

Mental Health in the workplace

situation analysis

Finland



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INTRODUCTION

Population:
5.2 million
GDP per capita:
20,100 (est. 1998)
Unemployment:
12% (est. 1998)

Mental health problems are among the most important contributors to the global burden of disease and disability.

The ILO's activities promote the inclusion of persons with physical, psychiatric and intellectual disabilities into mainstream training and employment structures.

Mental health problems are among the most important contributors to the global burden of disease and disability. Of the ten leading causes of disability worldwide, five are psychiatric conditions: unipolar depression, alcohol use, bipolar affective disorder (manic depression), schizophrenia and obsessive-compulsive disorder.¹

The burden of mental disorders on health and productivity throughout the world has long been profoundly underestimated.² The impact of mental health problems in the workplace has serious consequences not only for the individuals whose lives are influenced either directly or indirectly, but also for enterprise productivity. Mental health problems strongly influence employee performance, rates of illnesses, absenteeism, accidents, and staff turnover

The workplace is an appropriate environment in which to educate and raise individuals' awareness about mental health problems. For example, encouragement to promote good mental health practices, provide tools for recognition and early identification of the symptoms of problems, and establish links with local mental health services for referral and treatment can be offered. The need to demystify the topic and lift the taboos about the presence of mental health problems in the workplace while educating the working population regarding early recognition and treatment will benefit employers in terms of higher productivity and reduction in direct and in-direct costs. However, it must be recognised that some mental health problems need specific clinical care and monitoring, as well as special considerations for the integration or re-integration of the individual into the workforce.

Why should the ILO be involved?

Mental illness constitutes one of the world's most critical and social health problems. It affects more human lives and wastes more human resources than any other disabling condition.³ The ILO's activities promote the inclusion of persons with physical, psychiatric and intellectual disabilities into mainstream training and employment structures.

The ILO's primary goals regarding disability are to prepare and empower people with disabilities to pursue their employment goals and facilitate access to work and job opportunities in open labour markets, while sensitising policy makers, trade unions and employers to these issues. The ILO's mandate on disability issues is specified in the ILO Convention 159 (1983) on vocational rehabilitation and employment. No. 159 defines a disabled person as an individual whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognised physical or *mental impairment*. The Convention established the principle of equal treatment and employment for workers with disabilities.

Most recently, the ILO has recognised the need to promote increased investment in human resource development, which can help support employment productivity and growth. This focus pays particular attention to the human resource needs of vulnerable groups, which include

In the ILO study, Mental health in the workplace, situation analyses of Finland, Germany, Poland, the UK and the USA provide in-depth assessments of the impact of mental health problems in the workplace to determine the scope of the problem in paid competitive employment in the open labour market from recruitment to retirement

The prevalence of burnout and stress is alarmingly high in the Finnish labour force. Fortunately awareness of the scope of the problem and its consequences for productivity has risen, and occupational health care providers and employers are demonstrating their willingness to address the issue in the workplace.

individuals with mental health problems. As pointed out, employee mental health problems and their impact on an enterprise's productivity and disability costs are a critical human resource issue. Increasingly, employers, employers' organisations and international organisational bodies are recognising that the economic and social costs of mental health problems in the workplace cannot be ignored.

The purpose of the research

With a grant from the **Eli Lilly and Company Foundation**, the ILO conducted in-depth situation analyses in five countries. The five countries selected were Finland, Germany, Poland, UK, and USA. The primary purpose of these situation analyses was to conduct an in-depth assessment of the impact of mental health problems in the workplace in order to determine the scope of the problem in competitive employment. Related to this purpose was also the assessment of the specific ramifications of the impact of mental health problem for employees and enterprises such as workplace productivity, loss of income, health-care and social security costs, access to mental health services and good practices by employers.

An essential objective of these situation analyses is that the information collected and assessed may be used to create further educational materials and assist in designing programmes which can be used by governmental agencies, unions, and employers' organisations for mental health promotion, prevention, and rehabilitation.

The situation analyses were based primarily on a thorough literature review, including documents from government agencies, NGOs, employer and employee organisations, as well as interviews with key informants.

The case of Finland

The occurrence of diagnosed mental disorders, and of depression in particular, has risen markedly in Finland during the past decades. Currently, mental disorders are the most frequent group of diseases causing disability. The prevalence of burnout and stress is alarmingly high in the Finnish labour force. There are many reasons for the increase in the incidence of mental disorders. These include the economic recession of the early 1990s, high unemployment, improved recognition, and changes in the diagnostic system. Awareness of the scope of the problems and their consequences for productivity has also risen, and the occupational health care providers and employers are demonstrating their willingness to address the issue in the workplace. Mental health is included in the concept of *work ability* that has been of interest to governments, employees, and employers during the past decade in particular.

This situation analysis provides an overview of the current state of mental health issues with respect to the world of work in Finland. The following three areas are examined in depth: Mental health at the national level, The role of government and the social partners, and Managing mental health in the workplace.

MENTAL HEALTH AT THE NATIONAL LEVEL looks at the occurrence of mental disorders, burnout, and stress with an emphasis on work context; examines the economic burden of mental disorders to society and employers; and describes the health care and rehabilitation systems and legislative framework in Finland.

THE ROLE OF GOVERNMENT AND THE SOCIAL PARTNERS introduces the roles of Ministries of Labour, Health and Social Affairs, employees' and employers' organisations, and non-governmental organisations. It also introduces a number of research institutes active in the field.

MANAGING MENTAL HEALTH IN THE WORKPLACE explains the work ability maintenance activities in Finland and gives some concrete examples of what Finnish employers have done to promote mental health in the workplace.

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GLOSSARY

The definitions and terms related to mental health are evolving and still subject to much debate. Terms are often used interchangeably, which can be confusing as well as inaccurate. It is therefore useful to attempt to define the vocabulary of mental health and to make distinctions. Specific countries use different terminology to refer to the same issue. In the five situation analyses of mental health in the workplace, the reports have remained faithful to the terminology used by the mental health community in each country. This glossary therefore includes definitions of these nation-specific terms. The following definitions and terminology are based on current usage by such organizations as the WHO and ILO, participating countries in the situational analyses, and the European Union.

This glossary is conceptually oriented and will give the reader the familiarity with the vocabulary of mental health, which is necessary to fully understand the situation analyses.

MENTAL HEALTH: Though many elements of mental health may be identifiable, the term is not easy to define. The meaning of being mentally healthy is subject to many interpretations rooted in value judgements, which may vary across cultures. Mental health should not be seen as the absence of illness, but more to do with a form of subjective well-being, when individuals feel that they are coping, fairly in control of their lives, able to face challenges, and take on responsibility. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity specific to the individual's culture.¹

MENTAL HEALTH PROBLEMS: The vast majority of mental health problems are relatively mild, though distressing to the person at the time, and if recognized can be alleviated by support and perhaps some professional help. Work and home life need not be too adversely affected if the appropriate help is obtained.² In the situation analyses, the terms mental health problems and mental health difficulties are used interchangeably.

MENTAL ILLNESS: Mental illness refers collectively to all diagnosable mental health problems which become "clinical," that is where a degree of professional intervention and treatment is required. Generally, the term refers to more serious problems, rather than, for example, a mild episode of depression or anxiety requiring temporary help.

The major psychotic illnesses, such as endogenous depression, schizophrenia, and manic depressive psychosis, would fall in this category and would be seen less often in the workplace.³ Mental illness is sometimes referred to as *psychiatric disability*.⁴ This term is used primarily in the United States.

MENTAL DISORDERS: Mental disorders are health conditions characterized by alterations in thinking, mood or behaviour (or some combination thereof) associated with distress and/or impaired functioning. Mental disorders are associated with increased mortality rates. The risk of death among individuals with a mental disorder is several times higher than in the population as a whole.⁵

DEPRESSION: Depression is an example of a mental disorder largely marked by alterations in mood as well as loss of interest in activities previously enjoyed. It affects more women than men, by a ratio of about 2 to 1. It is projected that up to 340 million people will suffer from depression in the near future. The risk of suicide is high amongst those suffering from depression. Yearly, over 800,000 deaths attributable to suicide are recorded worldwide: The majority of suicides are due to depression.⁶

There is a great deal of information about the different types, causes and treatments of depression. However, it is important to realize that depression is not simple. There are different types and different degrees of each type. There is a high degree of variation among people with depression in terms of symptoms, course of illness, and response to treatment, all indicating the complexity and interacting causes of this illness. The most common form of depression is chronic unipolar depression (clinical depression). This category of depression has been frequently discussed and written about in the popular media in recent years, primarily due to new modalities of treatment.

Other types of depression recognized at this time are:

- Acute Situational Depression
- Dysthymia
- Bipolar Depression (manic depressive disorder)
- Seasonal Affective Disorder (SAD)
- Post Partum Depression
- Depression secondary to other diseases or drugs.

MENTAL HEALTH PROMOTION: Mental health promotion is a multidimensional concept that implies the creation of individual, social, and environmental conditions, which enable optimal overall psychological development. It is especially focussed, among other concerns, on personal autonomy, adaptability, and ability to cope with stressors, self-confidence, social skills, social responsibility, and tolerance. Prevention of mental disorders could be one of its outcomes.⁷

MENTAL HEALTH PREVENTION: Prevention is based on specific knowledge about causal relationships between an illness and risk factors. Prevention results in measurable outcomes. Within the context of the workplace, prevention is concerned with taking action to reduce or eliminate stressors. *Prevention* and *promotion* are overlapping and related activities. Promotion can be simultaneously preventative and vice versa.⁸

POST TRAUMATIC STRESS DISORDER: PTSD or post-traumatic stress disorder can occur as an acute disorder soon after a trauma or have a delayed onset in which symptoms occur more than 6 months after the trauma. It can occur at any age and can follow a natural disaster such as flood or fire or a man-made disaster such as war, imprisonment, assault, or rape.

REHABILITATION: A process aimed at enabling persons with disabilities to regain and maintain their optimal physical, sensory, intellectual, psychiatric, and/ or social functional levels, by providing them with tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/ or restore functions or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process does not involve initial medical care. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.⁹

STRESS: Stress is defined as a nonspecific response of the body to any demand made upon it which results in symptoms such as rise in the blood pressure, release of hormones, quickness of breathe, tightening of muscles, perspiration, and increased cardiac activity. Stress is not necessarily negative. Some stress keeps us motivated and alert, while too little stress can create problems. However, too much stress can trigger problems with mental and physical health, particularly over a prolonged period of time.¹⁰

JOB STRESS: Job stress can be defined as the harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources, or needs of the worker. Job stress can lead to poor health and even injury. Long - term exposure to job stress has been linked to an increased risk of musculoskeletal disorders, *depression*, and *job burnout*, and may contribute to a range of debilitating diseases, ranging from cardiovascular disease to cancer. Stressful working conditions also may interfere with an employee's ability to work safely, contributing to work injuries and illnesses. In

the workplace of the 1990s, the most highly ranked and frequently reported organisational stressors are potential job loss, technological innovation, change, and ineffective top management. At the work unit level, work overload, poor supervision, and inadequate training are the top-ranking *stressors*.¹¹

The following are specific examples that may lead to *job stress*:¹²

The design of tasks. Heavy workload, infrequent rests breaks, long work hours and shiftwork; hectic and routine tasks that have little inherent meaning, do not utilize workers' skills and provide little sense of control.

Management style. Lack of participation by workers in decision-making, poor communication in the organization, lack of family-friendly policies.

Interpersonal relationships. Poor social environment and lack of support or help from coworkers and supervisors.

Work roles. Conflicting to uncertain job expectations, too much responsibility, too many "hats to wear."

Career concerns. Job insecurity and lack of opportunity for growth, advancement or promotion; rapid changes for which workers are unprepared.

Environmental conditions. Unpleasant or dangerous physical conditions such as crowding, noise, air pollution, or ergonomic problems.

BURNOUT: This term is used most frequently in Finland to refer to job stressors and the resulting mental health problems that may occur. It is defined as a three-dimensional syndrome, characterized by energy depletion (exhaustion), increased mental distance from one's job (cynicism) and reduced professional efficacy.¹³

MENTAL STRAIN: This term is used in the German situational analysis to refer to psychological stress that impacts everybody in all realms of life.

WORK ABILITY: Individuals' work ability is based on their, physical, psychological and social capacity and professional competence, the work itself, the work environment, and the work organization. This term is often used in Finland in the world of work.

JOB INSECURITY: Job insecurity can be defined as perceived powerlessness to maintain desired continuity in a threatened job situation or as a concern about the future of one's job.¹⁴

STIGMA: Stigma can be defined as a mark of shame, disgrace, or disapproval, which results in an individual being shunned or rejected by others. The stigma associated with all forms of mental illness is strong but generally increases the more an individual's behavior differs from that of the 'norm.'¹⁵

INTELLECTUAL DISABILITY: This disability is defined by a person's capacity to learn and by what they can or cannot do for themselves. People with this disability are identified by low scores on intelligence tests and sometimes by their poor social competence.¹⁶ The term mental retardation is also used to refer to a person with an intellectual disability and is the most common term used in the situation analyses.

DISABILITY MANAGEMENT: The process of effectively dealing with employees who become disabled is referred to as "disability management." Disability management means using services, people, and materials to (i) minimize the impact and cost of disability to the employer and the employee and (ii) encourage return to work of an employee with disabilities.¹⁷ It should be noted that the term "disability management" is not commonly used, despite the fact that practices understood to be within the scope of disability management processes are now taking place within enterprises of all sizes worldwide.¹⁸

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Part 1

The mental health of Finns

"The good life is threatened by drastic changes in our working lives, and a hardening of values and the social atmosphere. The basic mechanisms of labour have been revolutionised all over the Western world. Unemployment, debt problems, even poverty are causing great anxiety in far too many homes today. And those who have work don't have it easy, either. A new competitive spirit lurks in the workplace. The strong survive, while the weak withdraw from society. Emotional and financial insecurity cast a shadow for example on the lives of young adults, and families with children. The mind reacts quickly to the changing pressures, while life gets shallower and more entertainment-orientated."

Eeva Ahtisaari
First Lady of Finland
World Mental Health Day,
October 10th, 1999

The overall health of Finns has improved steadily over the past 20 years, and by international standards, Finland can be regarded as a healthy nation.¹ This is especially true of people with stable careers and families and people who have just reached retirement.² However, despite improvements in general health, the incidence of mental health disorders has increased markedly over the past ten years. In Finland, one adult in ten reports suffering from a mental health disorder. In clinical terms, mental health disorders are even more common: the incidence of psychiatric disorders is about 15%.³ Though the occurrence varies depending on the assessment criteria, at any given time, approximately 20 % of adults suffer from mental health problems. Disability related to mental health disorders has also been increasing since the early 1970s. At present, mental health disorders are the group of diseases which most frequently cause disability.⁴

Depression

The substantial increase in the occurrence of mental health disorders is due to the rising prevalence of depression and anxiety. The incidence of depression, in particular, has increased over the past ten years. According to a recent study, approximately 9 % of Finns had suffered from depression in the course of the previous year. Twenty-five per cent of them had been treated, and 13 % took medication for depression. Previous studies on depression have shown that, at any given time, 5 % of Finns are depressed.⁵ For women, the risk of depression is double, and they suffer from overexertion and fatigue more often than men. Dejection or depression, nervousness or tension, lack of stamina or fatigue also are more common in the lowest income groups. There is an increasing tendency among young adults to be at risk for depression. This may be related to tougher demands at work and in other areas of contemporary life.⁶

Causes of the increased incidence of mental health disorders

The growing numbers do not necessarily indicate an actual increase in the prevalence of mental health disorders. Several factors explain the increase, particularly of depression. First, the awareness of mental health problems has risen among doctors and patients, improving the likelihood of recognition. This is due partly to the availability of new antidepressants and their marketing in the Western world. Clinicians have become more skilled at recognising depression. For instance, people reporting chronic backache and fatigue may also obtain a secondary diagnosis of depression. The stigma traditionally associated with mental health problems is diminishing, and both physicians and service users are more freely discussing these issues. This, in turn, is reflected in the recorded increase in mental health disorders.^{7 8}

Second, changes in the diagnostic systems are partly responsible for the increase. A number of cases that would have been classified under the category of neuroses in the old system now fall under the category of affective disorders (i.e. major depression). At the same time the number of diagnosed neuroses has decreased.⁹

The increased prevalence of mental health problems may reflect growing recognition by doctors and patients, changes in the diagnostic systems, and changes in the labour market which have caused long-term unemployment, and greater stress at work.

Job insecurity has become a relatively permanent state for an increasing number of employees. It negatively affects job attitudes, work behaviour, psychological health, and stress levels.

Summary of the study on the prevalence of burnout in the Finnish population

Stress related symptoms are common among employees. Over 50 % of the workforce experience some kind of burnout symptoms.

About 25 % of Finns feel extremely tired due to work.

About 7 % of employees suffer severe burnout so severe that it characterised by exhaustion, cynicism, and reduced professional efficiency. Altogether 165 000 employees suffer from severe burnout.

The risk of burnout is about double in organisations that have laid off personnel and which do not hire replacements.

The risk of burnout is even higher in organisations in which workers live under a continuous threat of dismissal.

Burnout is more common among those working more than 55 hours per week.

Women, ageing workers, and the less educated are more prone to burnout.

The changes in society are reflected in the burnout levels in different sectors. The burnout problem is most severe in the banking and insurance sectors, in teaching, industry, and agriculture.

Burnout is a significant predictor of sickness absence due to other illnesses.

The risk of increased early retirement because of burnout and the related decrease of working ability are major problems.

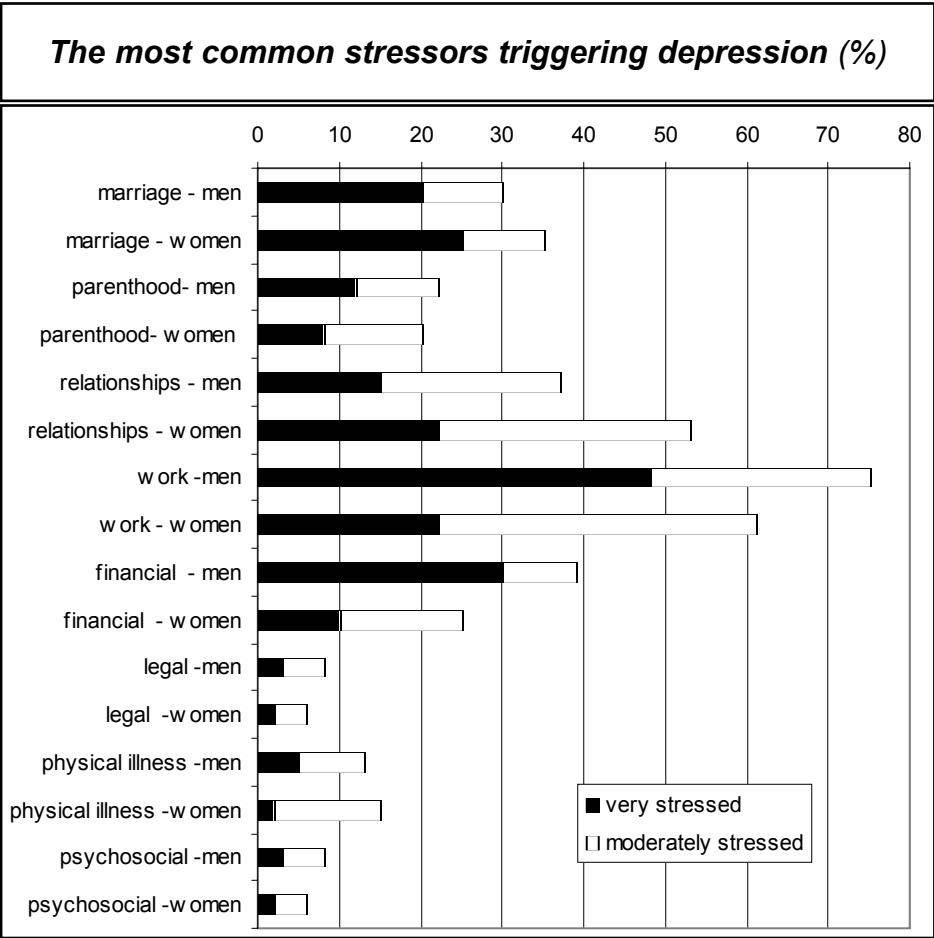
Third, changes in the labour market, the effects of long-term unemployment, and greater stress at work may be reflected in the increased incidence of mental health disorders.¹⁰ The 1990s were a decade of significant change in the Finnish labour market. This has affected the mental wellbeing of the Finnish workforce and may be reflected in the increased occurrence of depression. The recession experienced by all Western economies hit Finland particularly hard in the early 1990s. The private and public sectors reacted to the sudden downturn with restrictive policies; companies were merged and downsized; and the unemployment rate skyrocketed to nearly 17 % at its peak in 1994. Though the unemployment rate has been improving slowly, it was still relatively high at 10.2 % in 1999.¹¹ The structure of production, labour utilisation, and types of available jobs continue to be in transition.

In terms of the structure of production, some jobs are disappearing and new ones are being created. Traditionally secure jobs are being displaced by temporary fixed or short-term contracts,¹² which are becoming more prevalent, especially in less skilled jobs. Job descriptions vary a lot and workers are expected to be flexible. Short periods of unemployment are becoming normal transition periods in a worker's career.¹³ Job insecurity has become a relatively permanent state for an increasing number of employees. It negatively affects job attitudes, work behaviour, psychological health, and stress levels. Job insecurity can operate as a long-lasting job stressor, result in reduced wellbeing, and decrease the quality of human relations and workplace efficiency.¹⁴ Women appear to be more vulnerable to the effects of job insecurity, which can increase exhaustion and negatively impact home life.

As the labour force decreased in the early 1990s, productivity went up. Fewer people are producing more, often under conditions of uncertainty and insecurity. More people, in particular women, are experiencing time pressure and a frantic work pace. Time pressure, social conflicts, and mobbing have become more common in the workplace and have a direct effect on the work environment.¹⁵

In 1997, for the first time, the prevalence of burnout in the Finnish working age population was studied in conjunction with macro-level developments in working life.¹⁶ Since there are no previous population-wide studies on burnout, it is not possible to evaluate overall trends or make comparisons. However, studies on more limited population samples show that burnout has been increasing since mid 1980.¹⁷ According to the 1997 study, burnout and stress are severe problems in the Finnish workplace; 7 % of the population suffer from severe burnout and almost 50 % report some burnout symptoms. The risk of burnout is about double in organisations that have reduced personnel and even higher in those where there is a perceived threat of dismissal. Rapid reorganisation and restructuring are significant factors contributing to the increased levels of stress and exhaustion.¹⁸

Chronic long-term stress may cause exhaustion and burnout and trigger more serious mental health problems, such as depression. A recent study shows that the majority (43%) of people diagnosed with severe depression had experienced a major work-related stressor during the previous year.¹⁹ Loss of a loved one and serious illness, traditionally thought to trigger depression, were less common. There are, however, no epidemiological data on the relation between depression and unemployment, work-related stress, and economic recession.²⁰



During the 1990s, clearly positive developments also took place in the Finnish labour market. According to a study by the Finnish Institute of Occupational Health²¹ work has become less monotonous; 17 % of women perceived their work as monotonous in 1997, down from 29 % in 1987. Possibilities for personal development and control at work have increased. Employees report greater encouragement, respect, and opportunities to apply their own ideas. These are developments which may positively affect the work environment and employees' wellbeing.

Mental health problems and increased mortality

Since the the risk of death is several times higher among people with mental health disorders than among the population as a whole, mental health promotion can be seen as a way of bringing down the mortality rate.

Mental health disorders are clearly associated with increased mortality rates: the risk of death is several times higher among people with mental health disorders than among the population as a whole. Suicide and violence are the main causes of death associated with mental health disorders.²² It has been estimated that the risk of death for both men and women is ten or more times higher among 20- to 29-year-olds with mental health disorders than in the general population of the same age.²³ Mental health affects physical health and vice versa. People with severe mental health disorders have high rates of cardiovascular disease, respiratory disease, and malignancy. Therefore, mental health promotion can be seen as a way of bringing down the mortality rate.²⁴

Suicide is of particular concern in Finland, since the country has always had a high suicide rate compared with other countries. In 1994, Finland ranked eighth internationally in terms of male and female suicides (43.6 male suicides and 11.8 female suicides per 100 000 inhabitants). In 1996, a total of 1,247 people (965 men and 282 women), took their own lives in Finland. The figures for young men are particularly high; one in four suicides is committed by a man under the age of 35. For women the figures have remained quite stable.²⁵ Fortunately, the number of suicides, notably for men, has been declining steadily since their peak in 1990.

Every year 30,000 working years are lost due to suicides. Work can have a critical impact on the factors that influence an individual to commit suicide. The changes taking place in the labour markets, recession, and unemployment can increase the risk of suicide.²⁶

Part 2

The economic burden of mental health disorders

“Employment trends have a key position when it comes to the future of social protection: more people in work would reduce the need for social security and related costs.”

*Ministry of Social Affairs and Health
Trends in Social Protection*

The high incidence of mental health disorders is a heavy economic burden for society. In 1994, the total costs of mental health disorders in Finland were calculated at 2% of GNP.¹ Depression accounted for 50% of that figure and schizophrenia for 30%. The direct costs of schizophrenia are higher than the health costs of smoking.²

The burden of these costs does not fall equally on society, employers, employees, and insurance companies, but they all bear their share. Figures on the direct costs of benefits paid through the social security system are easier to obtain than figures on costs related to the work environment, such as reduced productivity and loss of potential output through reduction of the available labour force. The medical costs of mental health problems are considerable but difficult to define, since mental health problems contribute to so many other illnesses, such as cardiovascular disease and blood pressure and back problems. The scope of these problems for the individual cannot be measured in financial terms alone, but must include the toll of human suffering: social problems and isolation are not quantifiable.

Social security

Social security expenditures include expenses for pensions, municipal social services, health care, unemployment insurance, and health insurance. Social expenditures accounted for 37 % of GDP in 1992 and were estimated at 33.2% in 1996.³ The high figure at the beginning of the 1990s can be attributed to the rapid increase in unemployment. At the same time, the pressure to reduce social protection costs increased, and a number of savings and re-funding arrangements were introduced during between 1992 and 1995 to permanently reduce the cost of benefits and services. Relatively speaking, the biggest cuts were made in health care.⁴ During the same period, costs related to disability and old age increased significantly.

Social security expenditure by main groups /FIM million ⁵	1992	1993	1994	1995
Families and Children	23 708	23 371	27 259	27 400
Sickness and Health	43 291	42 521	42 378	44 800
Unemployment	22 252	27 813	28 126	26 100
Old age and disability	77 063	80 603	83 227	86 800
Other	3 370	2 903	3 220	3 300
Administration	4 890	4 992	5 389	5 700
Total	175 395	182 133	189 601	194 100

SICK LEAVE

In general, absenteeism is low in Finland. The rates are 4.6% for blue-collar workers and 2% for white-collar workers. However, absence statistics do not include sick leaves of fewer than nine days.^{6,7} According to the Finnish Health Care Survey 1995/96 the average number of days of self-

1997 national sickness allowance leaves by the most common disease groups*	
Diseases of the musculoskeletal system and connective tissue	33.2%
Injury, poisoning and certain other consequences of external causes	14.8%
Mental health and behavioural disorders:	10.3%
Diseases of circulatory system	6.8%
Diseases of respiratory system:	6.0%

*The diagnoses are based on the tenth revision of the International Classification of Diseases, which was introduced in Finland in 1996.

Though in general absenteeism in Finland is low, the number of sick leaves due to depression has increased drastically, doubling between 1990 and 1995.

reported absence due to illness was 4 per 100 days, amounting to a per-year total of two weeks per person and 73 million days for the entire population. These figures are increasing steadily. On average, the number of sick days is the same for women and men. The average length of sickness leaves is 33.9 days. However, in 1996 sickness leaves for people with mental health problems averaged 62.4 days, longer than for any other diseases. The number of sick leaves due to depression has increased drastically. It more than doubled from 1990 (5,467) to 1995 (11,600).⁸

To illustrate the problem, the Central Organisation of Finnish Trade Unions has calculated the direct financial burden of a three-month sick leave to the employer, employee and society.⁹

The financial burden of a three-month sick leave	
The starting points:	
Average wage:	10 000 FIM/month
Average length of the sick leave	3 months
Employers pay period	1.5 months
Costs to the employer:	
Pay plus other employment costs	-26 300 FIM
Sickness insurance reimbursement	+7 540 FIM
Replacement, pay and employment costs	-15 500 FIM
Total (minus indirect costs and occupational health care expenses):	-34 260 FIM
Costs to the employee:	
Salary	- 15 000 FIM
Sickness allowance	+10 900 FIM
Loss of income	- 4 100 FIM
Total loss of income (annual, gross)	-2 000 FIM
Costs to government:	
Lost tax contribution and other payments	-2 000 FIM
Tax and unemployment allowance for replacement	+ 7 200 FIM
Sickness Allowance	- 18 560 FIM
Medical costs are not evaluated	
Total cost to government	- 13 360 FIM
Total cost of a three month sick leave to the employee, employer, and government	- 46 920 FIM

In addition to the direct costs of absenteeism, it is likely that the productivity of a person suffering from mental health problems has been lower than normal for a long period prior to the sick leave. Employers can be said to be facing a problem of ‘presenteeism’. In other words, people turn up for work but are so distressed that they contribute little,¹⁰ increasing the costs outlined above.

UNEMPLOYMENT

Several Finnish and foreign studies point to the link between unemployment and mental ill health.¹¹ Statistically speaking, somatic diseases, mental health problems, and suicide are more common among the unemployed than in the active labour force.¹² However, unemployment can be both the cause and the effect of ill health.¹³

At the beginning of the 1990s, after a long period of low unemployment, the unemployment rate in Finland increased rapidly and has remained relatively high. Unemployment among people with disabilities has increased steadily since the 1980s, and currently 7% to 8 % of all jobseekers are classified as persons with disabilities. A considerable number are chronically ill, and mental illnesses represent the third most prevalent group of illnesses (12 %).¹⁴

Re-employment often helps improve the mental well-being of unemployed people with disabilities as well as prevent possible deprivation caused by unemployment. A lowered level of mental wellbeing does not render a person unemployable: “it is not ill health but lack of jobs that prevents re-employment”¹⁵. Unemployment is a serious challenge to the functioning and wellbeing of society. Groups at high risk among the unemployed, including people with serious financial problems or difficult family situations, should be identified and services addressing their problems improved.

Unemployment among people with disabilities has increased steadily since the 1980s, and currently 7% to 8 % of all jobseekers are classified as persons with disabilities.

A preventative intervention programme for jobseekers

One of the examples of how to tackle unemployment and wellbeing is a Finnish application of a JOBS programme, which originally was developed at the University of Michigan. The Social Insurance Institution and Finnish Institute of Occupational Health collaborated on developing and piloting the Finnish application of the programme. The JOBS programme aims to provide the job seeker with the confidence and skills to achieve re-employment and to prevent depression caused by unemployment through social support and active learning.

The Finnish application of the JOBS programme has proven to be an effective preventive intervention model. It had a significant effect on the mental well being of the participants, in particular of those diagnosed at risk for depression and long-term unemployment. The programme provided the participants with a positive learning experience that improved their self-confidence and strengthened their capacity to face obstacles to employment. Their psychiatric symptoms decreased. Though further research is needed, results of this study encourage the development of primary prevention programmes such as JOBS to enhance mastery of stressful situations and improve self-efficacy.

Silvonon, J & Vuori, J. The effect of the preventative ‘Työhön’ - job seeking programme on the psychological distress of the unemployed

PENSIONS

Mental health disorders have overtaken cardiovascular disease as the most common reason for disability pensions.

Disability pension statistics reflect the growth in the incidence of mental health disorders, which have overtaken cardiovascular disease as the most common reason for disability pensions.¹⁶ The prevalence of cardiovascular disease has been reduced significantly over the past two decades thanks to improvements in treatment and health education. On the contrary, disability pensions awarded because of severe mental health disorders increased fourfold between 1987 to 1995 (from 722 to 3022).¹⁷ Schizophrenia used to be the most common mental health disorder for which disability pensions were granted. Currently, depression is the leading cause (27%) of retirement due to mental health disorders.¹⁸

New disability pensions granted in 1997 by the most common disease groups ^{19*}	
Mental health and behavioural disorders	37.4%
Diseases of the musculoskeletal system and connective tissue	23.5%
Diseases of circulatory system	10.4%
Diseases of nervous system	6.5%

*The diagnoses are based on the tenth revision of the International Classification of Diseases, which was introduced in Finland in 1996.

By international standards, the average retirement age in Finland is relatively low, and it is one of the lowest in Europe²⁰. The ageing of the population puts extra pressure on the financing of social security and pensions. Persuading as many people as possible to stay at work until the normal retirement age and eliminating risk factors which lead to early retirement, such as burnout, would be a significant step.^{21,22}

Part 3

Common knowledge: access to basic information and services

Though in general Finns can rely on health and social services, where mental health is concerned, there is a gap between the needs and the services available.

To a large extent, responsibilities for mental health care have shifted from specialised psychiatric and social services to primary health care, requiring a new approach to health care management.

The Finnish welfare system resembles those of the other Nordic countries in terms of institutional structure, financing, and goals. The system covers the whole population. Service are mainly provided by the public sector and financed through general taxation. In general, Finns can rely on the country's health and social services, even though, at the beginning of the 1990s, the expansion of the health and social service network was terminated, staff numbers were trimmed, and the delivery of some services curtailed.^{1 2} In terms of mental health, however, there is a wide gap between needs and available services. The long-term unemployed, people with mental health problems, and drug abusers face a clear threat of exclusion from society, since the health and social service sectors cannot adequately respond to their needs.³

There are growing differences between provinces and municipalities across the country in providing for citizens' wellbeing. Since 1995, there has been a significant change in demographics. Population has shifted to the south, depleting the tax base in the north, where support for welfare services, including mental health has been reduced. The southern regions, which are experiencing a population influx, are finding it difficult to respond to the corresponding increase in welfare needs.⁴

Mental health care services

Municipalities are responsible for providing mental health care services, which are organised by primary health care, social services, and special medical care systems and financed through taxes and state subsidies. Individual municipalities are responsible for primary health. Joint municipalities (two or more municipalities acting together) are responsible for special medical care, such as psychiatric and mental health care services. Since the beginning of the 1990s, a greater share of responsibilities and resources has been directed to individual municipalities. This has meant an increase in the role of primary health care in providing mental health care services and a decrease in the roles of specialised psychiatric services and social services. In one third of municipalities, mental health care is organised as a part of local primary health.

The shift in responsibilities for mental health care from specialised health care to primary health care has not simply been an administrative change, but has required a new approach to health care management. The benefits of locally provided services are obvious. One in three primary health care appointments concerns mental health, and collaboration is easier to coordinate at the local level.⁵ However, many experts have argued that specialised psychiatric care is needed to maintain the quality of mental health services. When decisions are made locally, services can vary from one municipality to another, depending on local priorities and the needs of the population. Problems, such as lack of resources for community care, insufficient recognition of the needs of the severely mentally ill, and difficulties in guaranteeing continuity of services, have arisen as a result of the move from specialised psychiatric services to primary care.⁶

Until the 1980s specialised psychiatric care was based mainly on institutional treatment. In the early 1980s, Finland had almost 20,000 beds for

The dramatic decrease in inpatient care has been the overall trend in Finnish health care, mainly because of economic pressures but also because of a philosophical shift from institutionalised care to a more integrative approach.

Since occupational health care services reach up to 90% of the Finnish workforce and are in continuous contact with employees and the workplace, they are an excellent vehicle for preventive mental health care and promotion of mental health.

psychiatric patients (4.2 per 1,000 inhabitants). This was one of the world's highest figures. The number has been cut, and by the end of 1994, there were 6,500 hospitalised mentally ill patients (1.3 per 1,000 inhabitants). The dramatic decrease in inpatient care has been the overall trend in Finnish health care, mainly because of economic pressures but also because of a philosophical shift from institutionalised care to a more integrative approach. The reductions in inpatient care have been greatest in the hospitalised care of psychiatric patients. As a result, the outpatient community-based care system has been improved and extended. In 1991, the staff in community care numbered 5.1 per 10,000 inhabitants. The figure was 2.5 in 1981. The number of outpatient visits has risen from 520,000 in 1980 to 750,000 in 1990 and to 1,290,000 in 1997⁷. However, the development of outpatient care has not been able to compensate in every locality for the drastic decrease in hospital capacity.⁸

In addition to municipalities, various non-governmental organisations play a crucial role in providing mental health services and rehabilitation. In recent years a number of privately-run nursing homes and rehabilitation units have been set up for people with mental health problems. These are considered a form of residential service and are not subject to inspection by the health care authorities.⁹

The occupational health care services

The Occupational Health Care Act requires that employers provide occupational health services to their employees. Services can be offered through the employer's own occupational health unit, organised jointly with other employers, or purchased from the municipal health centre, other employers, or licensed health care professionals. Employers are entitled to reimbursement from the Social Insurance Institution (SII) of the necessary and reasonable costs of occupational health services.¹⁰ Entrepreneurs and other self-employed persons are entitled to reimbursement of the necessary and reasonable costs of the services they choose to purchase for themselves.¹¹ In 1992, occupational health services were provided in 1,025 occupational health centres. Of these, 496 were run by individual employers, and 48 were run jointly by several employers; 43 were regional state-run occupational health clinics, 243 were municipal health centres, and 195 were private medical centres.¹² Currently, the occupational health care services employ 200 occupational psychologists (in comparison to 5,000 general practitioners), whose services are available at one occupational health care centre in five.¹³

Since occupational health care services reach up to 90% of the Finnish workforce and are in continuous contact with employees and the workplace, they are an excellent vehicle for preventive mental health care and promotion of mental health. Over the past years, the demand for occupational mental health care services has expanded significantly. However, mental health promotion and prevention of mental health problems are relatively new issues and more knowledge is needed.¹⁴ According to occupational psychologists, occupational health care is too focussed on curative aspects. As a result, mental health issues, and particularly the prevention of mental health problems, have been ignored. This is despite the fact that increasing numbers of people suffering from depression become disability pensioners and that many new drugs and treatment options have become available.¹⁵

A recent reform in the occupational health care scheme emphasised the importance of preventive measures and the maintenance of work capacity and functional ability. The occupational health care service is now obliged by law to offer rehabilitation counselling and to contribute to the maintenance of work ability, which is defined as a function of both the work envi-

ronment and the person. Work ability is not considered an independent attribute of the individual, but includes the work environment and context.¹⁶ Mental health is an important part of a person’s work ability, but is often ignored or relegated to second place. Maintaining work ability and functional capacity requires a joint effort by the employer, the employee, and the occupational health service to provide support during the entirety of a worker’s career.

Rehabilitation

Traditionally, rehabilitation has been divided into vocational, educational, medical, or social rehabilitation. Rehabilitation services for people with mental health problems are also referred to for psychiatric, psychosocial, or psychological rehabilitation. The Finnish Rehabilitation Foundation, however, recommends the term “mental health rehabilitation,” since it also covers people with mental health problems such as burnout or severe stress who are not diagnosed with psychiatric illnesses. Mental health rehabilitation covers early rehabilitative activities and prevention of mental health problems in the workplace.

In Finland, the Social Insurance Institution (SII) and labour authorities have prime responsibility for organising vocational rehabilitation.¹⁷ The SII is required by law to provide vocational rehabilitation for people with impaired functional capacity and medical rehabilitation for people with severe disabilities. In addition, a person can be paid a rehabilitation allowance in connection with rehabilitation services arranged by the SII, or the primary health care, social services, or occupational health care services. The allowance is paid only if the purpose of the rehabilitation is to help the client remain in, enter, or return to the workforce.

In 1997 17% of those receiving rehabilitation from SII were diagnosed with mental health and behavioural disorders. The following charts illustrate the national expenditure on different types of rehabilitation benefits and the major diagnosis groups of benefit recipients in 1997.¹⁸

The Finnish Social Insurance Institution is required by law to provide vocational rehabilitation for people with impaired functional capacity and medical rehabilitation for people with severe disabilities. In 1997 17% of those receiving rehabilitation from SII were diagnosed with mental health and behavioural disorders.

Expenditure on rehabilitation benefits	
Rehabilitation allowances	22.2%
Vocational rehabilitation	9.7%
Medical rehabilitation	64.5%
Examinations	3.6%

Recipients of rehabilitation services by disease group:	
Diseases of the musculoskeletal system and connective tissue	46.7%
Mental health and behavioural disorders	16.7%
Diseases of nervous system	11.3%
Diseases of circulatory system	5.1%
Diseases of respiratory system	3%

A report by the Rehabilitation Foundation makes it clear that Finland needs to develop an effective rehabilitation system for people with mental health problems, with an emphasis on vocational rehabilitation.

Effective maintenance of work ability cannot focus solely on the employees, but should involve the work environment. The workplace would be a natural place to provide rehabilitation.

Vocational rehabilitation services for people with mental health problems provided by the labour authorities are limited. It has been estimated that only one in ten people in need of vocational rehabilitation due to mental health problems is provided with the necessary services. In addition to services provided by the SII and the labour authorities, the occupational health care services are responsible for rehabilitative measures aimed at maintaining work ability in the workplace. Often people, in particular young people, with mental health problems lack vocational qualifications. This can be a major barrier to employment. Therefore people with mental health problems often face a cumulative risk of marginalisation.¹⁹

A report by the Rehabilitation Foundation makes it clear that Finland needs to develop an effective rehabilitation system for people with mental health problems, with an emphasis on vocational rehabilitation.²⁰ Too often, early retirement is the only option for persons with mental health disorders who have problems maintaining their work ability and keeping their jobs. Existing rehabilitation services mainly target people diagnosed with schizophrenia, and there is a lack of rehabilitation programmes for people with depressive disorders.²¹ Rehabilitative measures should be provided earlier and involve the social and physical environments in which clients live their daily lives. Making services more flexible and accessible would reduce the stigma surrounding their use.^{22,23}

The need for rehabilitation of employees with severe job exhaustion and burnout challenges the traditional philosophy of rehabilitation, which is often diagnosis-based and focuses more on clinical and curative aspects.²⁴ Work ability is not just an absence of symptoms or illness and a personal attribute, but involves work motivation, possibilities for learning and development, and feelings of usefulness and participation. Effective maintenance of work ability cannot focus solely on the employees, but should involve the work environment. The workplace would be a natural place to provide rehabilitation and help employees to manage their daily lives, maintain their jobs, and minimise work-related stressors. This, however, does not underestimate the importance of medical and curative services, which are often required to address the symptoms.

Part 4

The legislative framework

A disabled person is defined in accordance with the ILO Convention No 159, 1983 on Vocational Rehabilitation and Employment. A disabled person is a person whose working ability and earning capacity have been substantially reduced as a result of an impairment, injury, or sickness.

Under the Employment Act discriminating against jobseekers or employees is penalised, and an employee cannot be dismissed without a valid employment-related reason.

Finland has no over-arching anti-discrimination legislation, quota, or preferential employment policies for people with disabilities. They are covered under mainstream Finnish employment legislation. However, special services such as vocational rehabilitation and training are provided to enhance the employment opportunities of persons' with disabilities, if needed.¹ A disabled person is defined in accordance with the ILO Convention No 159, 1983 on Vocational Rehabilitation and Employment. A disabled person is a person whose working ability and earning capacity have been substantially reduced as a result of an impairment, injury, or sickness.²

It is impossible to list all relevant legislation, but this report introduces some central legislation on employment rehabilitation, occupational health care, and working hours. A more comprehensive list can be found in the appendix.

Amendments to the **Constitution Act (969/1995)** of August 1995 renewed clauses on fundamental rights and adopted new ones. Though the Constitution Act does not specifically address employment, which is covered under separate labour legislation, it outlaws discrimination on the basis of disability.

According to the **Employment Act (275/1987)**, "A finding of unlawful labour discrimination will be given, if, in advertising vacancies, during selection of applicants or employment, the employee is placed in a different position, without sufficient grounds, because of, for example, his or her state of health."

Under the Employment Act discriminating against jobseekers or employees is penalised, and an employee cannot be dismissed without a valid employment-related reason. The employer cannot terminate a contract of employment for a reason related to the employee's disability unless it is impossible to make reasonable accommodations. In some cases, employers may be obligated to create tailor-made jobs for persons with disabilities. However, the employer has a legal right of dismissal after one year of partial incapacity related to sickness, if suitable work cannot be found. Information about the actual operations and effectiveness of this law is not available.³

The **Employment Services Act (1005/1993)** clarifies the duties of labour authorities by providing more specific provisions on employment services such as vocational rehabilitation services. There are 183 local employment authorities in Finland. Their main task is to promote access of the unemployed to the labour market. People with disabilities are entitled to use all the employment services available. Integration into mainstream employment programmes is preferred and promoted by employment services.⁴

Legislation on working hours was revised in 1996. It is now possible to set working hours at the local level and increase flexibility in the workplace.⁵ Part-time pensions, working hour banks, shortened working hours, and sabbatical leaves are examples of possible flexible working time arrangements.

Examples of working time experiments

The European Social Fund financed a research and development project called “Flexibility through six-hour shift”. The model is based on work done by Professor Paavo Seppänen in 1967. Seppänen suggests that, to promote both effectiveness and human considerations, productive organisations should operate for 12 hours, consisting of two six-hour day-time shifts, rather than the usual eight hours. In the project the model was applied in eight small size private firms and carried out on a shop floor in machine-bound work. Arrangements were agreed between the employer and employees and, in most cases, wages remained the same. Every firm in the study benefited in some way: production costs and absenteeism decreased, and productivity and flexibility increased.

Between 1996 and 1998, 20 municipalities participated in an experiment regarding shorter working time. 1,300 permanent employees reduced their working hours by an average of 20 %, resulting in an average workweek of 30 hours. The average wage loss was 7 %. 600 new part time employees were hired at the normal part-time wage to compensate for the loss of hours. The experiment was carried out primarily in female-dominated health and social services such as childcare, home care, dental care, and physiotherapy. Working time was reduced either daily or weekly. Some services benefited from the new working time arrangements: the availability of services improved and service times were lengthened. However, the research shows that the benefits of shorter hours were most visible in the improved quality of life and wellbeing of employees and in reduced stress.⁶

According to the **Occupational Safety Act (229/1958)**, employers are responsible for taking the steps necessary to prevent workplace accidents and provide safe work environments. Workplace arrangements must take account of special measures required by persons with disabilities or other workers with health and safety requirements.

The **Occupational Health Care Act (743/1987)** includes provisions on providing workplace assistance and support for persons with disabilities and guidance in obtaining treatment or rehabilitation. The mandatory occupational health service can take the initiative on rehabilitation or other preventive measures. The ultimate decision on transferring an employee to more suitable employment or rearranging the workplace environment remains with the employer.

Rehabilitation legislation

Finland has set up a National Advisory Committee on Rehabilitation in accordance with the ILO Convention No 159 on the vocational rehabilitation and employment of persons disabled by physical or mental health conditions. The Committee is a national co-operative organisation including workers’ and employers’ organisations and organisations for the disabled.⁷ The Committee’s main role is to adopt, implement, and monitor national action programmes on rehabilitation and implement rehabilitation legislation, which changed substantially in 1991. The purpose of the legislative reform was to reduce the necessity of putting workers on disability pensions or other long-term social benefits, and to develop opportunities for rehabilitation so that persons with disabilities or reduced work capacity could live independently and avoid institutional care as long as possible. Rehabilitation legislation now requires closer co-operation between providers of rehabilitation services, employers, and health care services; encourages earlier intervention; and standardises rehabilitation allowances. To ensure that rehabilitation begins as early as possible, rehabilitation is also covered by the **Occupational Health Care Act**. The occupational health care service is obliged to participate in activities promoting the maintenance of working capacity in the workplace.⁸

Under the **Act on Services for the Disabled (380/1987)**, municipalities are responsible for arranging services for persons with disabilities, includ-

Rehabilitation legislation was reformed in 1991 to reduce the necessity of putting workers on long-term social benefits and to develop opportunities for rehabilitation so that persons with disabilities or reduced work capacity can live independently as long as possible.

ing home help, housing services and rehabilitation services. However, municipalities have not always fulfilled their responsibility to provide people with mental health disabilities with the necessary services. It has always been difficult to define disability, particularly a multiple disability, in the mental health care sector. The Act has not been actively implemented, and the authorities do not have much experience in applying its provisions to people with mental health disorders.

In Finland mental health problems are usually seen as illnesses rather than disabilities for which accommodations must be made in everyday life. Mental health care users often do not receive the benefits and services to which they are entitled under the Act on Services for the Disabled.⁹ Mental health professionals may deliberately avoid using the term “disability” in order to cast mental health care problems as temporary issues, which most people deal with from time to time, and emphasise the possibility of recovery.¹⁰

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Part 5

The role of government and the social partners

Almost every decision taken in society, whether it is about environment, culture, family, or employment, somehow concerns mental wellbeing. The promotion of mental health and prevention of mental health problems are important tasks, which are addressed by many sectors of society, largely outside the formal health care sector. The following section discusses the roles played by the government, non-governmental organisations, and workers' and employers' organisations.

The role of government

In 1999, The Ministries of Labour, Social Affairs and Health, and Education, and the central labour market organisations launched a comprehensive research plan and action programme to maintain and improve work ability in the Finnish workplace.

Mental health promotion is associated with the work of all 13 ministries¹. For instance, promoting well being and preventing mental health problems are part of the work the Ministry of Foreign Affairs does in developing countries. The Ministry of Defence deals with mental health services as a part of health care in the military and peacekeeping services. Some 60 % of cases of interrupted military service can be attributed to mental health issues, and the Ministry of Defence has taken action to promote mental health in the military. The Ministry of Education plays an active role in promoting mental health in educational and cultural and physical activities.²

The Ministries of Labour and of Social Affairs and Health play the most important roles in employment and mental health. The Ministry of Social Affairs and Health and its Department for Occupational Safety and Health are responsible for maintaining the working capacity of employees.³ Several agencies and institutions within the Ministry of Social Affairs and Health perform research, development, and supervisory functions connected with social welfare and health care. These include the National Research and Development Centre for Welfare and Health (STAKES) and the National Council on Disability.

MINISTRY OF LABOUR

The Ministry of Labour defines the national priorities of employment policy. It is responsible for labour administration and for providing and developing employment services, including vocational guidance and rehabilitation, vocational training for adults, and vocational information services. Since 1992, the Ministry of Labour has used annual surveys to monitor the quality of workplaces in Finland and follow long-term developments and trends.⁴

The Ministry allocates resources to Labour District Offices, which are responsible for planning and implementing regional employment policies. The Labour District Offices set objectives for local employment offices. Employment offices seek to promote efficient labour market policies by helping unemployed people find work through activities such as matching applicants to vacancies. They also promote measures to help people with disabilities find work through mainstream services.⁵

In 1999, The Ministries of Labour, Social Affairs and Health, and Education, and the central labour market organisations launched a comprehensive research plan and action programme to maintain and improve

work ability in the Finnish workplace. The programme's overall goals are to disseminate information and good practices, initiate research projects, utilise existing knowledge more efficiently, update relevant legislation, and support concrete measures in the workplace.⁶

The Ministry of Labour is also involved in several nationwide workplace development programmes, such as the National Workplace, National Productivity, and National Ageing Programmes, which promote a good working environment and workers' wellbeing.

The National Workplace Programme ⁷

The National Workplace Programme, which is a part of Finland's National Employment Plan, was launched with workers' and employers' organisations, and will be allocated further financial resources in the near future.⁸ The overall goals of the Programme are to boost productivity and the quality of working life and to improve the wellbeing of employees by furthering full use and development of staff know-how and initiative in the Finnish workplace.

The Programme's group of experts is made up of the representatives of the central labour market organisations, the Confederation of Private Entrepreneurs, and the Working Environment Division and the Occupational Safety and Health Division of the Ministry of Social Affairs and Health. It decides which projects to fund (up to 50%). Projects must be workplace initiated, and workplaces can participate either individually or jointly. Both management and staff have to be committed to the project's aims and to carrying it out in co-operation with all the stakeholders concerned. So far the Programme has

involved some 300 projects and 500 workplaces. The following figures are drawn from an interest group survey that was carried out in November-December 1998. They highlight the Programme's success:

- Nine out of ten respondents saw the project as necessary; 95 % of respondents reported that effective management, the working ability of employees, and coping at work are the most important targets for workplace development in Finland;
- 90 % of those whose project had come to end by the time of the survey said that the project had improved team-work;
- More than 70 % said that the occupational skills and co-operation between management and staff had improved;
- Two out of three contended that productivity had improved;
- The entrepreneurs considered the time they had devoted to their projects to be a profitable investment.

Ministry of Social Affairs and Health

The Ministry of Social Affairs and Health directs and guides policies concerning social security, social welfare, and health care. It defines the main national guidelines of social and health policy; prepares legislation and key reforms; supervises their implementation in the municipalities; and handles the links to the political decision-making process. The Ministry of Social Affairs and Health is in charge of improving social and health care services and the wellbeing of the nation. It is also responsible for occupational safety and health and occupational health care.

In Finland, the concept of occupational safety and health is based on promoting a good working environment. It extends to mental wellbeing, satisfaction with work, improved skills and motivation, and effective organisation and management practices within overall productivity.⁹

THE DEPARTMENT FOR OCCUPATIONAL SAFETY AND HEALTH

The Department for Occupational Safety and Health is responsible for the activities of work organisations and identifying and promoting the neces-

sary policies which improve job security, health, job satisfaction, and outputs. It prepares legislation on occupational health and safety and instructions on the implementation of legislation and the application of research information. The Department's activities are implemented in close co-operation with the social partners and other interest groups. In its work plan for the year 1999, the Department emphasised the importance of maintaining the work capacity of employees. It is facilitating the work of the Districts in reducing excessive work stress and mental health problems at the workplace level.

THE DEPARTMENT FOR PROMOTION OF WELFARE AND HEALTH

The Department for Promotion of Welfare and Health is responsible, in co-operation with other departments, for promoting health and social wellbeing, preventing social problems and diseases, and ensuring a healthy environment. It guides and develops preventive work, drafts related legislation, and works to ensure that issues related to the prevention of social and health problems are taken into account in other aspects of social policy. It is also responsible for services for people with disabilities, mental health care, occupational health measures to maintain work ability, and health promotion.

THE NATIONAL RESEARCH AND DEVELOPMENT CENTRE FOR WELFARE AND HEALTH¹⁰

The role of the National Research and Development Centre for Welfare and Health (STAKES) is to safeguard the future of social welfare and health, to enhance the health and social well-being of the nation, and to promote high quality and cost-effective social welfare and health services for all citizens. STAKES undertakes activities concerning mental health and wellbeing and runs programmes aimed at preventing mental health problems and promoting mental wellbeing at the national and international levels. Examples of STAKES programmes follow:

Meaningful Life! Programme 1998 – 2002

The most recent programme is "Meaningful Life!" a nation-wide programme launched in 1998. Its aim is to improve the abilities of citizens, especially those suffering from mental health problems, to manage their everyday lives. In addition to the social and health authorities, Meaningful Life! involves ministries and other administrative agencies, non-governmental organisations, and individual citizens and service users in its activities.

The objectives of the programme are to:

- Enhance the value, visibility and understanding of mental health;
- Promote co-operation on mental health issues;
- Support the activities of citizens and non-governmental organisations in promoting mental health;
- Diversify the selection of mental health outpatient services;
- Promote the abilities and strength of mental health professionals;
- Create information technology systems which promote mental health.

The Swallow-Programme

Mental health in Primary Care (Swallow) 1998-2001 is a national education and development programme for mental health services. The programme was established to support the know-how and counselling skills of social services and health care staff. It attempts to widen the perspectives of those working in the field and to enhance interest in new working methods, effective teamwork, and co-operation with partners.

"In health policy, mental health must be seen as a component of all health, not as a separate entity assigned only too readily to second place."

*Eva Biaudet
Minister of Social
Affairs and Health
World Mental Health
day, 10 October,
1999, Tampere*

Suicide prevention in Finland

The rate of suicide has been high in Finland, especially among young men. To address the problem, Finland was the first country in the world to implement a nationwide suicide prevention programme. The programme took place between 1986 and 1996, during which the frequency of suicide decreased by 9%. The decrease is remarkable, though the initial goal of 20% was not reached. The main focus of the programme was on risk factors, such as mental health problems, recognition and treatment of depression, and substance abuse.

The project was carried out in co-operation with approximately 100 000 specialists from various sectors including health care, social work, the church, and the armed forces. The programme was implemented under real-life conditions in community-based settings and included 30 subprojects.

The project noted the need for further research in examining the relationship between depression and suicide.

Keep Your Chin Up! The National Project on Depression 1994-1998

STAKES ran a national depression programme called Keep your Chin Up 1994 - 1998. It was a part of a national suicide prevention programme and targeted depression, since depression is arguably the most important factor leading to suicide.

The project aimed to:

- Increase awareness among the general population and health care professionals ;
- Secure and develop adequate treatment, help and action programmes which respond to needs in a timely fashion;
- Enhance co-operation between various stakeholders at the regional and local levels;
- Improve the ability of the municipal health and social welfare services to recognise, treat, study, and prevent depression in all age groups.

The Suicide Prevention Programme

From 1986 to 1996, in response to its high suicide mortality rates and the World Health Organisation's call to reverse the upward trend in suicides, Finland carried out a nationwide suicide prevention program, which was co-ordinated by STAKES. The programme entailed comprehensive multisectoral co-operation across the country. It focused on preventing suicides by eliminating threats to mental health. The programme has resulted in two documents: *Suicide can be prevented* and *Suicide prevention in Finland 1986 – 1996, external evaluation by an international peer group* (see box above).

The European Network for Mental Health Promotion

For several years, Finland has been advocating for increased visibility of mental health issues in the European Union. STAKES initiated and co-ordinates the European Network for Mental Health Promotion (ENMHP) founded in 1995. The network brings together chief medical officers responsible for mental health, administrators, and experts to co-operate in promoting mental health. All Member States of the European Union are represented in the ENMHP, with the exception of Austria. The ENMHP plays a crucial role in the European Mental Health Agenda, which is an ongoing process, aimed at enhancing the importance and visibility of mental health issues in European programmes and decision making.

The Key Concepts Project, launched in March 1999, is one of the recent activities of the ENMHP. It collects information on existing mental health policies, wellbeing indicators, and information systems and seeks to develop a system of mental health measurements and standardised definitions in Europe. The driving forces behind the project are the growing need to eval-

Finland has been an advocate for increased visibility of mental health issues in the European Union.

uate the effects and impacts of mental health policies at the national level and the interest, at the European level, in comparing the mental health policies of different countries.

Mental health was on the agenda of the Presidency of the European Union, which Finland held for the latter half of the 1999. A conference on Promotion of Mental Health and Social Inclusion was held in Tampere. Its goals were to increase the importance and visibility of mental health in Europe and to seek synergies on strategies concerning future European action and co-operation. Workshop topics included the development of mental health indicators; promotion of mental health for children and adolescents; the possibilities of information technologies; and working life and mental health.

Information technology and mental health promotion¹¹

Information technology has been used in the Finnish mental health care system since the 1980s. For many years its use was restricted to crisis hot lines. Now, the Internet has greatly expanded the scope of services. Information technology includes integration of data transmission and data processing. The Internet, e-mail, the videophone, videoconferencing, and even the text messages on a mobile phone are examples of this technology.

Information technology offers clients and service-providers many advantages such as low costs, easy use, accessibility, and flexibility. It has been estimated that “traditional” mental health services reach only 10-15% of those in need. Experiments in information technology have tapped a much wider audience without reducing the number of people using traditional services. However, the potential number of users of Internet mental health promotion and substance abuse prevention services is still closely linked to household income. A survey conducted in 1999 found that while every other person in the medium or high income bracket had access to the Internet, the figure was only 28% among those in the low income bracket.

From 1991-1999, the Ministry of Social Affairs and Health funded the country’s first mental health promotion and substance abuse prevention information technology network. The network, called MEPT, is co-ordinated by STAKES. It consists of four sub-projects, each of which has produced valuable information on the utilisation of information technology in mental health promotion and substance abuse prevention. The projects aim to prevent problems, promote mental health, and develop new models of co-operation. All four subprojects seek to make the client an active player, who is willing to and capable of making choices, rather than a passive recipient of help prescribed and delivered by others.

<i>The MEPT subprojects</i>	
INSP is an Internet service set up by the Rehabilitation Foundation. It offers a discussion forum, an info column, and a self-help advisory service for various problem situations. It also serves as a channel for cooperation across the nation in seeking to promote mental health and employment projects (A Meaningful Life, Swallow, Mainstreaming and Trades).	mental health work on information networks. It targets students in the Greater Helsinki area. Its most popular service is the virtual shoulder, which gives support and advice via e-mail on an anonymous basis.
Valoa Verkko (Light on the Internet) is an experimental service testing the use of preventive	The Mental Health Centre of Turunmaa region and three other health centres are exploring the suitability of the videophone for transmitting mental health services between the mainland and the Turku archi-

continued on page 6

MEPT continued

saved money, and investments in equipment have paid for themselves in no time. Clients have been satisfied with their “neighbourhood” service. It has also led to the development of therapies appropriate for the videophone. The videophone has brought the psychiatrist into the client’s local health centre, saving the client a long and expensive sea crossing. The contacts established with clients would hardly have been possible without the videophones installed in the island municipalities.

In videophone therapy the time-place-distance configuration is very different from the conventional face-to-face meeting between doctors and patients. Therapists have experimented with a variety of methods to try and find the one most appropriate to the new technology. Videophone therapy has been least useful in efforts to communicate with children and large families.

Trade unions and employers’ organisations have actively participated in the development of regulations governing the conditions of working life in Finland and in the development of the social security system.

The role of workers’ and employers’ organisations

Finland has one of the highest rates of union membership in the industrialised world. Eighty per cent of employees belong to trade unions. Traditionally, the relationship between workers’ and employers’ organisations has been harmonious in Finland, as in the other Nordic countries. Trade unions and employers’ organisations have actively participated in the development of regulations governing the conditions of working life in Finland and in the development of the social security system. Employment issues are addressed in the context of their negotiations with the government over the budget.¹²

Finnish employers’ organisations have been particularly concerned about unemployment, controlling expenditure on social security, and improving the country’s overall economic situation. They are actively participating in national programmes on work ability and workplace development, but have been somewhat less concerned than workers’ organisations about the issues of stress and burnout. However, all the labour market organisations have expressed their readiness to take action to promote staff know-how, work ability, and wellbeing and to work in co-operation with Ministries of Labour, Social Affairs and Health, and Education.¹³

The Central Organisation of Finnish Trade Unions (SAK) considers that job insecurity and workplace stress are severe problems in Finnish working life. It argues that employees are stretched to the limit. SAK has called for preventive measures against burnout, the ability to alternate between work and training, and a reduction in working hours. SAK has also introduced the concept of “social accounting” and states that competition at the expense of working conditions should be stopped. SAK published a booklet “*Eväitä Jaksamiseen*” (1999) on coping with stress and preventing burnout, which provides practical guidance for workplaces on stress prevention. SAK emphasises that wellbeing at work and coping with work are closely related to management and leadership, working hours, and the planning and organisation of work.¹⁴

In 1998, the Finnish Confederation of Salaried Employees (STTK) launched a programme on mobbing. Mobbing involves hostile and unethical communication that is directed in a systematic manner towards one or more co-workers who are pushed into a helpless and defenceless position. There are occasional problems in every workplace, but to qualify as mobbing, they must occur on a frequent basis (at least once a week) and over a time period of least six months. This maltreatment can result in considerable mental, psychosomatic, and social misery. STTK’s programme includes local events, panel discussions, consciousness raising amongst its affiliated unions, and local campaigns, one of which resulted in a guidebook entitled “*Työpaikalla yhteishenkeä - ei kiusanhenkeä*” on preventing mobbing in the Finnish workplace.¹⁵

In response to concern among its members about the increase in working hours over the last few years, the white-collar union YTN Ry, an affiliate of AKAVA (the Confederation of Unions for Academic Professionals in Finland), has addressed the issues of time pressure, overwork, and work ability. White-collar workers work approximately 43 hours per week, which is more than the average for other wage earners.¹⁶ YTN's programme on time pressure seeks concrete measures to cut working hours. These could include the option of early retirement, shorter annual working hours, efficient bookkeeping of real working hours, and a "working hour account," in which extra hours can be saved and used when needed.

The role of non-governmental organisations

Finnish social security and disability policy is based on the Nordic welfare state model and, to a great extent, is organised through public sector services and financed through taxes. However, non-governmental organisations, mainly financed by the Finnish Slot Machine Association, (Rahautomaattiyhdistys, RAY) supplement and complement the range of public services available. RAY allocates the entire profit from its gaming operations to non-profit health and social welfare organisations. In 1996 RAY allocated 71 million Finnish marks to mental health activities.¹⁷

There are 110 registered national voluntary organisations and associations working on social and health issues in Finland. Seventy of them represent the interest of persons with disabilities. Most NGOs contribute to mental health promotion in some way, such as offering rehabilitation and training. Many NGOs provide rehabilitation services that are purchased by municipalities. Mental health patients and their families did not establish their organisations until the 1960s and 1970s, which is relatively late compared to other disability groups. Therefore, their memberships are relatively small compared to the incidence of mental health problems. Stigma associated with mental health issues is also a factor in the low level of organisation among people with mental health problems.

In 1996, The Association of Voluntary Health, Social, and Welfare Organisations asked its 110 member organisations to comment on mental health services in Finland.

The following points were brought up by many organisations and associations working in the field.¹⁸:

- Stigma associated with mental health problems and treatment is still strong.
- People with long term illness or disabilities are at a greater risk of developing mental health problems. This risk is often forgotten. Greater co-operation between the different authorities and organisations is required to fully understand and address this issue.
- The mental health needs of some special groups, such as the deaf and ethnic minorities, are difficult to meet.
- Adjustment training services have not been utilised efficiently, and information concerning different options is often lacking.
- Mental health services are often isolated and hard to get to.
- There is need for closer co-operation between voluntary social welfare organisations and government agencies.

THE FINNISH ASSOCIATION FOR MENTAL HEALTH

The Finnish Association for Mental Health is a non-governmental, voluntary, public health organisation that provides expertise and service in men-

There are 110 registered national voluntary organisations and associations working on social and health issues in Finland. Seventy of them represent the interest of persons with disabilities, and most NGOs contribute to mental health promotion in some way.

The Finnish Association for Mental Health, founded in 1897 is the world's oldest voluntary organisation promoting mental health.

tal health for professionals and lay people. It was originally founded in 1897 to support and help people recovering from mental health disorders. It is the world's oldest voluntary organisation promoting mental health.

Currently, the Association provides crisis and rehabilitation services, runs pilot projects, and disseminates information about mental health issues. It acts as a consultant to the authorities and as an umbrella organisation for its 47 member organisations, which carry out the same mission at the local level. The Association arranges training for mental health professionals, and is currently conducting a research project on mental health rehabilitation services.¹⁹ It also supports certain client groups such as foreigners living in Finland, people who have experienced job burnout or financial difficulties and the homeless. In 1999, the Association published a guide "Työterveydenhuolto uupuneen valmentajana" (Occupational health care for people with job exhaustion) to familiarise occupational health care staff with issues related to burnout, stress, and job exhaustion.²⁰

THE CENTRAL ASSOCIATION FOR MENTAL HEALTH

The Central Association for Mental Health, founded in 1971, is an association for the handicapped established by psychiatric patients. Its objectives are to give patients a voice, and to ensure that the mentally ill are entitled to good care and rehabilitation, an adequate income, and a normal life. Members of the nursing profession and the general public interested in the subject play an active part in the Association and its 132 member organisations. The Association provides training for living with disabilities, legal aid, and caregivers, and organises family vacations, physical exercise etc. It publishes a bi-monthly journal "Käsi Kädessä" (Hand in Hand), organises annual Mental Health Week,²¹ and maintains an infobase on rehabilitation services for people with mental health problems. The Infobase can be accessed at <http://www.mtkl.fi/tietopalvelukeskus/page.htm>.

FPED FOUNDATION (FOUNDATION PROMOTING EMPLOYMENT OF PEOPLE WITH DISABILITIES)²²

The FPED Foundation is a co-operative organisation promoting employment and rehabilitation of persons with physical or mental health disabilities. The Foundation co-operates with organisations and associations for and of persons with disabilities, government, regional authorities, business, industry, and other associations. It was established in 1993 by 19 national associations and organisations.

The Foundation runs programmes which develop innovative job opportunities for persons with disabilities. It is examining the suitability of work at home, telecommuting and entrepreneurship for trainees in rehabilitation. It disseminates information on successful models and experiences, and provides training for the staff of service providers, such as sheltered workshops and employment projects.

The Foundation promotes a variety of employment methods, such as supported employment, Clubhouses (Fountain House models) and social firms. Private associations and the public sector take part in its development programmes, and it runs activities at the international level. It is a member of the Confederation of European Firms, Employment Initiatives, and Co-operatives (CEFEC) and hosted the XII CEFEC Conference in 1999. Short descriptions of the Foundation's main activities can be found in the appendix.

CASETTI and E.C.H.O

CASETTI (Case management and supported employment for people with mental health problems)

The project (1998-2001) works with clients to develop counselling services, case management, supported employment services, and social and work skills training for people with mental health problems. Its services are for persons with mental health problems who are planning to return to working life. One of its main activities is supported employment which provides regular paid work in an integrated environment with the needed support, such as training and coaching in the workplace, social support outside the workplace, and transport arrangements. Clients receive support as long as they need it. CASETTI also offers support for employers on other employment-related issues.²⁵

E.C.H.O

The Rehabilitation Foundation was also involved in E.C.H.O, a programme co-ordinated by the STAKES Consortium. E.C.H.O targeted people with psychiatric or psychosocial problems who had difficulties in finding employment in the open labour market. It covered the establishment of social firms, transitional employment, supported employment, and tailored pathways. An evaluation of the programme carried out by the Rehabilitation Foundation shows that the number of participants who were employed or working in integrated settings increased sharply, from 5% to 31%. In addition participants reported that their general wellbeing, self-confidence, and social relationships improved through participation in the project.²⁶

REHABILITATION FOUNDATION²³

The Rehabilitation Foundation provides rehabilitation services and training for professionals and conducts research on rehabilitation. It assesses labour market policies which target people at risk of social exclusion. People with mental health problems are among its clientele. The Foundation is governed by a board which includes representatives from the Ministries of Labour and Social Affairs and Health, the Central Organisation of Trade Unions, and the Confederation of Finnish Industry and Employers.²⁴

The Research & Development (R&D) unit of the Foundation runs a CASETTI programme for people with mental health problems. The R&D unit was also involved in the evaluation of E.C.H.O which is funded by the European Union Social Fund (ESF) and co-ordinated by STAKES. E.C.H.O. whose target group are users of mental health services is part of the European Employment Initiative. The European Union-funded TRADES project also aims to develop and study employment models for people with disabilities, including persons with mental health problems. The project is one of the 25 partners in a European network, ACCEPT II. The network, funded by the ESF community initiative programme, is dedicated to improving the social integration and employment of people with mental health problems

The role of academic institutions

In Finland, the focus of research on working life has reflected international trends. In the 1960s, the emphasis, inspired by some U.S studies, was on more comprehensive research on job satisfaction and working conditions. In the 1970s, the idea of quality of working life started to command attention and resulted in job enrichment and job enlargement projects. After the 1970s, occupational health and safety research adopted a “work psychology” approach, which drew strongly on job satisfaction theories and stress models, with an emphasis on health. The aim was to create a sound knowledge base to influence legislative reform of the work environment, which was also underway in other Nordic countries.

Overall, research on working life has focussed on developing systems in order to encourage staff participation and increase occupational safety and health care. Quality of working life and “humanisation” of work have received less attention.²⁸ In the second half of the 1980s, however, rapid

“In Finland, productivity is promoted mainly by investing in technology and reducing human input. People seem to have largely forgotten that the more important aspect of raising competitiveness relies on using human resources as well. There has been a striking inability to exploit the powers that our high level of education should have given us. We have more or less learned how to develop our human resources, but we have a long way to go in using them.”

Matti Salmenperä, Ministry of Labour²⁷

economic growth, a decrease in job satisfaction, a labour shortage, and the increased availability of research funds led to rise in research-assisted workplace development. Sociologically oriented research into working life became well established at universities and other research institutions²⁹.

Currently, research on occupational health focuses on advances to foster individual health and wellbeing. The concept of health has been widened from the level of the individual to the company or organisation. For instance, studies on stress, which used to focus on the health of the individual, have been expanded to look at the organisation. As a researcher from the Finnish Institute of Occupational Health points out, “health has become an attribute of organisation”³⁰. Since job insecurity and work overload are reflected in employees’ wellbeing and work ability, an increased need for psychosocial research and services has emerged to foster smooth reorganisation in the labour market and to monitor and intervene against the negative consequences of reorganisation, such as stress and burnout.

Finland has over 40 units involved in research on work, including 24 units at universities and 18 other research units or institutes such as the Institute of Occupational Health, the Rehabilitation Foundation, STAKES, and the Technical Centre of Finland. The units at universities include departments of educational studies, political science, business, psychology, medical science, and technology.³¹. The following section describes some research units studying wellbeing in the workplace or organisational issues conducive to wellbeing. STAKES and the Rehabilitation Foundation, where research focuses more on rehabilitation, were introduced earlier.

THE FINNISH INSTITUTE OF OCCUPATIONAL HEALTH (FIOH) is a public corporation supervised by the Ministry of Social Affairs and Health. The FIOH is the biggest organisation in Finland working in occupational health care and has six regional institutes in addition to its central institute. FIOH’s mission is to promote employees’ health and well-functioning workplaces. FIOH conducts research, disseminates information, and offers expert services and training.

FIOH’s research concentrates on employees’ health, elements of a good working environment, physical and mental pressures in the workplace, potential dangers, safe work methods, and occupational accidents and illnesses. About 230 research projects are underway annually. One of these, Human Resources for Work, is dedicated to supporting and developing people’s resources for coping with the demands of working life. Its research focuses on human resources, well-being, stress, and burnout in the work environment as well as the impact of workplace culture and intrapersonal factors on an employee’s health and the ability to work.

WORK RESEARCH CENTRE, TAMPERE UNIVERSITY

The Work Research Centre (WRC), founded in 1988, is a unit of the University of Tampere Research Institute for Social Sciences. It is the largest unit in Finland in its field. The Centre is dedicated to research into work and working life and provides post-graduate training and extension studies. It covers a wide range of disciplines, including psychology, sociology, social policy, administrative science, and pedagogy. Current and future research concerns include: organisational learning; the emergence of the information society and evolving practices in working life; restructuring the labour market; equality and gender perspective in working life; public sector modernisation, human resources and work organisations; and work and education. Over the past years, the WRC has increasingly devoted its resources to participation in comparative research projects in Europe and in broader international research networks.³²

The concept of health has been widened from the level of the individual to the company or organisation.

Since job insecurity and work overload are reflected in employees’ wellbeing and work ability, an increased need for psychosocial research and services has emerged to foster smooth reorganisation in the labour market and to monitor and intervene against the negative consequences of reorganisation, such as stress and burnout.

CENTRE FOR ACTIVITY THEORY AND DEVELOPMENTAL WORK RESEARCH, UNIVERSITY OF HELSINKI

The Centre conducts research in work, technology, and organisations which are going through transformations and carries out development projects on change and learning in work organisations. It also creates and applies new conceptual tools for understanding and mastering transformations in work, technology, and organisations. Its current research focuses on mastering changes in team- and network-based learning organisations; technical innovations and organisation of research work; workplace communities and work ability in transition; and household work and coping with everyday life in families. The Centre offers consulting and training services to organisations facing major transformations and learning challenges.³³

TAMPERE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF TAMPERE

The Tampere School of Public Health is a training and research institute. It has a long tradition in occupational health studies. It offers graduate training and doctoral and postgraduate education, including a degree programme which trains physicians to be “Specialists in Occupational Health.” Research in occupational health includes investigating the association between work demands, health, functional capacity, and work ability in different occupational groups and among unemployed persons.³⁴

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Part 6

Managing mental health in the workplace

“Mental health is an important resource of life. It is generated, and regrettably often also endangered - in homes and schools, at workplaces, indeed in all aspects of our lives.”

*Eva Biaudet
Minister of Health and Social Services
World Mental Health Day, 1999, Tampere*

A healthy and competent workforce is a precondition for an effective and profitable work organisation. In turn, work and meaningful activity are essential components of mental health. Working life is an arena in which people, during their adult years, spend a considerable amount of time. The workplace is therefore an excellent venue in which to promote mental wellbeing, to address mental health problems, and prevent existing mental health problems from becoming more serious.

Activities which maintain work ability and promote wellbeing are common in the Finnish workplace, and more than two thirds of Finnish employees have access to them.¹ As the following list illustrates, most programmes focus on maintaining physical work ability, which can have a positive impact on employees' mental wellbeing. Programmes aimed at improving the organisation of work or the atmosphere in the workplace are also important to mental wellbeing.

Measures most commonly taken in the Finnish workplace aim to:

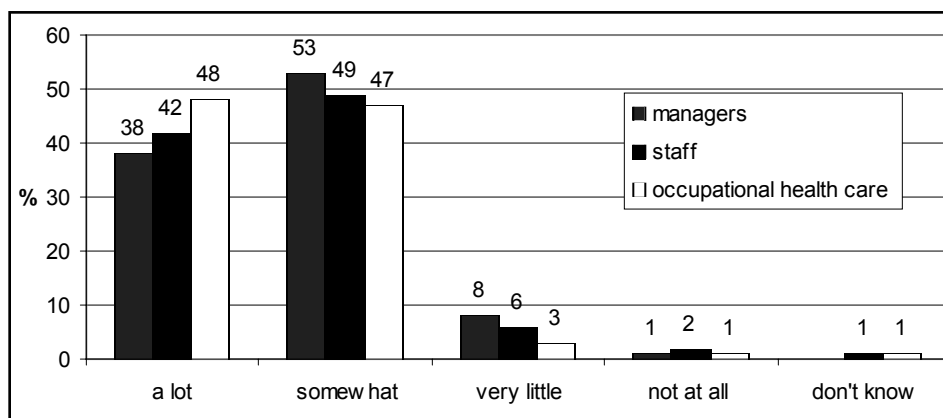
- Improve the working environment (e.g. enhancing occupational safety and ergonomics);
- Develop the management and organisation of work (e.g. better job design, good communication, clear goals, independence at work);
- Provide further training and learning opportunities (e.g. improving occupational and team work skills or promoting independent study);
- Promote health (promoting physical activity and a healthy lifestyle, offering rehabilitation, and preventing substance abuse).

However, activities or programmes in the Finnish workplace rarely address mental health issues directly. Employees suffering from severe burnout or stress may need early rehabilitation in order to maintain their working capacity and maintain employment.² Many employees, employers, and health care service providers feel that the programmes have not yet been integrated into workplace culture and are separate activities which lack continuity. There are disparities in the resources available to address the issue: larger employers (with more than 100 employees) often have better resources than small employers to organise activities which maintain work ability.³ This is usually because their human resources management structures are better organised rather than because of financial resources. In general, employers consider work ability programmes and activities cost-effective. As many as 90 % of employers believe that they benefit financially from them.

Employees, employers, and occupational health care service providers face the challenges of expanding the concept of work ability maintenance to address mental health issues more efficiently and clearly and to create early rehabilitation services which are integrated into management and occupational health care activities. The Finnish Institute of Occupational Health recommends the following ways to promote mental health in work organisations⁴:

- Increase awareness of the preconditions for and the value of mental health in the workplace;
- Implement and disseminate good practices;

**Perceived benefit of work ability activities to the company
managers (n=805), staff (n=735), occupational health care staff (n=686)**



Source: Peltomäki P, Husman K., Liira J., Nykyri E., Piirainen H., Pohjanpää, K, Räsänen K., Suurnäkki T. & Tuomi, K. 1999. Työkykyä ylläpitävän toiminnan barometri 1998 - Väliraportti.

- Increase co-operation of mental health professionals and occupational health care professionals;
- Train occupational health care professionals in mental health issues and mental health professionals in work-life issues;
- Increase knowledge among the general public about the preconditions for and the value of mental health in working life, and develop self-help skills for creating satisfactory working-conditions.

The Finnish Quality of Working Life Survey highlights factors of which employees and employers should be aware in order to create a supportive and enjoyable working environment, which promotes everyone's wellbeing.⁵ When asked what would make their current jobs more enjoyable, employees most frequently cite greater independence in their work followed by more variety and a higher interest level. Sixty per cent of respondents also mention feelings of usefulness and achievement. They list time pressure, enforced pace, poor pay, job insecurity, and lack of appreciation as the major factors making their current jobs less enjoyable.

Activities of Finnish companies: some examples

The following section introduces some measures taken by Finnish companies to promote employees' wellbeing and prevent mental health problems. The companies cited are participating in the European Network for Workplace Health Promotion, which was founded in 1996.⁶ Many of the activities are not specifically called measures to promote mental health but are examples of how to promote a supportive, flexible, and healthy working environment.

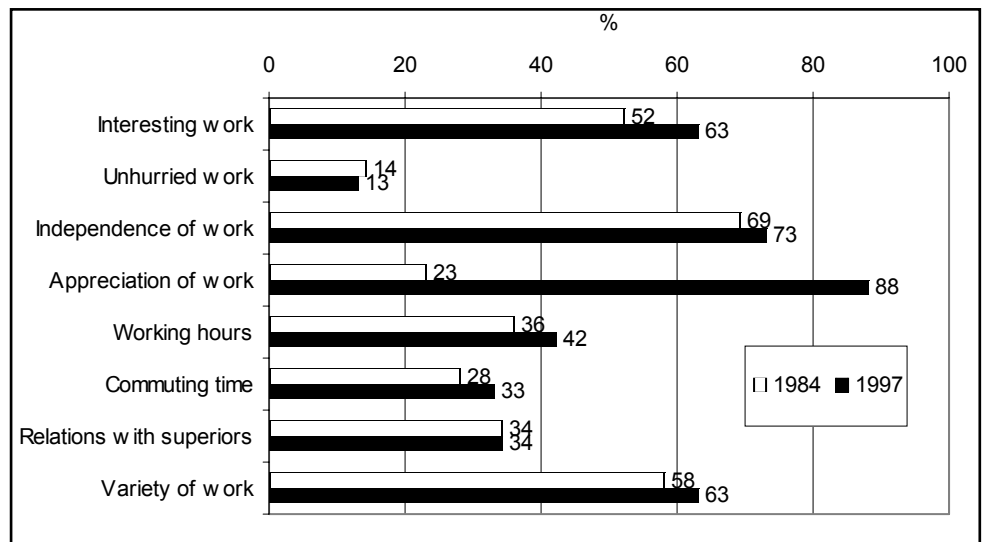
NOKIA

Nokia's key growth areas are wireless and wireline telecommunications. A pioneer in mobile telephony, Nokia is one of the world's leading mobile phone suppliers and a supplier of mobile and fixed telecom networks and services and fixed and wireless data communications. Nokia's head-office is in Finland, but it operates globally, with manufacturing facilities in over 10 countries on 3 continents and research and development centres on 4 continents. Nokia employs more than 51,000 people worldwide in over 45 countries.⁷

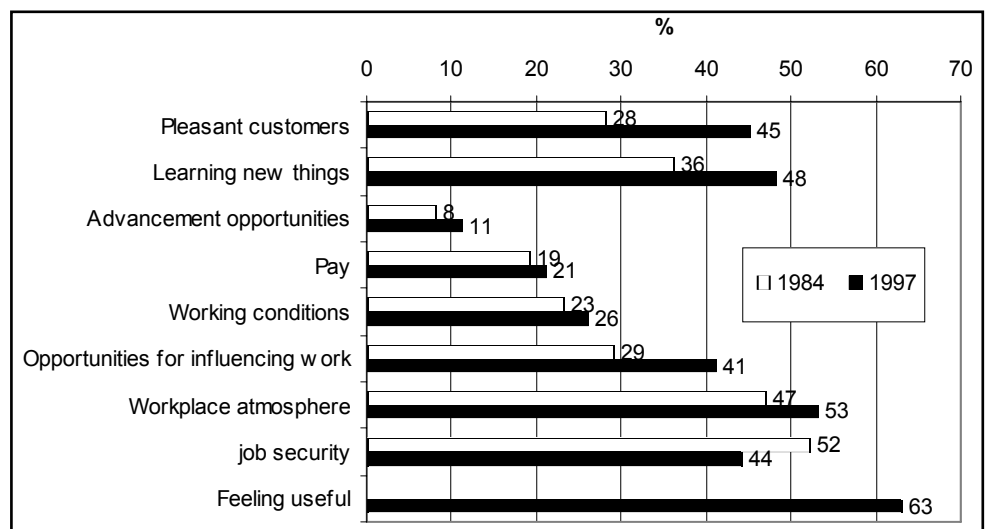
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Factors making current job more enjoyable 1/2
Quality of Work Life Surveys 1984 and 1997 (Source: Statistics Finland)



Factors making current job more enjoyable 2/2
Quality of Work Life Surveys 1984 and 1997 (Source: Statistics Finland)



Nokia runs a Total Wellness Programme for its employees, which was developed in collaboration with the Finnish Institute of Occupational Health.

Nokia's human resources and occupational medicine departments are responsible for workplace health promotion and prevention programmes. The company runs a Total Wellness Programme for its employees, which was developed in collaboration with the Finnish Institute of Occupational Health.

The company uses its own statistics on working days lost due to illness, industrial accidents, and occupational diseases and data on staff satisfaction and employees' health to plan its health promotion activities. The occupational medicine department organises systematic medical examinations and regular assessments of the need for rehabilitation. It administers a fitness survey of employees, which covers work, physical condition, ability to cope with stress, family life, social contacts, and hobbies. The survey is graded on a scale of one to five. A very low score by an employee in any section prompts quick intervention to improve the situation. Participation in the wellness programmes is evaluated on a regular basis. Work stressors, health, and career development are part of annual development discussions between employees and supervisors. Nokia places great emphasis on attaining further qualifications and has established its own global learning centre network.

OY METSÄ-BOTNIA AB, ÄÄNEKOSKI MILL

The Metsä-Botnia Group is one of the Europe's largest producers of chemical pulp. It produces high-quality bleached and unbleached pulps and linens, mainly from wood brought from private owners. The Metsä-Botnia Group has about 750 employees, approximately 300 of whom are employed by Äänekoski Mill. The Mill produces softwood, birch, and aspen pulp for fine paper and board manufacture.⁸

At OY METSÄ-BOTNIA AB, health promotion measures, a staff-orientated leadership style, and new forms of co-operation have contributed to a major improvement in the working atmosphere.

Metsä-Botnia Äänekoski Mill has established a health promotion working group, composed of staff from the human resources, occupational health and safety, and occupational medicine departments and workforce representatives. The need for health-related activities is determined on the basis of statistics on industrial accidents and working time lost due to illness. In 1995, the company surveyed the health conditions and physical fitness of its employees and did a study of its working atmosphere. Since then, the executive team has been trained to conduct appraisal interviews, which take place yearly with every employee. As a part of this exercise each employee has an individual development plan. In addition, the leadership qualities for management team members were identified and they have taken leadership development courses. The company publishes a manual of suggestions for day-to-day work. It supports staff sports activities and has a canteen for its employees. The health promotion measures, a staff-orientated leadership style, and new forms of co-operation have contributed to a major improvement in the working atmosphere.

RUOKA-SAARIOINEN OY, SAHALAHTI WORKS

Ruoka-Saarioinen is in the food industry. Its Sahalahti Works, which employs 80 people, produces ready-to-serve meals. Health-related activities at Sahalahti Works are geared to promoting responsibility, initiative, and skills among employees and to increase teamwork. A planning group was formed consisting of the managing director, the human resource manager, staff from the occupational medicine department, and workforce representatives. The company initiated improvements in working conditions at Sahalahti Works because of high staff turnover, premature retirement, and high levels of absenteeism. Most of the actual illnesses were related to back problems, so the company wanted to address the issue of work demands and increase the physical fitness of its employees.

Fundamental changes promoting employees' control over their work have taken place at Ruoka-Saarioinen. As a result, satisfaction and work motivation have increased, and teamwork has improved. In two years, the sickness rate has fallen by 8% to 16%.

Ruoka-Saarioinen began preparing the employees for new production processes. Autonomous working groups were developed to minimise organisational hierarchy. In so doing, the company wanted to enhance productivity and allow employees more initiative in their work. Representatives of management, the trade unions, the workforce, and a supporting group of researchers were involved in planning and implementing the entire restructuring process. Training programmes, a canteen, and sports facilities contribute to employees' wellbeing.

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VALMET CORPORATION, PAPER FINISHING SYSTEMS, JÄRVENPÄÄ UNITS

Valmet is the leading supplier of fibre and paper technologies and services in the global forest industry. They will supply single components and processes to complete projects and production lines.

Health-related measures have had a positive effect on the working atmosphere and teamwork at Valmet. The special care which older workers enjoy has resulted in fewer early retirements compared with other companies, and operating result have benefited.

Valmet has incorporated employee health promotion and the development of professional skills into its quality assurance system. Responsibility for planning workplace health promotion activities rests with the management team, the safety department, the department of occupational medicine, and work-force representatives.

Valmet's health-related projects place special emphasis on employees over 45 years old with particular attention to their medical check-ups and records of work stress. The company conducts regular workplace studies on potential health and safety deficiencies to detect problems as early as possible and avoid irreversible damage. It emphasises continuous training and holds annual personal development discussions with each employee. Quality and training issues are discussed every two-months at development meetings. The training programmes are well attended, and each employee spends an average of 6.24 days a year on training. Valmet regularly assesses the leadership qualities of the executive team, and offers its members opportunities to enhance their skills. The company supports sports activities and a canteen for its employees, and a physiotherapist is available for rehabilitation treatment.

Health-related measures have had a positive effect on the working atmosphere and teamwork at Valmet. The special care which older workers enjoy has resulted in fewer early retirements compared with other companies, and operating result have benefited.

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CONCLUSION

Good mental health is an essential part of an employee's work ability. This makes it of concern not only to employees themselves but to employers and governments as well. In Finland the framework for promoting mental wellbeing and the interest in doing so already exist, now it is time to reinforce the commitment.

In Finland over the past decade the occurrence of mental disorders has increased markedly. This can be attributed mainly to the rising prevalence of depression which has taken place despite the concurrent availability of new forms of treatment. Burnout and other severe mental health problems are common in the Finnish workforce. Time pressure, a hectic atmosphere in the workplace, and job insecurity have come to characterize the Finnish labour market following the economic recession of the early 1990s and have affected employees' wellbeing. The increased occurrence of mental health problems is reflected in disability pension and absenteeism statistics: mental health problems are the most common reason for disability pensions and sick leaves.

Finland has begun to respond actively to the obvious need to address mental health issues. Most Finnish employers are making efforts to maintain their employee's work ability, of which mental health is an important but often insufficiently acknowledged element. Government agencies, workers' and employers' organisations and many non-governmental organisations have been developing programmes and campaigns designed to raise awareness of issues such as work ability, burnout, stress, and suicide. The social and political climate in Finland is conducive to mental health promotion and prevention programmes, especially in the workplace. Recent reforms in occupational health care and rehabilitation legislation, the country's extensive occupational health care system, the high rate of unionisation, and the harmonious relationships between the various stakeholders in the labour market are all in place to foster social dialogue and action. Finland has been successful at advocating mental health promotion at the international level, particularly within the European Union.

However, there are still steps to be taken to address the issue of mental health more efficiently and to respond to the growing needs of the population. The rehabilitation system for people with mental health problems, in particular for people with depressive disorders, needs to be further developed. Rehabilitation and prevention of mental health problems could be tied more closely to activities in the workplace which maintain work ability. This would increase the flexibility of rehabilitation services and make them a natural part of the work culture. It would most likely reduce the stigma often attached to the use of specialised mental health services and help employees with mental health problems to more easily maintain their employment status.

Good mental health is an essential part of an employee's work ability. This makes it of concern not only to employees themselves but to employers and governments as well. In Finland the framework for promoting mental wellbeing and the interest in doing so already exist, now it is time to reinforce the commitment.

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APPENDIX

FPED - FOUNDATION

Examples of working arrangements for people with severe mental health problems:

SUPPORTED EMPLOYMENT: Work in integrated settings in the open labour market with ongoing support and competitive pay.

FPED set up the Finnish Network for Supported Employment, FINSE, to promote education, awareness and communication about supported employment. FINSE has about 133 members. Its activities consist of publications, national and international seminars, and training for job coaches. FINSE is a Finnish member of the European Union of Supported Employment (EUSE).

EMPLOYMENT MODELS FOR MENTAL HEALTH TRAINEES

Jobs suitable for mental health trainees undergoing rehabilitation are being developed in collaboration with work centres, i.e., transitional employment, which help people with mental health problems enter the open job market. A central part of this is comprehensive support, which covers working, housing, and meaningful leisure pursuits, such as hobbies and friends.

THE FOUNTAIN HOUSE: A social service, housing and employment programme for people who have experienced severe mental illness. Members can participate in meaningful activities and work at the House.

The Foundation has promoted clubhouses based on the Fountain House model of psychiatric rehabilitation in Finland. It disseminates information on the model and promotes the establishment of more clubhouses. The Foundation is a senior partner in the International Center for Clubhouses Development (ICCD).

SHELTERED WORKSHOPS: Sheltered workplaces provide individuals with disabilities with a prolonged period of learning and practice with lower rates of output and pay than in the open labour market.

The Foundation is co operating with sheltered workshops to develop a new workshop model, which will function independently in the labour market, and as part of a local and regional network of service providers in training and rehabilitation.

SOCIAL FIRMS AND ENTERPRISES: Businesses with a social mission in the open labour market, aiming to employ people with disabilities or other disadvantages. Workers are paid a market wage or salary appropriate to the work.

In 1997 FPED started a national development project of social firms in Finland. In this development work, the Foundation is making full use of its membership of the CEFEC - the Confederation of European Firms, Employment Initiatives and Co-operatives.

LAWS

The following legislation concerns people with disabilities, their employment, training and services¹:

Act on Services for the Disabled (380/1987)
Decree on Services for the Disabled (759/1987)
Act on Vocational Institutions (487/87)
Decree on Vocational Institutions (491/1987)
Decree on Special Vocational Institutions (677/89)
Occupational Safety Act (229/1958)
Occupational Health Care Act (743/1987)
The Constitution of Finland (chapter 2, amendment 969/1995)
Penal Code 47:3 (amendment 578/1995)
Contract of Employment Act § 17.3 (320/1970)

Finland's legislation concerning rehabilitation was revised entirely by enacting, inter alia, the following laws from 1.10.1991.

Act on Co-operation Regarding Rehabilitation Client Service (604/1991)
Act amending the Public Health Act (605/1991)
Act amending the Special Medical Treatment Act (606/1991)
Act amending §2 of the Occupational Health Care Act (608/1991)
Act amending the Sickness Insurance Act (621/1991)
Act amending §7 of the Employment Act (609/1991)
Act on Rehabilitation Provided by the Social Insurance Institution (610/1991)
Rehabilitation Allowances Act (611/1991)
Act amending the National Pensions Act (619/1991)
Act amending the Employees Pensions Act (612/1991)
Act amending the state Employees Pensions Act (618/1991)
Act on Rehabilitation Indemnification on the Basis of Employment Accidents Insurance Act (625/1991)
Act on Rehabilitation Indemnification on the Basis of the Motor Insurance Act (626/1991)

Revised legislation concerning employment services entered into force at the beginning of 1994:

Employment Services Act (1005/1993)
Employment Services Decree (1251/1993)
Decree on Benefits Related to Employment Services (1253/1993)

Other amendments:

Employment Act (275/1987) amendment to the Act from 1.1.1993 (1696/1992)
Employment Decree amended (130/1993), disabled persons, among others, to be employed with employment appropriation funds
Employees Pensions Act (1482/1995) and other pensions acts were revised from 1.1.1996 so that instead of the fixed period of disability pension, rehabilitation support based on a treatment or rehabilitation plan will be granted

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- 7 The sickness daily allowance is an income maintenance benefit compensating for the lost income during a period of incapacity for work. The allowance is paid to employed and self-employed persons aged 16 - 64 for a maximum of 300 workdays. However, the sickness allowance is not paid for the first nine days of absence. The salary during the waiting period is normally paid by the employer. After the nine days there is officially a loss of income as the benefit percentage paid is less than 100 % of the wage. However, the employer normally pays full salary for 4 to 8 weeks sick leave and gets a refund 70 % of gross earnings after the nine day waiting period from the sickness allowance scheme. The maximum period of temporary unfitness for work is 300 days. The regulations concerning extended or permanent disability are linked to the regulations covering the temporary unfitness for work.
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 - 20 Finland has two pension systems: the National Pension Scheme and the Employment Pension Scheme. Both pay old-age, disability and survivor's pensions. The National Pension Scheme provides pensions on the basis of residence and guarantees a minimum income whereas the Employment Pension Scheme is based on employment and related to earnings. The national pension is co-ordinated with the person's pension from the Employment Pension Scheme and paid to persons with low or no employment pension. Thus, when the employment pension exceeds a certain amount there is no entitlement to national pension. National pensions are administered by the Social Insurance Institution. The Employment Pension Scheme is managed by private insurance institutions. The Central Pension Security Institute (ETK) is the central body of the scheme. The public sector has its own pension institutions.
- The national pension insurance provides benefits in different categories based on old age, disability, unemployment or loss of spouse or parents. Disability pension is payable to people between 16 and 65 who on account of disease, defect or injury are not able to maintain regular incomes that, considering their age, occupation, education and place of residence would be suitable for them. The pension can be granted either indefinitely or for a specified period, in which case it is considered a rehabilitation subsidy.
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