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Abstract

Objective: Norway is a high-income and high-cost society with a generous welfare system, and has the largest mental health-related unemployment gap of the OECD countries. The aim of the current paper was to present a short history of Individual Placement and Support (IPS) services to increase work participation in Norway.

Method: We provide a narrative overview of the developments and research on IPS in Norway, from the introduction of supported employment to recent and ongoing randomized controlled trials (RCTs) investigating the effectiveness of IPS for various target groups.

Findings: While vocational rehabilitation services in Norway have traditionally followed a train-then-place approach, the introduction of supported employment in the early 90's led to a range of new initiatives to increase work participation. Early implementations were inspired by supported employment, but did not follow the evidence-based IPS methodology. More recent developments include a shift toward evidence-based IPS, and the first Norwegian RCT of IPS showed effectiveness on both work- and health-related outcomes among people with moderate to severe mental illness. Several ongoing trials are currently investigating IPS for new target groups including chronic pain patients and refugees.

Conclusions and Implications for Practice: The results suggest that IPS is more effective than traditional approaches to increase work participation, even in the Norwegian context of a high-cost welfare society. IPS has shown effectiveness in severe as well as more common types of mental illness in Norway, and results from ongoing trials will further reveal whether IPS may be expanded to various new target groups.

Keywords: Individual placement and support; Supported Employment; Norway.

Impact:

The Individual Placement and Support (IPS) model of supported employment for people with severe mental illness originated in the US, but has since gained international momentum. This paper shows that IPS is effective for various groups with mental illness in the Norwegian context of a high-cost and high-income welfare society, and suggests that the IPS methodology may be applicable to new and broader target groups.

A short history of Individual Placement and Support in Norway

Introduction

Norway is a high-income, high-cost society, characterized by a generous welfare system, high job security, and an unemployment rate of about 4% among the total labor force (OECD, 2018). Norway also has the largest mental health-related unemployment gap of the OECD countries, with a 1:9 unemployment ratio (1.8 vs. 15.4%) for severe mental illness (SMI) (OECD, 2013). During the last years there has been a shift from musculoskeletal to mental disorders as the main reason for work disability. This development has been especially prominent among young adults, where 63% of disability benefits are attributed to various mental and behavioral disorders (NAV, 2018a).

The Norwegian welfare system is comprehensive, and provides relatively high financial reimbursements compared to welfare systems in other countries. While these benefits represent an important safety net preventing poverty due to illness, it has been suggested that the high coverage and prolonged compensation may lead to a welfare trap, promoting system dependence and social exclusion among people with mental illness (OECD, 2013). Exclusion of individuals with mental illness from the workforce leads to considerable societal costs, including lost productivity and social expenditures such as sick leave and disability benefits (Evensen et al., 2016; Jin & Mosweu, 2017).

In line with the recovery perspective on mental health, the focus of the field has gradually expanded from mere symptom reduction and sheltering from the hardships of work, to include functional recovery in terms of participation in the labor market as a treatment goal (Davidson, Harding, & Spaniol, 2006). The transition from a traditional train-then-place model of vocational rehabilitation to Supported Employment (SE) and the Individual Placement and Support (IPS) model in the US, has been described as a paradigm shift in services for people with psychiatric disabilities (Corrigan, 2001). The effectiveness of IPS on

employment outcomes has later been confirmed in over twenty international trials (Modini et al., 2016).

This paper describes the history and development of SE and IPS programs within the Norwegian context of a high-cost welfare society. It is a narrative review, based on a non-systematic literature search combined with personal communication with experts and key stakeholders in the field of research and practice of IPS in Norway. Programs were included if they utilized or were inspired by IPS methodology, regardless of target group or level of fidelity to the IPS model.

Context and History

Norwegian mental health services provide community-based and specialized mental health care, while the Norwegian Labor and Welfare Administration (NAV) provides social services, vocational services, and benefits. The specialized mental health services mainly provide time-limited care, leaving long-term support to generalized community care. This organization makes the provision of time-unlimited support from mental health services in IPS, challenging. The health and labor services work under different legislations and are financed through different schemes, and services are often fragmented. Traditionally, the NAV have outsourced vocational services to agencies that provide sheltered work or other subsidized or unpaid work placements (Spjelkavik, 2012). Disability benefit schemes for young adults have been particularly generous, thereby creating an economic incentive for young people with uncertain work capability to apply for early disability benefits. This framework is the backdrop for the implementation of SE and IPS in Norway.

The first implementation of what was described as SE in Norway was a two-year project started in 1991 for job seekers with developmental disabilities, followed by a three-year pilot with broader inclusion criteria (Hernes, Stiles, & Bollingmo, 1996). Client groups were mainly people with developmental disabilities (32%), mental illness and drug abuse (19%), and neurological disorders and injuries (13%). The pilot consisted of 30 local projects

spread across the country. The aim was to gain competitive employment and integrate employment and training according to the place-then-train principle. Of the 515 participants, 384 found work; mostly in small companies in the private sector, with nearly 50% working full-time (Spjelkavik, 2012). Most jobs were however time-limited, and employers received wage subsidies in almost one fourth of the cases (Schafft & Sjelkavik, 1999). From 1996, SE became a standard vocational rehabilitation service in Norway, and was to be provided by all agencies. The agencies had broad experience in providing sheltered work, but limited experience in collaborating with employers to provide competitive employment. A review published in 2012 found that SE in Norway had maintained the tradition of using mainly non-competitive work (Spjelkavik, 2012). The review pointed out that agencies offering vocational services were based in sheltered workshops, where sheltered work is readily available. Thus, the implementation of SE in Norway did not comply with important aspects of the SE model.

In the early 2000's, the manualized version of SE, IPS, emerged in the US as an effective approach to increase work participation among people with SMI (Drake et al., 1999; Mueser et al., 2004). The main novelty of IPS was the close integration of employment specialists in mental health teams, and the focus on gaining competitive employment *while* receiving mental health treatment.

Since then, a range of services incorporating IPS to varying degrees have been introduced in Norway, and several have been evaluated using randomized controlled trials (RCTs). These will be described in more detail below. A few of the services were exclusively offered to people with SMI. There are however inconsistencies in the definitions of SMI. SMI is limited to psychotic disorders in some studies, while others include severe mood disorders, personality disorders and eating disorders, making comparisons between studies difficult. The most recent developments include IPS targeting new populations, such as young adults with

various social or health-related problems (Sveinsdottir et al., 2016), chronic pain patients (Linnemørken et al., 2018), and refugees (Clinicaltrials.gov, 2018).

IPS-inspired studies

To initiate research on IPS, the Norwegian authorities for health and labor/welfare funded several IPS-inspired studies. The earliest service utilizing IPS-inspired methodology in Norway was JobPrescription, which was later evaluated in a matched-control study. It was followed by the Job Management Program (JUMP) and the At Work and Coping (AWaC) trials, which were the first RCTs commissioned by these authorities. This was a unique initiative in a Norwegian—and probably also in an international—context.

Job- and SchoolPrescription

"JobPrescription" was an IPS-inspired service piloted in the city of Stavanger in 2003, aiming to establish job placements in local competitive settings for people with first-episode psychosis (Hegelstad, 2017). JobPrescription was a local addition to the early intervention (TIPS) study (Friis et al., 2005; Melle et al., 2004), and adhered to many IPS principles such as integrating work and treatment in all phases, close collaboration with employers, and competitive employment as a goal (Hegelstad, 2017).

The pilot was later followed by the Job- and SchoolPrescription study (2012-2015), which aimed to examine whether an adapted Norwegian intervention offering early IPS was effective for employment and education in first-episode psychosis (Hegelstad, Joa, Heitmann, Johannessen, & Langeveld, 2018). The main adaptions to the IPS model were the use of internships as an entrance into employment, and facilitating education on the same level as employment. Unlike the JUMP and AWaC trials, the Job- and SchoolPrescription study had a matched-control design. Control participants were assessed between 2007-2012 and drawn from the TIPS database matched on age, gender, educational level, and diagnosis (Hegelstad et al., 2018). The 33 participants and 33 controls met the criteria for a first-episode DSM-IV psychotic disorder. Participants receiving one year of IPS services were assessed at baseline

and post-intervention on diagnosis, psychotic symptoms, substance use, and outcomes of employment and education. Measures of employment and education were dichotomized as ≥20 hours a week at time of assessment vs. less (Hegelstad et al., 2018). Additionally, 22 participants were examined at two-year follow-up. Fidelity to the IPS model (scoring education as employment where appropriate) was rated as "good".

At post-intervention, 47% of the participants in the Job- and SchoolPrescription group were working competitively and 50% were in an educational setting. In the control group, 7% were working and 17% were in education. There were significant differences on both measures (p=.004 and p=.023 respectively). No differences in symptom levels were found. There were no longer significant differences between the groups at two-year follow-up. The main conclusion was that Job- and SchoolPrescription helped participants attain and maintain employment and/or education. It seems however, that the effect only lasts as long as the intervention is ongoing, indicating that the IPS principle of unlimited support may play a particularly important role (Hegelstad et al., 2018).

The Job Management Program (JUMP)

The JUMP study was launched in 2009, following favorable results from a pilot study (Steihaug & Harsvik, 2009). The study evaluated an innovative model for close collaboration between mental health and vocational services at political, regional and local levels with the aim of helping individuals with schizophrenia-spectrum disorders obtain employment (Evensen et al., 2017; Falkum et al., 2017). Sites across six Norwegian counties participated, with employment specialists based within the vocational services who were supervised by experienced mental health workers. The program was aligned with many of the IPS principles, but differed in terms of using unpaid work placements and sheltered work in addition to competitive employment. Also, IPS fidelity was not measured.

The JUMP study included 148 participants (Evensen et al., 2017; Falkum et al., 2017). The aim was to help participants obtain competitive employment, while other forms of work

were also registered. Employment data were collected from employment specialists at post-intervention (10 months) and from participants two years after inclusion. In an effort to reduce challenges related to cognitive deficits and symptoms often faced by individuals with SMI, the employment program was augmented with cognitive remediation (CR) or elements from cognitive behavioral therapy (CBT). Through a randomization process, three counties offered each of the treatments. Employment specialists who had undertaken 40 hours of training carried out the respective cognitive interventions twice a week over a six-month period (Evensen et al., 2017; Lystad et al., 2016).

Due to difficulties recruiting a control group, a comparison group based on diagnosis was drawn from the NORMENT database at Oslo University Hospital. The NORMENT/Thematically Organized Psychosis (TOP) project is an ongoing naturalistic multi-site study on psychotic disorders (Falkum et al., 2017).

The results indicated significantly better employment outcomes compared to treatment as usual (TAU) at post-intervention with 77% in the JUMP group vs. 18.2% in the TAU group having some type of employment (Falkum et al., 2017). At two-year follow-up, 60% of JUMP participants still had some type of employment, and 21.2% were competitively employed. Mean hours of competitive employment per week were 28.5 and work tenure since post-intervention was 13.2 months. There were no significant differences in employment outcomes between the two cognitive intervention groups (Evensen et al., 2017). It was also found that level of apathy was not related to the acquisition of work (Bull et al., 2016).

There were non-significant cost reductions and improvements in quality-adjusted life years among JUMP participants as compared to TAU. The main reductions were driven by reduced inpatient services and were similar for those who gained competitive employment and for those who had work placements or sheltered work (Evensen et al., 2018).

Considering the low employment rates for people with SMI in Norway, the effect of the JUMP intervention on vocational outcome points to the importance of providing tailored interventions for this group.

The At Work and Coping (AWaC) trial

While the IPS model is specific and detailed regarding employment specialists' tasks (Bond, Peterson, Becker, & Drake, 2012), there is no corresponding specification concerning the role of the mental health therapists. In the AWaC intervention, this was addressed by choosing work-focused CBT as the treatment approach (Reme, Grasdal, Løvvik, Lie, & Øverland, 2015a). The AWaC model of work-focused CBT and job support had previously been piloted in a small trial in 2006-2008 with promising results (Steihaug & Harsvik, 2009).

The AWaC trial involved newly established centers in six different counties, that were organized by the NAV but located separately from the NAV offices. Each center consisted of therapists providing work-focused CBT, and employment specialists providing follow-up to participants in need of job support. Participants included people on and at risk of sick leave, or on long-term benefits. A total of 1193 participants with common mental disorders, primarily anxiety and depression, were included and randomized to the AWaC intervention or a control group. The control group received standard treatment from their GP, NAV, and other health professionals, and received a letter with information and encouragement to use available services and self-help resources. The main outcome was participation in competitive employment using registry-based data, and secondary outcomes were changes in mental health and health-related quality of life (QoL) using survey-data, at 12-month follow-up.

The results indicated a significant effect in favor of AWaC (Reme, Grasdal, Løvvik, Lie, & Øverland, 2015b). In the AWaC group, 44% were fully or partially at work at 12 months, compared to 37% in the control group (p=.015). The effect remained at 18 months (p=.018). The effect was considerably stronger among those on long-term benefits at baseline, where 24% increased or maintained work participation in the AWaC group compared to 12%

in the control group at 12 months. The effect increased over time for those on long-term benefits, and at 18-months, 30% in the AWaC group were working compared to 11% in the control group. IPS was primarily offered to participants on long-term benefits, and may therefore have contributed to the stronger results in this subgroup. The AWaC intervention also showed beneficial effects on anxiety and depression (p=.002) and health-related QoL compared to the control group (p=.026).

The cost-benefit analyses did not demonstrate positive economic returns of the AWaC program overall, but for the subgroup on long-term benefits, the stronger effect sizes translated to a large positive economic net return. Cost-benefit estimates were based on the assumption of a treatment effect lasting for one year. Extending the treatment effect past this one-year assumption, the program would yield a higher economic return.

Fidelity to the IPS model was not evaluated during the project, as development and improvement towards the gold standard of IPS for this new target group was ongoing throughout the project period. Adherence to the eight IPS principles was, however, continuously pursued, and any diversions from the principles are explained in the study protocol available online (Reme et al., 2015a).

Combining CBT and IPS principles with an explicit work focus, makes the AWaC model unique within the field of work and mental health. The AWaC model produced significant effects on work participation at one-year follow-up, which was substantial for the sub-group further along a pathway towards permanent work disability. These results were still sustained at four-year follow-up (Øverland, Grasdal, & Reme, 2018).

Multicenter RCT of IPS for people with moderate to severe mental illness

In 2012, the Norwegian Directorate of Health and the Directorate of Labor and Welfare commissioned the first RCT of evidence-based IPS in Norway (Sveinsdottir et al., 2014), as part of a national initiative to implement IPS services on a large scale. The trial involved six IPS centers in different Norwegian counties. The aim was to evaluate the

effectiveness of IPS for people with moderate and severe mental illness on competitive employment, and secondary outcomes of mental health and QoL, at 12-month follow-up. The main outcome was measured using registry-based data from the NAV, in addition to self-reported survey-data in order to compare with international trials. Survey data was also used for secondary outcomes. The trial included 410 participants with moderate (55%) or severe (45%) mental illness, randomized to IPS (n=229) or high-quality usual care (n=181). The trial also included a process evaluation and a cost benefit analysis. There was a general increase in fidelity to the IPS model, and most centers reached "good" fidelity during the project period.

Results showed that 36.6% of the participants in the IPS group and 27.1% in the control group had obtained competitive employment at 12-month follow-up, based on registry data (Reme et al., 2018). The effect was maintained and slightly increased at 18-month follow-up (37.4% vs. 27.1%). IPS was also associated with significant improvements on non-vocational outcomes including psychological distress, disability, subjective health complaints, health-related QoL, and global well-being, compared to the control group. Subgroup analyses showed that the effect did not differ between participants with moderate vs. severe mental illness (Reme et al., 2018). While the registry data showed somewhat weaker findings on competitive employment than has been demonstrated in IPS trials in other countries, findings based on self-report were stronger and comparable to that of previous studies (43% employment rate in the IPS group). This may be due to the more conservative yet reliable and objective nature of the registry data, which provide information for all participants but exclude smaller or non-contracted jobs that may not be subject to notification to the registries.

The trial is one of the largest IPS trials to date, and the first to show effectiveness of evidence-based IPS in the Norwegian context. Furthermore, the similar employment rates among those with moderate and severe mental illness indicates that IPS has an effect beyond the original target group, and it is also one of few IPS studies to show effects on non-vocational outcomes. Other unique features of the trial were the co-commission of the

Norwegian health and labor/welfare authorities, and the collaboration between academic researchers and policymakers. This has important policy implications and should inspire future collaboration and scientific evaluations before large-scale implementation of new interventions.

Integrating employment specialists in ACT and FACT

Assertive Community Treatment (ACT)

ACT is an intensive multidisciplinary team approach for community mental health service delivery, that typically serves outpatients with SMI and severe functional difficulties (Dixon, 2000). In an effort to counteract fragmented services, fourteen ACT teams were established in Norway from 2007-2012, twelve of which participated in an evaluation (Ruud & Landheim, 2014). Fidelity was assessed through the Tool for Measurement of Assertive Community Treatment (Monroe-DeVita, Moser, & Teague, 2013). In terms of integrating IPS as part of the methodology, the ACT teams in the evaluation had low fidelity, and the employment specialist role was not clearly defined or prioritized in the teams. During the 24-month follow-up period none of the participants obtained competitive employment while the percentage in sheltered work increased from 7 to 12% (Ruud & Landheim, 2014). Team members reported that they did not have time or resources to prioritize integrating IPS in the teams, and that implementing the IPS model in the Norwegian setting was challenging due to system-related factors and stigma (Ruud & Landheim, 2014).

Flexible Assertive Community Treatment (FACT)

The Dutch Flexible ACT (FACT) model (van Veldhuizen, 2007) has received much attention over the past few years, and in 2015 a FACT team in Oslo was the first team in the country to be certified by the Certification Centre for ACT and Flexible ACT. The FACT model has much broader inclusion criteria than ACT, and utilizes the ACT approach and the case management approach interchangeably. A requirement of the FACT model is that each team includes one employment specialist and integrates the IPS model in

the team approach. Employment results from the FACT model are scarce, but a Dutch observational study of 2150 clients reported that the unemployment rate generally remained stable at 82% (Kortrijk, Mulder, Kamperman, & van Weeghel, 2018).

A currently ongoing research project with 40 participants is evaluating the first seven FACT teams established in Norway, using a combination of fidelity measurements, interviews and registry-based data to investigate methodology and patient outcomes. The project was financed by the Norwegian Directorate of Health and is run by the Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, and is expected to be finalized in 2019.

New developments

Young adults with early psychosis

The Section of Early Psychosis Treatment (SEPT) at Oslo University Hospital received funding to implement a combination of IPS and JUMP interventions for individuals with early psychosis. Based on the knowledge that cognitive impairments and psychotic symptoms may interfere with functional outcome in general and vocational functioning in particular for this group (Lystad et al., 2016; McGurk et al., 2016; Shamsi et al., 2011; Strassnig et al., 2015), IPS is augmented with work-focused CR and/or techniques from CBT. The aim of the study is to determine whether augmentation can improve vocational functioning and for whom augmentation may be sensible. The project started in January 2018 and has included 26 participants with schizophrenia spectrum disorders so far. Outcomes are measured using survey data as well as clinical, neurocognitive and functional outcome data. The trial is expected to be finalized in 2020.

Clubhouse + IPS

Time unlimited follow-up is a core concept in IPS, and is difficult to achieve within fragmented services and time-limited projects. The Clubhouse model is unique in that they offer their members time-unlimited support. Members of the Clubhouse have moderate to

severe mental illness but are not necessarily receiving treatment from mental health services (Mo, Hatling, & Heggen, 2012), and would thus probably not be included in IPS projects outside the Clubhouse model. Early in 2015, one of two clubhouses in the city of Oslo received funding from the Norwegian Directorate of Health to implement an IPS project, with one employment specialist and a caseload of 16 participants. Fidelity to the IPS model was rated as "fair". At the end of the year, 75% of participants were working in competitive settings; 44% in competitive employment and 31% in "transitional employment" (Furuholmen-Jenssen, 2015). Transitional employment is a clubhouse-specific program offering members an intermediate step between working in a clubhouse and doing unsupported paid work elsewhere. The clubhouse obtains part-time, entry-level jobs that do not require previous experience or skills. The employer trains a placement manager, usually a clubhouse staff worker, who trains a member to take on the job for a limited period of time, after which another clubhouse member takes over. The project was successful, in terms of both employment rates and members' interest in participating in an IPS-inspired approach within the framework of the clubhouse model. The project has since been continued, and other Clubhouses are currently starting to implement the same service.

IPS for new target groups

International literature has demonstrated the effectiveness of IPS across different demographic and clinical characteristics (Campbell, Bond, & Drake, 2011) and in a range of subgroups with mental illness (Bond et al., 2015; Davis et al., 2012; National Council on Disability, 2008; Rinaldi et al., 2010; Twamley et al., 2012), but evidence for IPS in non-psychiatric populations is currently sparse. Newer developments in IPS in Norway include several ongoing or recently finalized RCTs investigating the possibility of transferring evidence-based IPS to new populations.

Young adults who are not in education, training or employment

Young adults who are not in education, training or employment represent a problem across European countries (Eurofound, 2012), and the rate of young recipients of disability benefits in Norway is increasing (NAV, 2018b). The Supported Employment and preventing Early Disability trial (SEED-trial) (Sveinsdottir et al., 2016) was a RCT investigating the effectiveness of IPS for young adults aged 18-29 years who are at risk of early work disability due to various social or health-related problems (N=96) in and around the city of Bergen. All participants were eligible for traineeships in sheltered workshops; an employment scheme offered in cases of impaired work capability. Participants were randomized to either IPS or traditional vocational rehabilitation using sheltered traineeships. The main outcome was competitive employment, and secondary outcomes included physical and mental health and well-being. Outcomes were measured at 6 and 12-month follow-up, using survey data and registry-based data from the NAV. The trial was finalized in 2018 and the main paper on survey data is submitted for publication, with preliminary results indicating promising effects. Meanwhile, the NAV plans to establish IPS as a service for young disability recipients with various diagnoses in Bergen, starting with four employment specialists in 2019.

Chronic pain conditions

Individuals with chronic pain conditions represent a severely challenged group with reduced work capacity and high levels of sick leave and disability. Despite international consensus on the need for multidisciplinary and integrated approaches to complex pain conditions (Lambeek et al., 2010; Schatman, 2012), the IPS model has not previously been tested for this population. A pilot study published in 2017 investigated the feasibility of IPS for chronic pain patients who were eligible for interdisciplinary pain treatment in an outpatient pain clinic in the city of Oslo. The pilot study indicated that IPS could successfully be integrated with interdisciplinary pain treatment, and showed the intervention was well received among participants (Rødevand et al., 2017). The pilot was followed by the ongoing

RCT “IPS in Pain” (Linnemørken et al., 2018), investigating the effectiveness of IPS on competitive employment in addition to secondary outcomes of physical and mental health and well-being. Outcomes are measured using survey data at 6, 12, and 24 months. Approximately 60 patients were included, and randomized to either IPS + interdisciplinary pain treatment or to interdisciplinary pain treatment only. All unemployed patients who were referred to the pain clinic with a chronic pain condition, lived in reasonable vicinity to the clinic, and wanted to work, were eligible for participation. The trial is expected to be finalized by the end of 2019.

Refugees

Humanitarian crises related to the Syrian conflict have led to a large increase in refugees in Europe in the recent years, and there is need for effective approaches to increase work participation among refugees and reduce the impact of unfavorable exclusion mechanisms among this group. The ongoing RCT “Supported Employment for Refugees” (Clinicaltrials.gov, 2018) investigates the effectiveness of IPS for newly arrived refugees in the city of Bergen who are involved in the mandatory introduction program provided for all refugees in Norway. The program includes learning Norwegian language and culture as well as various traditional employment schemes offered by the NAV. Sixty-six participants have been included in the trial, and randomized to either IPS + the introduction program or to the introduction program only. The main outcome is competitive employment at 12 months using registry-based data, and secondary outcomes are acculturation, psychological distress, posttraumatic stress, global well-being and health-related QoL using survey data. The trial is expected to be finalized in 2020.

Substance use disorders

In addition to the RCTs described above, the initiative "Job First" provides IPS for individuals with substance use disorders involved in multidisciplinary specialized treatment (NAV, 2015). There are approximately 150 participants involved in the program, and fidelity

is rated as “fair”. The current competitive employment rate is approximately 35%, but the program has unfortunately not been involved in any research. Similar initiatives have also recently been established in other Norwegian cities, including Trondheim and Oslo.

Summary of studies and programs

Table 1 provides a summary of core characteristics of the various IPS or IPS-inspired studies and programs.

Table 1

General discussion and conclusions

Norway is unique among the OECD countries in having low general unemployment combined with high unemployment rates for people with mental illness (OECD, 2013), and implementing SE/IPS has been associated with several challenges. The first implementations of SE in Norway did not follow the evidence-based methodology, and although SE became standard vocational rehabilitation in 1996, the services maintained a marked preference towards providing sheltered employment (Spjelkavik, 2012). As the health and labor/welfare authorities in Norway looked into ways to increase competitive employment for people on benefits, IPS had emerged as a well-documented approach in the US. The Ministries therefore supported and funded several IPS and IPS-inspired studies, providing services to various target groups with mental illness across the country.

The strong emphasis on integrating treatment and vocational rehabilitation, inspired novel approaches in the IPS studies. The JUMP and AWaC studies did not have the opportunity to integrate employment specialists in mental health teams, so the JUMP study trained employment specialists to provide treatment and the AWaC study employed psychologists in the vocational services. Both approaches gave favorable results indicating that the integration is important, but may be achieved in various ways until services can be changed according to the IPS model. JUMP and AWaC services have both received continued funding and remain available for their respective target groups.

A national initiative to implement IPS services on a large scale in Norway, led to the commission of the first RCT of evidence-based IPS in Norway in 2012. The favorable results on both vocational and non-vocational outcomes showed that evidence-based IPS was also effective in a Norwegian context, for people with moderate to severe mental illness (Reme et al., 2018). The project had implications on the political level, and in the Norwegian State Budget for 2018 it was decided to increase the funding to make IPS a permanent service, by redeploying funds from other vocational services (Government of Norway, 2017).

Efforts to adapt the IPS model to new populations furthermore represent a promising way to extend the potential of IPS to reach additional groups who are excluded from working life. Meanwhile, transferring the methodology to new populations involves making relevant adaptations to the evidence-based model, which might in turn reduce generalizability. Examples may include challenges related to the principle of collaboration with health services in cases where participants have other social or health-related problems than mental illness, and challenges with the principle of zero exclusion in cases where language barriers among refugees prevent communication with the employment specialists. While these currently unpublished trials aim to adhere to the IPS model, fidelity measurements will determine to what degree this has been practically feasible and whether these interventions are indeed IPS or something else.

The history of IPS in Norway and the results of the various trials discussed in this paper, strongly suggest that the IPS model is a more efficient method for gaining competitive employment than earlier approaches, even when applied within the Norwegian high-cost welfare society. While IPS was originally developed for people with SMI, the methodology has also proved itself effective for more common types of mental illness in Norway. Results from currently ongoing trials will further reveal whether IPS may be expanded to target various new groups of people in need of assistance to obtain competitive employment.

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Table 1: Summary of studies and programs

Program	Target group	Fidelity to the IPS-model	Integration with treatment	Promoted competitive employment	Comments
Job- and SchoolPrescription	First-episode psychosis	✓	✓	✓*	*Matched-control design.
The Job Management Program (JUMP)	Schizophrenia-spectrum disorders	Not measured	✓	✓*	*Outcome included non-competitive employment. The comparison group was drawn from a database based on diagnosis.
At Work and Coping (AWaC)	Common mental illness	Not measured	✓	✓	
Multicenter RCT of IPS	Moderate to severe mental illness	✓	✓	✓	
Assertive Community Treatment (ACT)	Severe mental illness and functional difficulties	Below cut-off	✓	no	
Flexible Assertive Community Treatment (FACT)	Moderate to severe mental illness and functional difficulties	Not yet measured	✓	Not yet published	
Young adults with early psychosis	Early psychosis	Not yet measured	✓	Not yet published	
Clubhouse + IPS	Clubhouse members with moderate to severe mental illness	✓	no	✓*	*Based on observed employment rates. The program is not involved in research.
The SEED-trial	Young adults, no diagnostic criteria	✓	no	Not yet published	
The IPS in pain trial	Chronic pain	✓	✓*	Not yet published	*Integrated with interdisciplinary pain treatment
The SER-trial	Refugees, no diagnostic criteria	✓	no	Not yet published	
Job first	Substance use disorders	✓	✓*	✓**	*Integrated with multidisciplinary substance use treatment **Based on observed employment rates. The program is not involved in research.