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ORIGINAL ARTICLE

Implementation of individual placement and support in a first-episode psychosis unit: A new way of working

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Abstract

The aim of this study is to explore the IPS implementation process in a first-episode psychosis (FEP) mental health service team in Sweden. More specifically, the study explores how integration processes and critical situations are perceived over time by team members who originated from two diverse welfare organizations. A serial interview design was used (initially, at 6 and 12 months) to describe experiences of 16 team members. Material was analyzed using a constant comparison grounded theory approach. Team members dealt with the ambivalence of sharing mental health information, and whether the new way of working was a risk or benefit for users. They gradually learned new perspectives and knowledge, built trust and shared common views. After a year, the team workload perceived reduced and became person-centred. Some members described remaining unclear roles and requested further support. Negotiated goals for integration and early knowledge transfer are critical. Organizational change and trusting team relationships have to be facilitated. Anticipated gains of integration should be clearly described and discussed early on, and continuous support for sustainability should be considered. This study confirmed the importance and potential of integrating IPS into FEP teams.

KEYWORDS
early intervention, individual placement and support, integrated teams, interorganizational collaboration, supported employment, vocational rehabilitation

1 | INTRODUCTION

People with a first-episode psychosis (FEP) recognize the importance of employment in their lives. However, not many of them receive vocational support from mental health services (Rinaldi, Miller, & Perkins, 2010). Instead, their mental illness and patient role often become the center of their world (Bejerholm & Roe, 2018). The Individual Placement and Support (IPS) model is an evidence-based approach for supported employment (SE). Several controlled trials and systematic reviews have consistently demonstrated that IPS is more effective than traditional vocational rehabilitation in terms of vocational outcomes (Bond, Drake, & Becker, 2012; Kinoshita et al., 2013; Modini et al., 2016). Traditional vocational services typically focus on skills training and support in less demanding, sheltered environments (Bejerholm, Areberg, Hofgren, Sandlund, & Rinaldi, 2015; Bejerholm, Larsson, & Hofgren, 2011). In contrary, IPS is designed to support people with severe mental illness in gaining and keeping competitive employment in regular work settings without any prevocational preparation (Bond, 1998), also referred to as place first, then train (Corrigan & McCracken, 2005). Effectiveness includes using IPS as an early intervention for young adults to obtain competitive employment (Bond, Drake, & Campbell, 2016). IPS also supports opportunities for developing a worker role, personal recovery (Bejerholm & Roe, 2018; Strickler, Whitley, Becker, & Drake, 2009) and community integration (Bejerholm et al., 2015; Bond, Salyers, Rollins, Rapp, & Zipple, 2004). IPS is based on eight principles—(a) the goal is competitive employment; (b) eligibility is based on individual choice and desire to be employed; (c) rapid job search; (d) individual preferences and interests guide interventions; (e) customized on-going support as long as needed; (f) personal counselling about finances and benefits; (g) an integration with a mental health care team; and (h) systematic recruitment of employment and engagement with employers (Bond, Drake, & Becker, 2008).

The Swedish welfare context involves multiple stakeholders, and responsibility for supporting individuals with mental health problems is divided among several different authorities. The regional councils are responsible for health and medical care. Persons with common mental health disorders typically receive care from general practitioners working in primary health care, while persons with more serious conditions are treated by specialist health care services, provided by multidisciplinary teams consisting of psychiatrists, clinical nurse specialists, psychologists, occupational therapists and social workers. Sweden's municipalities are responsible for social services and provide community-based support, including residential care, daily activities and pre-vocational training. The responsibility for providing pre- and vocational rehabilitation is shared between mental health care service, municipalities, employers, the Social Insurance Agency and the Public Employment Service. Financing, responsibility and coordination, depends on the user's unique situation. According to several of the country's political steering documents, including national guidelines (National board of health and welfare, 2011, 2018), implementation of IPS with high program fidelity according to the original evidence-based IPS model (Becker, Swanson, Reese, Bond, & McLeman, 2015) is prioritized. Yet, the division of roles and responsibilities creates a great need for collaboration across agency boundaries and coordination of rehabilitation activities among stakeholders on behalf of the users. However, these different types of services overlap, but have at the same time diffuse borders between them. Different laws, as well as lack of regulations and policies, do not denote who has the actual responsibility for vocational rehabilitation of persons with severe mental illness. This situation is recognized as a barrier to meet users' needs of employment (Bejerholm et al., 2015; Bergmark, Bejerholm, & Markström, 2018b; Hillborg, Danermark, & Svensson, 2013).

Internationally, a number of studies show the possibility to implement IPS with good fidelity in US and other countries (Bond et al., 2012; Bonfils, Hansen, Dalum, & Eplov, 2017). However, implementation of IPS in diverse contexts involves different types of challenges in terms of high program fidelity versus local model adjustments (Bergmark, Bejerholm, & Markström, 2018a; Bonfils et al., 2017; Corbière et al., 2010). Bonfils et al. (2017) reviewed 21 implementation studies from the US, Australia, Belgium, Canada, Netherlands, Sweden and the UK. The result showed that contextual, local organizational, cooperation and individual factors influenced the implementation of IPS. Some key barriers were related to that policy and regulations were not aligned with the place-and-train model of IPS. Collaboration between IPS services and other welfare actors was also insufficient, with contrasting views and beliefs on recovery which were rooted in local organizational contexts. Key facilitators were concluded as the ability to secure funding, leadership, supervision and education of the employment specialist, along with IPS fidelity ratings.

One critical IPS principle for users' mental health is a joint service, with IPS employment specialists integrated into the psychiatric care team, and studies indicate that close integration and good communication ensure more successful work and health outcomes for the users (Cook et al., 2005). Work and mental health need to be supported at the same time (Lexén, Hofgren, & Bejerholm, 2013). Furthermore, to mitigate the risk of becoming marginalized, it is essential that people with FEP get IPS early on in their personal recovery. However, there is a lack of knowledge concerning the implementation process for innovative interventions, such as IPS in mental health (Brooks, Pilgrim, & Rogers, 2011). This is especially true for early interventions.

Swedish implementation studies show that barriers exist on contextual, organizational and individual levels, and deficiencies concerning continuous support for sustainability (Bejerholm et al., 2011; Bergmark et al., 2018a; Hasson, Andersson, & Bejerholm, 2011). As addressed by Bonfils et al. (2017), different barriers may interact differently in relation to contextual settings. For example, IPS was successfully integrated into teams during trial periods, while collaboration problems with employment services were initial barriers (Bejerholm et al., 2011; Bejerholm et al., 2015; Hasson et al., 2011). However, the dynamics of implementation barriers changed when the national policy recommended that IPS should be provided within the municipalities' social services. Collaboration problems between the mental health services and social services were frequently reported (Bergmark, Bejerholm, & Markström, 2017). As a consequence, participants are typically not recruited from the mental health services in Sweden, neither are the severely, mentally ill prioritized (Bergmark et al., 2018b; Markström, Svensson, Bergmark, Hansson, & Bejerholm, 2018). This later development of systematic implementation challenges provided us with the necessity to study the implementation process of IPS in an FEP team.

When focusing on the team's dynamic in an implementation process, a team's ability to successfully implement IPS is dependent on a number of circumstances. These include organizational culture, attitudes towards organizational change and interpersonal contacts within and between organizations (Palinkas & Soydan, 2012). According to Damschroder et al. (2009), successful implementation is dependent on an active change process at several levels. Individuals influence implementation by their motivation, identification and knowledge, and familiarity with the innovation, influenced by norms, values, implementation climate and handling of goals and feedback in the organization. Stakeholder perception of the legitimacy of the intervention is also critical.

To date, no studies exist that describe the implementation process and dynamics of implementing IPS into FEP teams. There remains a lack of understanding about how this joint service can be built. While barriers for implementing IPS into teams have been generally described, fewer qualitative studies have been performed on its process. The aim of this study was to explore the IPS implementation process in an FEP mental health care team in Sweden. More specifically, the study (a) explores how integration processes and critical situations are perceived over time by team members who originated from two diverse welfare organizations, and (b) discusses how integration of services can be understood through the use of theoretical concepts from implementation research literature.

2 | METHODS

2.1 | Design, setting and participants

The present study had a qualitative and serial interview design that entailed interviewing participants on multiple occasions to explore change or variation over time (Calman, Brunton, & Molassiotis, 2013). In addition, the study also investigated the extent to which the service was in accordance with the underlying IPS principles, using the IPS fidelity scale (Becker et al., 2015). The scale defines the critical ingredients of IPS in order to differentiate between programs that have fully implemented the model and those that have not.

The project was initiated by a supported employment service and an FEP unit situated in Sweden, and was conducted between October 2014 and September 2015. In the present study, interviews were performed initially, at 6 and 12 months. The study was approved by the regional ethical committee in Lund, Dnr 2014-577. Based on stimulus grants from the National Board of Health and Welfare, and the recognition that people with FEP did not receive person-centred and evidence-based employment support, the idea of implementing IPS at the FEP unit was developed. Improving the quality of the service, for persons with schizophrenia and psychosis, in line with national guidelines (National board of health and welfare, 2011, 2018) was considered important.

The FEP team, prior to the integration of IPS, had basic responsibility for about 350,000 citizens and provided psychiatric services to people with a first-episode psychosis aged between 18 and 45 years. The team was multidisciplinary and specialized in meeting the need of people with FEP. The team intervention concerned assessments of diagnosis, medical treatment, early family involvement and family psychoeducation, individual and group therapy, social counselling, and initiatives for community-based services. Disciplines represented were psychiatrists, nurses, mental health assistants, social counsellor, psychologists, occupational therapist and the unit head. Most team members also functioned as case managers, except for the psychiatrists. The SE service that provided with employment specialists was financed by the municipality, provided vocational services to persons with mental health problems living in the community, and covered about the same catchment area as the FEP unit. Employment specialists had at least 3 years of academic training in subjects such as social work or behavioural science.

Initially, a steering committee, with members consisted of the people in charge of the project (including managers and stakeholders of the two organizations involved), was formed to ensure joint ownership. The committee had responsibility for strategic directions, information exchange and discussing key issues during the course of the project. In October 2014, one full-time and two part-time employment specialists from the SE service joined the FEP team and had a caseload of less than 20 service users each. The part-time specialist also worked at the SE service center. They were previously trained at the online Dartmouth Supported Employment Center in the US, and had undergone supervision in IPS for 2 years, by a trained supervisor from the SE service. A full-day IPS course was also conducted with the original FEP team. Once implementation started, weekly team meetings were organized to enable integration of professional roles, that is, to facilitate communication and joint discussions. Team meetings with users and team members, as well as on-going support to the users were organized in accordance with IPS principles, and IPS career profiles and plans were used (Becker et al., 2015; National board of health and welfare, 2012).

Sixteen team members participated—13 from the original FEP mental health team (henceforth referred to as *mental health clinicians*), and the three IPS employment specialists from the SE service who joined the FEP-team (henceforth referred to as *employment specialists*). A participant could be interviewed 1–3 times (see Table 1). The mental health clinicians were divided into two groups in order to have the suggested number of focus group participants (Kreuger & Casey, 2015).

TABLE 1 Type of data collection and number of team members during the study period

Data collection groups	Initially (*n*)	6 mo (*n*)	12 mo (*n*)
1 Focus group a. *Mental health clinicians*	7	7	7
2 Focus group b. *Mental health clinicians*	5	6	5
3 Group interview *Employment specialists*	3	3	3
4 Individual interviews *Mental health clinicians*	6	6	6
Total interviews	**21**	**22**	**21**

2.2 | Procedure

In order to explore the evolving experiences of the team members, interviews were performed at three times—initially, 6 and 12 months. Two semi-structured interview guides were used to collect data—one for focus group and group interviews, and one for individual interviews. The focus groups and the group interviews focused on professional perceptions related to the IPS implementation process and covered three domains as follow: (a) the role and responsibility of mental health services in vocational rehabilitation, (b) new working methods and procedures involved working in accordance with the principles of IPS and (c) the experiences of working with IPS in the FEP team. Probing questions were used to facilitate discussions. Each interview session was guided by the third author (UB) while the first author (HH) observed and took field notes (Kreuger & Casey, 2015). The interviews lasted 45–60 min. Individual interviews focused on each mental health clinician's unique role in the team, vocational rehabilitation in relation to their own profession and in mental health care in general, and their contributions to IPS implementation. Interviews were performed by HH or UB and lasted 20–45 min. All interviews were digitally recorded and transcribed verbatim.

2.3 | Analysis

The interview transcripts were analyzed using a constant comparison, grounded theory approach as described by Corbin and Strauss (2015). Initially, all transcripts were read several times for an overall understanding. Next, an open coding process was conducted, and tentative concepts emerged. The analysis advanced through a more detailed line-by-line coding to verify the initial interpretation. Thereafter, similar concepts were grouped together and tentatively labelled with subcategories and categories. A constant comparison approach refers to the act of taking each timepoint into consideration and in relation to each other, both within each group and between groups. This enabled identification of common factors, and highlighted differences and changes over time. Constant comparison allows questions to be asked about what is being said or done, and why. This was a way to get a deeper understanding of team members' evolving and changing experiences, and to capture critical situations of strain and benefit over time. As the analyses progressed, the concepts were transformed into graphic illustrations and revised in an iterative process. Finally, concepts were defined in a main theme that described the implementation process as a whole.

In addition to the semi-structured interviews, the manual of the supported employment fidelity scale (Becker et al., 2015) was used to address the extent to which the service, organization and delivery of IPS were in accordance with the underlying IPS principles of the evidence-based practice. The scale ratings are based on present behaviour and activities, not planned or intended behaviour, and assesses 25 critical components, divided into three areas—staffing, organization and services. Items are rated on a 5-point Likert scale, ranging from 1 (no implementation) to 5 (full implementation). Possible total scores range from 25 to 125. Scores below 73 correspond to “not IPS,” 74–99 to

"fair IPS," 100–114 to "good IPS," and 115–125 to "exemplary IPS." Data were collected in accordance with the manual and gathered from the interviews of the present study, except for the service users and manager data that were collected face-to-face or by telephone. Employment records were consulted for accuracy of employment status.

3 | RESULTS

Results are presented as one main theme, three categories and sub-categories (see Figure 1). The main theme, Moving towards a common ground, highlights the team members' integration process and their adaptions to each other's views and ways of working. The changes evolved through working with users according to the person-centred principles of IPS, and also from new experiences and reactions based on the collaborative work between the mental health clinicians and the employment specialists.

3.1 | Dealing with ambivalence

The sub-category, *Shared information and confidentially*, stems from mental health clinicians' ambivalence about active participation of the employment specialists in weekly team meetings. On one hand, mental health clinicians had high expectations and positive views about IPS and team integration. On the other, they saw possible detriments in care and confidentiality. Each IPS user had agreed that their mental health information could be shared. Nevertheless, the mental health clinicians were uncertain about the degree to which their new team members should be involved because they did not belong to the same organization. The mental health clinicians felt that access to health information ought to be on a strict need-to-know basis, but lacked experience in what defines relevant information that could be shared for IPS planning and support.

> *"What does shared information mean? Which information are we supposed to provide to the employment specialists? And… what kind of information is appropriate to share with an employer?"* (Mental health clinician, 6 month)

This question was high on the agenda in the focus group discussions throughout. Initially, the employment specialists were frustrated by these discussions and felt excluded when there was ambivalence.

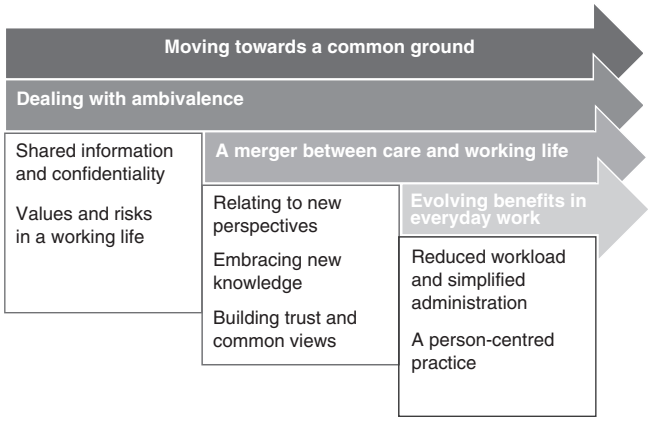

FIGURE 1 The implementation process as reflected by a main theme, categories and sub-categories

> *"It's a kind of a secrecy barrier. They are reporting their activities with the patients to us, but we are not allowed to discuss the patients' health conditions… it's more like a debriefing than sharing of information. The strategy we are using makes me feel that we haven't understood what this collaboration is about."* (Employment specialist, initial interview)

The employment specialists described mental health information as critical for successful career planning and to prevent failure. In some cases, the mental health clinicians' uncertainty about disclosing health information was an obstacle for a successful job match. These critical incidents gave the mental health clinicians new insight into how working life and mental health are related, and something that they had to balance in an ethical and reasonable way. The need for spontaneous recourse meetings, with the user and in smaller groups, was the most discussed improvement work in the team. These meetings were experienced as a positive and respectful collaborative strategy and were used to overcome secrecy and confidentiality concerns. Team work developed over time, but after 12 months, identification of potential improvements in how to collaborate remained.

> *"They have great knowledge of the individual's personal attributes and status, and that is the kind of information we need in our work. The sharing of information has gotten better over time… but sometimes I wish that the information could have come at earlier stage."* (Employment specialist, 12 month)

Ambivalence regarding *Values and risks in a working life* relates to the mental health clinicians' caring and concern about their users. The mental health clinicians generally valued the IPS approach as an attractive intervention, because of its rapid job search and goal of employment. Despite this, some statements at 6 months indicated a concern about ethical issues related to the risk of possible failure at work, and that it could cause an additional strain on the users. For example, they said that some users could be disappointed if they found an internship instead of competitive employment, and that jobs with low status sometimes did not match their higher education level. Other statements concerned stigma and negative societal attitudes. The mental health clinicians feared the risks of being bullied at work and of employers taking advantage of the welfare system since the Swedish welfare system supports internships and wage subsidies for persons with disabilities.

At the same time, the mental health clinicians appreciated IPS as a valuable opportunity that provided strong benefits for user recovery. One psychiatrist said, *"When I talk to patients in the corridor, IPS is the intervention they say good things about, even if they do not yet have a job"*. The mental health clinicians saw benefits and described that failures might be positive learning experiences for users if they were supported in finding ways to regain control of as many aspects of the situation as possible, and so avoid feelings of failure or hopelessness.

Over time, experiences of the intervention and the employment specialists' collaboration with users boosted mental health clinicians' confidence and trust in IPS. The mental health clinicians described employment specialists as very loyal to the users and genuinely engaged in their recovery process.

> *"They take responsibility seriously and accomplish so much. I think that we can sit back and relax […] because persons who really wanted a job, they finally have got the support. You feel that they are in good hands."* (Mental health clinician, 12 month)

3.2 | A merger between care and working life

Relating to new perspectives stems from the team members' new orientation to IPS interventions, and how care and vocational support over time were perceived as complementing each other. As one mental health clinician said at the end of the project, *"It feels like they have knowledge about things that we do not have… they run their work, but in good cooperation with us."*

After 6 months, several team members stated that the collaboration had visualized their different perspectives of clinical recovery and personal recovery, and that sometimes these clashed. Some mental health clinicians thought that the employment specialists had too little clinical knowledge and because of that sometimes acted naively when they matched jobs with the user. The employment specialists thought that some of the mental health clinicians had too little knowledge about the power of focusing on a person's resources and supporting the user's personal employment goals. Apart from these difficulties, the team voiced the great advantages of integrating clinical and personal recovery goals. The mental health clinicians stated that because of integration of services, they had an increased focus on conversations about working life with their users, that IPS promoted their recovery, and so it was an important complement to their care and the medical perspective. One psychiatrist said, *"The difference is that we are now more actively involved. Instead of just saying it, we can actually bang our fist on the table, this is it! Work is important!"*

The employment specialists articulated that the mental health clinicians had knowledge critical to supporting their users' progress towards a working life. As time went by, perspectives on providing support and recovery were integrated and exceeded the differences that inevitably existed in team and user meetings.

> *"Overall, I think that they are very positive that our perspective differs from theirs, and that we in many ways, maybe have a 'higher ambition', if I can put it that way (the goal is to gain competitive employment, not to care for [the user])."* (Employment specialist, 12 month)

Embracing new knowledge is a sub-category that denotes the learning process among the team members. Knowledge about each other's competence, working strategies, vocational support in general, recovery and patients' mental health needs increased over time and fostered the growth and sustainment of IPS. One insight, expressed by the mental health clinicians, was that psychiatry needs to be an active part of the vocational process, and this was not as clear initially.

> *"It has become even more clear how important it is, the thing about work…. Mental health care needs to be a part of this, to makes it sustainable in the long run."* (Mental health clinician, 12 month)

The mental health clinicians' knowledge about users' rights and needs, welfare authority rules, and community resources increased. They felt more confident in their role when negotiating with other agencies about user vocational needs. The mental health clinicians explained that they had learned more about user capacities. Sometimes the mental health clinicians were surprised at how rapidly some users started to work, and how well they had succeeded in their new jobs.

Building trust and common views are related to the FEP-team's increased respect and trust for each other's knowledge, roles and positions. The weekly meetings were considered an important factor in team building. After 12 months, internal collaboration and integration were improved, and it became easier to contact team members and create dialogues about matters important to their daily work. The initial skepticism had developed into increased confidence in each other's competence and assignments and created new ways of working together.

> *"For me, it is obvious that the employment specialists are doing a great job to support the patients [transition] into a working life as quickly and genuinely as possible. I think about that a lot: this is good, things are going into the right direction, they are doing the best they can. I am not worried anymore."* (Mental health clinician, 6 month)
>
> *"Indeed, I have had many prejudices! But now it's just go ahead, they are so positive."* (Employment specialist, 12 month)

Despite a general perception that knowledge about IPS had increased, some mental health clinicians said that after 12 months they still needed continuous supervision in order to gain a deeper understanding of the model. They still felt unsure about their role in IPS support and which cooperation strategies to use.

> *"How far should we be involved, where is our outer limit, and what can be shared in common? What shall our support consist of and how much time shall we spend on individual patients?"* (Mental health clinician, 12 month)

Since no explicit directives for sustainability of the IPS initiative were provided by management, they feared that progress achieved during the implementation was at risk of ending due to high workloads, daily routines and several other unit projects that required attention.

3.3 | Evolving benefits in everyday work

Reduced work load and simplified administration illustrate the advantages experienced with IPS compared to traditional vocational support (pre-assessment and training). The mental health clinicians described how their work load decreased when administration of vocational support was simplified. At enrollment, each user interested in working had access to IPS, regardless of job readiness. Thus, IPS was seen as a non-bureaucratic process that did not require written expert opinions and assessments of work capacity—things that were usually considered difficult, time-consuming and not beneficial to users who wanted to work.

A person-centred practice was the new way of working when giving support and care towards a working life. The mental health clinicians considered the IPS model appropriate for providing person-centred and tailored support. Above all, they appreciated the small-scale and intimate set-up, which made it possible for users and employment specialists to build relationships. This was considered innovative and different than the traditional support with a vast array of professionals involved. This new way of working was something they believed their users needed and which was not found in previous team work that involved less time with the user and limited vocational support.

3.4 | In summary

The evolving experiences of IPS convinced the mental health clinicians that vocational support towards regular employment is important for users' clinical and personal recovery. Mental health service should be an active part of IPS for persons with FEP. The critical next step is how to ensure sustainability of the model within their regular services. This had not been solved when the project ended.

> *"How can we maintain the culture around this? Because, that is the risk of projects, that yeah, that's all for now, now let's go back to our routines."* (Mental health clinician, 12 month)

Overall, the IPS-supported employment fidelity scale (SEFS) (Becker et al., 2015) assessment helped to evaluate to what level the program was implemented according to the evidence-based practice of IPS. The FEP-unit and the employment service were initially assessed separately. The mental health clinicians were judged as not working according to IPS (42 points), while the employment specialists had fair IPS fidelity (91 points). However, the joint team reached good fidelity (102 points) at 6, and at 12 months (108 points). With regard to the critical principle of integration of IPS with the mental health service, two SEFS items belonging to the organization domain of the scale, (a) *Integration of rehabilitation with mental health treatment through team assignment* and, (b) *Integration of rehabilitation with mental health treatment through frequent team member contact*, helped to explore the integration process of our study aim. At the beginning, the team, as a whole, failed to integrate mental health services into their support and was not developing opportunities for competitive employment and time-unlimited support. However, these item scores increased by 1, 3 and 4 at 0, 6 and 12 months, respectively, reflecting that the team managed to become a

joint service during the study period. Accordingly, the fidelity findings corroborate with the interview results on the implementation process presented above.

4 | DISCUSSION

In the following section, the results are discussed in relation to the main theme and the categories. Relevant theoretical concepts from implementation research are used in order to enrichen the discussion and deepen the understanding of pressures and benefits when implementing IPS in an FEP team. Initially, the mental health clinicians had to deal with ambivalence about whether to share information, and if the new way of working was a risk or benefit for users. During implementation, the team gradually learned new perspectives on mental health and work, built trust, and shared common views. They learned from critical situations, and insight increased about benefits of mixing clinical and personal recovery perspectives. For the mental health clinicians, this confirmed the importance of integrating mental health services and IPS for people with FEP. Since some mental health clinicians had a lack of clarity concerning work strategies and roles after 12 months, the organization should offer long-term active and adequate support to promote a sustainable IPS implementation. This was also found in previous research (Bergmark et al., 2018a).

Team integration includes working across organizational boundaries (Huxham & Vangen, 2005). Integration of mental health services and social services is reportedly difficult in several worldwide contexts (Bergmark et al., 2018a; Kuluski, Ho, Hans, & Nelson, 2017; Markström & Lindqvist, 2015). The results of this study suggest that the mental health clinicians were ambivalent towards implementation, because they considered IPS an attractive model for vocational support but also experienced uncertainty about unfamiliar collaboration strategies and information sharing. Jensen, Johansson, and Löfström (2006) have contrasted different ways in which uncertainty related to relationships in collaborations might hamper organizations in accomplishing their tasks. Such "interactional uncertainty" can arise in horizontal (staff at the same hierarchical level) and vertical (actors at different hierarchical levels) relationships. The FEP team members experienced horizontal uncertainty, caused by building a new team consisting of members with disparate professions, and unclear roles within the team. Vertical uncertainty was related to tension between the confidentiality laws, their professional roles and a desire to implement the IPS principle of integrated mental health services. Furthermore, uncertainty was expressed in goal conflicts between the team members' home organizations (clinical recovery focus vs. personal recovery focus).

Trust within an organization is a basic element of a culture that supports change (Schmid, 2010). The user–staff relationship was described as important, but the mental health clinicians felt uncertain about how their knowledge of users' mental health was received and used further by the employment specialists. Initially, this hampered their willingness to share information in team meetings. Since information sharing is critical for integration (Cameron, Lart, Bostock, & Coomber, 2014), this was a barrier to effective IPS implementation. Arranging meetings that included a mental health clinician, an employment specialist and the user was a functional strategy to gradually overcome this barrier. Trust within the team increased as the members experienced the benefits of new ways to work, but there was also a wish that this would have happened earlier in the implementation. Cameron et al. (2014) suggest promotion of team integration by education or the development of national information-sharing protocols. The mental health clinicians had a full-day pre-service training in IPS, but similar to other IPS studies, they expressed a need for more knowledge about the model and networking strategies (Bergmark et al., 2018a).

Practitioners tend to value the same piece of evidence in different ways (Kitson, Harvey, & McCormack, 1998; Rycroft-Malone et al., 2002, 2013). IPS challenged the mental health clinicians established knowledge, values and cultures, and the team members had difficulty in understanding each other's perspectives and knowledge (clinical recovery vs. personal recovery). The employment specialists emphasized the benefits of IPS, while the mental health clinicians were ambivalent to the model since they saw both benefits and risks for users. Such disparate views are a risk in collaborations. For this reason, Rycroft-Malone and Bucknall (2010) suggest that a process of appraisal and consensus should be performed to increase the likelihood of implementation. Collaboration is described as an arena

where various institutional affiliations and institutionalized rules are negotiated (Phillips, Lawrence, & Hardy, 2000). As the team carried on the implementation, motivation to deepen collaboration gradually increased. Team members described a learning process, where they improved step by step, and became more confident in new ways of working. Although the team members still saw room for improvement after 12 months, they considered many of the critical components of IPS and their collaboration as being in place, confirmed by the fidelity assessments.

Despite the improvements gained during the initial 12 months, the staff expressed doubts concerning the long-term sustainability. Since many publicly funded initiatives start as project organizations with necessary resources guaranteed for a limited period of time, sustainable implementation is dependent on the elementary components, financing and time (Aarons et al., 2016; Beidas et al., 2016; Bonfils et al., 2017; Stewart et al., 2016). From a worthwhile perspective, it is difficult to promote an organizational change if most barriers are present from the start (e.g., collaboration problems and unclear roles). However, if the organization promotes facilitating barriers, such as in the present study, benefits may be gained later (e.g., reduced workload, simplified administration and a person-centred practice) (Bergmark et al., 2018a). The perseverance needed to see things through is described as key for successful implementation (Aarons et al., 2014).

Coordinated collaboration across stakeholder groups is important for successful implementation (Beidas et al., 2016), and leadership strategies have the potential to influence staff trust and confidence during organizational change (Tyler & De Cremer, 2005). In this study, some team members described unclear roles and lack of management support as barriers. They struggled to develop own strategies for collaboration and team integration. Several implementation studies suggest leadership should play a key role in promoting effective teamwork and facilitating effective and sustainable implementation (e.g., Bonfils et al., 2017; Markström et al., 2018; Rycroft-Malone et al., 2013; Stetler, Damschroder, Helfrich, & Hagedorn, 2011). In reality, managers do not have enough time or resources to take an active part. Rycroft-Malone and Bucknall (2010) propose the role of implementation facilitator who can play a key role in shaping the context and helping practitioners "make sense of" and apply evidence.

4.1 | Methodological considerations

Serial interview design allows for an exploration of process and possible change by looking forward and backward in time (Saldaña, 2003). The intention was to explore and understand process and dynamics of how integration of two distinct welfare services and critical situations are perceived over time. More results developed from the 6- and 12-month timepoints than the initial interviews. This may be because process and change were in focus later, but unclear at the outset. As described by Calman et al. (2013), it is common for initial data to be less relevant. Our analysis focused on integration of IPS into an FEP unit, and evaluated differences, similarities, tensions, benefits and progress between the mental health clinicians and the employment specialists rather than on differences between professions or disciplines. The use of individual interviews with mental health clinician members helped to validate focus group findings. None of our results could be ascribed to belonging to certain disciplines. Furthermore, the IPS fidelity assessments, the assessment of items that regarded the organization's capacity to integrate mental health- and vocational services, helped to corroborate interview findings.

5 | CONCLUSIONS

Implementation research has highlighted many barriers to effective implementation of evidence-based models and organizational change. Implementation involves several activities that are perceived to be difficult. In addition, organizations with different norms and cultures add further barriers to collaboration and integration. Implementation is sensitive to local dynamics. When an integration process is studied, separating organizational cultures from the norms and values each of the participating team members is difficult. Some individuals may exaggerate cultural

differences, and others might neglect them. Individual expectations and anxieties about cultural clashes and organizational change can either be drivers or restraints to change. Consistent with implementation theories, this study indicates that negotiated goals for integration, knowledge transfer early in the implementation process, and support from management are critical for successful implementation. Furthermore, social processes among staff should be considered in order to provide the team with the support necessary to create conditions that promote trusting relationships within the team. For example, anticipated gains of integration should be clearly described and discussed, because actual gains might become visible only after a period of ambivalence related to new ways of working and collaboration.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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