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Implementing individual placement and support in Norway. From vocational rehabilitation to an employment scheme

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Abstract

We explore the implementation and development of individual placement and support (IPS) in Norway. IPS is an evidence-based practice for supporting people experiencing mental illness to obtain and maintain competitive employment. Implementation of IPS into routine practice has been challenged by different paradigms in vocational rehabilitation, health and welfare policies. Data were mainly collected through individual and joint interviews of IPS experts and key stakeholders involved in the implementation of IPS. Data were analysed using thematic analysis. Three themes were derived from the analysis, representing different phases in the implementation process: (1) seeking a way to meet unmet need in work and mental health practice, (2) gathering knowledge and national evidence, and (3) embedding IPS into routine practice. The study demonstrates how health and welfare policy gradually developed IPS from vocational rehabilitation to a mainstreamed welfare employment scheme. This development may secure the future of IPS in Norway. However, the implications for practice in the longer term are unknown. Our study provides insight into how implementation of an evidence-based

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practice both influences and is influenced by national policymaking.

KEYWORDS
employment, implementation, individual placement and support, individual placement and support, policy, vocational rehabilitation

1 | INTRODUCTION

The proportion of people experiencing mental illness who are outside the workforce is increasing, with mental illness being the leading cause of disability in most western societies (OECD, 2015). This is challenging for individuals but also societies in terms of the economy, lack of workers and impact on health services (McDaid, 2005). Labour market participation is key for inclusion in society, and various vocational rehabilitation approaches aim to help individuals attain or remain in employment (Waddell et al., 2008). Individual Placement and Support (IPS) is an evidence-based vocational rehabilitation approach developed for people experiencing mental illness, and is based on eight principles: (1) focus on competitive employment, (2) eligibility based on client choice, (3) integration of employment support and mental health services, (4) attention to client preferences, (5) personalised benefit counselling, (6) rapid job search, (7) systematic job development and (8) time-unlimited individualised support (Bond & Drake, 2014). These principles are enacted through an IPS team supporting people experiencing mental illness seeking competitive employment. The team consist of an IPS employment specialist, an employment and benefit advisor and health service professional. The IPS team is not a stand-alone team; the employment specialist is integrated into the clinical team providing mental health treatment for service users. IPS is a manualised method of supported employment (SE) for ordinary jobs with competitive wages (Drake & Becker, 1996). IPS differs from traditional SE by being integrated into health services and recognises that a team approach to helping the person to gain and retain work is needed. The effectiveness of IPS has been extensively reported through randomised controlled trials (Burns et al., 2007; Drake et al., 1996), systematic reviews and meta-analyses (Metcalfe et al., 2018; Modini et al., 2016). A meta-regression study also demonstrated IPS effectiveness across different countries with different health and welfare systems and structures (Brinchmann et al., 2020). Further, some studies have reported positive long-term employment outcomes of IPS (Hoffmann et al., 2014; Holmås et al., 2021).

IPS has been described as a paradigm shift in helping people with mental illness gain and retain employment (Corrigan, 2006) that requiring considerable change in clinical practice needed to effectively implement IPS. Most critical is moving from a 'train and place' to a 'place and train' approach where the individual is assisted to gain employment and then supported to maintain the role. The 'place and train' approach challenges the stigma and discrimination associated with mental illness and promotes positive change in the persons' role in society, their human rights and citizenship (Corbiere & Lecomte, 2009).

IPS has spread to four continents over the past two decades but it is unclear to what extent IPS is implemented in routine practice (Bond et al., 2020) or how the process of national implementation efforts have progressed. Several challenges to IPS implementation exist at contextual, organisational and individual levels (Bonfils et al., 2017; Hasson et al., 2011; Mueser & Cook, 2016). The implementation of IPS requires a specific form of organisation, described in the IPS fidelity scale (Bonfils, 2020). Fidelity refers to the degree of implementation of an evidence-based practice, which in the context of IPS is the Supported Employment Fidelity Review Manual (Becker et al., 2019). Challenges of integrating healthcare and employment support are described in countries characterised by two sectors providing health and employment services operating independently of each other, with different objectives and regulated by different authorities, (Bonfils, 2020; Shepherd et al., 2012). A health service' objective

would be to promote, protect and improve health, whilst an employment service' primary objective would be to help people find employment (Wharakura et al., 2022), although these can be mutual and complementary goals. Questions have been raised on whether it is possible to use an integrated model such as IPS in a sectorised welfare system (Bergmark et al., 2018). Local initiatives such as IPS employment specialist training programmes, mainstream funding, plans for collaboration and assessments of programme fidelity can help facilitate implementation (Bergmark et al., 2019; Oldman et al., 2005; van Weeghel et al., 2020; Vukadin et al., 2018). However, there is a lack of published knowledge concerning governmental initiatives and policymaking related to the process of implementing IPS.

A national policy on mental health can help raise awareness, secure resources for services, and coordinate actions across many different sectors (McDaid, 2005). It is therefore important to see how IPS can be embedded into mental health policy, where this is seen as an official statement of a government conveying "an organised set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population" (WHO, 2018, p. 62). This study is conducted in Norway, where social policy is at the core of the welfare state and where policy development can have considerable public impact (Høydal & Tøge, 2021). Our study aims to explore initiatives made to implement IPS nationally, the driving forces behind these initiatives and how policy and legislation have affected the IPS delivery.

2 | THE EMPIRICAL STUDY

2.1 | Study context

The aim of Norwegian employment policy is to increase and maintain employment for people experiencing difficulties entering the labour market. Norway is characterised by a low unemployment rate (OECD, 2020), yet has high general sickness absence and is among OECD countries with the highest levels of disability and rehabilitation benefits (Hemmings & Prinz, 2020). Health and welfare services are rooted in two different sectors regulated through different legislation and funded separately. The Norwegian mental health services provide community-based and hospital-based care. A national action plan for mental health (Ministry of Health and Care, 1997) laid the foundation for "new" mental health services by promoting values such as normalisation and service-user involvement. The plan prioritised employment. The Norwegian Labour and Welfare Administration (NAV) provides social and vocational services, and social welfare benefits for those who cannot work. NAVs main responsibility is to provide economic security for residents and assist unemployed people to gain employment through employment schemes. The schemes represent various plans for getting people into work based on their individual needs (NAV, 2022). NAV offices represent Norway's Public Employment Services, defined at EU level as "the authorities that connect jobseekers with employers" (European Comission 2022, para 1). The Directorate of Health and the Directorate of Labour and Welfare lead the implementation of IPS nationally. Before IPS, employment support was mainly provided by NAV and an extensive industry of non-governmental vocational rehabilitation agencies. These agencies are mainly privately run, even though some receive public funding. Traditionally, these agencies offered sheltered work opportunities for people with mental illness and 'place and train' approaches to SE for some people with developmental disabilities.

2.2 | Methods and data

This study has a qualitative design, with empirical data drawn from interviews and document analysis. Both data collection and analysis were empirically-driven, without a pre-defined conceptual implementation theory. This approach is grounded in reflexive thematic analysis emphasising the importance of deep reflection on, and engagement with,

data (Braun & Clarke, 2019). By this approach, we sought to highlight both harmony and tension between priorities at the policy level and the reality of implementation in practice (Broomfield & Reutter, 2021).

2.2.1 | Participants, recruitment and data collection

The main source of empirical data was individual and joint (two interviewees) interviews. CM conducted the interviews between August 2018 and August 2019. Altogether, 13 interviews were conducted with 17 participants. Participants were national IPS experts and central stakeholders involved in the initiation, development and implementation of IPS in Norway. All participants had been involved in IPS-related work for more than 10 years. They had different professional backgrounds and represented the three main sectors in the health and work field: health sector, NAV and vocational rehabilitation agencies. Mainly, participants represented national and regional institutions such as the Directorate of Labour and Welfare, national business organisations, IPS organisation and regional NAV offices and health services. Two participants had followed employment support in Norway over several years from an academic perspective and some had moved between sectors during the IPS implementation process.

The recruitment of participants followed a snowball method (Polit & Beck, 2012). The first participants were well-known actors within the IPS-field in Norway. During interviews they suggested other participants for this study. Participants were contacted by e-mail, informed about the study, and asked if they were willing to participate in a research interview. The interviews took place at the participants' workplace, by telephone or at a suitable location based on the participants' preferences and lasted from 45 to 90 minutes. The semi-structured interview guide was sent to participants before the interview, but all participants were encouraged to speak openly about their actions and experiences related to the implementation of IPS. The interview guide was developed by the research team based on previous knowledge of IPS in Norway. Questions asked during interviews were for instance: When did IPS start in Norway, and what was the background for IPS implementation? And, How was IPS implemented, and by who? As the expansion of IPS in Norway has developed rapidly in recent years, there was a need for follow-up conversations with two participants 12–24 months after interviews to gain updated information on implementation and published documents.

Reviews of a wide range of published documents complemented the interview data. Documents were collected continuously based on participants statements of published documents that have influenced the implementation of IPS. Documents included official governmental publications, legislation and reports. After analysing 13 interviews and a selection of 17 documents, we found the data to be sufficiently saturated for the aims of this study. The reviewed documents are cited in the result section.

2.2.2 | Data analysis

A thematic analysis was performed to produce a systematic overview of the data material. We followed the six phases described by Braun and Clarke (2006). In phase one, CM familiarised herself with the data by reading the interview transcripts and notes taken during and after interviews. Ideas of emerging patterns or categories such as "Where does IPS belong?" were noted accordingly. In phase two, the transcripts from interviews and notes were carefully read line-by-line and inductively coded. A code represents a sentence or paragraph describing initiatives, background for initiatives and reactions of initiatives for IPS implementation. Documents mentioned by study participants were reviewed and included in the further analysis. Initiatives were systematised chronologically and organised as a meta-narrative following a timeline. In phase three CM organised the initiatives into broader categories and into further themes covering actions and driving forces in a period of time. The themes were reviewed and refined by CM and BB. In the last two phases we named and defined the final themes, actions, driving forces and how IPS was viewed (all authors), and the content of the themes was merged into analytic text about the implementation of IPS. Interviews were conducted in Norwegian, and quotes were translated to English in the final phase of developing the analytic text.

3 | RESULTS

The results are presented by themes derived from the analysis. Each theme represents a phase in the implementation process. Themes are presented by descriptions of initiatives made in each phase, the driving forces for these initiatives and how IPS is viewed in this phase. The phases were developed by the authors, with each new phase assumed to begin when the implementation of IPS was perceived or practiced in a different way. An overview of the phases, driving forces, important initiatives and how IPS was viewed is presented in Table 1. The analytic text is exemplified by quotes from participants and references to documents. A participant ID is added to show variation in use of quotes. Background information of participants is not included to ensure anonymization.

3.1 | 2005–2010: Seeking a way to meet the unmet need in work and mental health practice

> "What is interesting is that it wasn't politicians who decided to establish IPS. The practitioners felt that something was missing in their field of practice" (Participant 2)

The first phase involved a period where practitioners in health, NAV and vocational agencies gradually realised how their way of working was incomplete and not meeting the employment needs of people they supported. National

TABLE 1 Overview of phases (themes), driving forces, initiatives and how IPS is viewed

Timeline	Phases (themes)	Initiatives for implementation	Driving forces of initiatives	How IPS is viewed
2005–2010	Seeking a way to meet the unmet need in work and mental health practice	Health care professionals searched literature and discovered IPS. Elements of IPS were integrated into local projects.	Practice experiences	Vocational rehabilitation
2011–2015	Gathering knowledge and national evidence.	International IPS experts from the health sector were invited to Norwegian strategic meetings. Key IPS documents were translated to Norwegian. Remove doubt of the effect in Norway. Define the IPS actors.	Lack of national knowledge.	Collaborative model for NAV and Health services
2016–2021	Embedding IPS into routine practice	Five regional IPS resource centres Regional IPS advisors Regional centre for work and mental health. Agreeing a structure for fidelity reviews National IPS courses National recommendations for training and toolboxes/ handbooks for IPS implementation. Expert committee for work and mental health	Policy and implementation	Welfare employment scheme

policy sought to promote closer collaboration between the fields of "work" and "mental health" through governmental documents such as a National strategy plan for labour and mental health (Ministry of Labour and Inclusion & Ministry of Health and Care, 2007–2012) and a National Health Plan (2007–2010) highlighting work and health as one of six "support beams" which should characterise all health services (Ministry of Health and Care, 2006–2007). Despite this, participants spoke of how they realised that the ambitions of policies and strategies for helping people with mental illness into work were not making a difference in practice. Participants observed that people experiencing mental illness were excluded from participation in society when they began receiving disability benefits and/or entered sheltered work from young age. They realised there was an unmet need in the health and work practice field, but did not know how to meet this need.

From NAV, participants described how they tried to transfer the SE approach used for people experiencing learning disabilities and other developmental challenges to people experiencing mental illness. This shift was challenging: "We saw that they [the clients] needed something more than SE could offer. They needed a different kind of support" (Participant 6). Clients needed support from health services, but NAV practitioners found it hard to involve health care professionals in providing employment support: "A number of initiatives from NAV tried to increase the attention towards work for people experiencing mental illness, but we did not manage to engage health services in these initiatives" (Participant 1).

Health services were described as having a step-wise rehabilitation tradition in line with a 'train and place' approach, involving a period of time in sheltered work before the next step of competitive work. Furthermore, active vocational rehabilitation for people with mental illness was primarily not considered a task for the health services. Typically, employment support was provided (by NAV and vocational rehabilitation agencies) after mental health treatment. Despite these traditions, a few health care professionals, independent of each other, introduced employment support into treatment. During interviews, these professionals told stories of how they searched the literature and found support for their new way of working. By searching the literature, they discovered IPS: "I cheated the system and got patients experiencing psychosis to work. I asked myself: 'what can explain this?' I searched the literature and discovered IPS" (Participant 5).

By discovering IPS literature, elements of IPS were integrated in local health service projects such as "Job prescriptions" in Stavanger (Hegelstad et al., 2019) and "The Job House" in Bodø (Brinchmann, 2012). IPS-inspired projects were also established within NAV that is, "Individual follow-up" in Østfold (Frøyland & Spjelkavik, 2006) and the "Work Proficiency Follow up programme" (Steihaug & Harsvik, 2009). The vocational rehabilitation agencies provided both 'train-place' sheltered employment and SE services based on a 'place and train' approach for people experiencing mental illness.

3.2 | 2011–2015: Gathering knowledge and national evidence

> "We have several experiences where small local initiatives have been made, and we [the Directorate] have picked them up and kind of spread them out again when we have tested them and seen that they worked. This was also the case with IPS" (Participant 8)

Initial IPS practice stakeholders invited representatives from Health, and Labour and Welfare Directorates to learn about their initiatives. The aim of engaging the two directorates was support for knowledge dissemination and policy-development underpinning IPS implementation. To disseminate IPS knowledge to a broader group, several initiatives were made. Participants were involved in arranging national IPS conferences with invited international speakers, and a study trip to meet the founders of IPS at Dartmouth Psychiatric Research Center, Dartmouth College, in New Hampshire, USA. These events were described as significant for implementation. They were described as indicating that "the pieces fell into place", and finally they learned about a vocational rehabilitation method that fully embraced the approach they had sought. They learnt about possibilities for clients to go straight into

employment without a 'practice placement' first, seeing positive results from effectiveness studies and noting the importance of good fidelity to the approach set out in the IPS manual.

However, this enthusiasm and optimism related to IPS was also met by scepticism from all sectors: "There was resistance and people worked against us from vocational agencies, NAV and health services" (Participant 11). Scepticism was mainly related to how vulnerable clients' health would be affected by work, whether employment support should be a task for health services, and about how well the results from studies conducted in other countries, including European counties, could be translated to a Norwegian context. There was also a lack of clarity relating to who should be the IPS actors and who had the overarching responsibility: «It was chaotic, vague about who should manage it" (Participant 14). As a response to these IPS concerns, initiatives were made to prepare for IPS implementation in a Norwegian context. We identified two main steps: (1) remove doubt of the effectiveness in Norway and (2) define the IPS actors and their responsibilities.

3.2.1 | First step: Remove doubt of the effectiveness in Norway

In 2012, the Directorates commissioned a multicentre RCT-study. The study addressed the uncertainty of IPS effectiveness (in terms of employment) in a Norwegian context: "Politicians said we could not rely on 17- year - old American research. Then we initiated the Norwegian RCT promptly" (Participant 11). Six IPS sites were included in the RCT and the results showed positive effects of IPS on all outcomes compared to the control group (Reme et al., 2019). This RCT is highlighted as an important marker for the policy development and implementation of IPS because it provided evidence of effectiveness in a Norwegian context. Even though participants mentioned European RCT studies during interviews such as the multi-country IPS trial of Burns et al. (2007) they sought specific IPS effectiveness in a Norwegian context.

To argue for involvement from health services within IPS, the Norwegian Knowledge Centre for the Health Services was commissioned by NAV and the Directorate of Health to conduct an updated systematic literature search for relevant research on the health effects of employment. The results built on a literature review of van der Noordt et al. (2014) and indicated that employment may have positive effects on health (Nøkleby et al., 2015).

3.2.2 | Second step: From three employment support and treatment sectors to two IPS sectors

Before 2015, NAV mainly outsourced vocational services to agencies providing sheltered work, subsidised or unpaid work placements, and SE initiatives. Gradually, NAV decided to take SE initiatives in-house (Ministry of Labour and Social Affairs, 2015–2016). Even though the vocational agencies still provided SE, the IPS actors were defined to be NAV and health services. For some participants this was an unwanted strategy because the vocational agencies had significant competence within vocational rehabilitation and were a major industry where human and financial values were at stake. For other participants, excluding the vocational agencies was the right thing to do because they argued it would be hard to adhere to the IPS fidelity scale, and thus the vocational agencies disappeared from IPS because of the complex collaboration with NAV and health services: "They are still working on it, but they haven't been able to make it work. A lot of agencies want to work with IPS, but it does not come out as IPS" (Participant 14).

Representatives from the UK (such as author MR) were closely attached to the Norwegian process of preparing for IPS implementation. MR had spoken widely internationally on experiences in the UK, across Europe and acted as an advisor to several Norwegian governmental initiatives and was the host for various study visits to UK. Training and advice from both UK and US emanated from the health sector. The Norwegian initiatives were in this phase jointly initiated by the health sector and NAV, and there was an explicit aim of building bridges between these sectors. The policy related to IPS implementation was supportive and a follow-up plan for work and mental health laid

out guidelines for development as well as priorities for people experiencing mental illness who wanted to work (Ministry of Labour and Ministry of Health and Care, 2013–2016).

3.3 | 2016–2021: Embedding IPS into routine practice

"There shall be IPS and there shall be fidelity reviews to ensure good quality IPS." (Participant 1)

In 2017, the Norwegian government strengthened NAV providing IPS by redirecting funding from other vocational services to IPS with the aim of making IPS a permanent service (Government of Norway, 2017). Several national initiatives were made to implement IPS within routine practice and to ensure IPS was provided as intended. From the origin of IPS within health services, we identified a change in the anchoring of IPS at NAV in this scale up phase. The following initiatives were mainly provided and managed by NAV and supported economically and professionally by the Health Directorate and the National Competence Centre for Mental Health (NAPHA). Four *regional IPS resource centres* were established in 2016 and a fifth in 2020. These centres provided support for sites offering IPS in their area. In addition to the resource centres, *regional IPS advisors* were employed by NAV in 2021 to support IPS practitioners. In the health sector, *A Competence Centre for Work and Mental Health* was established by the Northern Norway Regional Health Authority in 2016, mainly focused on implementing IPS in Northern Norway, and a national Expert Committee for Work and Health was established in 2017 (Directorate of Health, 2022a).

A process for regular independent *fidelity reviews* at each IPS site was established in this phase. This process involved two independent reviewers performing fidelity reviews following the Supported Employment Fidelity Review Manual (Becker et al., 2019). The fidelity reviews were organised and led by NAV. According to participants (and previous research), a prerequisite for good quality and sustainable IPS services was regular fidelity reviews. Despite this, the participants realised the fidelity reviews in their current form were resource-demanding and they were concerned if they would be able to conduct reviews when the number of IPS sites increased. "The fidelity review is essential, but we have to figure out how to manage to review all the new sites coming up now" (Participant 11). In addition, there were established *national courses* in IPS, *recommendations for training* and *toolboxes/ handbooks* for IPS implementation. These were made by the IPS resource centres in collaboration with NAPHA.

Despite IPS's origin from vocational rehabilitation, and research documenting the health benefits of working, an ongoing discussion within the health sector was whether employment support should be part of healthcare responsibilities. Some participants argued for IPS being part of healthcare by saying it promotes health and originates from the vocational rehabilitation field. Other participants emphasised that IPS was firstly a model of collaboration for getting people into work. At the end of this phase, IPS was defined as part of NAVs portfolio of employment schemes (Ministry of Labour and Inclusion, 2019). Here, we find IPS being referred to as work solely undertaken by the employment specialist, not the health team. For health services, it was stated that IPS, provided by NAV, should not be defined as healthcare (Directorate of Health, 2022b). There was a shared recommendation from the two Directorates for anchoring IPS employment specialists within NAV (Directorate of Work and Welfare and Directorate of Health, 2019) with the aim of close collaboration with health services. However, the two Directorates struggled to establish common guidelines, and according to participant 14: "The Health Directorate is engaged, but their organisation does not match NAV. Health and NAV are not compatible and it is hard to establish common guidelines". Participant 14 also reflected on the implementation: "The problem is that we are trying to adapt IPS to our systems [health and NAV systems], not the systems to the model".

By the end of 2021, Norway had approximately 380 IPS employment specialists employed at NAV, and there were approximately 100 IPS teams (including IPS youth teams) (e-mail correspondence Directorate of Work and Welfare, 29.08.2022). For some participants Norway was quite successful in implementing IPS in routine practice and they expressed the view that NAV's role had been significant. Still, there were concerns with the operationalisation of IPS: "I have no doubt about the anchoring at NAV, they have plenty of money to

implement [IPS] within NAV. I am more concerned about the operational work. It is like doing theoretical training without taking it to practice" (Participant 5). Concerns were also expressed related to earlier experiences from establishing SE:

> "I am afraid it will be made into a light-version of the [IPS] fidelity scale, like what happened with SE. They thought it was too comprehensive, that we could not work this way, and made it simpler without thinking of the consequences." (Participant 8)

Participants saw a tendency for IPS to become more similar to SE because of a lack of integration with health teams. An expansion of IPS to other target groups (see Sveinsdottir et al., 2020), especially to people with mild to moderate health problems, made some participants worry there would be a selection of clients for IPS based on an assessment of their employability. For some participants who also were involved in the implementation of SE in Norway, they remembered what happened with SE: the target group was expanded so wide that the original target group "disappeared". In addition, participants saw a move to gradually "phase" IPS into existing NAV routines: "I see intimations of an increased use of screening and use of wage subsidies at NAV" (Participant 14). This was partly explained by NAV practitioners not being used to their work being manualised: "In NAV, we are quite allergic to follow recipes, right? We are used to thinking independently and picking elements from here and there and putting them together again." (Participant 8). The transformation of IPS, from vocational rehabilitation to a NAV employment scheme made some participants worry that IPS in Norway would become something very different from the original evidence-based practice. Still, some participants also expressed doubts whether the IPS scale-up and implementation would have been this successful if IPS had been anchored and managed by health services.

4 | DISCUSSION

In this study we explore the implementation and development of IPS in Norway. Three themes were derived from the analysis, representing different phases in the implementation process: (1) seeking a way to meet unmet need in work and mental health practice, (2) gathering knowledge and national evidence, and (3) embedding IPS into routine practice. The findings present new insights concerning national strategies for IPS implementation. Implementation initiatives were the result of driving forces, triggered by tensions in the practice field. Bakkeli (2022) shows how frontline workers handle tensions when implementing policies. Our study adds to the literature by showing how unmet client needs and tensions initiate policymaking. Throughout the phases, we have recognised a change in how IPS has been viewed; from being a health service intervention, to becoming an employment scheme. In this shift, we discovered a tension within policymaking and implementation of evidence-based practices, which is broadly useful. We discuss the findings related to the possible implications of the change in IPS provision.

4.1 | Policy developed IPS away from the original health service approach

IPS originated from a rehabilitation and recovery health tradition (Drake & Becker, 1996). This study found the Norwegian stakeholders received IPS training and advice from international IPS experts working in health services. Even though the Norwegian Directorate of Health was closely involved in the implementation of IPS, Norwegian policy developed in a way that moved IPS away from being a health intervention. We found that NAV, at the end of the implementation process, embedded IPS into their routine practice. We discuss two potential implications of this policy development:

4.1.1 | IPS loses the protection of being an evidence-based practice in mental health services

For over 20 years, health practitioners have been steered towards using evidence-based interventions and many countries have committed to delivering evidence-based practices as a health policy priority. These interventions are considered the most effective and cost effective (Oliver et al., 2014). IPS delivered to fidelity is an effective evidence-based practice. Whilst barriers to integration with health teams have been identified (Fyhn et al., 2021; Moe et al., 2021; Wharakura et al., 2022), the introduction of the legislative regulation stating IPS is outside the remit of health services has the potential to change the delivery of IPS in Norway by violating the evidence-based principle of integration with clinical teams. It is still too early to know how this is being interpreted or how it will affect IPS practice in Norway. Several unintended policy challenges potentially arise from this: the regulation could be interpreted as meaning that NAV no longer needs to integrate with health teams. Such a stance would negatively impact on IPS fidelity, weakening the effectiveness of the intervention and in turn the impact on individual lives and wider society. Despite the original intention to scale-up IPS for people experiencing mental illness across Norway there is now the potential for creating an inequity in access to IPS as each local health service leader is left to interpret the regulation and decide whether to implement IPS within their services as it is deemed outside the scope of responsibility for health services. Irrespective of whether the unintended consequences arise, the regulation goes against the wider international policy context of integrating mental health and employment policy and services (OECD, 2021) and goes beyond the original policy goals of IPS in Norway.

A lack of, or a diluted form of integration, makes IPS provision differ from the approach tested in international effectiveness studies, including the Norwegian RCT (Reme et al., 2019). IPS, solely delivered by NAV and not within a structural collaboration with health services, has the potential to lose the protection of being an evidence-based practice. Public employment services do not have a history of using manualised evidence-based vocational interventions in the delivery of services as highlighted by participants in our study, they work in a way that individually makes sense to them. Whilst for mental health services, despite the importance of employment being essential to enable people experiencing mental illness achieve their recovery goals and live a more meaningful life (WHO, 2022), employment might not be seen as a typical outcome of treatment or the "right type of evidence" for the performance of mental health services (Lockett et al., 2018; Royal College of Psychiatrists, 2022).

4.1.2 | IPS as an employment scheme might increase risk of creaming

Tension between the policy development and implementation of IPS might increase the risk of 'creaming'. The phenomenon of creaming is known in the literature as "when caseworkers prioritise those who seem most likely to succeed in terms of bureaucratic success criteria" (Lipsky, 2010, p. 107). Participants shared concerns that the service offered to clients experiencing mental illness might decrease when IPS was led by NAV due to creaming. Some participants commented on how they observed a tendency to screen for employment readiness at NAV contrary to the evidence-based principle of zero exclusion in IPS. Creaming was also identified by Gjersøe and Strand (2021) in their study of SE job coaches in NAV. They identified how job coaches through subjective assessments of their work ability were able to filter to the most motivated clients. The policy development of anchoring IPS in NAV might facilitate creaming and move the focus away from people with mental illness. However, we do not know if creaming happens when IPS is anchored in health services as mental health specialist's attitudes towards employment can play a significant role (Craig et al., 2014). Still, NAV has an explicit activation policy and the outcome of obtaining employment is highly measurable, increasing the risk of creaming (Gjersøe & Strand, 2021).

4.2 | Did the mainstreaming of IPS secure IPS in Norway?

Despite implementation and integration barriers, IPS was embedded into NAVs routine practice. In Norway, IPS has been systematically studied since 2012, documenting the effect in a Norwegian context from short to long-term perspectives (Holmås et al., 2021; Reme et al., 2019). Sveinsdottir et al. (2020) provided an overview of research projects in Norwegian settings. Moe et al. (2021) studied the implementation process as experienced by employment specialists, Butenko et al. (2022) studied turnover rates in the implementation process, and IPS attitudes and practice within NAV have been studied, (Bakkeli, 2022; Bakkeli & Breit, 2021; Brinchmann et al., 2022; Gjersøe & Strand, 2021). These studies support our finding of IPS being embedded into routine practice in NAV.

A national mental health policy can help raise awareness, secure resources for services, and coordinate actions across many different sectors (McDaid, 2005). Our study finds that policy development has been stepwise, something that is also identified in Sweden (Bergmark et al., 2017) strengthening the view of policy development being an ongoing process, not a specific situation. Norway has gradually developed national policies on "work and mental health", supporting initiatives for securing resources for the implementation of IPS. Of the IPS fidelity reviewed sites in 2020, 38 were rated as fair, good or exemplary (Ministry of Health and Care, 2021–2022). The process of implementing IPS in Norway can be viewed as a loop, where employment support started and ended at NAV. The implementation of IPS was an attempt to share the responsibility between NAV and health services. Bakkeli and Breit (2021) demonstrated two different ways of practicing IPS at NAV: standardisation to promote a shift in institutionalised practices and, standardisation as a revival of traditional professional work practices. Our study embraces both insights from NAV and the health sector and identified a shift in the way of practicing IPS: first, standardisation (through the IPS manual) was used to promote a shift in the institutionalised practices. After meeting resistance and barriers, IPS was adapted to NAV practices to support the revival of traditional professional work and the mainstreaming of a 'place and train' approach within the organisation. Still, there are elements of change. The close collaboration with health services is significantly strengthened and the (partial) seating of employment specialists in health teams is IPS specific. The collaborative work within "work and mental health" at the governmental level is also strengthened and enacted through policy documents.

Nonetheless, it seems like structural integration is hard to achieve. This is a recognised international phenomenon. According to the OECD (2021), only a few OECD countries have been successful in implementing integrated health and employment policies. Like the other Scandinavian countries (Bergmark et al., 2017; Bonfils, 2020), Norway has healthcare and employment support organised in separated organisations. Both organisations have different aims, objectives and cultures: Health services are led by a clinical model which is focused on individual treatment and cure, whereas NAV is led by a social model more focused on support and adjustments to enable the individual to be part of society. The different objectives and cultures can also be identified in the implementation literature. While policy implementation is grounded in social science, implementation science was founded in evidence-based practice derived from natural science (Nilsen et al., 2013). This difference can help us explore the barriers to integration. To understand these barriers, Bonfils (2021) identified different discourses in the respective institutional settings in Denmark and explored implementation of IPS from mental health services' perspective. IPS was viewed as a parallel, rather than an integrated service. The practitioners in mental health services did not see IPS as a mutual responsibility. That said, in contrast to work as a stressor, Bonfils (2021) identified an appreciation of work as part of a client's recovery throughout the implementation. This might also be the case in Norway. The anchoring of IPS at NAV might be a strategic policy move to secure funding for IPS employment specialists. The early initiatives of health care professionals gaining support for IPS implementation through policy making, also made them lose control of the democratic bottom-up implementation process. When national policy was developed, the adaptions to local conditions were replaced with national considerations (DeLeon & DeLeon, 2002).

Our study has some limitations. The development of IPS policy and implementation was experienced in different ways by participants, thus several important reflections and incidents were necessarily left out when writing the overall story. To be able to tell a coherent story, the storyline presented in this article is more streamlined than the stories presented by participants. The actual process was both iterative and had several parallel processes. Tensions and conflicts were identified, but some were left out to protect participants. The various perspectives on the

implementation process are a strength of the study. Altogether, the participants' views make a more coherent and nuanced description of IPS in Norway.

Members of this research group have been closely involved in the implementation process. Two of the article authors (BB and MR) have had dual roles in this process. BB has experience from health leadership and has been an actor in the implementation process, and MR has been an advisor for Norwegian governmental initiatives. Their comments on the analysis and article manuscripts were also based on their own experiences during the implementation process. To handle their pre-understandings, the first author checked the empirical data regularly to ensure consistency in the presentation of findings.

5 | CONCLUDING REMARKS

Our study provides insight into how implementation of an evidence-based practice both influences and is influenced by national policymaking. Supported by government, the Norwegian Directorates of Health and Labour and Welfare, and health and NAV professionals, have undertaken several initiatives to facilitate the implementation of IPS nationally. As IPS is settled within routine NAV practice, we can conclude that the mainstreaming of IPS in NAV secured the future of IPS in Norway, but it is too early to know the long-term outcomes or consequences. The Norwegian way of implementing IPS is untraditional, and future studies should seek to investigate the consequences from a longer-term perspective. All of this Norwegian experience has international relevance as it shows how policy developments impact on the implementation of an evidence-based practice along with the challenges and successes of two government departments working together to achieve a policy goal.

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CONFLICT OF INTEREST

The authors of this study have no financial conflicts of interests.

DATA AVAILABILITY STATEMENT

The data generated and analysed during the current study are not publicly available due to participant confidentiality.

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