their recovery and increase their possibilities of gaining employment.

Results

The perspectives of individuals regarding critical factors in their RTW-process

Study I explored the critical factors for the RTW-process for individuals with affective disorders, who had participated in either IES or TVR for 12-months. The following three themes emerged: *Experiencing hope and power, Professionals' positive attitudes, beliefs and behaviours,* and *Employing a holistic perspective and integrating health and vocational services* (Table XI).

Table XI. Critical factors for the return-to-work process

Theme	Categories
Experiencing hope and power	Prejudice and lack of knowledge about mental health problems Dilemma of disclosing mental health problems Self and identity roles The family's participation Low self-esteem, little belief in changes and support along with low self-efficacy
Professionals' positive attitudes, belief and behaviour	A genuine interest and engagement from those who provide support and treatment Gender impact on treatment To understand the individual needs and conditions in the vocational rehabilitation Letting the individual's needs lead the intervention
Employing a holistic perspective and integrating mental health and vocational services	Need of coordination and person-centred service Bureaucratic structures hinder vocational rehabilitation Traditional vocational rehabilitation is unable to help the individual Advantages of the place-then-train IES vocational approach

Experiencing hope and power

Experiencing hope and power was the strongest theme perceived by most of the participants as critically important for enabling the RTW-process, regardless of the vocational approach. Several barriers prevented the feelings of hope and power. Prejudice towards those with mental health problems was perceived as a common negative experience among most participants. Participants had a fear of being disadvantaged at work if their mental health problems were known by others. Worry

about negative consequences was a reason given not to disclose or hesitate to disclose mental health problems. A 47-year-old women (IES) explained:

> "I think that it would have been easier if I have had a nicer (with irony) diagnosis like cancer. Then you get much more sympathy because then you have not brought it on yourself but have just become ill."

Experiences of disclosure were positive for some, but negative experiences were the most common and seen as leading to undignified work tasks and of being judged as "crazy". The participants with positive experiences, of disclosing to their managers, described disclosure as leading to a better understanding of their problems. Among the IES participants, more positive disclosure experiences were described, and the Employment Specialist supported them in their decision whether to disclose or not.

The work role was perceived as one of the most important roles in the participants' lives (the other being the family role) and was strongly linked to their self-identity and feelings of hope and power. Even though the family role was regarded as significant in the participants' RTW-process, the participants often felt a lack of support and understanding from family members of their mental health problems and the challenges they faced.

The work role was of great importance in how they perceived themselves and gave them confirmation, meaning and a feeling of being competent. Some of the participants expressed that losing their work role lead to them losing a feeling of identity. One women 39-years old (IES) explained how important the work role was to her and her feelings both when she had work and had lost it:

> "To feel like I am part of a context, that I am part of society. When I was unemployed, I felt outside, I felt like the earth was spinning without me being part of it. When I had a job, I felt I was also a part of the spinning, then it was totally okay."

Whilst all participants had previously experienced low self-esteem and little confidence in a positive outcome of work, this belief had changed for the IES participants who now felt hope and believed in the prospect of finding work. This change of belief was strongly linked to the collaboration with the Employment Specialist.

Professionals' positive attitudes, belief and behaviour

The second critical factor was the importance of the RTW professionals having positive attitudes, beliefs and behaviours towards the individuals with mental health problems. The showing of a genuine interest and commitment by the professionals was seen as being vital by those with affective disorders and was to a great extent

lacking in the TVR approach. The professionals using the TVR approach were described as cold and with a hard attitude (PES) and showing a lack of commitment (SIA). A 26-year-old women (IES) expressed her previous experiences with a handling officer at PES;

> "The handling officer showed no understanding. He wanted to see results, so he was very cold and hard in that way."

The experiences of the IES participants were very different, they described the Employment Specialist as an enabler who had a positive behaviour, was supporting and believing in their ability, and showed them respect.

Understanding the individuals' needs and conditions was considered vital yet lacking in the TVR approach. There were deficiencies in the understanding of depression and strategies to give support both among professionals and among employers. Most participants in the TVR approach expressed a feeling of hopelessness. Conversely, the Employment Specialists were viewed as having a supportive behaviour and being flexible to the individual's needs. This support from the Employment Specialist helped to prevent misunderstandings regarding the individual's problems. The participants spoke of the importance of the intervention being adapted to their needs and of having the same professionals involved in the RTW-process, which was largely absent in the TVR approach.

Employing a holistic perspective and integrating mental health and vocational services

The final theme corresponded to the critical importance of a holistic perspective, integrating both mental health and vocational services. The participants described that improved coordination between the actors involved in the RTW-process would allow for an enhanced person-centred service. This was considered lacking in the TVR approach, where extensive contact with a number of authorities was experienced as a common and a very negative aspect. The turnover of professionals was also experienced as commonly occurring and stressful, impairing the development of relationships and trust. Bureaucratic structures were viewed as a hindering factor embedded in the TVR approach and authorities were perceived as inflexible and the support was not adapted to the individual's needs. A 58-year-old women (TVR) expressed how she had initiated an internship placement herself that suited her needs, which was not approved by the handling officer at PES, she expressed;

> "I fixed an internship placement myself that I knew was going to work out because I know myself, but they [PES] didn't accept that."

The experience of the TVR approach was that it was incapable of helping the individual. The commonly used prevocational training was viewed as insufficient and contributed to a feeling of hopelessness in the rehabilitation. Some participants even perceived their depression to worsen or relapsing due to their negative outlook on the TVR approach. Conversely there were several advantages in the IES approach: The Employment Specialist worked in a holistic way, was supportive regarding administrations tasks and contact with authorities, and was also easy to reach.

The effect of Individual Enabling and Support on empowerment and depression in persons with affective disorder

Study II evaluated the effect of IES and TVR on empowerment and depression severity in individuals with affective disorders at three points in time; baseline (T1), 6-months (T2), and 12-months (T3).

Baseline data

There were no significant differences between participants in the IES or TVR interventions at T1 other than age (mean score IES 38 years, TVR 44 years, p=0.04), and alcohol use (Mdn (median) score IES 3 and TVR 1, p=0.03) (Table XII). No significant differences in baseline characteristics were found between those included in the analysis and those lost to follow-up (Bejerholm et al., 2017). Furthermore, there were no statistically significant differences found between the imputed ITT material and the primary data (prior to ITT).

Table XII. Baseline comorbidity screening for exhaustion, attention disorder, and alcohol misuse

Characteristics Comorbidity evaluation	**IES (*n*=33)** Median (min-max)	Mean (SD)	**TVR(*n*=28)** Median (min max)	Mean (SD)	**Total(*n*=61)** Median(min-max)	Mean (SD)
KEDS	27(15-43)	26.3(7.4)	25(10-39)	26.4(7.7)	26(9-49)	26.3(8.3)
ASRS1[a]	20(7-31)	19.7(6.2)	19(1-30)	17.3(6.9)	20(1-31)	18.6(6.6)
ASRS2[b]	16(3-28)	14.6(6.5)	13.5(2-29)	14(6.6)	15 (2-29	14.3(6.5)
AUDIT	3 (0-10)	3.4(2.7)	1 (0-6)	1.8(1.8)	2 (0-10)	2.7(2.5)

SD: Standard deviation; KEDS: Karolinska Exhaustion Disorder Scale: ASRS: Adult ADHD Self-Report Scale: AUDIT: Alcohol Use Disorders Identification Test
[a] Inattention
[b] Hyperactivity

Differences between IES and TVR on empowerment

At T1, there were no differences between the intervention groups regarding empowerment scores, where IES showed Mdn 75.0 points and TVR 71.5 (p=0.205, r=0.162). At T2, only marginally but no statistically significant differences were seen between the groups where IES participants increased their Mdn empowerment scores to 79 and TVR to 72 (p=0.053, r =0.248). However, at T3, there was a statistically significant difference regarding empowerment between IES and TVR participants, where IES participants perceived themselves with a higher empowerment score Mdn 80 than TVR 72 (p=0.004, r=0.373).

Differences between IES and TVR on depression severity

The MADRS-S score showed no statistically significant difference at T1 between the intervention groups with both showing moderate depression. The Mdn for IES was 22 and for TVR 23.5 (p=0.132, r=0.193). At T2 there was a statistical difference as the IES participants had decreased their Mdn scores to 17 points (less severe depression) and the TVR participants were still observed as having moderate depression Mdn 22 (p=0.046, r=0.225). Similarly, at T3 the differences between IES and TVR were statistically significant as the depression scores for the IES participants continued to decrease to Mdn 15 (less severe depression), while the TVR participants remained stable at Mdn 22 (moderate depression) (p=0.033, r=0.273).

The logistic regression performed at 12-months revealed that neither the empowerment (IES p=0.681, TVR p=0.955) nor the depression scores (IES p=0.399, TVR p=0.339) had any effect on the outcome of having employment or not.

Within group changes on empowerment and depression severity

Within-group analysis showed that IES participants increased their perceived empowerment between measurement points T1-T2 (p=0.006, r=0.339), and T2-T3 (p=0.010, r=0.315) and T1-T3 (p= 0.000, r=0.466). The TVR participants also showed an increase in Mdn score over time, but the development was not statistically significant (T1-T2, (p=0.575), T2-T3, (p=0.951), T1-T3 (p=0.400).

Within-group analysis regarding depression showed that IES participants significantly decreased their depression scores between T1-T2 (p=0.011, r=0.313) and T1-T3 (p=0.004, r=0.357) but no significant differences were seen between the

T2-T3 follow-up (p=0.341, r=0.117). This suggests that the benefit was gained at the 6-months point in time and then maintained to the 12-months follow-up. No statistically significant differences for the TVR participants were observed between the measuring points (T1-T2 p=0.279, T2-T3 p=0.884, T1-T3 p=0.204).

Correlations between empowerment and depression

For the IES group there was a statistically significant correlation between empowerment and depression between the three measuring points (T1: p=0.003, r_s -0.498; T2: p=0.000, r_s=-0.735; T3: p=0.000, r_s =-0.700). The TVR participants showed a statistically significant correlation at T3 (p=0.000, r_s =-0.624). Using the primary data did not change the results.

Mental health literacy among vocational rehabilitation professionals and their perception of employers in the return-to-work process

In Study III the mental health literacy of vocational rehabilitation professionals was explored together with their perception of employers in the RTW-process. Three categories emerged (Table XIII) in relation to the study aims: *Holding a position of power in the RTW-process, Viewing and believing in individuals' work ability plays a central role*, and *Recognizing the employer's role as a key factor for realizing employment.*

Table XIII. Professional mental health literacy influences the return-to-work process

Categories	Sub-categories
Holding a position of power in the RTW-process	Diverse power roles in the RTW-process Deficient knowledge in combination with power is a barrier Lack of collaboration causing time and service gaps
Viewing and believing in individuals' work ability plays a central role	Varying views of work for individuals with mental health problems View of disclosure as both a positive and negative action Stigma is a part of the view of work ability
Recognizing employer's role as a key factor for realizing employment	Employers as both barriers and enablers Employers in need of knowledge and support Financial situation impacts employers' actions

Holding a position of power in the RTW-process

Holding a position of power emerged as a strong category reflecting the position professionals have in the RTW-process. The professionals' power roles were diverse in the RTW-process, which originates from their varied professional roles within their authorities and organizations, governed by political decisions. They spoke of following regulations as being a part of their professional role and which impacted their use of knowledge and collaboration with other professionals. The assignment given to the professionals focused to a great extent on the individual's functional limitations.

The professionals talked of their role as supporting individuals and being open to what they wanted. The professionals, who mainly worked with unemployed individuals, expressed the importance of making an individual job match and networking with employers (CA, IPS and PES), and working in a holistic way (CA, IPS, PC). They also described their role as giving support to employers including providing advice regarding workplace accommodations (CA, IPS, OHS). The Employment Specialists (IPS) specified that they continued to support employers after employment for the individual had been established. This was contrary to the PES handling officers who expressed that this possibility was limited (PES). Furthermore, SIA expressed that their role did not include supporting employers, and that instead the employee was encouraged to deal with that contact themselves (SIA).

A lack of knowledge regarding mental health problems in combination with power as experienced by SIA's handling officers was viewed as a barrier in the RTW-process (MHS, OHS, PC). SIA's handling officers were open to the fact that they were not medically trained and desired more support from their own experts, e.g. medical doctors (SIA). The lack of knowledge at SIA was confirmed by the other professionals with one medical doctor at the MHS referring to SIA's handling officers;

> "It is a bad sign for a society that we allow an authority to have such poorly educated staff."

The professionals generally agreed that a lack of collaboration caused time and service gaps which negatively affected the RTW-process. Most professionals viewed this as a common and needing improvement as it negatively affected the individuals with mental health problems.

The lack of collaboration could be caused by SIA's handling officers having too great a workload and thus not being present at status meetings (MHS). The turnover of SIA's handling officers could be an additional reason (MHS). A lack of collaboration was also seen by employers and the MHS, leading to insufficient

understanding of the employee's mental health problems (OHS). The professionals at PC experienced that patients could be overlooked due to an inadequacy in the collaboration between PES and SIA, leading to different views of the individual's work ability i.e. being too well for SIA and too ill for PES (PC). The handling officers at SIA identified a dilemma, with the inadequacy of the collaboration between the individuals and the specialist doctors at MHS manifesting itself as waiting time for the individual to see a specialist doctor at MHS. SIA's handling officers concluded that the inactivity in coordination between the professionals in the RTW-process lead to the process being slower with time and service gaps (SIA). In conclusion, the power of different authorities or organisations to collaborate or not with other actors in the RTW-process can affect both the individuals in the process and the other actors.

Viewing and believing in the individuals' work ability plays a central role

Professionals held varying views of the work ability of individuals with mental health problems. The common view was that individuals with mental health problems could work. The SIA handling officers stated that very few individuals did not have any work ability and that most individuals wanted to work but sometimes did not want to return to work particularly when work was the reason for the sick leave (SIA). A distinction was however observed, as work could be viewed as meaning employment with or without wage-subsidies. Wage subsidies were believed to be a way of returning to the labour market after sick leave (CA, IPS, PES, SIA). The individual did not have to be free from symptoms when starting to work as wage subsides compensated employers for the functional limitations (PES). The Employment Specialists spoke of the importance of assessing when internship placement and wage subsidies were no longer needed as the goal, according to them, was regular work without a financial subsidy (IPS).

A commonly held belief was that it was vital to find the right employment together with the right social environment in order to be able to make work sustainable, (CA, IPS, MHS, PES, SIA). Furthermore, the Employment Specialists maintained that matching the individuals' abilities to the right job was also vital (IPS).

There were varying views concerning whether mental health problems should be disclosed to the employers or not. Professionals described both positive and negative consequences from such disclosures, although all the professionals agreed that the decision to disclose this information or not was in the end the individual's choice. Some felt that total openness was best (OHS, PES, SIA) while other professionals were more cautious and focused more on the individual's abilities to do the job (IPS). The professionals at PES talked of it being essential to disclose to

the employers, so they knew about the functional limitations and why a wage subsidy had been granted (PES). The professionals at PC expressed both positive and negative aspects about disclosure but said that prejudice was common and a diagnosis could thus be a limitation (PC). The professionals at OHS stated that employers needed to be informed as they were responsible for paying for their services, but to which extent was the individual's decision (OHS).

One Employment Specialist drew parallels with how healthy individuals would act:

> "If, say, you or I are looking for a job…we will not tell all about our dark sides or stuff right away when we are trying to get a job."

Stigma was a common concern among most of the professionals affecting how the professionals viewed the individuals' work ability i.e. if they believed an individual with mental health problems could have a regular job or not. The individuals themselves could also exhibit self-stigma manifested as low self-belief in their work ability and being too self-critical (CA, MHS, PC). The medical certificate could serve to stigmatise the individual as it put an emphasis on the illness (MHS, PES). The wider society was also seen as being stigmatizing for individuals with mental health problems (OHS, PC, SIA), where women were more affected then men (SIA, PC). Additionally, society was experienced as lacking tolerance for individuals with mental health problems (MHS, PC, PES, SIA). Among the professionals themselves and their authorities, stigma was experienced as manifesting itself as insecurity, fear, and disrespect of clients due to their mental health problems (PES, SIA). A SIA handling officer, referring to stigma and to the general societal prejudice, commented:

> "Because we are like most people, it's unfortunately so."

Recognizing employers' role as a key factor for realizing employment

Employers were recognized as both being an enabler and a barrier in the RTW-process, although the most common view was that employers created a barrier towards employees and jobseekers with mental health problems due to their negative attitudes, lack of knowledge, and need for professional support. The employers' need for knowledge and support was commonly expressed and a lack of knowledge among employers could lead to fear and misunderstandings. Finding an employer who wanted to employ an individual with mental health problems was described as very difficult (CA, IPS). Nonetheless, when individuals had a pre-existing employer, SIA stated that most employers wanted their employees to return to their work after the sick leave period (SIA). The professionals at OHS stated that employers usually tried to make adaptations in accordance with their employees' needs (OHS). Furthermore, employers with previous positive experiences of

individuals with mental health problems were also more positive of the RTW-process (IPS). The use of internship placements could be a useful approach to find employment, as then the employer would have the opportunity to meet the individual behind the diagnosis without the commitment of employment (CA).

The financial situation impacted employers' actions since their main interest is in productivity and profits (CA, IPS, PES, SIA). There were some employers who were socially committed and wanted to help, while others saw an economic benefit in hiring an individual with wage subsidy (CA, IPS, PES). The professionals who worked with individuals who were unemployed on sick leave spoke of discussing with potential employers about wage subsidy before the individual had even started to work (CA, IPS, PES, SIA). The motive to hire thus became the wage subsidy and the employment was not possible without it (PES). Even when employers were financially compensated due to an individual's functional limitation, they could still expect a completely productive individual (PES).

Employers' perspectives on mental health problems

In Study IV the beliefs, knowledge and strategies used by employers (mental health literacy), in providing support to employees with mental health problems were explored. The results showed two categories (Table XIV) related to the aims: *Comprehending mental health problems is complex,* and *Lacking established conditions to support work.*

Table XIV. Employers mental health literacy affects the return-to-work process

Category	Sub-category
Comprehending mental health problems is complex	Being more or less familiar with different types and causes of mental health problems Experiences of mental health problems affect beliefs in work ability Disclosing leads to better understanding but risks stigmatization Identifying own lack of knowledge and strategy gaps
Lacking established conditions to support work	Uncertainty regarding strategies and work accommodations required Needing support and collaboration in the RTW-process Needing financial compensation to enable work

Comprehending mental health problems is complex

The employers presented a broad spectrum of beliefs and experiences in their interviews, showing that comprehending mental health problems was complex and diverse. Most employers had experiences of employees who had suffered from stress or who had depression and they could see the link to the workplace, as a heavy workload and reorganization could generate these problems. However, most employers believed that mental health problems were not only related to the workplace, but private life could also be a significant cause such as when an employee had problems in his/her family, e.g. if a child was bullied in school, the loss of a close relative, or going through a divorce. The employers said they could more easily comprehend this type of life crisis and relate to them through their own or someone else's experiences. A few employers with positive experiences of individuals with mental health problems spoke of it being a natural part of life, a source of strength, and work could make them feel better. One employer stated:

> "I think those who have had a mental health problem or have a diagnosis of any kind…who live with it and can manage it…they are usually rather stable because then they have strategies for handling it."

The dominant beliefs were, however, that mental health problems were difficult to comprehend and negatively affected the workplace, the employee themselves or co-workers, and could cause financial losses for the company. Employers gave several examples of employees' lack of work ability such as making mistakes, not working at all and seeking conflicts.

Most employers wanted to support their employee but needed them to disclose to initiate that support. Knowing if an employee had problems could be difficult, as employers did not always work alongside them. Colleagues could also try to help with work tasks and thus hide the problems from the employers. Employees might also hide their mental health problems behind a physical problem. The results revealed that employers were aware that disclosing were not always easy as employees could be worried about being stigmatized. The difficulties of disclosing were elaborated by one employer:

> "Unfortunately, mental health problems are still accompanied by a sort of shame. When having a physical illness, then everyone feels sorry for you. If you have a mental health problem, then you're crazy and people don't feel sorry for you."

Some employers considered diversity in the workplace to be a strength and stated that mental health problems were not something that required disclosure if the job was done. In terms of the employer's own knowledge, a vast majority of employers were honest about their own lack of knowledge and strategies and wanted to be better equipped to support their employees. One employer described how he wanted

to help but his effort was not received in a positive way by the employee, leaving him puzzled;

> "I really didn't have the tools to handle it, and I didn't really know how to do it."

Employers presented several suggestions for reducing the knowledge gap and the most commonly expressed suggestions were lectures or training as a way of increasing knowledge. Strategies to communicate were mentioned as important skills since it could be challenging to approach an employee with mental health problems. More skills were also requested about SIA's system of regulations in order to gain a greater comprehension of their regulatory framework.

Lacking established conditions to support work

A great majority of employers wanted to help their employees with their mental health problems but did not have established conditions to follow, leading to uncertainty regarding how to support them and for how long. They could feel uncertain about what was appropriate to ask regarding the employee's problems. The employees' own solutions were spoken of as being important to consider, such as working from home, reducing or adapting the workload and facilitating flexible work hours. However, work accommodations were not always possible as one employer who worked in the education sector stated:

> "There is a limit to how much you can adapt the work task. You can't have a teacher who can't teach."

Furthermore, the time needed to adapt caused uncertainty among the employers. The co-workers could also limit how long they could consider supporting a colleague and jealousy could arise if the adaptations seemed unfair. Employers were also limited themselves as to how much time they could devote to supporting an employee due to their own workload.

The employers saw the need for support and collaboration from vocational rehabilitation professionals in the RTW-process but viewed this as being lacking to a large extent thus leaving them alone in the process, not knowing how best to support and adapt work for their employee. Employers were not always informed about the mental health problems, when hiring an individual through PES, despite having requested that information, thus leaving them unsure if the job matched the individual's ability. This created a wariness of hiring employees through PES due to the lack of transparency. Some employers also viewed PES as lacking sufficient competence and being unsupportive. Other employers had more positive experiences and had hired employees though PES that matches the requirements of the work.

A majority of the employers who had contact with SIA viewed the collaboration and support as negative. SIA was known primarily for aiming to achieve a rapid RTW regardless of whether the employee had sufficient work ability for the job. Those employers who had contact with the OHS viewed them as helpful and supporting.

Employers were aware of their financial responsibilities and a majority believed that an employee with mental health problems could potentially have a negative impact on the financial situation of the company. Employers could be offered various wage subsidies in order to enable employment if an individual had reduced work ability. The wage subsidy could make it more appealing to hire as the costs for employment were partially covered. Employers spoke of it as being difficult to discern an employee's work ability following sick leave and said it was important to separate the actual work and the work training in order to know what level of work ability to expect. Having an employee who did not deliver could cause frustration as one employer expressed:

> "It's like we…rent a car with three wheels and think is has four."

Discussion

This thesis has explored critical factors in the RTW-process for individuals with mental health problems, from the perspectives of the individual themselves, the vocational rehabilitation professionals working with them, and employers. All these perspectives were included in order to obtain a broad representation of the RTW-process from the actors involved. The results revealed how the different welfare actors could affect each other's actions, ranging from enabling factors to creating disabling barriers for the individuals with mental health problems in the RTW-process.

Mental health literacy enables the RTW-process

The perspective of individuals suffering from mental health problems on what constituted critical factors in their RTW-process was fundamental for this thesis (Study I). The individuals perceived that the quality of support provided by professionals and employers was critical in their recovery. The themes reflected the need for professionals to provide hope and power, to believe in the individuals' work abilities, and that the RTW-support needed to be holistic and person-centred. It is noteworthy that the Employment Specialist who worked according to the IES approach initiated and addressed these critical factors. When this person-centred and enabling approach of IES was applied, the results showed that participation contributed to both the individual's personal and clinical recovery, with an increased level of empowerment, and reduced depression severity (Study II). Other studies confirm that the beliefs, knowledge and skills used by the Employment Specialist enable a flexible support that is individualised to the service user's needs (Areberg et al., 2013; Gammelgaard et al., 2017; Johanson et al., 2017). However, Study I also showed that the recovery enhancement factors of IES were not experienced among the participants in TVR. Instead, they often had an opposite negative experience (Study I), and no increase in their ratings of empowerment or reduction in depression was observed (Study II). These results generated the need to explore and more fully understand the existing knowledge and attitudes towards individuals with mental health problems and which support strategies were used by vocational rehabilitation professionals and employers in the RTW-process. The aims and focus of Studies III and IV were thus created in the initial phases of the development of this thesis.

The results of the thesis did not only reflect the individual perspectives of the two diverse vocational rehabilitation paradigms and how these differed in relation to the quality of support provided as experienced in Study I and rated Study II. The results also revealed how professionals originating from different welfare authorities and organisations perceived their power role in the RTW-process, and how this role could affect collaboration with other professionals and employers (Study III). The results revealed discrepancies in how professionals viewed work ability, and how their action, or lack of action, also affected employers' behaviours (Studies III and IV). In turn, employers' actions, i.e. if they were prepared to enable work or not, were dependent on their previous experiences and support from the professionals. This finding is in line with supported employment research showing that professionals' knowledge and support strategies were key enabling factors for the employers' willingness to employ and provide workplace support (Bejerholm et al., 2015; Bejerholm et al., 2017; Lexén et al., 2016). Another enabling factor (Study IV), when employers considered employing an individual, was the financial subsidies that could be given to the employer in order to compensate for the reduced work ability of the employee (Gustafsson et al., 2013; Lexén et al., 2016). In conclusion, professionals' and employers' mental health literacy such as knowledge of mental health problems, and support strategies, appeared to be critical factors for enabling the RTW-process for individuals with mental health problems.

Barriers disabling the RTW-process

When exploring the perspectives of the vocational rehabilitation professionals (Study III), barriers for a successful RTW-process were revealed in the TVR approach. This corresponded to the findings of the individuals' own experiences (Study I), and previous research on the bureaucratic structures which are common in the TVR approach (Bejerholm et al., 2011; Lexén et al., 2016). Surprisingly, inadequate mental health literacy was prevalent (De Vries, Hees, Koeter, Lagerveld, & Schene, 2014; Lexén et al., 2016), which could be seen in terms of not understanding mental health problems, and not believing in the prospect of the individual successfully obtaining competitive employment (OECD, 2012). One could question whether the focus on problems is in itself part of the problem, since this is how the Swedish Social Insurance system is constructed. The decisions on sick leave originate from the medical certificate based on the individual's diagnosis and functional limitation (Försäkringskassan, 2017). A scoping review of General Practitioners (GPs) in primary healthcare revealed that GPs, who are often the initial contact for individuals with mental health problems, considered work important for their patients (Alexanderson et al., 2018). However, issuing medical certificates for sick leave was the most common intervention prescribed (Reed & Kalaga, 2018). Doctors considered it difficult to assess work ability and for how long an individual

needed to be on sick leave due to their functional limitations at work when information regarding their employment situation was limited (Alexanderson et al., 2018). This research supports the findings of the present thesis, which shows the critical importance of collaborating with other actors in the RTW-process, together with further knowledge concerning the individual's work ability and mental health problems (Studies III and IV).

The medical certificate might thus be the explanation as to why the focus in the TVR approach corresponds to problems and limitations connected to the disease. Both sick leave benefits and wage subsidies are based on this negative perspective of mental health and reduced work ability. Wage subsidies could potentially constitute a negative path for the individuals, as shown in Study I. The individuals could be presented with a subsidized employment where the employers are compensated by PES despite the actual work not necessarily being suitable for the individual's work abilities or competence, nor sought for by the individual. It is possible that the subsidized employment instead signals disbelief in the individual's work ability and disempowers them of the hope of obtaining a competitive job. Further research should explore this in greater depth. On the positive side, most vocational rehabilitation professionals expressed confidence that individuals with mental health problems could work (Study III), although when referring to work, the majority suggested it to be linked to a subsidized employment where the employers benefit financially.

Notably, on the one hand subsidized employment to compensate for lack of work ability was commonly used by professionals in order to enable work for the individuals, and competitive work could be seen as an impossible alternative for some individuals with mental health problems. On the other hand, in the cases where individuals already had an employment to return to, the employee could be made to return to their job by SIA, even though they lacked the required work ability. This could generate frustration among employers since they were paying salary for work that was not delivered (Study IV). This inconsistency and lack of mental health literacy even, was further illustrated when individuals with mental health problems were assessed to be fit for work by SIA but were too sick for work according to a PES work ability assessment.

The results of this thesis also indicate that this belief in the benefit of subsidized employment could be due to a lack of mental health literacy. Moreover, the contradictory assessments from different authorities and organizations could potentially constitute a source of confusion for the individual, when the authorities they depend on assessed their work ability differently in relation to their problems. Most importantly, the consequences of being involved in such a RTW-process affects the individuals negatively as they might not see competitive work as a realistic goal due to lack of hope and beliefs from others (Study I). The lack of

empowerment support, and the time away from work itself, together with self-stigma may result in low levels of self-esteem and self-efficacy (Audhoe et al., 2018; Johanson et al., 2017), which can present a barrier and negatively affect them when applying for work (Audhoe et al., 2018; Corrigan & Watson, 2002). Based on the results in Study I and other research in the field (Audhoe et al., 2018; Slade, 2009c; Sturesson, Edlund, Falkdal, & Bernspång, 2014), it is thus vital that the professionals can provide support and convey hope in order for the individual to be able to get him/herself out of a train of negative thoughts, which might serve to be a disabling barrier in the recovery process in connected to RTW. A very important task for the professionals is thus to believe in the ability of the individual, and to provide hope of a successful outcome, which should be a priority in a recovery-oriented RTW-process (Slade, 2009c). As shown in Study II, individuals receiving person-centred IES support demonstrated an increased level of empowerment and reduced level of depression, as well as more frequent RTW (Bejerholm et al., 2017).

The results in Study III showed that the collaboration between the actors in the RTW-process was regarded as important, however, a lack of collaboration was often found (Audhoe et al., 2018), for example, between SIA and PES. This could potentially exacerbate the different and non-coherent views on their clients' work ability. The lack of collaboration between the different welfare actors, might also extend the time and service gap (Audhoe et al., 2018; Bejerholm et al., 2011; Ekberg et al., 2015), which can lead to the individual becoming trapped and not progressing in the RTW-process. In Study II, for example, approximately four years had elapsed since the participants had last been in employment (Bejerholm et al., 2017). The lack of collaboration among the actors in the RTW-process found in the results did not reveal any actors taking full responsibility for resolving this deficiency. The justification given by some professionals was that they followed the assignment and regulations specified in government directives or they blamed the lack of mental health literacy among other professionals or employers. Structural barriers between different authorities and organizations have shown to be a problem (Bejerholm et al., 2011; Ekberg et al., 2015), as well as a lack of mental health literacy when not prioritizing collaboration in a person-centred service.

A holistic approach was another factor found to be critical for individuals in their RTW-process (Study I). Research has shown that individuals can have difficulties in different domains in their lives, such as the financial and social life, and might need help and support to resolve these problems in order to focus on work (Audhoe et al., 2018). Not addressing the individual in a holistic way and considering the work-life balance might also be due to a lack of mental health literacy among the different actors in the RTW-process. It is possible that they do not completely comprehend how the individual's mental health problems can affect their life situation, and what they might require in the RTW-process to address this. A critical passage in the IES model was thus to address time use and how a lifestyle can be

built in order to support a working life and mental health (Bejerholm, 2016, Bejerholm et al., 2017).

Employers are critical in the RTW-process

In Study IV it was found that employers perceived employees with mental health problems in terms of their previous experiences. On the positive side, the majority of employers wanted to help and support their employees with mental health problems and some even saw experiences of previous mental health problems as a source of strength, and suggested work could help their recovery (Jansson & Gunnarsson, 2018). The dominant view was however, that employees were not as productive and could potentially cause problems in the workplace.

Vocational rehabilitation professionals could perceive employers as both enablers and barriers to the outcome of work (Jansson & Gunnarsson, 2018) as implicated in Study III. Even though employers were acknowledged as being essential to enable work, they could also be reluctant to give jobs to individuals with mental health problems and were perceived as possessing inadequate mental health literacy. This finding corresponds with earlier research showing inadequate knowledge among employers (Burke et al., 2013; Jansson & Gunnarsson, 2018). These results were confirmed in Study IV as employers recognized their own need to gain greater knowledge about mental health problems and the need for support in the RTW-process. However, when support was requested by employers, the result showed that no or limited support was available, leaving them alone with their employee's support needs, grasping for the right strategies to apply.

Stigma can be a barrier in the RTW-process

Based on the results of the thesis, a question can be posed as to why TVR is such a commonly used RTW approach in Sweden when the outcomes are less successful than with the IPS and IES approaches? The results in the thesis and in the related trial on RTW outcomes (Bejerholm et al., 2017) demonstrate that TVR does not work effectively for the individual, vocational professionals or employers. Yet this stepwise rehabilitation chain, built on the train-the-place paradigm (Corrigan, 2001), with reduction of symptoms as the main concern, is still the approach often provided in Sweden (Ekberg et al., 2015). Numerous explanations could be possible. The train-then-place paradigm aims to prepare and teach individuals new skills in a safe environment through support from professionals, so that they are able to cope with the demands of work that lie ahead. Failing to prepare the individual in a safe environment can be assumed to lead to relapse into illness or the possibility of the individual being reluctant to pursue similar goals in the future (Corrigan, 2001). The result of Study I did not confirm that this was a helpful route to recovery. Internship

and subsidized employments were not always regarded as positive and recovery oriented. More research is needed on the perception of subsidized employment viewed from the perspective of the individual with mental health problems.

Stigma and negative attitudes towards individuals with mental health problems, and a lack of belief that they can RTW could be other reasons why the TVR approach is less successful in supporting individuals in their RTW-process. Such negative views are common in the general public (Jorm et al., 2012), among professionals (Dickson & Taylor, 2012), and employers (Brohan et al., 2014; Brouwers et al., 2016; Dickson & Taylor, 2012). Public stigma and self-stigma in relation to mental health problems, were not explicitly explored and stated in the aims in this thesis. However, stigma was reflected in the experiences of the participants with mental health problems in Study I and was explored in Studies III and IV in relation to the concept of mental health literacy, which particularly addresses attitudes and beliefs. The participants in Study I experienced the TVR professionals as not believing in them and their potential for RTW and obtaining a competitive job. This "public" negative attitude affected them and how they viewed themselves as working individuals (self-stigma). Furthermore, professionals (Study III) showed a disbelief in the individuals' work ability (public stigma). This is in line with a cross-sectional study in Sweden, which showed that mental health professionals (n=140) believed that employers would disregard individuals with mental health problems in favour of other applicants (75.6%). Similarly, the individuals with mental health problems in the same study (n=141) believed that their prospects of RTW were low, with an agreement rate of 72.5% (Hansson et al., 2013). Furthermore, a systematic review concluded that internalised stigma can lead to individuals isolating themselves, and due to public stigma, they can become marginalised by others and feel as though they are more of a diagnosis than a person (Perkins et al., 2018). These findings and the results in this thesis regarding the TVR approach illustrate the serious nature of stigma and the consequences of negative attitudes and beliefs in the individuals' RTW-process and opportunities for recovery. It is not possible to ask the individuals suffering from mental health problems to believe in their own strengths and abilities and view competitive work as a reality when the responsible professionals and employers indicate their disbelief in a positive outcome. Notably, this view was not to be found in the reflections on person-centred and recovery-oriented IES approach. Instead, the individuals were supported in a way that made them feel more empowered and less depressed (Study II). In summary, it is important to reverse this negative trend and focus on how professionals and employers in the RTW-process may increase their mental health literacy and understanding of enabling work support.

Moving towards a person-centred paradigm in the RTW-process

Two diverse RTW pathways have been identified in this thesis. The first, an enabling pathway (Figure III), reflects the IES approach with the RTW support focusing on empowering the individual, providing hope and belief in their ability to work, and displaying positive attitudes. Employment Specialists integrated welfare actors in the RTW-process, supported the individual in a holistic manner, and recognized employers' need for support as a critical factor for enabling work.

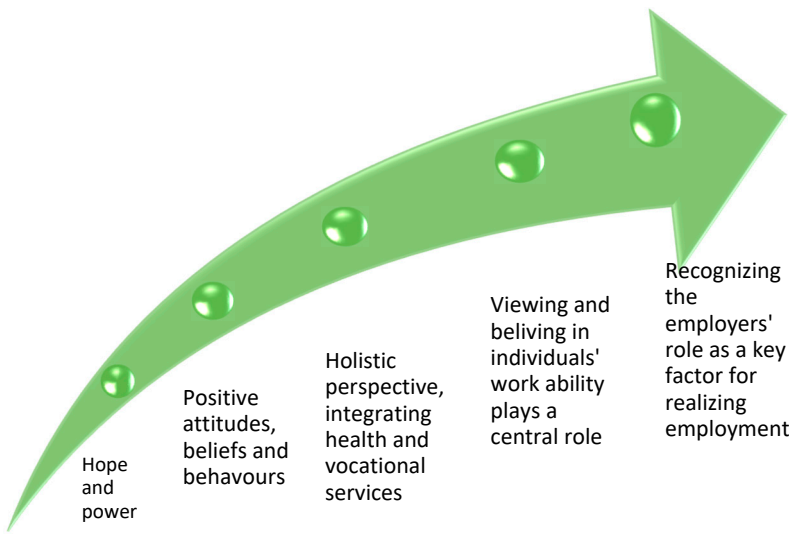

Figure III . Enabling factors in the RTW-process

In the second, a disabling pathway (Figure IV) as reflected in the TVR approach in the results of this thesis, it is shown that professionals and employers hold a position of power for enabling work, whilst simultaneously demonstrating difficulties in comprehending both the mental health problems and work capacity of the individuals. The employers lacked established conditions for supporting work and the RTW-process when an employee suffered from mental health problems in terms of struggling to know how to support their employee, and how to adapt for their needs. When employers needed their own help about how to support their employees, it was seen that adequate support was not available. The lack of mental health literacy among vocational rehabilitation professionals could negatively affect the RTW-process. This was manifested through prolonging the process, lack of belief that individuals with mental health problems could obtain a competitive employment, and the individuals themselves not feeling included in decision-making leaving them disempowered with limited control.

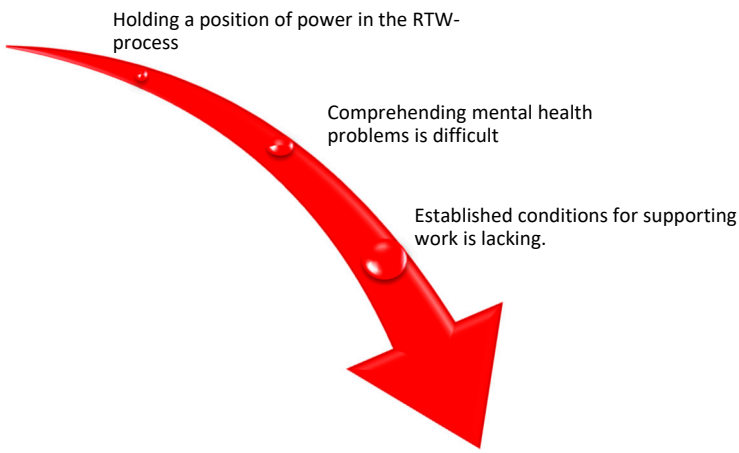

Figure IV. Disabling barriers in the RTW-process

The findings reflected in Studies I and II, and in the IES place-then-train paradigm, are in line with the personal recovery CHIME conceptual framework. As stated in the background, the CHIME framework uses five components of recovery; *Connectedness*, *Hope and optimism about the future*, *Identity*, *Meaning in life*, and *Empowerment* (Leamy et al., 2011).

- *Connectedness* is demonstrated in the results by the importance of the relationship between the individual, the professionals and the employer. How the RTW-process is perceived by the individual depends on that relationship and the outcome of work. When the relationship functions, connectedness enables work, such as with the Employment Specialist connecting with the individual, building a work alliance.
- *Hope and optimism about the future* relates to the professionals implanting hope of a positive outcome in the RTW-process and having a positive attitude and behaviour towards the individuals, and the outcome of work. This includes having a holistic perspective on the individual's life situation and supporting the individual's motivation to change his/her life.
- *Identity:* The working role together with the family role was viewed as the most important roles in the individual's life, and an important part of who the individuals were and how they were perceived by others. Regaining the work role was an important part of the recovery process.
- *Meaning in life*: The work role gave life a meaning both through the role as an employee, and economically when receiving a salary.
- *Empowerment*: was experienced as regaining control of life again, sharing responsibility with the Employment Specialist and collaborating with them towards the goal of work. The IES enabling strategies focused on the individual's strengths instead of their limitations.

As stated earlier, the right to sick leave is related to the individual's diagnosis and work limitations (Ekberg et al., 2015; Försäkringskassan, 2017). The consequences of this clinical perspective could possibly lead vocational rehabilitation professionals to focus on the problems and limitations and to make the presumption that subsidized employment was a requirement for enabling work. The experiences of the RTW-process for the individuals who participated in TVR were mainly negative and they did not experience recovery in this process. The vocational rehabilitation professionals and employers also defined barriers in this approach and a lack of collaboration between different actors was common. Based on the findings in this thesis and on other research performed on supported employment in a Swedish context (Bejerholm et al., 2015; Bejerholm et al., 2017; Bejerholm & Roe,

2018), a shift towards a more person-centred paradigm should be considered (Bejerholm & Roe, 2018). The RTW-process would benefit from changing the perspective of considering individuals as having limitations to one of focusing on the individual's preferences, strengths and work ability in order to promote a more positive RTW-support.

The power of belief in the individual's work ability should not be underestimated. In the IES approach the Employment Specialist showed belief in their potential to work, and empowered them to take on an active role in their own RTW-process. This positive person-centred IES approach can also influence other actors in the RTW-process including employers to view the individual with potential instead of with limitations. This optimistic reinforcing effect is perhaps the most critical factor shown in this thesis. Whilst Study I comprised a modest sample size, the results clearly demonstrated the critical factors perceived by the individuals in their RTW-process. A transition to a more person-centred paradigm, with a focus on hope, power and belief would help the individuals to gain control, to take responsibility and to be the leading actor in their own RTW-process.

Methodological considerations and limitations

Study I

Qualitative methodology can contribute to understanding complex interventions (Campbell et al., 2007). Qualitative content analysis, which can be used for focusing on the experiences of an intervention, the context and the similarities and differences (Graneheim & Lundman, 2004), was therefore chosen for this purpose.

Several aspects were considered for increasing trustworthiness. *Credibility* comprises the focus of the study and how well the data and analysis address the intentional focus, such as how the participants were selected, the type of context and the method used when collecting data (Graneheim & Lundman, 2004). In Study I, the participants were included by means of purposive sampling as diversity was sought regarding age, gender, approaches e.g. IES or TVR, outpatient unit, Employment Specialist (IES) and handling officer (TVR), in order to gain a broad view of the individual's experiences of the different approaches. The use of this technique enhances trustworthiness by increasing the possibility for capturing a wide range of opinions from various participants (Patton, 2015).

IDI, an interview method that is applied on a smaller number of participants (Boyce & Neale, 2006), was used in Study I for the data collection. The IDI combined with open-ended questions allowed the participants to express themselves in detail

concerning their thoughts and experiences (Boyce & Neale, 2006). This was considered important as, to the thesis authors knowledge, no previous qualitative research has been performed with the same aims. Manifest content analysis was applied and proved to work well in order to stay close to the analysis material but also when moving on to the more latent phase of developing the themes (Graneheim & Lundman, 2004). Quotations were included in order to give the reader a profound understanding of the participants' views and to increase the credibility of the analysis, (Graneheim & Lundman, 2004). The thesis author joined the team when the data had been collected and coded but performed the text verification of all the transcribed interview material by replaying the audio files and validating it against the transcribed text and codes (Kvale, 2008). Thereafter all the authors came to an agreement on the codes, categories and themes to be included.

Dependability is another aspect of trustworthiness, which includes taking into account the inconsistency of the data collection (Graneheim & Lundman, 2004). The interviewer took measures to limit this risk when using pre-written questions to ensure all participants had an opportunity to answer the same questions. The questions were tested twice prior to the start of the study and thereafter discussed in relation to the study aims.

Trustworthiness also includes *transferability*, which comprises the provision of a clear description of the context, the selection of participants, the data collection, and the applied analysis method. A broad presentation of the results, and the use of quotations also increased the transferability (Graneheim & Lundman, 2004). These concepts were applied in Study I. The researcher who performed all the interviews had a long clinical background of working with individuals with depression and applied suitable interview techniques, such as showing interest and respect for the participants' experiences, avoiding binary questions and not revealing any personal opinions (Boyce & Neale, 2006).

A limitation of the study is the context of the research. The two different approaches were used in a Swedish context, with participants who spoke Swedish. More research is needed in additional contexts and with participants with other backgrounds than Swedish in order to increase credibility. It is also warranted to broaden the geographical area within Sweden to include different areas than the County of Scania. A further limitation in Study I was the difficulty in recruiting participants. There were 15 eligible participants who did not join the study and their reasons for declining participation are unknown. This is unfortunately a common problem when using similar groups of participants (Andersen, Nielsen, & Brinkmann, 2014). Even though 15 potential participants declined, the analysed data was felt to reach saturation when similar issues, topics and stories emerged during the interviews (Boyce & Neale, 2006). Furthermore, is should be noted that when using qualitative methods, the results cannot be generalized due to the small sample

size and not having applied random sampling (Boyce & Neale, 2006). However, our results might be transferred to a similar context with similar groups of participants.

Study II

Study II followed the CONSORT guidelines recommended for parallel randomized controlled trials. The authors used the CONSORT checklist (Moher et al., 2010) and the flow diagram (Figure II), which serve to increase transparency for the reader when reporting RCT studies (Moher et al., 2010).

There were more women than men included in the study which can be a limitation. However, as more women than men are diagnosed with depression, the uneven gender distribution thus reflects the gender distribution of depression in society (Folkhälsomyndigheten, 2019; Försäkringskassan, 2017; Skovlund, Kessing, Mørch, & Lidegaard, 2017). A further limitation was that the sample size was smaller than predetermined and the power calculation was not performed on the scores of empowerment and depression, but was instead made on the primary outcome of employment rate in the earlier RCT study (Bejerholm et al., 2017).

However, the similarity among groups at baseline, valid instrument usage, and controlling fidelity and the process of the interventions were further factors strengthened the internal validity (Kazdin, 2007) together with the use of the CONSORT guideline (Moher et al., 2010). Moreover, the Empowerment Scale has shown satisfactory reliability in relation to internal consistency, and the MADRS-S has displayed satisfactory construct validity, internal consistency, and sensitivity to change. The Cronbach's alpha values were satisfactory for both instruments when measured at the three different measurement points. Furthermore, there were only a few participants who were lost to follow-up and a limited amount of data was missing. Both ITT and the primary dataset were applied in the analysis, as recommended when doing RCT studies, in order to preserve the benefit of randomisation and include all participants who were randomised in the analysis, but also to show transparency whilst also performing analysis on the primary data (Moher et al., 2010). Additionally, all the data collection, for both IES and TVR, was carried out by an experienced researcher. Even though the sample size was smaller than intended, the result displayed a small to moderate r-value, which indicated an effect between and among the intervention groups. However, this research needs to be replicated in larger studies in order to be able to draw stronger conclusions from the results.

Studies III and IV

A grounded theory methodology for qualitative studies, following the guidelines established by Charmaz (Charmaz, 2014), was applied in Studies III and IV, and prescribed measures to enhance trustworthiness were used. Grounded theory was seen to work well for exploring the experiences and perceptions from the vocational rehabilitation professionals in Study III and the employers in Study IV. The interviews were transcribed and analysed separately and discussed among the authors until agreement was reached regarding codes, categories, sub-categories and theory building. The authors used memo-writing as an ongoing measure to reflect on the analysis and connections between the emerging categories and sub-categories. Moreover, the authors included quotations to give the reader a deeper understanding of the participants' views and to enhance credibility. It could be claimed that the settings where the vocational rehabilitation professionals in Study III and the employers in Study IV worked were too diverse in nature to be able to draw strong conclusions. This is, however, not the purpose in grounded theory and instead the aims were to develop a conceptual model, that could clarify the grounded result found in the data, and to identify connections and possible explanations (Charmaz, 2014).

To further increase trustworthiness when using grounded theory, Charmaz applies four criteria: The first is *credibility* by which the researchers reach familiarity with the topic during the data collection and the analysis process. This was considered to be achieved as the authors all had first-hand contact with the data and the analysis material. This was attained as after the audio recordings were transcribed, the thesis author (SP) subsequently listened to the recordings, comparing the audio files as text verification. The purpose was to validate the data (Kvale, 2008) but also to get to know the data material as SP had not performed the interviews. The interviews were then familiar to all the authors. Theoretical sampling allowed the researchers to gradually include participants to elaborate and refine the categories and explore connections between them. It also allowed inclusion of a broad selection of participants with different perspectives and experiences. The aim in both Studies III and IV was to include a wide range of participants from a variety of settings with different experiences. The authors systematically compared the categories, sub-categories and codes throughout the entire analysis process. Theoretical saturation was assumed to be reached when no further theoretical insight was developed in relation to the categories.

Originality, the second criteria, was reached as the categories in both Studies III and IV are, to the best of thesis authors knowledge, original. Both studies provide a deeper understanding of the mental health literacy of professionals and employers, which was shown to be lacking. In terms of work ability for individuals with mental health problems, the focus was shown to often be on the work limitations and

finding jobs with wage-subsidies. These findings challenge current practice commonly applied in Sweden, where the primary focus is on symptom reduction, and need to be considered when improving the RTW-process.

The third criteria was *resonance* which reflects whether the grounded theory results apply for other individuals who share the same circumstances as the included participants. Both Study III and Study IV included individuals from the outside of the study sample to give the authors feedback on the results. No changes were necessary as these individuals agreed with the authors' interpretation. *Resonance* also portrays the fullness of the studied experiences. The sub-categories in both Study III and IV included negative cases thus presenting a broad collection of opinions in order to increase transparency. Quotations were also used to provide the reader with a deeper sense of the participants' perspectives.

The final criteria, *usefulness,* can be seen as satisfactory for both studies given that mental health problems are a major concern affecting many individuals of working age in Sweden. A deeper understanding of the RTW-process as experienced by those who are responsible for the delivering the service, could lead to an improved understanding of how to increase the success rate and substantially enhance the RTW experience among the individuals with mental health problems. Finally, Charmaz (Charmaz, 2014) states that the bottom-up approach strengthens the method as it allows the researchers to question and engage in the data as the result emerges from the data.

Conclusion and implications

- Study I presented critical factors for a positive RTW-process perceived by individuals with affective disorders. It was perceived as critically important that professionals provided hope and power, belief in their potential, were supportive with a positive attitude, and worked holistically in a person-centred manner towards the outcome of work.
- The Employment Specialists working according to the IES approach were thought of by the participants as working according to the above critical factors. They provided the participants with hope, power, and believed in their ability to obtain competitive employment. The Employment Specialists worked holistically and integrated mental healthcare with vocational services. The participants in the TVR approach often had the reverse and negative experience of support or lack of support provided.

- Study II demonstrated that when enabling, person-centred factors were provided in the IES approach, there was a significant increase in empowerment and reduction in depression after 12-months of intervention. This positive result was not shown among the TVR participants.
- Study III found that vocational rehabilitation professionals can lack mental health literacy despite having power and control in the RTW-processes related to their professional roles.
- Vocational rehabilitation professionals working with individuals with mental health problems would benefit from increasing their mental health literacy by understanding symptoms and the ways to empower the individual, encouraging them to be the leader in control of their RTW-process.
- The TVR approach presented a complex process surrounding the individuals, which included the involvement of different actors and settings, where the diverse regulations of the different authorities and organizations framed the RTW-process.
- The focus in TVR was mainly on the limitations of the individuals and subsidized employment was a common approach to enable work.
- Employers could be perceived by the vocational rehabilitation professionals as both enablers and barriers to employment. The professionals did not always view it as an obligation to support employers.
- Study IV showed employers could also lack mental health literacy exhibited as difficulties in comprehending mental health problems, and not knowing how to support these employees.
- Employers acknowledged that they lacked strategies to handle their employee's mental health problems in the workplace and requested support and collaboration from other actors in the RTW-process, which they expressed as being inadequate.
- An increase in the mental health literacy among employers could contribute to preventing time off work and increasing the potential for providing relevant support and adaptations to employee's needs.
- Vocational rehabilitation professionals should strengthen their support and collaboration with employers, which could increase the probability of allocating individuals with mental health problems to work. The combination of employers feeling they are not alone, that support is available and having relevant knowledge themselves, could increase their confidence to hire individuals with mental health problems.

Future research

All four studies in this thesis would benefit from replication with larger sample sizes. It is also warranted to perform similar studies in Sweden enlarging the context to include participants from different areas from both larger and smaller cities and including a more even gender distribution. Future studies should also include a diversity of ethnicity to obtain a broader perspective from individuals with mental health problems in their RTW-process. Vocational rehabilitation professionals and employers who have a non-Swedish ethnic background should also be included.

Another field that to the author's knowledge has not been explored is the degree of mental health literacy among Swedish professional politicians. Earlier research exploring political ideology and stigmatising attitudes in Sweden, showed more conservative ideologies and party affiliation was associated with more stigmatising attitudes toward individuals with depression (Löve, Bertilsson, Martinsson, Wängnerud, & Hensing, 2019). A further study should build on this finding and explore the mental health literacy of politicians including stigmatizing attitudes. Politicians in Sweden belong to a profession with no requirement for an academic or clinical background in mental health and yet possess great responsibility and influence in the field. Their mental health literacy affects, through the decisions they make, not only the individuals with mental health problems but all the professionals and employers in the RTW-process. One possible reason for the TVR approach retaining its predominant role in the Swedish RTW-process, might be a lack of mental health literacy among politicians, which thus needs to be explored.

Svensk översättning

Bakgrund

Psykisk ohälsa är ett stort problems bland människor i arbetsfördålder. Det innebär stort lidande för individen, inkomstbortfall och en ekonomisk börda för samhället genom sjukfrånvaro, sjukvårdskostnader samt produktionsbortfall. Psykisk ohälsa ökar markant risken för utslagning från arbetsmarknaden, därför är det viktiga att hitta långvariga och hållbara lösningar. När människor återgår i arbete efter sjukskrivning behöver de ofta stöd både från arbetsinriktad rehabiliteringspersonal och arbetsgivare där otillräckligt stöd kan vara ett hinder för arbete. Forskning har visat att både arbetsinriktad rehabiliteringspersonal samt arbetsgivare kan sakna kunskap om psykisk ohälsa. Det är därför det viktigt att utforska individens, arbetsinriktad rehabiliteringspersonals och arbetsgivares perspektiv på psykisk ohälsa och processen återgång i arbete.

Studie I

Syfte: Att utveckla en förståelse för personer med affektiv sjukdom, egna upplevelser och erfarenheter av faktorer som har hindrat eller underlättat för dem i processen återgång i arbete. Syftet var också att jämföra upplevelser av att ha deltagit i två olika arbetsinriktade interventioner under 12-månader: Individual Enabeling and Support (IES) och traditionell stegvis rehabilitering, Traditional Vocational Rehabilitation (TVR). **Metod**: Inklusions kriterier: Individer som diagnosticerats med depression eller bipolär sjukdom enligt ICD-10 kriterier (F33, F33.1, F30, F31, F32). Den stegvisa rehabiliteringen TVR, innebär att individen först behandlas för sina symtom och därefter erbjuds arbetsinriktade interventioner i syfte att öka arbetskapaciteteten och så småningom erbjudas någon form av praktik och på sikt reguljärt arbete. Olika aktörer i den stegvisa rehabiliteringen, med olika uppdrag, utför sina arbetsförmågebedömningar och interventioner utan direkt samverkan. Den andra interventionen, IES bygger på Individual Placement and Support (IPS) metoden men där motiverande, kognitiva samt tidsanvändande strategier har lagts till för att bättre möta behovet för individer med affektiv sjukdom. I IES arbetar en arbetsspecialist i en arbetsallians med individen mot målet reguljärt arbete. Arbetsspecialisten samarbetar med de olika aktörerna som

psykiatrin, Försäkringskassan, Arbetsförmedlingen, arbetsgivare, med individen i centrum, alla mot samma mål reguljärt arbete. Studie I bygger på en randomiserad kontrollerad studie (RCT) av individer med affektiv sjukdom *n*=63 (Bejerholm et al., 2017). Studie I var en kvalitativ studie som använde sig av djupintervjuer som analyserades med innehållsanalys. Det var 31 individer som valdes ut ändamålsenligt utifrån det totala stickprovet i RCT studien. Syftet var att inkludera olika åldrar, kön och erfarenheter av de både interventionerna. Av de 31 som valdes ut tackade 16 ja varav 8 hade deltagit i IES och 8 i TVR, men båda gruppernas deltagare hade erfarenhet av TVR innan studien startade. **Resultat:** Tre teman framkom som upplevdes som kritiska i processen återgång i arbete: 1). Att uppleva hopp och makt, 2). Att professionella har positiva attityder, tro och beteenden, 3). Använda sig av ett holistiskt arbetssätt och integrera psykiatrin med arbetsinriktade insatser. **Konklusion:** Att uppleva hopp och makt, att möta professionella som tror att man kan arbeta, som arbetar personcentrerat och holistiskt och integrera psykiatriska med arbetsinriktade insatser, är avgörande faktorer som möjliggör återgå i arbete. Alla dessa kritiska faktorer återfanns i IES metoden och det är viktigt att de professionella i TVR även inkluderar dessa faktorer i sitt arbetssätt för att underlätta återgång i arbete för personer med affektiv sjukdom.

Studie II

Syfte*:* Att studera skillnaden mellan upplevd egenmakt och grad av depression mellan deltagare som deltog i IES och i TVR under 12-månades intervention. **Metod:** Studie II var en RCT från samma ursprungs studie som studie I (Bejerholm et al., 2017) och inkluderade det totala antalet deltagare (*n*=63). Deltagarna randomiserades antingen till IES (*n*=33) eller TVR (*n*=28). Två deltagare exkluderades efter randomiseringen då de inte uppfylld inklusions kriterierna (*n*=61). Analyser gällande egenmakt och grad av depression gjordes vid tre mättillfällen; vid baslinjen, samt efter 6- och 12-månaders intervention. Den binära logistiska regressionen gjordes efter 12-månaders intervention. De olika statistiska test som användes i relation till huvudsyftet var: Mann-Whitney U-test i syfte att studera skillnaderna mellan de två olika interventionerna, Wilcoxon's signed rank test användes för att studera skillnader över tid inom de två interventionerna och Spearmans rangkorrelations koefficient (r_s) för att studera korrelationer mellan egenmakt och depression. Den binära logistiska regressionsanalysen undersökte om egenmakt och depression påverkade arbetsutfallet, det vill säga arbete eller inte efter 12-månaders intervention. Den dikotoma variabeln arbete var den beroende variabeln medan egenmakt och depression var oberoende variabler. **Resultat:** Det fanns en statistisk signifikant skillnad mellan deltagarna i IES och TVR när det gällde egenmakt efter 12-månaders intervention. När det gällde grad av depression sågs både vid 6- och 12-månaders intervention en statistisk skillnad mellan

grupperna. IES deltagarna ökade statistiskt signifikant sin egenmakt och minskade graden av depression över tid, vilket inte kunde ses bland deltagarna i TVR. Den logistiska regressionen vid 12-månaders intervention visade att varken egenmakt (IES p=0.681, TVR p=0.955) eller depression (IES p=0.399, TVR p=0.339) påverkade arbetsåtergång. **Konklusion**: Resultatet visar att IES är mera effektiv med avseende på att öka egenmakt och minska depression över tid i jämförelse med TVR. Eftersom resultatet visade att varken egenmakt eller depression påverkade arbetsutfallet efter 12-månaders intervention kan effekterna av IES istället bero på de personcentrerade, motiverande, kognitiva och tidsanvändande strategierna.

Studie III

Syfte: Att undersöka arbetsinriktad rehabiliteringspersonals (professionella) hälsolitteracitet om psykisk ohälsa samt deras uppfattning om arbetsgivare i processen återgång i arbete. **Metod**: Studien inkluderade professionella som arbetade med arbetsinriktadrehabilitering för människor med psykisk ohälsa och hade erfarenhet av arbetsgivare i processen av återgång i arbete (n=22). Grundad teori var den metod som användes och deltagarna inkluderades gradvis enligt teoretiskt urval. **Resultat**: I resultatet framkom tre kategorier: 1). Arbetsinriktad rehabiliteringspersonal har en maktposition i processen återgång i arbete, 2). Synsätt och tro på individens arbetsförmåga spelar en central roll, 3). Arbetsgivare har en avgörande roll för att möjliggöra anställning. **Konklusion**: Resultatet i studie III visade att arbetsinriktad rehabiliteringspersonal behöver öka sin hälsolitteracitet eftersom de har en viktig roll både i relation till sina klienter och till arbetsgivare. De behöver ändra fokus från individens begränsningar i relation till arbete till att istället fokusera på deras förmåga att arbeta. De behöver också öka sin förståelse för arbetsgivarens situation och öka sitt stöd till och samarbete med dem som en del av den arbetsinriktade rehabiliteringen av personer med psykisk ohälsa.

Studie IV

Syfte: Att undersöka arbetsgivares (chefers) tro, kunskap och strategier i att ge stöd till anställda med psykisk ohälsa. **Metod:** Studien inkluderade 24 arbetsgivare med personalansvar som arbetade inom olika verksamhetsområden, både större och mindre organisationer inkluderades, från privat, offentlig och statlig sektor. Studien använde sig av grundat teori och deltagarna inkluderades gradvis enligt teoretiskt urval. **Resultat**: Två kategorier framkom i relation till syftet med studien: 1). Psykisk ohälsa är komplicerat och komplext, samt 2). Chefer saknar etablerade rutiner för att möjliggöra arbete. **Konklusion**: Arbetsgivare vill stötta arbetstagare med psykisk ohälsa men kan sakna både relevant kunskap och strategier. Arbetsgivare upplever även att det de saknar stöd och samarbete med arbetsinriktad

rehabiliteringspersonal i processen återgång i arbete. Arbetsgivare behöver öka sin hälsolitteracitet om psykisk ohälsa då de kan sakna både kunskap och strategier för att kunna hjälpa och stötta arbetstagare med psykisk ohälsa. Det är även viktigt att andra aktörer ökar sin förståelse för arbetsgivarnas situation och erbjuder dem det stöd de behöver i processen återgång i arbete.

Slutsats

Det övergripande syftet med den här avhandlingen var att utforska vilka kritiska faktorer som är viktiga för de olika aktörerna i processen återgång i arbete sett från individen som lider av psykisk ohälsa, arbetsinriktad rehabiliteringspersonals och arbetsgivares perspektiv. För individen är det kritiskt att de professionella ger hopp och makt, att de har positiva attityder, tro och beteende samt använder sig av ett holistiskt arbetssätt och integrerar psykiatrin med arbetsinriktade insatser. Arbetsinriktad rehabiliteringspersonal behöver öka sin hälsolitteracitet för att bättre kunna förstå individerna med psykisk ohälsas behov och sin egen kritiska roll i processen återgång i arbete. Samarbetet mellan de olika aktörerna behöver ökas för att minska tids- och interventionsglappet. Fokus behöver ändras från att se på individer med begränsningar till individer med arbetsförmåga. Arbetsgivare behöver också öka sin hälsolitteracitet i psykisk hälsa för att bättre kunna stötta och anpassa för arbetstagare som drabbas av eller riskeras att drabbas av psykisk ohälsa. Andra aktörer behöver också öka sin förståelse för arbetsgivarnas situation och erbjuda dem stöd i processen återgång i arbete.

Framtida forskning

Alla fyra studierna i den här avhandlingen skulle gynnas av replikering med flera deltagare. Det är också motiverat att utföra liknande studier som också inkludera deltagare från andra delar av Sverige än Skåne, både större och mindre städer med en jämnare könsfördelning. Framtida studier bör också fokusera på en mångfald i etnicitet för att få ett bredare perspektiv från alla inblandade i processen återgång i arbete (individen, arbetsinriktad rehabiliteringspersonal och arbetsgivare).

Ett område som inte undersökts tidigare till författarens kännedom, är kunskapen om psykisk ohälsa bland svenska yrkespolitiker. Tidigare forskning som undersökte den politiska ideologin och stigmatiserande attityder i Sverige visade att mer konservativa ideologier och partianslutning var associerad med mer stigmatiserande attityder gentemot individer med depression (Löve et al., 2019). En framtida studie

bör bygga vidare på detta resultat och då utforska svenska politikers kunskap om psykisk ohälsa, inklusive stigmatiserande attityder. I Sverige är politiker ett av få yrken utan krav på akademisk eller klinisk bakgrund men som trots detta har ett omfattande ansvar och inflytande inom sina områden. Deras kunskap påverkar genom de beslut de fattar, inte bara individerna med psykisk ohälsa, utan alla yrkesverksamma inom arbetslivsinriktad rehabilitering inklusive arbetsgivare. Ett möjligt svar på varför den stegvisa rehabiliteringen fortfarande är så vanlig i Sverige trots uppvisade brister, kan vara brist på kunskap om psykisk ohälsa bland politikerna och det är hög tid att undersöka detta vidare.

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