Abstract
Purpose – The aim of this paper is to identify initial barriers influencing implementation of supported employment (SE). SE, according to the individual placement and support (IPS) approach, has been recognised as an evidence-based method to help people with severe mental illness to find regular employment. Design/methodology/approach – A systematic implementation evaluation of the first randomized controlled SE (IPS) trial in Sweden was conducted in August 2008 and August 2009. Data were collected on a regular basis from SE employment specialists, process heads, clients and representatives from mental health care units and vocational services (social insurance and public employment offices) using interviews, non-participant observations and document analysis. Findings – SE employment specialists reported that existing regulations for social insurance and employment regulations presented major obstacles to implementation. Difficulties were reported in cooperation with handling officers at the vocational services. Scepticism towards persons with mental illness was common and employers expected to receive subsidies if they hired a person with mental illness. SE participants expressed fear of losing their social benefits. Originality/value – The results illuminate a collision between an innovative evidence-based practice and the existing systems for social benefits and work rehabilitation.

Keywords: Evidence, Implementation, Mental health care, Supported employment, Individual placement and support, Evidence-based practice, Sweden
Introduction
Health care organisations worldwide are expected to use evidence-based practices (EBP) when treating patients (Fixsen et al., 2005). However, the implementation of EBPs has been shown to be complex, and many of the methods are not routinely available (Bond et al., 2001). Thus, many people, such as those with severe mental illness (SMI), are not receiving evidence-based care (Bond et al., 2001). Supported employment (SE), according to the Individual Placement and Support (IPS) has been widely recognised as the most effective approach to increasing work opportunities for people with SMI (Bond, 2004; Bond et al., 2008; Burns et al., 2007; Crowther et al., 2001; Twamley et al., 2003; Cook et al., 2005; Campbell et al., 2009). SE has been tested in the USA (Salyers et al., 2004; Becker et al., 2007), Canada (Latimer et al., 2006), Hong Kong (Wong, 2008) and in some European countries such as the UK, Germany, Italy, Switzerland, Bulgaria (Burns et al., 2007) and The Netherlands (Van Erp et al., 2007). Earlier the spread of evidence was seen as a linear and technical process at the individual level. However, major difficulties may arise when introducing such guidelines into daily health-care practice (Grol and Grimshaw, 2003; Godin et al., 2008). The implementation of an innovative method does not occur in a vacuum; instead, existing contextual factors might influence the acceptance of new knowledge (Fixsen et al., 2005; Greenhalgh et al., 2004; Hill and Hupe, 2002; McCormack et al., 2002). It has been reported that implementation of SE programs in different social contexts has led to adaptations of the original SE components, which has in turn had a negative impact on the fidelity of the program and the quality of the services (Corbie’re et al., 2009). However, no prior studies have investigated SE implementation in Sweden. Thus, factors affecting implementation in the Swedish mental health care and welfare context are unexplored.

The Swedish work rehabilitation model and SE
SE/IPS represents an innovative service approach, with rapid job searching (Place-Then-Train) compared to the traditional stepwise work rehabilitation model (Train-Then-Place). Currently, the Swedish work rehabilitation model represents the Train-Then-Place model. In such a model, professionals typically work according to a caring and illness perspective (Boardman et al., 2003), while professionals in IPS instead work according to a rehabilitation approach, and how to accommodate disability (Corrigan and McCracken, 2005). The essence of IPS is a direct, individualized search for competitive employment, which in general does not involve prolonged pre-employment preparation, counselling, and training (Rinaldi and Perkins, 2007). IPS follows seven principles:

1. focus on competitive employment outcomes;
2. availability to anyone who wants to work;
3. rapid job search;
4. attention to client preferences in services and job searches;
5. individualized and long-term support;
(6) close cooperation between employment specialists and psychiatric treatment team; and
(7) personalised counselling for clients on social security and other benefits.

Implementation of evidence-based practice
The Swedish welfare model has traditionally been described as uniform, where high-quality services are provided by the state to all citizens, regardless of income, social background or cultural orientation (Blomqvist, 2004). Unemployment and sickness benefits have traditionally been generous (Carling et al., 1996). However, the Swedish vocational rehabilitation for mentally ill people has been reported in a national government investigation as not functioning optimally (Ministry of Health and Social Affairs, 2006, p. 100). The reasons for this were weak and fragmented services, poor coordination between different service givers, too much “caring perspective” instead of rehabilitation and working focus, and lack of EBP methods. In addition, social insurance policies tended to lock people with mental disabilities into social benefit dependency (Ministry of Health and Social Affairs, 2006, 100).

Potential implementation barriers
When introducing a new work practice such as the EBP there are potential obstacles to successful implementation (Bond et al., 2001). According to Tansella and Thornicroft’s (2009) recent model of implementation of EBP, the potential facilitators and barriers exist at individual, local and national levels. They proposed that financial incentives, guideline flexibility, and effective monitoring and feedback systems were potential barriers or facilitators at the national level in the early implementation stage of EBP. At the local level, early implementation barriers included availability of resources, leadership, champions, work culture, consistency of local policy and practice guidance and training. Individual level factors were practitioners’ preferences and knowledge regarding the particular EBP. Prior studies of SE have identified implementation barriers at all three levels included in the model presented by Tansella and Thornicroft (2009). Priorities and recommendations at national and state government levels as well as mental health department levels, for example regarding funding, have been reported to influence SE implementation (Barton, 1999). In The Netherlands the traditional “caring values” instead of “rehabilitation values” towards persons with mental illness interfered with the IPS principles (Van Erp et al., 2007) and thus hindered the implementation process. Due to national unemployment protection systems, potential employers in The Netherlands experienced a risk when hiring an individual with a disability (Van Erp et al., 2007). The protection system made it difficult for employers to fire an employee (Van Erp et al., 2007). The unemployment protection systems also had implications for individual level factors. For instance, clients reported a fear of losing their social benefits if they started to work (Van Erp et al., 2007). Barriers to SE implementation at more local and individual levels included mainly inadequate cooperation between employment specialists and mental health organizations (Van Erp et al., 2007; Corbie`re et al., 2009; Bond et al., 2001). Factors
reported to hinder cooperation include geographical distances (Corbie're et al., 2009), mental health care practitioners’ limited knowledge of SE (Gill et al., 1997; Shafer et al., 1999) negative attitudes towards employment among people with mental illness (Van Erp et al., 2007; Crane-Ross et al., 2000), scepticism about employment specialists not having psychiatric knowledge (Handler et al., 2003), general resistance to change (Bond et al., 2001; Rapp et al., 2009) and limited time to engage in SE (Bond et al., 2001). On the other hand, SE employment specialists were also reported to resist collaboration with mental health teams due to fear of a focus that was too medical, as compared to vocational, on the patients’ problems (Drake et al., 2003) and due to feelings of intimidation from clinicians (Handler et al., 2003). Figure 1 presents a conceptual model for the present study and summarizes barriers identified at each level in the Tansella and Thornicroft (2009) model and in prior SE studies.

The aim of this study was to describe initial implementation barriers of SE (IPS) in a Swedish context (see Figure 1). This is done to determine the feasibility of SE in the Swedish context and to identify possible obstacles that may need to be overcome when using SE in Sweden or other countries with similar social benefit systems or vocational training models.

**Methods**
The study was conducted in Malmö, which is a city in Southern Sweden with 291,574 inhabitants. Malmö’s mental health care consists of units that specialize in psychosis, general psychiatry, alcohol and drugs, children and adolescence, and forensic care. Most of them have both outpatient centres and emergency and inpatient care.

**Description of the SE implementation process**
The SE project was developed and implemented by researchers at the Va˚rdal Institute, the Swedish Institute of Health Sciences at Lund University. The researchers organized all practical issues related to the study such as recruitment of staff and study participants, facilitation of the project implementation and outcome evaluation of the study. It should be noted that this project was not a natural implementation of SE but an implementation of SE within a randomised controlled trial.

Three employment specialists were recruited from the Malmö’s mental health care and from the Malmö municipality. They met the qualities suggested in previous SE research (Rinaldi et al., 2008) such as experience of vocational rehabilitation and ability to co-ordinate interactions with clients, mental health staff and employers. The employment specialists were trained by an experienced IPS specialist, who also supervised them every second week by means of telephone conferences. The employment specialists also received continuous support from the project head. Twice a year the researchers arranged workshops for all actors involved in the project, i.e. representatives from the mental health care staff, the social insurance and employment offices and the municipality of Malmö to facilitate the implementation. In between
workshops the researchers visited the mental health care team regularly and were in contact with the social insurance and employment offices.

The study participants were recruited from five mental health care centres. The target group was people with SMI, which mostly meant having a diagnosis of psychosis. The inclusion criteria were: interest in working in the near future, access to a case manager or professional in the mental health team, and ability to communicate in Swedish. Exclusion criteria were organic or physical disabilities in addition to SMI. A total of 120 participants were recruited and randomly divided between the intervention and control group. In the control group the participants received treatment as usual according to the stepwise rehabilitation, the Train-Then-Place model.

**Content of the SE program**

According to IPS, the employment specialist is the head of the intervention and works closely with the mental health care team (Rinaldi et al., 2008). Thus the participants also had access to psychiatrists, psychologists, nurses, social workers, occupational therapists and other care providers. The job-seeking process starts with identifying participants' skills, abilities, strengths and vocational goals. The employment specialist assists the participants in actively selecting a job compatible with their interests and lifestyle conditions. In order to maintain the motivation to work, the job-finding should begin as soon as possible after the initial assessment. The job-finding involves individualizing the finding according to the strengths, preferences and experiences of the participant, networking to identify job leads and involving the mental health team and family to maintain support. A meeting with the identified employer is often organized to discuss areas such as skills and experiences required by the employer,
terms and conditions for employment. Finally, IPS requires ongoing support from the employment specialist to participants who are working. (Rinaldi and Perkins, 2007).

Data collection and analysis
Data was collected in August 2008 and August 2009, the first out of two years of the RCT. Table I summarises the number and nature of the data sources. Data collection methods included key informant interviews, non-participant observations and document analysis. Interviews were conducted with SE employment specialists, process head and project head, heads of mental health teams and a selection of clients, mental health care staff and handling officers at social insurance and public employment offices. The semi-structured interviews lasted between 45 and 75 minutes. The interviews were recorded and were later transcribed. The interviews with clients, mental health care staff and social insurance and public employment officials were conducted for SE implementation fidelity measurement. This measurement was conducted with the Supported Employment Fidelity Scale (Becker et al., 2008), which measures how well the seven IPS principles are implemented.

<table>
<thead>
<tr>
<th>Nature of data source</th>
<th>Number of individuals/meetings/documents included</th>
<th>Number of times conducted</th>
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<tr>
<td>Interviews with:</td>
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<td>SE employment specialists</td>
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<td>2</td>
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<td>Process head</td>
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<td>Project head</td>
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<td>Heads of the local social insurance office</td>
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<tr>
<td>Head of the local public employment office</td>
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<td>Mental health care staff</td>
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<td>Handling officers at the local social insurance office</td>
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<td>Handling officers at the local public employment office</td>
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<td>Clients</td>
<td>15</td>
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Non-participant observations of meetings among:
Collaboration meetings for SE project team and vocational services | 2
Process head and employment specialist | 1

Document analysis:
Minutes of meetings
- Collaboration meetings for SE project team and vocational services | 4
- Process head and employment specialist | 7
- Research meetings | 2
- Project newsletters for collaborators | 10
- Project reports for external financier | 2
- Project head’s notes and e-mail correspondence | 1
- Process head’s work diary | 1

Notes: a Interviews conducted for SE implementation fidelity measurement. b Documents for the period August 2008-August 2009 were analysed. c For the period April 2009-August 2009.
Non-participant observations were made of a selection of meetings in which SE employment specialists and process heads participated. These meetings were also recorded and transcribed. They included:

- process heads and employment specialist monthly meetings; and
- regular meetings for process head, project head and heads of social insurance and public employment offices aiming to improve cooperation.

When no observations of these meetings were made, we analysed the minutes of meetings. Other documents gathered included the process head’s work diary, project newsletters for collaborators, project reports for external funders, project head’s notes and e-mail correspondence. Content analysis of the data material was conducted to identify barriers to SE implementation. As proposed by Weber (1990) a coding scheme was created and tested prior to the analyses. The coding scheme comprised categories representing the Frequency of data source barriers identified in the prior SE studies. An option, “Other barriers”, was also included in the coding scheme. In this category, barriers that had not been identified in the prior studies could be reported. Two researchers (the first and second authors) coded the data independently. A comparison was made between the two codings and a high degree of agreement was found between them. The SE project was approved by the regional ethical review board in Lund (No. 202/2008). All SE participants were assured that their responses would remain confidential and anonymous.

Results
The most frequently mentioned barriers concerned the “Other barriers” category. In this category, barriers that have not been identified in any of the prior studies were coded. The other identified barriers consisted of two sub-categories: 1) difficulties in conducting SE according to the IPS model due to the national social insurance and employment regulations; and 2) difficulties in cooperating with social insurance and public employment offices.

**Difficulties in conducting SE/IPS model due to work rehabilitation regulations**
From the employment specialists’ and the process head’s perspective it was difficult to conduct SE, which includes rapid job searching (Place-Then-Train), as the regulations for work rehabilitation supported the traditional stepwise work rehabilitation model (Train-Then-Place). For instance, there were major difficulties in obtaining insurance for participants starting a practical or vocational training. According to the social insurance office, the SE project was not allowed to insure their clients. The social insurance and public employment offices could only offer workplace insurance if the participants were registered in the traditional stepwise work rehabilitation system. In order to be included in this system an assessment of participants’ capacities for work had to be conducted.
However, such an assessment would not have been in accordance with IPS principles, as the participant’s own desire to work should be in focus instead of experts’ work assessments. Handling officers at the social insurance and public employment offices experienced that they needed to follow the rules and regulations for their work and were not able to do any special procedures for the participants participating in the study.

Cooperation difficulties between the SE employment specialist and handling officers at vocational services

Cooperation with handling officers at vocational service was experienced as problematic by the employment specialists and the process heads. They reported that handling officers at social insurance and public employment offices did not focus on clients’ wishes, made decisions without taking clients’ or employment specialists’ views into consideration, were only interested in following their regulations, were not open for new approaches and did not have enough knowledge of SE. The handling officers and heads at the social insurance and public employment offices also experienced cooperation problems. Some of them thought that SE employment specialists had too little knowledge of work rehabilitation regulations and that they ignored the regulations. Public employment handling officers also expressed frustration because their competence was not taken seriously by the employment specialist, and the specialist did not listen to their wishes and suggestions. They also expressed scepticism about the IPS model, especially about the rapid job searching with the IPS model. They expressed anxiety for clients’ wellbeing, since they thought that the too-fast job searching could be harmful for the clients in the long term.

Regulations at national government level

All of the involved actors, including mental health practitioners, employment specialists, process heads and handling officers at vocational services, expressed anxiety regarding new government regulations on rehabilitation of people with illnesses. These regulations would start to apply on 1 January 2010 and would bring, among other things, radical changes in the system of sickness benefits and a faster rehabilitation chain for people who previously had sickness benefits. Handling officers at vocational services said that there was very little information available concerning the new regulations and that they did not know what consequences the regulations would have for the clients. Many of them expressed concerns for how well SE would manage to find employment for the clients in accordance with the new regulations. They felt that they had the final responsibility for the clients and if SE did not succeed in finding employment, there would be no time for vocational services to help clients due to the faster process. For instance, a representative of the social insurance office reported that they would not have got involved with the SE project if they had been aware of the new regulations at that time point. They considered these regulations to be radically changing their way of working, making it even more difficult to cooperate with SE.
*Culture of free labour*

SE employment specialists experienced that potential employers were expecting to receive some type of subsidy if they were to hire their clients. Employers were well aware of the different type of vocational training programs and other type of subsidies available. Since many of the participants lacked work experience and education, the employment specialist felt that it was not easy to argue that these individuals would be hired for a competitive employment instead of a training place. They also reported that handling officers at the public employment offices often recommended a vocational training instead of employment. Handling officers expressed that it would be too risky to ask an employer to hire a client with mental illnesses and no prior work experience with full salary. If clients could not manage to work it could jeopardize relations with employers.

*Scepticism about mentally ill individuals working*

Scepticism among participants, their families, mental health care practitioners and handling officers at vocational services about mentally ill individuals working was a barrier to implementing SE, as experienced by the employment specialists. For instance, some handling officers at the vocational services had directly said to client who wanted to work that she/he could not work because she/he had psychosis. Even mental health care practitioners who appreciated the SE program could express anxiety for increased ill health if clients were to start working. This naturally caused more fear for the participants.

*Risk of losing benefits*

Some participants were also afraid of losing their benefits, such as sickness benefits. The mental health care practitioners and the employment specialists also experienced implementation of evidence-based practice this fear since they felt a strong responsibility for the participants’ economic situation. They could have a desire to work in a competitive market, but at the same time they felt unsure about their ability to work. After considering the risks for losing their benefits, they chose to try vocational training instead.

**Barriers regarding employment specialists’ cooperation with mental health organisations**

In general, mental health practitioners seemed to perceive the cooperation as positive. Employment specialists also reported positive overall cooperation, but some of them also reported difficulties in cooperating with some of the mental health teams. At times, they felt that mental health practitioners’ scepticism towards a new profession (employment specialists) and their general resistance to change were working as barriers to establishing a good collaboration. Employment specialists also felt that mental health practitioners’ feared for the participants’ health if starting work was hindering them from working in accordance to IPS model. For example, at one occasion
some mental health team members wanted to set up limits of how the employment specialist should support the participants when they worked. They considered that one client had had a relapse as a result of starting work and wanted to protect the client from too heavy stress.

**Discussion**

Our findings showed that from the perspective of the employment specialist it was difficult to conduct SE according to the original model as the regulations for social benefits and work rehabilitation supported the traditional stepwise work rehabilitation model. Thus, there were some clear initial collisions between the innovative evidence-based model and the existing national systems and regulations for mental health care, the social security system and work rehabilitation. It is possible that the collisions concerned the different work rehabilitation approaches that the stepwise model and the evidence based model represented. In the stepwise model the professionals typically work according to a caring perspective (Boardman et al., 2003). In fact, the Swedish work rehabilitation model has been criticised as having too much caring focus instead of rehabilitation (Ministry of Health and Social Affairs, 2006, p. 100). The professionals’ value according to a care or rehabilitation approach probably impacted on collaboration on different levels. At individual client level, the professionals’ power relationship with them could have differed between the models. The employment specialist could be interpreted as having an empowerment and individual approach while the professionals working according to the stepwise work rehabilitation approach were perhaps guided by diagnosis and rules and regulations that supported that approach. The different underlining assumptions of the models perhaps also were reasons for the identified difficulties in cooperation that both employment specialists and different handling officers at vocational services reported. Too little knowledge of each others’ work was frequently reported. Employment specialists experienced that handling officers did not take clients’ perspectives and wishes into consideration. Handling officers expressed scepticism towards the IPS model of rapid job searching. It has been suggested that resistance to new methods might be stronger if the method is not compatible with the current professional values and working methods (Rogers, 2003; Greenhalgh et al., 2004), which perhaps was the case with SE and the stepwise work rehabilitation model. It is possible that the problems with collaboration were due to the fact that the work rehabilitation models differed greatly from each other. Still, what hinders or collisions that appear in the intersection of the Train-Then-Place and Place-Then-Train approaches need to be researched further. Similar findings have been reported from The Netherlands (Van Erp et al., 2007). The study concluded that changes in employment and disability laws might be required in order to be able to successfully implement SE in The Netherlands. The findings of the present study suggested that perhaps changes are needed in the Swedish regulations regarding social security and employment protection if implementation of high-fidelity SE programs is a goal. The other option could be that SE will be adapted from the original model and a risk of losing the core components would exist (Corbie’re et al., 2009). In that case,
there would be a risk of not obtaining the greatest impact on clients’ vocational outcomes (Becker et al., 2001). This is a timely issue, since implementation of SE in Sweden on a broader level is likely to happen in the years to come. The Swedish vocational rehabilitation for mentally ill people has been criticized for not using evidence-based methods (Ministry of Health and Social Affairs, 2006, p. 100) and The National Board of Health and Welfare is currently involved in suggesting national guidelines that involves SE implementation (The National Board of Health and Welfare, 2010). However, before implementing SE in Sweden on a broader level it is crucial to perform further research on how the Swedish welfare system impact on IPS-fidelity. We also found that a general scepticism among mental health practitioners, handling officers, employers, the participants themselves and their families towards mentally ill individuals working hindered the SE implementation. A prior study corroborated these findings (Van Erp et al., 2007) and yet another study reported that mental health care practitioners underestimated clients’ abilities to work (Boardman et al., 2003; Corrigan et al., 2009). The participants entered this project since they desired to work, and the SE program also actively addressed issues regarding self-stigmatization. However, it is possible that participants had internalised negative attitudes towards themselves working, since all other actors, except employment specialties, doubted their abilities to work. The findings also showed that there was a culture of hiring persons with mental illness for free or reduced salary among potential employers and even among handling officers at the public employment office. One of the principles in IPS regards finding a regular job, but this culture made it difficult to obtain that type of work for the clients. These findings have not been reported in the prior SE studies and may be related to cultural issue in the Swedish labour market. Different types of vocational training subsidies for employers have been often used instead of employment. Handling officers expressed that it would be too risky to ask an employer to hire a person with mental illness. It has been previously reported that a lack of knowledge about persons with mental illness working can foster a belief that these individuals cannot work. The risk of hiring a person can be overestimated (Boardman et al., 2003). Perhaps this picture would be mitigated if more people with mental illness had jobs, and if this observation were accompanied by working life research. Many of the barriers to SE implementation reported in the prior studies have involved inadequate cooperation between employment specialists and mental health Implementation of evidence-based practice practitioners (Van Erp et al., 2007; Corbie’re et al., 2009; Bond et al., 2001). This was not a main barrier in our study. Instead, mental health care practitioners seemed to perceive the cooperation as positive. Employment specialists were also positive over all, although they also reported difficulties in cooperating with one mental health care team. An extensive information dissemination regarding SE to mental health practitioners was performed prior to starting this project. The progress of the SE was also continuously reported to mental health teams. In addition, the employment specialists were located at the offices of some of the mental health teams. It is possible that these factors contributed to good collaboration between the employment specialists and the mental health practitioners.
Some participants were afraid of losing their benefits when participating in SE, which is in line with prior SE studies (Van Erp et al., 2007; Bond et al., 2001). In several European countries the degree of disincentives within their benefit system predicted employment success among study participants (Burns et al., 2007). A national Swedish investigation also concluded that social insurance policies tended to lock people with mental illnesses into a social benefits dependency (Ministry of Health and Social Affairs, 2006, p. 100). During the study period the Swedish government announced new rules for sickness benefits and a rehabilitation chain for individuals with sickness benefits (Government Bill 2009/10:45, 2009). All actors involved in this study reported anxiety regarding the new rules. However, it is difficult to determine how these rules influenced SE implementation. The rules might also have an impact on SE implementation in Sweden in the long run, but it is too early to say what that impact could be. The aim of the new benefit regulations was to increase the work rehabilitation speed for people with mental illnesses (Government Bill 2009/10:45, 2009), which is in line with SE principle of rapid job search with minimum pre-vocational training. However, further studies will be needed to investigate how SE fits these new regulations.

Methodological discussion
The main strength of the analyses was the use of multiple sources of evidence, i.e. interviews with different stakeholder groups, observations and analyses of documentations. This allowed a data triangulation, which has been proposed to increase the validity of the study (Yin, 2003). As a consequence different perspectives on the SE implementation were highlighted. It is also important to mention that the first author of the paper, being also involved in the Va˚rdal Institute, was not involved in the development or implementation of the SE trial. Thus, the present evaluation was made with an “outside” perspective of the project, which could have increased the quality of the evaluation. One of the limitations of this study is the fact that the impact of the identified barriers cannot be investigated. Thus, it is difficult to determine how much the different factors influenced the actual implementation and the results of the SE programs on participants’ outcomes. Longitudinal study designs with multiple settings would be needed for such analyses. It is also important to keep in mind that this SE study was a research project. Many of the barriers that have been reported in the prior SE studies, such as financial difficulties (Bond et al., 2001), were taken care of by the researchers and not by any of the actors in mental health care or vocational services.

Conclusion
The results illuminate some clear initial barriers for implementing an evidence-based practice for work rehabilitation in Swedish mental health care. Some barriers, such as attitudes and lack of knowledge, may only be initial and can perhaps be overcome with information and experience of SE. Other barriers, such as regulations for social benefits and work rehabilitation, seem more difficult to change in the short term. The current
trend in mental health care is on evidence-based methods. However, due to implementation difficulties many EBP are not available for all clients. For future implementation of SE in Sweden and other counties with similar regulations for social benefit and work rehabilitation two main options seem feasible:

(1) adapting the original model with a risk of losing the core components; or
(2) changing some contextual factors, such as models for collaboration and work rehabilitation regulations, in order to obtain high program fidelity.

Thus, a relevant question is whether a large-scale implementation of SE could withstand the challenges encountered and be delivered with high fidelity. It is suggested that a future SE implementation will be systematically studied in a Swedish context and in other countries.

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Government Bill 2009/10:45 (2009), “Kompletterande förändringar i sjukfrsa¨kringen, m.m. i samband med första¨rkta insatser för a¨terga¨ng i arbete” (“Additional changes in sickness benefits, in connection with increased actions for work rehabilitation”) (in Swedish).


