Project Title

Impact on Changing Social Structures
on Stress and Quality of Life:
Individual and Social Perspectives

Project Acronym/Logo

STRESS IMPACT

Work Package 6
Professional Study: Finland

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Table of Abbreviations

GP   General Practitioner
OHP   Occupational Health Physician
OHN   Occupational Health Nurse
GM   General Manager
HRM   Human Resource Professional
MHP   Mental Health Professional
        (Psychiatrists, Occupational Health Psychologists, Clinical Psychologist)
HSO   Health and Safety Officers and Delegates
CM   Case Managers and Social Workers

Section 1: Overview and Commentary on the Professional Study

1.1. Overview and commentary on the professional study

The objectives of Professional Study are to:

- Conduct a study to investigate professional opinions on stress and long term sickness absence,

- Determine whether current professional thinking is comparable to the experience of individuals, who have a stress related complaint, and

- Explore the relevance of existing diagnostic and prescriptive protocols to current professional and management responses to stress related conditions.

Thus the professional study mediates between the jurisdiction study and the family study.

In our earlier report "Review and Inventory of National Systems and Policy: Finland" (Joensuu, Kivistö and Lindström, 2003), we examined Finnish legislation and different stakeholder policies regarding long-term sickness absence, with specific regard to mental health issues (Annex 3). We described different stakeholder partners who play a role in sickness absence and disability issues.

The most relevant pieces of legislation concerning the rehabilitation and employee health have been changed in the last couple of years. Changes are also being considered to the sickness benefit system that would promote reintegration to work. The challenge at the moment is how the principles and aims behind the new legislation translate into practise? This will most certainly require co-operation between different parties. The new act on 'Client Co-operation within Rehabilitation' also changed 13 other acts where co-operation in rehabilitation matters are required. The 'Occupational Health Care Act 2001' stresses the cooperation between the employer, the employee and the occupational health care providers to promote well-being at work. In guidelines for good occupational health care practice cooperation with representatives of other health care services, labour authorities, educational authorities, social insurance, social services and the labour protection authority is enacted. The share of responsibilities with the operators is essential. Therefore, general agreement should be reached for the division of the responsibilities and secure

adequate resources for the operators for the fulfilment of these responsibilities. This should include a decision on the co-ordination of responsibility in sickness absence and rehabilitation situations.

We concluded that the issues related to absenteeism and stress have been acknowledged by all relevant parties in Finland. There is a lot of discussion and collaboration on the issue and the government has taken an active role by renewing the legislation and setting up programs aimed to promote employees' well-being.

There seems to be a general consensus of the importance of the issues but the different parties are still searching for remedies that they see as appropriate to tackle the problem.

In this study we interviewed 40 professionals of five different parties to learn how they see things going in practise. The search was made through contacts of Finnish Institute of Occupational Health (FIOH), or by cold calls. One aim was to reach regional representativeness. The interviewees got an information sheet and the interview questions before the appointed call. The interviews lasted 30-60 minutes and were recorded in order to make it possible to check details of information later on. The semi-structured interview schedule functioned rather well. Eight medical professionals were interviewed (General Practitioners, Occupational Health Physician and Occupational Health Nurse). 7 General Managers, 7 Human Resource Managers and 4 Case Managers were interviewed. Lastly, 7 Mental Health Professionals (2 psychiatrists, 4 occupational health psychologists and 1 clinical psychologist) took part in the study. Some GPs and OHPs refused due to the lack of time, but otherwise contacts were positive.

1.2 Overview of the Report

In Chapter 2 we review the issues and trends that arouse within each professional category, and what they see as being important in successful return to work. Relevant professionals were asked if there were some issues in the current legislation preventing the adoption of best return to work practices and about the preventative practices reflecting their prevention concept. In Chapter 3 we look for general similarities and differences between categories of professionals concerning the

awareness about stress and absence and their general beliefs held about stress, effective/ineffective interventions at work and in work/life balance. In Chapter 4 we comment on the current approaches adopted to stress and absence within the jurisdiction understudy. Chapter 5 concludes our reflections and recommendations.

Section 2: Description of types/categories of professionals

2.1 Issues and Trends

2.1.1. Incidents of stress and related complaints over the past five years

General Managers, Human Resource Managers, Case Managers and Health and Safety Officers

3 out of 4 of the CMs, 3 out of 7 of the GMs, 6 out of 7 of the HRMs and 6 out of 7 of the HSOs interviewed reported an increase in the frequency of stress over the past five years. These professionals mentioned several aspects in relation to this increase; the situation varies according to different trades (CM), different staff groups (HRM), age (HRM) and position. Three GMs reported that stress level was the same over the past five years and one reported a decrease. Of the partners in the workplace HRMs and HSOs have noticed an increase in the incidents of stress, more often than the GMs.

2.1.2. Frequency of stress related complaints over the past five years

General Practitioners, Occupational Health Physician and Occupational Health Nurse

Four of the respondents reported that their clients talk about their situation using the word stress often, and 4 GPs reported "sometimes". Patients use terms other than stress e.g. "burnout". Five of the professionals say that in the last 5 years stress related complaints have increased, one says they have stayed the same. One says it has decreased since the deepest depression years in nineties. One OHP had worked only three years and could not report on this question.

Mental Health Professionals

More than half of the MHPs answered "do not know" or "stayed the same". Two occupational health psychologists reported that they spoke with their clients about stress more than before.

2.1.3. Reasons of increase/decrease of stress over the past 5 years

General Practitioners, Occupational Health Physicians and Occupational Health Nurses

One OHP mentioned that compared to the worst times of depression in the nineties the situation is better. Others saw that the frequency of stress had increased (one: stayed the same) due to workload, demands and urgency, and fear of getting fired. The OHN mentioned the tightened work pace, the constant monitoring of money and a necessity to bargain, and the client's increased demands in social care.

Case Manager

3 out of 4 case managers reported that the frequency of stress has increased due to economic pressure, changes in the organizational culture and hard competition. However, in applications for pension stress is not a relevant issue, there must be a "real" disease reported. One case manager did not know if the frequency of stress had changed in the past five years.

General Managers

3 out of 7 GM's reported that the increased frequency of stress comes from demands for effectiveness, conflict of values, lack of resources, managerial culture e.g. communicating through e-mail, which means that there are no possibilities for real interaction. Ongoing changes in work life create stress, for example, pressure to be more efficient and more productive all the time. The discrepancy between what you do and what you should do causes stress. 2 GMs said the level has stayed the same and 1 said it had decreased. One GM mentioned that the level of stress prevails and despite changes there is a humane pace where people can keep up. Work pace has however tightened. The reason for one decreased case was the full order book; the volume of orders in the firm was satisfactory.

Human Resource Managers

The stress level has increased in the last 5 years according to 6 out of 7 HRMs. One HRM noticed that even though the stress level has stayed the same, it is divided unevenly, the ageing workforce feels it effects more.

Mental Health Professionals

MHPs raised the issues of work pressures, inflexibility, job uncertainty, tightened work pace and lowered tolerance for the consequences of ill-health as causes for increased stress level. They also mentioned ageing of the workforce as a factor.

Health and Safety Officers

HSOs analyze the increase of stress thoroughly. Uncertain feelings due to organizational changes, lack of personnel, increased work demands, experience of inequality are the typical causes. There is a growing amount of different tasks; if the employer cannot concentrate on the basic work, the result is a stressed feeling. The nature of work has changed, competitive atmosphere, information overload, and facilitating employer communication prevails. Some workers lack the sufficient level of professional competence, ageing of workforce and generation changes also have their effects. The clients require more and maybe are more difficult.

2.1.4. Models of stress adopted

General Practitioners, Occupational Health Physicians and Occupational Health Nurses

Half of the GPs and OHPs describe stress through the symptoms of their patients. Physical symptoms mentioned included musculoskeletal complaints, rapid pulse, sweating, heart, blood pressure and abdominal problems. Mental symptoms mentioned were, sleep disturbance, anxiety, nervous tension, lack of concentration, sense of inadequacy, subjective feeling of mental overload, difficulties distancing oneself mentally from work. Half of the respondents described not the symptoms but the imbalance between the demands and possibilities to control the work or the high workload.

When diagnosing stress 6 out of 8 GPs, OHPs and OHNs use interviews to get a comprehensive picture of the general work/life situation of the client. None of those interviewed mentioned any laboratory tests or physical examinations. They want to gather anamnesis information, gain understanding about client's beliefs in stress, if he or she admits that stress causes symptoms and if the patient perceives that he or she is suffering from stress. Because stress is a subjectively perceived issue, some enjoy

being under stress, therefore it is important to check the factors related to it. One OHP wants to get an understanding about the worldview of the patient. One sees it the other way around: could there be stress problems behind the offered physical symptoms. One of the respondents investigates the reasons behind stress in the whole life situation and how the causal factors could be affected, this is sometimes done by contacting the supervisor of the client. Two of the physicians mentioned that it is the ethical responsibility of the physician to check the physical complaint in order to rule out other illnesses. 2 of the 8 respondents reported that symptoms like sleep disturbances, pulse, sweating, and sensibility to noises, blood pressure and abdominal dysfunctions are checked out. The OHN pointed out that plenty of time is needed for listening and asking questions about the patients stress problems.

Three main conditions where stress is seen as a causal factor to a great extent are mental disorders, cardiovascular problems and digestive problems. GPs and OHPs mentioned stress being a causal factor to some extent in neurological and sensory problems, respiratory, skin, endocrine and metabolic diseases and blood diseases. Five GPs stated, surprisingly, that stress in not at all a causal factor in tumours (2 respondents "to some extent", the OHN did not have an answer to this question).

Case Manager

The rehabilitation case managers point out the discrepancy between high demands and a person's resources which leads to anxious feelings and no way out of the situation. Profit responsibility in business and fear of getting fired causing stress is one form of this discrepancy. A stressed person is overdriven, cannot calm down, things go round and round uncontrolled. Most often the clients applying for rehabilitation or disability pension from insurance companies are diagnosed with depression and anxiety disorders combined with physical, mostly musculoskeletal disorders. Stress complaints alone do not form an adequate ground for getting official rehabilitation services.

General Managers

Organisational definitions of stress hardly exist. Only two of the GMs reported that stress is discussed when the work community has developmental meetings or have got some information about stress from the occupational health unit.

In personal descriptions of stress the majority of the GMs mentioned difficulties sleeping at night and difficulties concentrating at work, which leads to disorganized distribution of work and an uncontrollable situation e.g. workaholism, "pressure in the head". One definition stresses the disturbance in customer-relationships, "at customer service jobs, when you can't smile anymore, then you're over the limit with stress". If you start to dislike customers, then it is dangerous to work in a service." Another definition relates to work/life imbalance, "Stress is when you are totally exhausted after work". However, one GM stated that stress mostly originates from factors outside work.

Human Resource Managers
3 out of 6 HRMs did not know of any organisational definitions of stress. In one organisation guidelines concerning work related stress were just launched, even though stress was not defined very well. The aim is to prevent stress and decrease absences caused by stress. Stress is defined in some organisations according to the questionnaires used in well-being surveys for employees.

Personal descriptions of stress focus on the HRMs responses to the uncontrollability of the situation, sense of inadequacy, performance difficulties, and a state where the functional capacity of the person weakens. The person has got him/herself too much to do, goes into overdrive, resources are insufficient, and there may be also other unlucky life events causing pressure. To some extent stress is always connected with some problem which is somewhat abstract, one cannot focus on what it is, stated one HRM.

Mental Health Professionals
All mental health professionals spoke about the discrepancy between demands and performance and coping resources. In individuals this discrepancy causes anxiety, irritability, lack of concentration, sleep disturbances, loss of control. Complete lack of stress is not ideal either, it can cause perceived uselessness. In stress cases the most commonly used diagnoses are depression and anxiety syndromes.

Health and Safety Officers

All of the HSOs reported that in the field of Health and Safety the word stress is not used, but instead: wellbeing at work and work, community or mental overload.

Personal descriptions of stress by safety officers and delegates focus on the imbalance between a person's resources and demands, which can be an under/or overload situation. Due to the imbalance there are symptoms of tiredness, insomnia, unwillingness and tearfulness. The person does only compulsory tasks, and has trouble concentrating.

Summary: All the professionals model stress more or less as an off balance situation: GP, OHP; OHN discrepancy, CM discrepancy, GM disturbance, HRM uncontrollability, MHP discrepancy, HSO imbalance. HSOs do not use the word "stress" at all. As a consequence of the imbalance the professionals describe several physical and mental symptoms. More deeper, core issues are seen differently according to the "eyes" of the respective task of the professional; GP, OHP,OHN and HRM mention a change in personality "sense of inadequacy". CMs describe a situation without any choices, "no way out". GMs see the consequences of disturbance at work; disorganized working, disturbed customer relationship and work/life imbalance or even "causes other than work". HRMs add to the consequences the question of sickness absences and the issue of life-events. MHPs connect the stress to the sense of being valued, without stress there might be a feeling of uselessness. One common theme in the answers of all professionals was the continuous activation of the self-regulatory system of the stressed people "no distancing from work" "cannot calm down".

2.1.5. Problems and reservations in identifying stress

General Practitioners, Occupational Health Physician and Occupational Health Nurse
The main problem in diagnosing stress is differentiating between stress and somatic complaints. If the patients focus on somatic symptoms it is not easy to understand how the psychosocial factors are intertwined in the case. Two respondents mentioned the fact that

some patients are uncommunicative, can't talk about stress, will not accept that they might be suffering from stress or deny the stress problem. Sometimes patients don't want to be treated in occupational health care. Physicians must stay alert by ruling out other diseases. It can be difficult to define, what is normal or abnormal, because stress is a subjective experience. The OHN pointed out, that the difficulty lies with the occupational health personnel; if the way of working is diagnostically oriented, stress is a difficult issue, but if the orientation is comprehensive, there are no difficulties.

With regard to reservations in using stress as a primary diagnosis GPs, OHPs and OHN define two reservations. Firstly, using stress in physician's certificate is not possible because the diagnosis is not accepted in insurance-related questions. The second problem concerns medical aspects of diagnosis; stress is a normal and positive thing, which should be handled in a normalizing way in care contacts.

General Managers

Nearly all GMs mention work-related issues in stress cases like delay in performing tasks, difficulty grasping the essential things, inefficiency, constant sense of rush and long working hours. In some workplaces workers come to talk about what lies in the past, but there are also experiences that employees rarely talk about their stress to the boss. Some people are stressed, some lack "joy at work". If people cannot cope, it can be noticed. Individual signs are frustration, nervousness, crying, irritation, constant complaining, and insomnia. There might be sick leave first occasionally, then regularly.

Human Resource Managers

To recognize stress two of the HRMs collect feedback from employees and the occupational health unit. TYKY-tiimi, the Finnish form of health promotion team has sessions to discuss the subject. In addition to these monitoring ways the stress situation is recognizable through disinterest, marks of rush, undone work, and in some cases resigning. How actively a person takes part in the joint tasks in the work place can also be monitored. Individual signs are sick leave, especially unexplained 1-3 days absence spells, tiredness, lack of joy. The general appearance is frowned facial expression.

Health and Safety Officers

All of the interviewed HSOs (7) have been contacted concerning stress issues, but one mentioned that there are other words than stress used, e.g. conflicts, fatigue, lack of replacement during absences etc. All HSOs have reported stress causing situations to the HR and OH-unit, after getting the required permission. After this some changes in human resource policy are made and cooperation with occupational health care is activated. GMs, OH-units and employees actively contact HSOs. Maintaining mental well-being is focused in the work of some Health and Safety districts in Finland.

When recognising stress the HSOs pay attention to both individual symptoms like restlessness, irritation, "schizophrenic feelings", absent-mindedness, flightiness, insomnia and psychosomatic symptoms and to indirect excuse seeking. All in all the performance of the worker suffers.

2.1.6. Knowledge requirements of professionals

General Practitioners, Occupational Health Physician and Occupational Health Nurse

GPs, OHPs and the OHN evaluate their knowledge about stress as relatively good, "sufficient knowledge". However, there is never too much information, some of them add. The knowledge is acquired in basic training or if through their work the doctor has learnt to treat and examine it quite well. One doctor has the information from supervision of work in previous job. "A doctor has never enough knowledge", state 4 of the 7 respondents.

Case Manager

Case managers judge that they have good knowledge about stress, but nearly all add, that the need for information is continuous. However one of them adds that one question that remains is should stress be taken into account another way. One would like to know more about the work-relatedness of stress and how it could be intervened. But in social insurance case management, there is more need to know about depression, stress is lightweight.

General Managers

Three GMs answered that they have sufficient knowledge or not so much interest in the question. Most of them judged themselves to have a good level of knowledge, which they have got from media and literature, occupational health, and e.g. by taking part in "Ikäkehys"-training (ageing) during the last 2 years. Management training has been helpful, however managers are not psychologists. One GM felt that he needs more information about handling situations because he can't recognise stress in certain kinds of people.

Human Resource Managers

All human resource managers think that they do not know enough about stress for the HR department to intervene effectively. Some have learned to see symptoms, but stress cases are not dealt with early enough. Some HR managers reported that they would like to learn more about how work community phenomena have an affect at the individual level. One HR manager likes to be in cooperation with occupational health care and specialists.

Mental Health Professionals

All MHPs judge that they have rather good knowledge about stress. They have acquired it in training, in research and in work community interventions. Most important are courses provided by the employer, especially on organisational issues, says one. MHPs would like to learn more about effective and well-timed interventions of stress and burn-out. Two of the MHPs wish for more knowledge about posttraumatic stress disorder.

Health and Safety Officers

Two of the HSOs think that at present they do not have sufficient knowledge about stress, because for example, concepts change and new research results are published everyday. Others are more satisfied, but mention, that there is never too much knowledge. Practical questions are, how to advise people not to take too much pressure and how to maintain distance, how and when should one intervene or how to maintain their willingness to refer the person on.

Summary HRMs and HSOs say that they lack sufficient knowledge, they wish they "could intervene efficiently enough", "concepts change and new research results is published at every turn", "when should one intervene". Others judge that they have more or less good

knowledge about stress, but they share the theme of interventions "should stress be taken into account another way"? ,"more about work-relatedness of stress and how could it be dealt with" (CM), "information about handling situations" (GM), "about effective and well-timed interventions of stress and burn-out" (MHP). GPs, OHPs and the OHN are most satisfied with their knowledge. They have "learned to treat and examine quite well", but they add that you can "never have never have too much knowledge".

2.1.7. Important factors in successful return to work

Enabling factors which were stated are classified into three categories:
1. Work-related factors like work/workplace/work of supervisor/new arrangements at work,
2. Work/life-balance, personal resources (enterprising etc), functional networks, decent income, and
3. Support and care, medication, therapy, counselling, and prevention of traumatic stress disorder.

General Practitioners, Occupational Health Physician and Occupational Health Nurse
GPs, OHPs and OHN mentioned mostly supportive and curative factors (12) as enabling factors (20 statements): "help from the OHP, medication, taking better care of himself"; then work-related factors (8): "interesting work", "good work community" "manager's support and willingness to make arrangements" and work/life balance. A third area (2) was "happy family life".

Case Manager
The most frequently stated enabling factors (9 statements) was supportive and curative measures (3), e.g. "successful treatment relationship & medication", " sufficient psychotherapy", "OHS and specialist in rehabilitation working together". Case managers pointed out the importance of the functional networks (3), "employer, OHS, rehabilitation specialist and employee working together to prepare the return to work", "good contacts with the employer, HR and OHS", "without the extensive team return to work is not successful", "active approach in preparation phase" "good timing

of the interventions". Also the work/life balance is significant (2), "the employee him/herself must be willing", "decent income enables the focusing on work".

General Managers

Enabling factors stated (9 statements) by GMs were most work-related arrangements (5), e.g. "Problems were related to work atmosphere, we changed work environment, even though the process was long and difficult, this decision and process was successful", " Delegating, training other people in the team", "Clarification of job description after a long substitute supervisor period". GMs also point out supportive and curative measures (3) like. "One month sick leave", "open discussion with OHS", "checking the factors causing stress, trying not to create guilt". Also the work/life balance, recovery and career promoting measures help (1). "Attitude towards work changed during one years study leave. The main changes happened in the person's mind work conditions did not change".

Human Resource Managers

Enabling factors (13 statements) experienced by HR managers are mostly work-related measures (9): "Early discovery and reaction", "All members of work team had four appointments with psychologist and the team was analyzed", "changed work arrangements", "Work community has a positive attitude towards return", "Changing job description", "work adjustments", "Networking and interventions made by the network members". Work/life questions are important, too (3). "Person returning is aware of own limitations", "supplementary training", "divorce crisis solved". Curative help is sometimes needed as well (1), "one month sick leave during the most stressful crisis situation".

Mental Health Professionals

Enabling factors (20 statements) of a curative nature mentioned by MHPs were often helpful discussions, where the patients could get new structure in the situation or gain new perspectives (9): "Questioning of dichotomised assumptions", "self reflection", "the counselling tried to promote new interest in life, limit stress factors", "Company had had lay-offs. Person had lost interest, was insecure about his situation", "after-care contact long enough". MHPs working together with work place partners can enable successful return to work (8). "New work arrangements together with the

supervisor", "conversations with the employer", "possibility to return to work after a work trial period". Support to get work/life balance regained after a crisis period help in return phase (3), "Daughter's situation also improved", "professional development through further training".

Health and Safety Officers

H&S officers and delegates have a lot of experience of cooperation in return to work matters. Enabling factors (18 statements) they mention include work-related issues (10): " Work team took the return well", "changing work conditions, of whole work community", "clarifying the tasks of the employee", "cooperation with occupational health care", "keeping in touch with H&S representative and worker representative during absence, was not alone", "superior had changed during absence", "at first did only day shift instead of night shifts (3-shift-work)", " positive reception, co-workers wanted her back", "got a school helper in the class (teacher)". H&S officers and representatives see many types of curative measures positively (6). "Sick leave was long enough (2 months), competent treatment, medication", "stress management courses". HSOs have recognized some aspects in work/life balance, too (2): "Own will to return", "rearranging personal life".

2.1.8. Factors specified as causing stress

We asked about 11 different issues that might be related to stress. If the answers 'often' and 'sometimes' are combined, the five leading causes of stress are job, health, finances, sleep and relationship with partner. In all professional groups the job issue is the number one. The following is the specified cause of stress seen in each group respectively.

General Practitioners, Occupational Health Physician and Occupational Health Nurse
GPs, OHPs and the OHN stated that sleep, relationship with partner, health were often or sometimes causes of stress.

Case Managers

CMs stated that finances, health and sleep were often or sometimes causes of stress.

General Managers

GMs stated that sleep, relationship with partner, children and death/mourning were often or sometimes causes of stress.

Human Resource Managers

HRMs stated that relationship with partner, health and sleep were often or sometimes causes of stress.

Health and Safety Officers

HSOs stated that health, sleep and finances were often or sometimes causes of stress.

Mental Health Professionals

MHPs stated that sleep, relationship with partner, loneliness and finances were often or sometimes causes of stress.

The client contacts the professional most often because of job stressors, then sleep disturbances, relationship with partner among the work/life balance issues, then health and finances.

2.1.9. Causal factors in stress

General Practitioners, Occupational Health Physician and Occupational Health Nurse

When patients are talking about stress with their GPs, OHPs or OHNs, they refer to individual factors like sleep and mood disturbances or being anxious, worn out, un-enterprising, and inefficient. Work-related factors are workload, conflicts with manager, hurry and difficulty to go to work. As work/life factors they refer to unemployment in the family, difficulties in marital relations or divorce, death in the family and economic financial problems.

Case Managers

To the case managers their clients talk about problems in the workplace; hurry, problematic workplace climate and relationships, changes, unjust leadership, uncertainty about their professional future. As work/life problems they refer to finances, alcohol problems of the spouse, divorce, single parenting. Individual problems are mentioned such as ageing, stress-related physical problems and the prognosis of health condition.

General Managers and Human Resource Managers

Both GMs and HRMs addressed the same themes concerning stress by the employees. Changes at work and uncertainty of the future, too much work, long working hours, not possible to do the work well, unhappiness with work conditions, not treated appreciated at work, and some bullying cases. Work/life imbalance refers to chaotic situations at home, difficulty having mind on work during leisure time, personal life suffers from work overload. Also individual problems like sleep disturbances, frustration and physical symptoms are addressed.

Health and Safety Officers

While talking about stress with HSOs employees mention hurry, lack of resources and too much work, lack of replacement workers, bullying and rivalry, unfair treatment, lack of workplace facilities, lack of clear leadership and appreciation. The balance between core and supplementary tasks is not optimal any more. Workers speak about the need for sufficient time for mental processing in the care professions.

Mental Health Professionals

MHPs clients talk about the changes at the workplace, about rapidly changing roles, increased responsibilities, unfair treatment at work and tantrums of the supervisor, work pace, ergonomic problems like noise, violence of customers. In work/life area finances, problems of family members, responsibility for old parents or relatives, and alcohol problems are mentioned. Individual problems are fatigue, sleep disturbances, ageing, anxiety, thoughts going round and round, lack of enjoyment, "grey life full of musts" and irritability.

Some people in professional groups mentioned that people do not speak in stress terms with them; the words are situation related and descriptive.

2.1.10. Most frequently mentioned interventions

General Practitioners, Occupational Health Physician, Occupational Health Nurse and Mental Health Professionals

The most frequently mentioned interventions used by GPs, OHPs, OHNs and MHPs were the mental health services like counselling, psychotherapy, psychological treatment and psychiatric interventions like psychotropic drugs. Also non-health interventions like vocational training, occupational rehabilitation, case management, workplace adaptations were used quite often. Majority of them rarely or never used alternative interventions like acupuncture or homeopathy.

GPs, OHPs, OHNs and MHPs evaluated the effectiveness of interventions in scale 1-5. The most effective were mental health services and non-health interventions.

In a case of a stress related condition MHPs normally tried structuring the situation by a thorough interview, explore the work and discuss with the supervisor if the employee agrees to this. Active support is needed to maintain a sense of competence. Required medication and sick leave is used and crisis help given. Negotiations with the OHS team and cooperation with the workplace are promoted. Discussions help the client to gain a new perspective to the situation. Sometimes the client is referred to psychotherapy.

General Manager, Human Resource Manager and Health and Safety Officer

GMs try to prevent employees going out absent by changing work environment, "discussions about the difficult things", decreasing work load or redesigning job, improving ergonomics, arranging free working hours (one GM), planning of work, developing leadership in organisational changes. Some companies start MWA (maintenance of work ability) activities like physical exercise. Three GMs mentioned financial support for the exercise activities or massage. They also ask the Occupational Health Nurse to carry out work place surveys or use rehabilitation services.

HRMs assess motivational aspects, work safety, further education, health check-ups in OHS, and personnel surveys. H&S officers and delegates do risk assessments; refer to work arrangements, rotation of work tasks, and temporary absences allowed by industrial relations legislation.

2.1.11. Relevance and effectiveness of interventions

General Practitioners, Occupational Health Physician, Occupational Health Nurse and Mental Health Professionals

OHS and MHP experts refer to and see mental health services, psychiatric interventions and non-health interventions along with occupational rehabilitation and workplace adaptations as the most relevant intervention partners. Case managers refer mostly to vocational training and occupational rehabilitation combined with work place adaptations. GPs, OHPs and OHN all see recognizing and diminishing the causal factor of stress as effective, most often decrease of workload. Discussions, support and medication are sometimes needed, too. Sick leave offers the possibility to distance oneself and combined with new arrangements at work it can be a good intervention. Some clients need help to get a balance of work/life issues. One GP pointed out, that people manage their stress by themselves. Totally ineffective interventions are plain sick leaves and painkillers or symptomatic care without any measurements at the work place. The OHN added that continuous ruminating about stress is harmful if the expert does not point out the necessity to escape out of the situation.

MHPs judge structuring the worker's situation at the workplace, help of multi professional network and working time arrangements as efficient interventions. Good individually focused interventions are: support the worker's own resources, negotiations with employer and part-time work. Ineffective are blaming, ruminating, complaining or listening without active solution seeking or letting patient go out on long term sick leave on their own with medication. Sometimes medication and psychotherapeutic interventions are the wrong type and therefore ineffective or even harmful.

Case Managers

Case managers see effective interventions being related to the good timing of relevant treatments, discussions about the situation and seeking of solutions in a process like manner and time management. Ineffective interventions are long waiting times for measurements, infrequent appointments, medication only or excessive medical approach to work-related problems. One respondent points out, that without trust no intervention is effective.

2.1.12. Return to work objective in investigatory procedures and intervention

General Practitioners, Occupational Health Physician, Occupational Health Nurse and Mental Health Professionals

Every single GP, OHP, OHN or MHP professional has a routine for investigating if the patient is absent from work. All of them give assistance in return to work and if the patient agrees they contact the workplace. Work is also a healing factor, and people should not be allowed to become disconnected from work, but MHPs say that return to work should not happen at too early a stage. The client must feel that he/she is in a fit condition for work. Return is difficult if the absence is long and the client's own decision is to apply for retirement. Arrangements at the work place are necessary. Those, who need assistance, usually go back to the workplace through OHS.

Case Managers

Case managers see assistance in return to work as a well-timed treatment, listening to patient, invoking patient's motivation, giving information, clarifying the network of specialists as good interventions. They offer to be available after the treatment relationship is over. Discussions, professional opinion statements, financial support and work try-outs help the way back to work. Case managers contact actively the employer and the occupational health unit. Insurance companies can support financially in the return phase from one to six months, so that the employee can begin with part-time work and progress slowly to normal work.

General Managers

General Managers help in the return to work phase by decreasing workload. They try to motivate the team to receive the returnee well, but in most cases this doesn't work. "People are too busy and too occupied with their own work". The GM can clarify the job description and quantity of work, not demanding 110% work but waiting until the work runs smoothly after a while, like after a summer holiday.

Human Resource Managers

Human resource professionals recognized several types of work arrangements that help workers to return to work: "influence to the payroll system", "yearly survey of work climate", "plan of action in case of mistreatment", "training program", "supervision", "part-time work". One HR manager mentioned that giving stress information in the work place is a difficult task.

Health and Safety Officers

Health and safety officers had more critical comments than other professionals. "Left on the shoulders of the work team" or "No proper, general guidelines". One HSO said " There is no organized model, but this issue is being thought of at the moment." In the return phase it is important to try to include the employee in the everyday life of the work place as soon as he or she returns", pointed out one H&S officer. Lack of resources in occupational health care services is troublesome.

2.1.13. Referrals

General Practitioners, Occupational Health Physician and Occupational Health Nurse
Four GPs, the OHPs and the OHN answered that there might be no referrals, first the situation is investigated in the OHS. Specialist referral depends on symptoms and situation. Sometimes further examination is needed to get the diagnosis confirmed. One OHP refers the patient to an OH psychologist most often. One respondent described the referring practice: musculoskeletal problems to physiotherapist or orthopaedist, long term situation to psychiatrist, issues which are related to work community to psychologist and problems with family issues or economy to social worker.

General Managers

3 of the 8 general managers referred on to occupational health unit (physician, nurse). Others to no one, "these situations should be dealt with in the work community, with manager and fellow worker" or "at first checking out things at work, then to the OHS or to some existing care connection". One GM said "First try to deal with the issue on the office level, shift workloads, however you cannot give too many breaks, otherwise other employees get annoyed if someone gets special treatment". Three of the human resource professionals referred on to own managers and four refer to own manager and/or occupational health services.

Health and Safety Officers

3 out of the 7 Health and Safety Officers would refer cases to occupational health services, physicians, nurses, psychologists. Nearly all point out that open discussion is important in the work community and with managers and would refer people to their own manager first.

Case Managers

The clients are referred to case managers by occupational health care units. The Social Insurance Institution of Finland, insurance companies and employment offices refer patients for work ability evaluations. Physicians refer when there is a need for vocational rehabilitation.

Mental Health Professionals

The causes of referrals to the mental health professionals are depression, difficulties managing the work, crying, and people in a conflict situation. Some referrals are for assessment of the situation (treatment, rehabilitation) or short counselling. The Social Insurance Institution of Finland asks for an assessment in long-term sickness absences.

2.1.14. Professional Involvement in return to work

General Practitioners, Occupational Health Physician and Occupational Health Nurse
All GP's, OHP's and OHN's give their assistance in return to work, if the patient gives permission. Joint negotiation of all parties involved gives a good start.

Case Managers

All 4 case managers assist in return to work. They describe the measures: well-timed treatment, listening to the patient, invoking the patient's motivation, giving information, clearing up the network of specialists, offer to be available after treatment relationship is over. Insurance company can give financial support to work try-outs. Searching for solutions starts there. Making contact with the employer and occupational health care is important.

General Managers and Human Resource Managers

General managers offer their assistance by decreasing workload, motivating the work team to the reception of the returnee. Task clarification and judging the quantity of work tasks help in the return to work phase. Only one human resource professional answered this question and the respondent pointed out that the situation is dependent on the case.

Mental Health Professionals

Mental health professionals were all willing to get involved in the return phase. "Absolutely, if the person is recovering and the situation at work is critical, MHPs know what is stressing the patient and can help the employer" and "MHP should come to the meeting at the work place. If the mental health system is active, the results are good". In joint discussions with supervisor and in work community the problem should be studied carefully, keeping related to work, concentrating on the reasons of stress. Psychotherapy doesn't help, stated one MHP.

Mental health professionals reflected about the best timing of the return. The employee must feel that he or she is able to return, it is not good to return too early. MHPs send the clients back to work through OHS.

Health and Safety Officers

According to HSOs individual interventions like retraining, job assessment and redeployment and moving to another job within the organisation are often needed. Decreasing workload, changes in work environment, provision of technical aids and stress awareness programs are also helpful. In order to deal successfully with the return to work process a clear model concerning return to work should exist in workplaces. Employees

should have confidence in returning, there should be more permanent staff and also the required number of standby personnel. Questions relating to workload and responsibilities should be covered in management training. There is a need for more conversation at work places, change of attitudes, and consideration needs to be given to how the employee returning to work could be paid attention to better. The immediate superior is often in the key position. "Soft landing" is preferable; at first they should concentrate on the main tasks possible. The ideal return management means normal, good behaviour from fellow workers. Meeting the employee during absence, at least a conversation about the reasons behind stress and about employee's wishes, manager's point of view etc. Proper follow up of the situation is needed.

2.1.15 Family Interventions in Return to Work

General Practitioners, Occupational Health Physicians, Occupational Health Nurse, Case Managers and Mental Health Professionals
Three GPs invite family members to appointments, but only sometimes or rarely "If issues are home related, if patient wishes to". Others answered no. None of the case managers include family members.

Five of the 7 mental health professionals welcome family members to be involved in the return phase. "Patient can invite his/her relatives; the intervention is psycho-educative", "...giving information to family members, getting more information from the family". One MHP mentioned that meeting family members is quite exceptional, another meets family in the treatment phase, but not in the return to work phase.

2.1.16Employers and social protection agencies

General Practitioners and Occupational Health Physician
All except one of the GPs had been contacted by the employer. The questions have been how real the reason for absence is, "might it be just faking". More accurately the discussions concern need for work arrangements, the length of the absence and how to make the return easier. One mentioned that managers are often uncertain how to handle the situation and seek help.

Regarding the role of social protection agencies in return to work, only one of GPs/OHPs mentioned that the Social Security Department had made contact. The reason was to get more information and also to get the occupational health unit's view on the situation. Others have not been contacted, one told that it is other way around; OHS makes contact with the Social Security Department.

Case Managers

One case manager tells "Half the battle is won if the employer makes contact. If the employee wants to return back, the insurance company helps by financing work try-outs for e.g. 3 months". "Employer inquires how the insurance company could support, what are the grounds and criteria for the support?" Cooperation with workplace and case manager seems to be a standard.

Mental Health Professionals

Two MHPs said the employers had not contacted them. "No, clients usually do not wish to tell that they have seen a psychologist". Others told about positive and negative experiences. "Employer is often confused, as well", "Conversation with employer, if the patient gives the permission". Some inquiries are difficult "Supervisor may give a (hidden) task to keep the worker away, especially in case of personality disorder", "Sometimes, on long-term absences employers ask for the plans. They want to know what's going on."

2.2. Illustrations from Cases

In this section we report the part of the interview in which we asked the professionals about case studies. First is a successful case, then an unsuccessful return to work.

General Practitioners, Occupational Health Physician and Occupational Health Nurse

Help of OHP; discussion, medical care and some change in personal projects

The worker contacted the OHP. He was willing to discuss his problematic situation. The basics, such as interesting work and a good family situation were there. Depression was cured by medication. He started to take care of his family more than he had previously.

Being irreversibly insulted

In the background there were problems concerning professional skills. Then there was an incident adding insult to the picture. Even others could not see the point of being insulted. The discussions with the OHP, sick leave, cure of sleep disturbances, joint negotiations with worker, line manager, occupational physician and nurse did not help. The worker did not get the compensation or reconciliation that she wanted. Her return to work was sour and negative.

Case Managers

Cooperation, timing , steady income

The worker was a work pension rehabilitation client in an insurance company. From the point of view of the insurance company (return to work-function), the work community, line manager and occupational services unit worked well together. Timing of rehabilitation measurements was optimal. The worker's life was OK and she could concentrate on work without financial worries.

Inflexibility, no preparation for return

There was overload from the first moment after the return. No preparations were made the person just returned. Some flexibility and work arrangements after return are needed - without this the situation doesn't have a good prognosis.

General Managers
No continuity in leadership

There was a long period under which the manager of the department had got several absence leaves and had replacement managerial work in the department. The worker's job description was unclear and she got tasks from several people. The amount of tasks increased and the worker could not know the importance level of different tasks. She reacted by suffering migraine and had sick leaves due to other reasons as well. The new permanent manager made a new job description with the worker. The delegation of tasks was also sorted out.

Part time-return to work not effective

The worker herself wanted to get part-time work after return to work. She had chronic musculoskeletal complaints and several of her relatives were ill.

Human Resource Managers
From undermining to appreciation

The competencies of an older male employee were undermined despite his reformist attitude and he was bullied by his work mates. After 5-6 months absence the new managing director offered the person a new post in another work unit, where his expertise was appreciated. The insight of the new manager was crucial in the happy solution.

Not quite happy

A thorough worker had much work and a lot to answer for but was not officially ranked. The senior colleagues questioned the status of this young man. His absence was 2-3 weeks, he tried to negotiate with his manager. The manager tries to keep the worker distanced from his natural work group. The returned worker does not seem happy.

Change form toughness to 'wholeness' possible?

The role of the managerial solutions are important, and in recruitment of new managers another type of leadership is looked for in order to develop organizational culture which sees the worker as a whole person even under hard economic pressure conditions. But the hard values of the work place culture are still there. The tough ones cope, the stressed ones are weak and must suffer alone. They visit the occupational health unit or HR-department with their individual worries.

Mental Health Professionals

Do not be afraid of long sick leave either

The worker returned to work through work trial period lasting several months. At first he was given shorter working hours, and less demanding tasks. This was done because after the first return to work everything went wrong. The care contact and sick leave were long enough, as well as psychiatric medication.

Don't want to be set aside

A well-educated senior worker had experienced disappointment before. He did not get tasks corresponding to his professional skills; his know-how was not in use even though he had got further training. He did not get the expected promotion. There was some mood disturbance but it was not the primary cause.

Clarifying the overall situation and measurements for the professional renewal

The work of a senior information officer had changed a lot, and the amount of tasks increased as well. Her discussions with the occupational health psychologist helped her gain some new perspectives. With her line manager she made some new work arrangements, and got training in new information technology. She felt satisfied with her professional renewal. The sickness absence could have been avoided if she had made contact with the occupational health nurse in an earlier phase and got help immediately.

All disputes cannot be resolved

One senior woman in care profession had taken already several rehabilitation courses because of her physical problems, which, were of no remarkable help. Communication with work mates made waves and the dispute could not be solved even with the help of the OHP. Her professional competencies were not good enough any more for the demands of care work. The tolerance of the work community had diminished. In this case it could have been helpful it the manager renewed her job description in an earlier phase. The too big, unthinkable responsibility taking in care work could have been prevented. In municipalities the line managers do not dare to fulfil needed solutions in job changes.

With a little bit of understanding-or without

A safety delegate assisted in the case where the employee could come back after sick leave to a day shift instead of three-shift work. The supervisor had changed during the absence. The worker was relegated and the result was finally the disability pension. More understanding from the supervisor's side could have prevented this outcome.

Section 3: Description by Themes

3.1 The level of awareness about stress and absence

General Practitioners, Occupational Health Physician and Occupational Health Nurse

4 of the GPs, OHPs and OHNs said that patients refer to stress often when talking to them and 4 said that patients refer to stress sometimes. Five of them reported that the frequency has increased in the last five years and one stated that it had decreased since the worst depression in the nineties. One felt that the level had stayed the same and one could not tell. Stress as a primary diagnosis is given in 5-30% of cases. One professional said that they diagnosed depression in 5% of cases, backache in at least 5% and anxiety in 2% of cases.

Case Managers

For case managers the stress issue in the applications for work pension or vocational rehabilitation is not a relevant issue, because the formal procedure of social benefits require a diagnosis of a disease lasting at least one year. 3 out of 4 case managers said that the diagnostic labels most often used are depression and anxiety in connection with physical symptoms or depression ICD F 32. Stress does not exist as a primary diagnosis but is referred to as an additional condition in 10-80% of cases. However, case managers pointed out the necessity to monitor the change of stress level within different trades.

General Managers

4 out of 7 General Managers have not generated an organisational definition of stress, but in some cases the issue is handled in cooperation with the OH unit or in developmental seminars. As managers they have formed their personal definition of stress connected to the work performances. GMs recognize stress problems when the work of an employee is disorganized, passive or the customer service is not satisfactory. At the individual level they notice changes in work behaviour, workaholism, uncontrollability, fatigue and mood disorders. These stress signs have increased according to 3 GMs, 3 say they have stayed the same and one GM feels they have decreased since the economic situation in the company is stabilized. Stress is

recognized when the employees cry, complain constantly, are frustrated, in a rush, are inefficient and nervous and the need for sick leave increases. Work performance delay, and the employee has difficulties grasping the essential things.

Human Resource Managers

One HR manager gives a definition used in the organisation "Work-related stress is the discrepancy between work demands and the know-how of the person, which can lead to burn-out". Others rely on definitions of stress questionnaires and information provided by OHS. Their personal definition points out the uncontrollability of the situation. One HRM added "stress is always connected with some problem which sometimes is to some degree abstract, one cannot get clear idea what it is". All HRMs said that the frequency of stress has increased, one added, that the situation within the organisation is uneven, others raised the question of ageing of the work force. To recognise stress in an organisation 3 HRMs use surveys or cooperate with health promotion (MWA, maintenance of work ability) teams. Others recognise stress in different visible symptoms and behaviour and by increasing sick leave. All HRMs have provided information about the company welfare policies to the staff through brochures or the intranet, but they doubt how well this information is used and known by workers.

Mental Health Professionals

5 mental health professionals reported that stress is referred to by the patients often. 2 said it was referred to seldom because the word "stress" is not used or is described implicitly. Their personal description of stress grasps an array of reactive symptoms and is more conceptually expressed as "how well resources/coping strategies/knowledge and expertise fit to demands". Other MHPs define features such as unclear, unfocused ways of working, overburden, too much strain, contradictory expectations at work and in personal life. As diagnostic labels the MHPs use depression, some personality disorder diagnosis (ICD F60.3). One summarised the stress state "It is a web of many things…work…problems in workplace relationships…fatigue, anxiousness, tearfulness". The frequency of stress as a primary diagnosis varied greatly from one MHP to another and ranged from as little as 5-10% of cases up to 70-100% of cases. Of those who reported stress as a primary diagnosis

in 70-100% of cases they pointed out that they considered that "stress was one of the factors".

Health and Safety Officers

Health and Safety Officers (HSOs) and representatives do not have an organisation definition of stress in use. Two of them say that they speak not in stress terms but about wellbeing at work and of work community or about mental overburden. As a personal description they have like MHPs a systemic view on stress; the organisational factors are mixed up with the personal factors resulting in strain. All see that the frequency of stress has been on increase, one adds that the situation is different for different staff groups. They have all reported their view to HR or OHS representatives. Stress may be recognizable as fear of work and lack of self confidence, behaviourally there is restlessness, absent mindedness and seeking of pleas of trial (e.g. mould). A lot of information about the policies and health services is available nowadays in company intranets, but how every policy runs in practice may be unclear to the workers. Four of the HSOs interviewed said that monitoring and evaluation of policies was in use. 3 out of 7 reported that they were not in use or that they were not monitored and evaluated efficiently.

3.2. General description of the beliefs held about stress

General Practitioners and Occupational Health Physicians

GPs and OHPs base the diagnosis on the client's description, symptoms, findings through clinical examination, and they want to rule out diseases. Stress problems GPs and OHPs investigate in interviews, no one mentioned any laboratory etc tests. Depression and backache are the most common diagnostic labels used in patient's records. Half of physicians present symptom and clinical findings approach. However, some of physicians mentioned in their reasoning work-related factors, too (see Table 1), mainly in stress, burn-out and fatigue cases (work pace, mental overload, critical incidence). The problem of perceived, unspecific symptoms and the restrictions of social insurance accepting these diagnoses came up. "Depression is a safe diagnosis to use".

Table 1: Frequency and reasons for the diagnostic labels on a patient's record, GPs and OHPs (n=7)

Diagnosis	1. Frequently	2. Sometimes	3. Rarely	4. Never
Stress A4 Critical incident (death, suicide) and stress symptoms A6 Mental pressures exceeding coping resources A7 Difficult to use, serious condition, diagnosed by psychiatrists		2	3	2
Burnout A4 As additional diagnosis if there is work-related problems, depression as main diagnosis A5 Is not a diagnosis A6 High work pace, cynical attitude to the work, weak resources, can not recover A7 Practicing physicians wish to be allowed to use burn-out as dg	1	4	1	1

Depression A1 diagnostic criteria met A2 Obvious symptoms and clients' perception A4 Diagnostic criteria met, not on shaky grounds. There are patients where work exhaustion or burn-out would be the proper label A5 Based on clinical examination A6 Depressed mood over two weeks, no enjoyment A7 Depression means "help"	5	2	37	
Backache A1 Symptoms and findings A2 Unspecific dg, according to patient's complaint and if there are not more specific diagnosis. A3 Symptoms described by the patient and the clinical findings A4 Back pain, it there are MSD problems and work load is heavy. A5 Based on clinical examination A6 Perceived pain, physical condition A6 Cannot be a very specific dg at the beginning	4	3		

Anxiety A2 Do the anxiety symptoms constraint the patient's life A4 Anxiety seldom as alone, mentioned with depression as a primary dg. A6 Objective findings during the examination and patient's description A7 Difficult to clarify during the appointment	2	5		
Fatigue/TATT Tired all the time A4 Additional diagnosis A5 Is not a diagnosis A6 Powerlessness, indifferent, no interests A7 Exhaustion, but is not approved by social insurance	1	2	2	2
Other A1 Obesity, diabetes A3 Insomnia A7 If dg label is needed for social benefits, depression is the most common dg, does not fall flat				

Case Managers

Case managers point out more than others the client's situation without alternatives. 3 case managers see stress as having increased. They consider the increase in stress to be the result of economic pressures, changes in organisational culture, temporary employment and staff reductions. Rehabilitation or disability pension applications, depression, anxiety and musculoskeletal diagnosis are most common. Description of stress situation is not a sufficient reason for social benefits, but can be included as a complementary aspect in 0-80 % of medical certificates. Thus stress problems may be accepted as a part in occupational rehabilitation.

General Managers and Human Resource Managers

General managers describe stress problems mostly as an over activated state of mind, at worst workaholism. The adverse effects at work are difficulties concentrating and keeping things in control. A couple of respondents among GMs and HRMs emphasize that stress is a natural issue. HRMs as a group have a many-sided description about stress; they mention psychological issues such as sense of inadequacy, imbalance according to the demands-control model of stress, they mention life events, weakening of functional capacity, and refer to the abstract forms of causes of stress. They handle a lot of narrative material in organisations, work together with WHP teams, and carry out organisational surveys.

Mental Health Professional

One respondent among the mental health professionals (MHP) states the positive meaning of stress, stress helps to achieve things, it gives a sense of importance. On the problematic side MHPs refer to quantity of work, difficult life situations, demands-resources fit and neglect of the necessary medication. In organisations there is less tolerance towards workers with lowered working capacity.

Health and Safety Officers

Health and Safety Officers describe stress according to the imbalance of a person's resources and work demands, one safety inspector adds that stress is not only work-related. There are some features of a systemic model thinking stress among HSOs "state of load in persons system", "atmosphere gets tense", "use of pleas of trial like mould".

3.3. Issues raised in relation to stress and absence

General Practitioners, Occupational Health Physician and Occupational Health Nurse

All GPs and OHPs continue examination in conditions which could be stress related in order to rule out "additional conditions"/ "somatic"/ "other illnesses", even though the patient does not present the complaints that way. Stress as a primary diagnosis is given in 5 – 30 % of cases. The reservations in use the diagnosis of stress related condition or its equivalent are based on the fact that stress can be a well discussed

issue in examination "stress is such an everyday thing", but in written papers not because "the sickness benefits will not be allowed for stress reasons".

In positive return cases reported by GPs, OHPs and OHNs enabling factors for return were style of leadership, help and support from the official, professional and natural network, as well. After a traumatic incident one supervisor tailored return-to-work with extra help from the psychiatrist and psychologist. Means to prevent the absence in GPs and OHPs cases were early detection of the problematic situation, cooperation with employee, supervisor and OHS, adjustment of work load and flexibility in work arrangements. Personal factors in some cases could be to solve the problem of excessive ambition and accept more help from outside the family, too.

6 GPs, OHPs and OHNs said that the preventing factors identified were related to the difficulties with the supervisor. In two cases the employee's personality factors were the main reason for unsuccessful comeback. If a supervisor was indifferent, not receptive for advice or did not react to hazards, the prognosis for return to work was not good. Four GPs stated the work place climate factors as a preventing factor. Two cases where the personal problems of the worker were more difficult factors were hurt feelings and endless revenge seeking which no one could help any more. In the other case the worker refused to make contact to the supervisor. To prevent the absence totally had been difficult in some cases, we should go to the early childhood relationships or the first choice of career. However, possible preventive measures even in difficult cases could have been to intervene in the work community relationships, to gain more understanding from supervisor, agreement to make contact with the supervisor together with OHP and assessment of the capabilities for work.

General Managers

Enabling factors that GMs have noticed were grouped according to whose effort the successful return was mainly addressed to. There is one clear example mentioned of the change in worker's working attitudes during one year's study leave, but related to stress problems. 6 respondents said that interventions which belong to the GM's responsibilities have been clarification of job description also in exceptional periods of time like replacement, transfer to other tasks, change of work environment, training other people in the team, not blaming the workers and causing guilty feelings but

changing the hazardous things. One GM held the support of the employee's self confidence important and pointed out that he or she should learn to seek help and delegate tasks. One GM saw special importance in open dialogue with OHS. One GM had not noticed any interventions needed after sick leave, special actions have not been necessary. Would it have been possible to prevent the absence? 3 GMs did not see any other possibilities to prevent the absence discussed. One responded said that the earlier detection of stress symptoms could have helped. Others point out the cooperation with different actors "channels for feed back", "decision latitude", "understanding and cooperation".

As inhibiting factors in the return phase GMs recognize the lack of sufficient possibilities to influence and to communicate and get feedback. One respondent mentioned that the earlier recognition of stress symptoms could have prevented the sick leave, another pointed out better arrangements for the period when the permanent supervisor had leave of absence.

One GM said that there were also non-work related issues. To prevent the absence in this case would have been difficult. Another GM reported that everything was done but nothing was helpful. 4 out of 7 cannot imagine any prevention possibilities, two mentioned ways of understanding, influence and cooperation as possible factors may that may help to prevent absence in the first place.

Human Resource Managers

In the positive return to work case human resource professionals describe situations where several type of interventions were taken; early detection and proper treatment, arrangements at work or change of job description, help for the work community, if needed. In some cases re-education and supplementary training helped, and in one case the returnee had gained a new awareness of his/her own limits. In hindsight, 3 HRMs see that the first absence could have been avoided, if there was better follow-up of the worker's condition or if the supervisor had defined the goals of work more clearly. Actions from the manager's side and actively listening to the person had helped them to continue at work without absence.

As inhibiting factors in return threshold the HRMs report several problematic prolonged situations with work/life balance difficulties, alcohol abuse, undermining and questioning of a young colleague by senior work mates, lowered motivational and functional capacity due to a long term absence. One case was a pattern of several unhappy coincidences, but the main reason was that the behaviour of the employee who became mentally ill was not understood early enough before the referral to compulsory treatment was necessary. After that the person was unable to work. Reasons were both work and family related, but at the workplace there were no knowledge and no contact with the relatives. About this case the HRM says "If the issues had been properly understood, there probably would have been a lot to do." Other HRMs see, that despite the severe situations the absences could have been prevented if there was enough time to adjust oneself back to work, take care of professional capabilities, listened too and given immediate help. Changes in the work place culture where stress is held as a sign of weakness is needed, too. On the organisational level information about the staff policies and health services is provided in all organisations of the interviewed HRMs, even though a couple of them said that the information may not work as well in practice as it should.

Health and Safety Officers

Enabling factors raised by H&S officers and delegates contain a variety of actions in return phase. Two of the safety officers attributed the success to the right timing of return and that sick leave was long enough. Competent treatment, medication and stress handling courses organised by OHS were helpful for the recovery. Keeping in touch with the H&S representative during the absence prevented the loneliness. Actions to ease the return included changing work conditions of whole work community, clarifying the tasks of the employee and rearrangement of work shift according to 3 respondents. One HSO mentioned that own will to return and positive reception are important. Preventing the absence in the first place would have required interventions such as work arrangements, more support, and referral to occupational health care in earlier phase. Superiors should understand the importance of managing & human relations skills, says one HSO.

As unsuccessful cases HSOs report several examples. Monitoring the functioning of the work team was forgotten, feedback was not given and work burden was not thought of. The situation was not recognised earlier and the situation went too far. Employee could not "heal" the mental side enough during absence and was not able to work. Absence stretched and returning got harder. She didn't feel capable of work. The situation was left like it was before. Two HSOs mention person-related factors such as lack of sufficient education and divorce as a final straw in another case. The main obstacle for return was her unwillingness.

HSOs mention several absence inhibiting factors e.g. employee had been replaced by a new employee and transferred to different assignments. Members of work community should have accepted that everyone is different. Issues should have been handled right there and then. Management was in a key role. One HSO raised the issue of relapse prevention.

Mental Health Professionals

To the interviewed mental health professionals clients are referred by GPs, OHPs or OH nurses, medical specialists by self-referral and once in each group by therapist, psychologist, psychiatrist, case manager, insurance company and some legal profession. Work-related stress is stated as a big part of the situation.

To enable successful return MHPs engage in a large variety of actions which have turned out to be helpful: careful structuring of the situation by discussing, questioning of dichotomous assumptions, gaining new points of view in therapeutic supportive discussions, and psycho educative approach like promoting new interest in life, expanding life outside work. Two MHPs (OH-psychologist, psychiatrist) mentioned that successful medication is necessary. Sick leave and adequate curative contact guarantee a more positive outcome. In addition to the proper counselling and treatment conversations with employer, new work arrangements together with the supervisor and positive encouragement from fellow work mates are also helpful. To prevent the absence there should have been actions taken like rapid intervention by occupational health care, meeting with employer, employee & occupational health care, part-time work and aid for the employee. Supplementary training, short absences (few days) for resting, fairness of leadership could help, as well.

Several preventative measures for unsuccessful return to work cases were mentioned by the MHP's. Contacting the OH nurse at an early stage, quick recognition of the situation and intervention in relation to the impossible work situation, checking the situation of workers, concern about their well-being and health. In cases of severe mental illness in background the rehabilitation actions must be sufficient enough to prevent the inability to work. Work trial for several months, shortened working hours and less demanding tasks after return help to regain the normal situation. Possibly the first absence could have been prevented, if there was a proper assessment and the role in the workplace had changed towards less responsibility. There are also unmanageable situations like deep anxiety, mental distancing between employer & employee, no contacts with fellow employees and no changes in workplace after absence.

Inhibiting the absence according to one MHP could have been assertive and supportive leadership, new job description, prevention of excessive responsibility taking, awakening of the supervisor and reorganizing the work. Earlier intervention, only a very short sick leave, should help to deal with stress more effectively, argued one MHP. If the person got new tasks more relevant to him after a further training; better use of his know how could have prevented absence. Clarifying whose responsibility it is to act in the situation if the person did not understand his/her own situation also helps.

Case Managers

To the case managers the clients were referred by GPs, OHPs or medical specialists, psychologists or neuropsychologists, insurance companies and then one of each: physiotherapist, psychiatrist, rehabilitation advisor, social worker, HR-manger, The Social Insurance Institution of Finland, Employer/Occupational Health Unit, Employment centre.

Case managers refer clients presenting with stress related conditions mostly to non-health interventions including peer help groups (AA, depression) and to support persons, then to mental health services. The Case Managers found these referrals to be effective in the majority of cases. Case managers never refer their clients to alternative interventions and they don't generally see these as effective. Instead they encourage hobbies. Judgement of effectiveness of allied health interventions ranged

from 2-4 on a 5 point scale with 5 being highly effective. Psychiatric interventions were rated between 3-5 and other medical interventions 2. They also pointed that treatment is only effective if it is well-timed. Concerning depression, therapy and other forms of medical rehabilitation are effective, but would need some more focusing on social environment issues. Clarifying the causes of stress at the workplace and intervening in those issues leads to a good outcome. One specific issue is time management. Interventions can be ineffective if they are delayed, not intensive enough and the communication is not based on mutual trust. Solely medicine or individual focused interventions in conditions which are work-related are not sufficient.

Basic enabling factors according to case managers are successful treatment relationship & medication and sufficient psychotherapy. The patient's own personality matters, and functional networks are needed, too. An extensive team; employer, OHS and specialist in rehabilitation, working together gives good results. The employee him/herself must be willing, but without a team effort return to work is not successful. Through networking the superior receives information about employee's health status and is able to make changes at work. An active approach in the preparation phase and good timing of interventions are important. One return to work case manager mentioned the proper income of client, which enables him/her to concentrate on work.

Could any interventions have prevented the absence? Case managers suggest that during the sick leave, employers with the help of OHS develop the work and create a scheme for managing problems. These issues should not only be occupational health services' responsibility. Early prevention by mutual discussions and seeking for example, managing with threat of unemployment must not be undermined in absence prevention.

One case manager stated large structural inhibiting factors for good return beyond the work place: unemployment, threat for unemployment, uncertainty. In one case there were no preparations for return, just coming back to the workplace and the work load began from that moment. If the employer is rigid, shows no flexibility, then the prognosis is poor. Which measurements could have helped? Early recognition of

symptoms, redeployment, earlier treatment, creating possibilities and creating a working model could have helped. OHSs should shuttle actively between the employer and the employee.

Preventing absence and enabling a successful return in case of absence is an issue of good cooperation and team work of several actors.

3.4. The main interventions

3.4.1. Interventions described by professionals

General Practitioners, Occupational Health Physician and Occupational Health Nurse
From the responses to the question about the treatment in the case of a patient presenting with a stress related condition, we could differentiate four models:

- The "mini model" is medicine and sick leave.
- The "checking model"; is some medical treatment and referral.
- The "tailor made model" includes the basic clinical examination and care, clarifying the job description, life situation, psycho-educative approach (among others assertiveness), and cooperation with manager.
- The "process model" was described by an OHN. A patient with stress related conditions needs first the permission not to worry, permission to take time off. This permission comes first, thereafter begins the discussion about what things should be improved.

According to frequency (often and sometimes) the GPs, OHPs and OHNs use the following interventions: mental health services, psychiatric interventions, allied health interventions (physiotherapy), non-health interventions and other medical intervention. They seldom use alternative interventions.

Effective treatments according to GPs and OHPs are firstly to find out what causes stress, then working on stress causing factors "eliminating the cause of stress", states one OHP, another "negotiating with all partners to reduce stress causing factors". The patient may need medication especially if he or she suffers from depression or insomnia. Treatment remains ineffective in stress cases if it consists only of

symptomatic care (drugs, sick leave) without checking out the causal factors and without cooperation of the place of work. One OH-nurse considers just harping on about stress without looking for new viewpoints and showing the necessity to get rid of the bad situation as ineffective.

According to the frequency (frequently and sometimes) OHPs refer patients with stress conditions to the psychologist, then to medical specialists, physiotherapist, and psychiatrist and to others less often. OHPs define why they have the preference to send the patient to the psychologist, "in-depth discussion", "life control, issues related to the work community", "assessment of work ability and rehabilitation needs". An OHN mentioned that clients wish to get a referral to a psychologist. The reason for referring to medical specialists is mostly the diagnostic problem, especially to psychiatrists in protracted mental health conditions, "difficult stress reactions", "and treatment for depression".

General Managers

Some interventions to prevent sick leave. In cases where employees present with stress related conditions, 2 out of 7 GMs want to clear the situation by own means in the workplace, "these situations should be dealt with in the work community, with manager and fellow workers". Other GMs rely on occupational health services after first checking out things at work and refer the employee to an OH-nurse or physician. To prevent the employee going out absent, GMs focus mostly on rearrangements at work, "flexible working hours", "changing work organisation when needed", "reasonable planning of work, allocating time for tasks in personal organizer". 4 GMs tell that they arrange TYKY-activities (MWA, maintaining work ability, the Finnish concept of workplace health promotion), sponsor exercise leisure activities and of course free occupational health services with its health check ups, and some rehabilitation activities as well.

Changes in workplace in order to prevent sickness absences used by GMs were grouped into four types:

1) Resource enforcing and relief to the stressed employee, e.g. reducing working hours, giving day-offs, transfer tasks to other employees, referral to OHS, accepting sick leave that is long enough, rehabilitation and further training.

2) Improvements at the workplace like new computers with user-friendly programs, arrangements in office design, ergonomic office furniture etc.

3) General procedural instructions e.g. instructions against bullying, part-time working solutions, regular superior-subordinate development discussions and use of backup personnel.

4) Monitoring of well-being, work climate surveys and required improvements.

Some issues to pay attention to were raised during professionals responses. Part-time work or diminishing working hours may not always be a good solution, on the contrary, an additional stress factor. In small offices the absence of one worker requires the manager to share the tasks of the employees. One detail to pay attention to is the notion of ergonomics, what do GMs understand about it? Offering massage to the employer was uttered as an example of ergonomic improvements.

One GM stated: "One stressed employee in the work community and it depletes the energy of others and inhibits the positive development". [Yhdenkin työntekijän stressi työyhteisössä syö energiaa ja haittaa positiivista kehitystyötä]. This statement could be a good motto for the struggle against hazardous stress in every workplace.

Only 2 of the 7 GMs answered 'yes' to the question about an absence policy being present. It seems to us, that the existing OH-services as such are taken as "we have an absence policy". One GM mentioned that once a year they have a meeting with the OH-unit where the sickness absence statistics are studied. Another GM requires that the employee call him, not just someone in the office, in case he or she becomes sick. About striving to improve the existing return to work process, GMs state that clarification of the tasks and job description is the basis and it is also necessary to identify and remove causes of hazardous stress by joint discussions in workplace. To disseminate information about stress should be done in a normalizing way, not blame

stress for a monster. However, one GM remarks that stress issues are becoming a part of everyday life and requirement for understanding of the affected should not allow any exploitation or malpractice.

In the interview we asked about the existence and relevance of 19 policies and health services included in the schema interview. GMs reported on existence of MWA (health promotion), which was not the highest on relevance. From both, relevance and frequency points of view, GMs valued periodic health screening for all staff, sick leave, sick pay and alcohol control programmes as the most valued and helpful services.

Many GMs held flexible time and work arrangements as relevant, and four out of seven actually reported on existence of these policies. Some policies which were rated as high in relevance but not actually existing by four out of seven GM's were; work/life balance, return to work, leave of absence/career breaks, bullying and harassment, health education/promotion programmes, stress management, and wellness-programme. The policy for employment of people with disabilities scored the lowest frequency in both relevance and existence.

All managers reported that their employees know how to access information on the existing policies and services, two of them added "people do not read notices" or they don't read them fully.

Human Resource Managers
To learn more about the work experience of HR-managers concerning main interventions, we asked about their referral practices in cases of stress related conditions, interventions to prevent absence and especially about the return to work-practices in the organisation.

There are a large variety of actions in different levels of organisation mentioned by HRMs. Preventive interventions at the individual level were for example, the possibility to change the additional holiday pay for a free day. 3 HRMs mentioned financial support for exercise or cultural activities in leisure. One argued that the work must be designed to be motivating and safe, another mentioned that the division of

labour among the workers must be even. Nearly all HRMs talk about the TYKY-activities, which are defined by Occupational Health Care Act 2001: "*activities to maintain working capacity*". This means "systematic and purposeful activities concerning work, working conditions and employees organized through cooperation and which occupational health care uses to help promote and support the working capacity and functional capacity of those in working life." Several HRMs mentioned the training of managers and supervisors and the organisational monitoring surveys.

Regarding changes made in the workplace by the organisation to prevent employees going absent we asked about the issues in six categories of interview schema. 5 respondents spoke generally about the interventions, but specified only some actions. One HRM remarked that changing work organisation always requires anticipation. Examples of changing employment conditions were part-time work due to health condition, part-time work by arrangements due to the employee's will, flexible working hours, reduced working hours. If the absence affects the pay after a certain amount of sickness absence days, employer-employee-negotiations are needed. Work environment intervention examples are regular work climate surveys, regular checking the work premises, actions against mental violence. Examples of individual interventions are negotiations after a certain amount of sickness days, assessment of workload, redeployment. One HRM mentioned, that all mentioned interventions were in use, but were not thought about from the point of view of sickness absence prevention.

What is needed to improve the return to work process? HRMs' suggestions began with "preparations with the work team, what can be done to ensure a successful return" and then continued with the possibility of "soft landing", i.e. enough time to adapt to the work, not immediately having full performance requirements. One HRM pointed out, that usually the first part of absence process functions well, but what should be improved is the follow up, e.g. some appointments with the supervisor after the comeback. "Stress should be a more legitimized matter. Information about stress should be disseminated to all in the organisation. Supervisors need training about what stress is, how it develops, and how to help. Based on this information the supervisor can discuss, what changes should be made", said one HR-manager.

For employees in the organisations there are available union representation, human resources, health and safety officers and delegates, and occupational health services including ergonomic expertise of physiotherapist (except one organisation). Five out of seven HRMs reported that there were no return to work-coordinators. The supervisor or supervisor and occupational health nurse together are responsible for return to work.

In terms of frequency of existence and relevance of good policies are according to HRMs are: periodic health screening for all staff, sick leave, sick pay, leave of absence/career breaks and employee welfare programmes. HRMs reported further as quite often existing and relevant, valued flexible time, work arrangements and work/life balance policies. MWA (health promotion) and alcohol control programmes exist more than would be expected according to the relevance scores. Scored more relevant than existing were return to work and equal opportunities policies. Stress management and pre-pension coaching were reported as policies that did not exist and were not considered relevant. Unfortunately employment of people with disabilities policy gets low scores from HRMs, similar to the GMs. All 7 HRMs said that information about the policies is available for employees, but when asked if they think employees use this information some of them add "hopefully".

Health and Safety Officers

All the safety officers and delegates reported about the referral practices, that negotiations together with all partners, employee, supervisor, work community and occupational health nurse or physician are important. One HSO adds the cooperation with the psychologist or therapist on the list. In actions to prevent absences HSOs work with occupational health care personnel and make work site visits– often too late, states one of them, but hearing the employees has been ensured. TYKY-actions (MWA maintaining work ability) are supported by HSOs, too, and include workplace early rehabilitative and supported leisure time activities.

Due to the Occupational Safety and Health Act (No. 738/2002) the employer shall need to have a policy for action in order to promote safety and health and to maintain the employee's working capacity. The policy must incorporate the need to develop the

working conditions and the impact of the working environmental factors (occupational safety and health policy). The objectives for promoting safety and health and maintaining working capacity deriving from the policy must be taken into account in the workplace development and planning (Section 9). All interviewed H&S officers and delegates reported that this policy existed, two of them mentioned that the policy paper was updated recently. Stress comes up as one aspect of work load, "Stress-related issues are not very well covered. The term "mental well being" is used. "Bullying and harassment are covered", "Informs how to seek help if needed".

On the threshold of leave there are mixed feelings "not again!" and getting worried. First the supervisor gets the notice about the employee falling ill, and it follows the contact to OHS. The supervisor arranges the replacement. There is not that much discussion about return to work at this time. Two of HSOs said that there is no overall absence policy in their organisations. In 5 cases there are some administrative instructions, most often there is some defined critical point (e.g. sick leave longer than 20 days, certain amount of spells) after which the causes for absence are checked out, work wellbeing questions are taken up and the situation is investigated. Meetings may be arranged with occupational health unit and safety delegate.

Assistance in return to work lacks general guidelines, "left on the shoulders of the work team", "manager has responsibility". Three HSOs said that in practice there are some measures, like joint meetings, familiarizing in the return phase, support to include employee in the everyday life of the work place as soon as he or she returns and maintain same tasks. One HSO mentioned that redeployment, work trials and rehabilitation measures are used, too.

When asked about the seven types of work arrangements/adaptations made by the organisation to assist an employee who has been out absent to return to work, individual interventions and redeployment changes were the most used ones according to all Health and Safety Officers interviewed. They are new furniture or equipments for improved ergonomics, work trials and supervision. The tailor-made work suitable for the worker with lowered working capacity is done according to 2 HSOs and re-education or training such as indenture training may help. Redeployment practices have been improved according to one respondent. Insurance companies may

financially support some of these measures. Measures which are focused more on changed work organisation or work environment are e.g. HSOs make work site visits together with OHS, extra help for work such as school assistants for teachers, allowance for development of work community, job evaluation, planning of workplace. Only one HSO mentioned the risk assessment-procedure, which was going on in the organisation. Other helpful interventions were mentioned such as IT-support person, programmes for ageing employees, work group to check out the internal information practices.

Functions available for employees in organisations of interviewed HSOs were union/worker representations, human resources, safety system and occupational health services, in most cases onsite ergonomist (physiotherapist), too. Services of return to work coordinators and case managers were available only in one organisation as a consultant.

Asked about the 19 policies and health services, all the HSOs report periodic health screening for 'at risk' staff as existing and 4 value it as relevant. Existing and relevant are sick pay, TYKY (MWA) activities, alcohol control programmes, sick leave, leave of absence/career breaks, bullying, harassment prevention instructions and employee welfare programmes. Relevant, but not existing are work/life balance, return to work, stress management, private health insurance and company funded pension schemes. Existing but not relevant is the equal opportunities programme.

Information about the policies or services is available (e.g. in intranet), but HSOs notice that in addition to that, supervisors should advice employees.

Mental Health Professionals
MHPs who work on multi-professional team get their patients from the OHP or Medical specialist working in the same unit. Clients come by self referral, too, especially in case of conflicts in the workplace. On the symptom level the referral is mostly based on depressive and anxiety states, they have difficulties managing their work performance, they can't go on any more. Sorting out the situation and short counselling are the main reasons for the referral. Referral assessment questions relate

to work ability, especially in prolonged situations, and treatment and rehabilitation. Sometimes the referral is to assess the suicide risk.

Treatment consists of supportive discussions seeking new viewpoints. Physicians order sick leave and medication. The counselling aims to sort out the situation, mapping the problems (at home/work), proportioning and distancing issues, enhancing self-reflection skills, encouraging activity and sense of control. In some cases conversations with the manager are helpful, too.

Most frequently used treatments and interventions are mental health services, psychiatric interventions and non-health interventions, which are also judged as effective. Alternative interventions are rarely used, but sometimes asked about by patients.

Effective treatments or interventions at the individual level are the possibility to sort out the situation, taking stock and challenging assumptions held. This encourages them to take up things at their workplace. To rely on means judged effective by the patient is good, like joining in peer groups. Relaxation exercise and healthy ways of living are worthwhile to support. Sick leave, psychotropic medication and psychotherapy are effective. Multi-professional teamwork (occupational health care, GP, mental health professionals) is effective, one professional alone and disconnecting the treatment from work, is ineffective. Another ineffective way of helping is to blame, to overmedicate, not to intervene in work in work-related issues, to leave a patient on his/her own on long-term sick leave. To bang on and complain about problems without any goal is also ineffective.

Assistance in return to work by MHPs is usual, "but not too early". Helping is difficult if the absence is long and the client has decided to apply for retirement allowance. Arrangements in the work place are necessary. Involvement of MHPs is to support in negotiations with supervisor and in work community, "absolutely, if the person is recovering and the situation at work is critical", "If the MH-system is active, the results are good". However, the professional secrecy matters must be ensured. In cooperation with relatives and in contacts from the employer's side, the will and permission of client is crucial. In case of mentally handicapped workers the

cooperation is important. The collaboration may be psycho educative information, or studying practical solutions.

Case Managers

The interviewed case managers got their clients from occupational health services, from medical specialists, psychologists/neuropsychologists, community social workers, employment offices and The Social Insurance Institution of Finland. The reasons for referral were assessment of work ability and/or rehabilitation needs, clarity of livelihood was not clear and occupational rehabilitation.

Treatment or interventions used were psychotherapy, medication, group workshops, professional re-education and vocational rehabilitation. Rehabilitation is mostly done in teams of several professionals. Valued as effective are mental non-health interventions, most often mentioned as vocational training, occupational rehabilitation, workplace adaptations and mental health and psychiatric services.

Case managers see as effective interventions good timing of relevant treatment, discussions about the situation and seeking of solutions in a process like way, one case manager mentioned the issue of time management. Ineffectiveness in interventions arises from long periods of waiting, appointments, which are not frequent enough, medication only, or overmedication in work-related problems. Without trust no intervention is efficient, adds one case manager.

Employee pension insurance companies allow a subsidiary for a work try out- period of some months or half a year. The returnee can start working part time and then proceed to full time. This procedure requires good cooperation of all parties. One case manager pointed out the importance of well timed treatment and rehabilitation, thus the sick leave can be short. Giving relevant information, clarifying the helping network and offering to be available in the long run, is the way of working of one case manager/social worker. Another tells, that after a long term sick leave contacting workplace and occupational health unit is important in addition to rehabilitation guidance and occupational rehabilitation counselling. Work arrangements and changes at work are issues to negotiate. Direct contacts with the family members are not made. Three of the four interviewed case managers have been contacted by the

employers and they appreciate their initiatives. Employers ask about the criteria of occupational rehabilitation and services. Job Demands Analysis and Functional Capacity reports are not used by the interviewed persons. In the insurance companies and rehabilitation services assessments are done by different schemes.

3.4.2. Some particular issues in relation to interventions

Periods of Sick Leave or Absence

Mental health professionals warn of premature termination of sick leave. Return to work should not be at a too early stage, the employee must feel that he or she is in adequate condition. On the other hand MHPs point out that work is also a healing factor and people should not be allowed to become disconnected from work. Keeping in touch during the absence prevented the loneliness in one successful case, told one H&S representative. The Social Insurance Institution of Finland asks for an assessment of ability to work in long-term sickness absence cases. Pension institutions offer financial support to the return phase, e.g. enable part-time working for some months or half a year.

Physicians do not speak about length or number of spells of sick leave. Sometimes they have been contacted by employers with tricky questions about faking ill, or the length of sick leave.

Medication
All professionals see medication as part of a treatment very helpful, but only medication without any further measurements does not change anything. Medication can sometimes be of the wrong type and inhibit a favourable process, just like wrong type of psychotherapy, too. None of the professionals spoke about the cost of medicines.

Counselling and Psychological Interventions
The most frequently mentioned interventions used by GPs, OHPs, OHNs and MHPs are counselling, psychotherapy, psychological treatment and psychiatric interventions like psychotropic drugs, and these interventions are considered as relatively effective. Ruling

out the physical illnesses is done in the basic clinical examination, but physicians do not mention laboratory or X-ray tests in diagnosing stress conditions.

Some descriptions gave hints as to what is the focus in the counselling sessions. The approach is psycho-educative; listening to patient, invoking patient's motivation, giving information, offering active and informative negotiations in the workplace with all partners in return phase. In discussions the client's situation is structured, new viewpoints and orientation reflected upon, black and white assumptions questioned. The patient is encouraged to take up problematic things with the supervisor. Relapse prevention is another aim of counselling. A favourable change is possible only, if there is trust in the communication.

Only a minority of professionals, the MHPs, raised the question of how difficult the dissemination of stress information in workplaces is. All professionals are rather satisfied with their knowledge of stress in general, but there is a need for knowledge and skills to be applied in organisations. "How to intervene efficiently?" One professional asked for information about how the workplace level issues effect the individual stress process. Knowledge of effective and well-timed interventions is claimed. In these instances a stage specific approach for stress prevention is needed.

Changes to work organisation and the work environment including redeployment
Coming back to the workplace after sick leave without any preparations is a risky arrangement. GPs OHPs OHNs want to give assistance in return to work. Joint negotiations mean a good start for work. HSOs criticise the lack of an organised model or general guidelines. Good timing of the return is the responsiblity of MHPs. To ensure a dignified comeback, include the employee in the everyday life at the work place as soon as he or she returns, recommend MHPs. In lucky cases there have been substitute persons at the work place and the soft landing of the returnee is assured. He/she is allowed to concentrate on the main tasks.

While every professional has his or her own duties, cooperation is essential in preventing sickness absence and promoting successful return to work. HRMs help by offering training for superiors, they arrange surveys and monitoring of work climate together with occupational health services. They create training programmes, influence the payroll

system, help in working hours arrangements. The trade unionists maintain the proper income share, which enables the employee to concentrate on work. HSOs are most worried about the increase of stress levels in organisations, they know how important the fight against work hazards is. In the interviews HSOs pictured themselves as skilful negotiators. Case managers in insurance and pension companies and social work have changed their culture from ordering authority to a service oriented partner, and they appreciate the employer's desire to cooperate.

All the professionals speak about the need for tailor made return to work after sick leave, work adaptations and protection of the returnee's resources. A few of the interviewed professionals say that there is no need to do anything that things take care of themselves. One GM raised the question of justice, the special arrangements for a returnee can negatively affect the work place climate.

Rehabilitation and Reintegration Measures

One HRM says, that the start of sick leave is rather well managed, but the return phase and the follow-up is neglected. Vocational rehabilitation, re-education, training, financial support for return to work e.g. half a year's time after comeback and work trials are means that the social insurance and pension institutions can offer in addition to guidance and information dissemination. However, the successful comeback is mostly based on very simple things; discussions at the work place concerning how better attention could be paid to the returnee, is a natural way of workplace rehabilitation. In addition to that, a clear model concerning return to work helps the shy or confused partners handle sensitive issues. Some people affected by stress can benefit from peer support groups. However, to some extent the rehabilitation system is a difficult area; the legislation requires hard evidence of sickness, defect or injury before the rehabilitation measures can come into operation. Stress is a soft thing; therefore it is difficult to help.

3.5. Stress and return to work – effective interventions and activities

Two General Managers consider that the most important thing is to find out and eliminate the factors causing stress. Conversation between the employee and the manager is important. One GM mentions that stress awareness of all staff should be increased. Overall,

there should be a more permissive atmosphere towards people returning to work. One of the GMs also stresses the importance of clear directions concerning return to work.

The Health and Safety Officers and Human Resource Managers have very similar views about ideal return to work. Both groups emphasize the significance of the reception of employee returning to work. HSOs point out that the behaviour towards the employee returning should be fair and "normal". HRMs reckon that the work community should be prepared for the return and the return should be paid attention to. Both groups state that there should be conversations between the employee and the manager. Overall, the employee returning to work should be paid attention to. Both HSOs and HRMs point out that employee returning from sick leave should be entitled to a "soft landing". The employee should be given enough time to adjust to work. All in all, there should be understanding and flexibility towards the person returning to work. It is also mentioned that the employer should keep in touch with the employee during absence, and the situation should be followed up properly after the return.

3.6. Opinions about the 'causes' of the stress

When presented with a list of issues that might be related to stress, all professional groups agreed that job is most often mentioned as a cause of stress by clients/ employees. The most rarely mentioned factor from the list was friends. When the professionals described the causal factors in their own words, all groups stated that different aspects of work are most often referred to by clients/ employees as the cause of stress. These aspects include urgency, work load, changes and insecurity, work environments and relationships in the workplace. Urgency is the factor most often referred to.

The second most often mentioned group of causal factors is related to personal life. The professionals point out that issues such as couple/relationship problems, illness or death in the family, financial problems and drinking are quite often referred to as causes of stress. The third group of causal factors are mental and physical symptoms. This group includes issues such as sleeping problems, exhaustion, depression and anxiety.

All professional groups agree that work issues are most often referred to by the clients/ employees when they talk about stress. In addition, the OHPs stressed the mental and

physical symptoms. Also MHPs highlighted the mental symptoms and issues related to personal life along with work related factors. Some of the GMs and HRMs pointed out that employees don't often talk to them about stress.

Section 4: Discussion

4.1. Current approaches adopted to stress and absence within Finland

As we pointed out in the jurisdiction study, there is a lot of discussion and collaboration on the issue. The government has taken an active role by renewing the legislation. Ministry of Social Affairs and Health, the labour market organisations, entrepreneurs' organisations, Ministry of Education, Ministry of Labour, Ministry of Trade and Industry, and the Institute for Occupational Health have started the national Veto Programme to maintain and promote the attractiveness of work and working life. It is a programme for well being at work and extending working life.

The Veto Programme continues the projects that have been developing Finnish working life, like the National Programme for Ageing Workers and the National Well-being at Work Programme. Veto started in 2003 and continues until 2007. The programme deals with factors that influence the:

- maintenance and promotion of individual's ability to work,
- prevention of marginalisation from working life,
- prevention of premature incapacity to work, and
- improvement of the opportunities to return to work.

In the Finnish study we asked GPs, OHPs, OHNs, MHPs and CMs two additional questions:

1. In your opinion, is some issue in our current legislation especially inhibitory regarding the return-to-work?
2. How the principle of preventive work is functioning in the context of your work? What do you consider as the most important target concerning the return to work in stress-related condition?

General Practitioners, Occupational Health Physician and Occupational Health Nurse
The act about partial sickness benefit will be most welcomed according to the Finnish professionals, the question of working hours in general. One of the OHPs remarked that stress is an issue of attitudes, the legislation is in fact good after all the amendments in

recent years. Regarding prevention the most important issue was the leadership function in workplaces. An OHN pointed out that if there was in the workplace 1-2 employees with lowered work ability, the supervisor should get extra resources as compensation. "Otherwise we do not have supervisors any more". MWA, maintaining work ability was mentioned as a good preventive practice.

Mental Health Professionals

Several MHPs mentioned the importance of work try-outs. They mentioned that the legislation and insurance regulations may hinder the return to work. Those who are unemployed, on part-time or pension, do not dare to come back to work because of those regulations. One MHP suggests that there should be other options besides sick leave and that the contact with OHS should be obligatory. Another MHP stated pessimistically "we take care of chronically ill people", and another said "to get treatment you must be really ill; where do the minor cases go?" Another highlighted "In acute psychiatry return to work does not exist". The older somatically ill, with mental symptoms and less educated people were seen as those at greatest risk. In the eighties and nineties there were more tolerant enterprises, now that is over. There is less loyalty towards old-timers; instead there is pressure to exclude the people with lowered working capacity. One MHP noticed that in working life the excessive use of information technology causes difficulties for a large number of employees.

Case Managers

CMs/social work are worried about the disconnectedness of the system; there is much ignorance, false rejections of the benefits. The clients have additional stress about financial problems. The lack of means test and rigidity of diagnostic work cause short-sighted decisions and leads to continuous complaints.

4.2. Satisfaction of respondents regarding their understanding of stress and work

At first all professional answered "yes, I know what I need, I know". Then they continued that one can "never have too much information, the need of information is continuous". One OHP wanted to know evidence based issues about stress. Physicians raised the question about the cooperation with stress patients, sometimes they will not talk, will not accept, deny, hide behind the somatic symptoms or don't want to be treated in occupational

health care. Some physicians raised the difficulty of recognition and diagnosing stress, which is psychosocial in origin. But there is a discrepancy in this point; other physicians "normalize" the stress problem and ask "why should there be any reservations, stress is such an everyday thing" or state that stress is a subjective experience. And physicians know that the sickness benefits will not be allowed on the ground of stress or burnout. But in the return phase physicians want to be involved in actions helping the successful return.

Most of the case managers work in multi-professional teams where they have studied about stress. One CM asked: "Should the stress be taken account of another way is a question. What is the work-related stress and how can we intervene?"

General managers have learned about stress from media and literature. Some report, how helpful the longer (2 year) training programs or manager training are to get information and learn how to put this information into practice. Some GMs told that they are not interested in stress issues despite the good supply of information given by OHS, another told about the difficulties of recognizing stress.

Human resource professionals tell that they have learned much about stress in cooperation with OHS. They see symptoms, but the question is, how the HR department could intervene efficiently enough and how to combine the workplace level and individual level focus.

MHPs require more knowledge about posttraumatic stress reactions and support and care after the traumatic events, and about life-events and mental health.

Health and safety officers are the most willing to learn more. "Absolutely not [enough knowledge]". Their questions are practical, when and how to intervene, how to advise people to protect themselves, how to promote and maintain people's willingness to ask for help.

4.3. Awareness about stress related claims for absence

General Managers and Human Resource Managers

GMs and HRMs tell that there is information –intranet pages, handouts, available about stress, but at the same time they doubt that the staff use this information actively. About monitoring and evaluation policies they say the same; in principle yes, in practice not well enough.

One HRM picked up one important point; how far does the responsibility of the employer go in protracted cases of major depression? The return to work has not succeeded, the person is a member of the work community, even if he or she is not there anymore and will not come back either, but he or she is not eligible for disability pension.

Health and Safety Officers

HSOs are more ambivalent in their answers; in principle information about policies and services is available, but 2 out of the 7 interviewed say that in practice the staff do not know, if they are not familiarized well enough. 3 of the HSOs are not happy with the monitoring practices; reports are done, but there is a gap between these reports and the practice. The rest of HSOs are more positive about this question.

Section 5: Conclusions and Recommendations

This section includes the specific conclusions we have reached and makes recommendations.

5.1 The salience of stress and absence as a problem in Finland

The increase of stress level is most critical from the safety perspective, as well as from the human resource and disability management's point of view. In occupational health and public health sectors there is some concern about the stress level increase in five years´ time. The reasons for the increase could be divided in two levels. The job-level reasons are associated with the tightened work pace, demands of continuous effectiveness, flooded information, competitive atmosphere, detached managerial style, organizational changes creating uncertainty etc. Causes on the working life – level are connected to the downsizings, economic pressure, lowered tolerance for the consequences of ill-health, generation changes and ageing of the work force.

5.2 The adequacy of system responses in Finland

The OHS system functions as a good bridge; the consultants outside the workplace can cooperate with OHS professionals who know "the way back" to work from sick leave.

There are two poles in system responses; workplace arrangements and occupational and other health care services. The mental health services are in a problematic stage due to lack of resources, but there is a willingness to cooperate and offer help to the workplace. The responsibility of return to work does not belong to anyone and the cooperation is not satisfactory, even the relevant legislation points out networking. Good timing of treatments and interventions and trust between the partners are prerequisites for successful outcomes.

The return to work objective is not handled well enough, the health and safety system had the most critical views to the issue "it is left on the shoulders of the work team". Even though every single professional in the curative sector wants to help the success of return to work, some discrepancy was found between the supervisor's "self –help" attitude "these

situations should be dealt with in the work community" and the willingness of others to offer help to the supervisor. One warning voice said that the situation of supervisor is impossible and that no one will do this job any more.

The absence policy in organisations means some administrative instructions, most often there is some defined critical point (e.g. sick leave longer than 20 days, certain amount of spells) after which the causes for absence are checked out, work wellbeing questions are taken up and the situation is investigated. Meetings may be arranged with the occupational health and safety delegate. More narrowly threshold-specific instructions are mostly lacking in organisations or in the cooperative work of involving parties. Assistance in return to work lacks general guidelines, the issue is often considered to be the "manager's responsibility".

5.3 Satisfaction of understanding and knowledge of stress and absence in Finland

The satisfaction about the understanding of stress as a phenomenon is good. But the professionals apparently do not know the return to work phase from the point of view of the returnee; they were not very familiar with descriptions or models of return to work as a process.

Those professionals who tell that they lack sufficient knowledge refer to two points; the wish to perform efficient and well-timed interventions and to the constantly published new information about stress. Those who judge that they have more or less good knowledge about stress however have thought about whether the issue of stress should be taken into account another way, especially how to handle work-related stress or traumatic stress. The group of physicians were the most satisfied with their knowledge.

5.5 Confidence in current approaches to return to work and stress in Finland

The main feature in conceptualizing stress refers to the imbalance of demands and resources. However, there are several difficulties in really judging the situation. Mostly the consensus of definitions of stress lack in workplaces. The estimates of the scale of the stress varies a lot. Physicians report 5-30 %, case managers 10-80 %, mental health professionals 5-100 % of cases. It is difficult to think about relevant cooperation in

interventions if the starting points are seen very differently. Maybe therefore all professionals raise the question of effectiveness and right timing of interventi

5.6 Recommendations for Future Action

There is good awareness of ineffective interventions to return to work; doing nothing, just taking sick leave and medication. All the professionals speak for the tailor made return to work after sick leave, work adaptations and protection of the returnee's resources. Professionals in Finland welcome the new law for part-time sickness benefit, like in many countries there are models for early and safe return to work during recovery process.

However, despite of TYKY/MWA activities as preventive strategy appreciated by the professionals, it came up that the knowledge and resources in health policies and services in companies is not actually used effectively. Some professionals point out that disseminating information about stress is not an easy task.

Annex 1: Summary of responded profiles by category

General Practitioners

Gender	Years of Experience	Location of Practice	Client Base
Female	12	Outside Helsinki	Public/Occ.Health

Occupational Health Practitioners

Gender	Years of Experience	Location of Practice	Sector
Female	19	Outside Helsinki	Medical Card
Female	25	Outside Helsinki	Private clinic
Male	32	Outside Helsinki	OHS/Company
Female	18	Outside Helsinki	Public health
Male	34	Outside Helsinki	OHS/Company
Female	13	Outside Helsinki	Occupat. health
Female	28	Helsinki	Occupat.health

Mental Health Professionals

Gender	Years of Experience	Location	Type of Clients
Female	14	Outside Helsinki	Public health
Male	15	Outside Helsinki	Private
Male	35	Outside Helsinki	Occup.health
Female	20	Outside Helsinki	Public health
Female	4	Helsinki	Personality disturbances, depression, anxiety
Male	17	Helsinki	General psychiatry, consulting OHS

Case managers / Return to Work Specialists

Gender	Years of Experience	Location	Client Base
Female	8	Helsinki	Public Organisation
Male	20	Helsinki	Rehabilitation Centre
Female	10	Helsinki	Insurance Companies
Male	15	Helsinki	Insurance Companies

Managers

Gender	Location	Sector	Number of Staff
Female	Outside Helsinki	Public	19
Male	Outside Helsinki	Public	650
Male	Outside Helsinki	Private	32
Female	Helsinki	Private	40
Male	Outside Helsinki	Private	3
Female	Helsinki	Private	3
Male	Helsinki	Private	9

Human Resource Managers

Gender	Years of Experience	Location	Sector
Male	23	Outside Helsinki	Public
Female	1	Helsinki	Private
Female	6	Outside Helsinki	Public
Female	16	Outside Helsinki	Public
Female	3	Helsinki	Private
Female	18	Outside Helsinki	Public

Health and Safety Officers

Gender	Years of Experience	Location	Sector
Female	10	Helsinki	Public
Female	19	Outside Helsinki	Public
Male	11	Outside Helsinki	Public
Male	30	Outside Helsinki	Public
Female	8	Outside Helsinki	Public
Female	7	Helsinki	Public

Annex 2: Roles and Responsibilities of each professional in Finland

General Practitioner

About 47% of Finnish doctors work in hospitals, 22% in health centres. Lower percentages are employed in other public medical centres, occupational health centres, teaching, research and administration.

Primary Health Care

Finland is divided into some 450 municipalities. Each municipality is responsible for arranging health care for its inhabitants. Primary health care is provided by health centres established by a single municipality or jointly by neighbouring municipalities. Municipalities have the right to buy services from other municipalities or from the private sector.

Health centre services include medical consultations and provision of dental care, preventive care and environmental health care. Health centres run maternity and child health clinics, and arrange school and occupational health services. Health centres vary greatly in size. The largest employ hundreds of doctors and provide highly specialized services. In health centres in remote areas, doctors have to be able to cope with emergencies as well as offering basic health care. Attached to each health centre there is usually a hospital for people with mild or chronic illness, a small laboratory, a radiological unit and a physiotherapy unit.

Most Finnish municipalities have switched from a primary health-care system to a family doctor system. Each family doctor is responsible for about 2000 patients. The aim is for a patient to be able to contact her or his doctor and have needs for treatment assessed within three working days. The system has proved very successful. Treatment can be provided more quickly than before. Relationships between doctors and patients have become closer. Benefits of long-term treatment relationships include a reduced need for hospital examinations. This has helped reduce health-care costs. Outpatient care is also provided by occupational and private health-care units.

Occupational Health Professionals (OHP and OHN)

Occupational Health Services

Employers are under an obligation to arrange occupational health care for employees. Occupational health care can be arranged through municipal health centres or private practitioners. About 4% of Finnish doctors work in occupational health care, offering both preventive services and primary health care. All licensed Finnish doctors are covered by the reimbursement system, which is administered by the Social Insurance Institution.

Occupational Health Care Act (1383/2001) definition: *occupational health care professional* means a health care professional as referred to in the Act on Health Care Professionals (559/1994), who is qualified as an occupational health care specialist or other licensed physician or is qualified as a public health nurse and has the necessary training to perform occupational health care.

There are about 400 physicians employed in the OHS health services.

Occupational Health Nurse

The goals of the work of an OHN are:

- To promote health and safety at the working environment,
- To support the balance between the individual and work,
- To support and strengthen the individual resources of the worker, and
- To support the working community in developing their working conditions.

The main duties of an OHN are:

- Surveillance of the working environment,
- Health promotion,
- Actions in order to support maintaining the ability to work,
- To give information of work-related illnesses,
- Health education,
- Health examinations,
- To plan and put into action first aid courses, and
- General health care services.

In the work of the occupational health nurse, stress is covered in health promotion and preventive actions from a holistic point of view. The OHN acts as an impartial occupational health expert. The work requires personal and professional skills such as flexibility, creativity and collaboration.

Case Managers

In the professional category of case managers they are social workers, physiologists, and case managers in pension institutions. In addition to the individual rehabilitation process CM knows about the legislation, have theoretical and historical understanding of the issue, plans, implements and evaluates a goal-oriented comprehensive rehabilitation system.

General Managers

There are two kinds of GMs interviewed in this study. Some are spearheads in their organisation or division director, line manager enterpriser. Others are more clearly supervisors, in close supervision of work and thus direct representative of the employer.

Human Resource Professionals

HR-professionals are responsible for the management and development of human resources in Finnish companies and organizations aiming at personnel welfare and business success. In their association, The Finnish Association for Human Resource Management – HENRY ry (registered) there are about 2000 members.

Mental Health Professionals

Occupational health care act (1383/2001) definition: occupational health care expert means a person qualified as a physiotherapist or psychologist and possessing sufficient knowledge of occupational health care. There are about 230 OH-Psychologists working in OH-services most of them part time.

Psychiatrists are medical specialists whose responsibility it is to offer the best possible cure in mental diseases, rehabilitate psychiatrically ill persons and promote mental health.

Memorandum of the Working Group studying the labour division and work stress in mental health services (Ministry of Social Affairs and Health, 2003) stated, that the responsibility for services is scattered between various actors. The actors have not been able to agree on workable models for labour division and co-operation clarifying the operations. The consequence has been unreasonable work stress and, in particular, that a large number of psychiatrists have left the public sector. Stress at work is increased and the attraction of work in mental health services is weakened because it is not possible to meet the demands of today by the present resources allocated to mental health services and the present posts and know-how.

With a view to improving the division of labour the Working Group proposes development of specific cooperation models, improvements in the labour division between social welfare and health care, co-ordination of specialised psychiatric care and mental health work on a larger scale, and development of new patterns of action.

Actions to develop the division of labour, to relieve work stress and to increase the attraction of work in mental health services presuppose concrete measures at the local, sub-regional and hospital district levels. The state and provinces must support mental health work projects carried out in individual hospital districts that aim at developing, experimenting with and studying the proposed reforms and creating new patterns of action.

Health and Safety Administration

Besides the traditional inspection and monitoring services, the HSO administration focuses on the development of multi-faceted instruction, guidance and information services.

Occupational Safety and Health Manager

The employer nominates an occupational safety and health manager for the co-operation concerning occupational safety and health, unless he wishes to take the position himself.

Occupational Safety and Health Representative

Employees can choose an occupational safety and health representative and two vice representatives for negotiations conducted with the employer and the occupational safety and health authorities. A representative has to be chosen, if there are more than 10 employees.

Occupational Safety and Health Committee

At workplaces with a minimum of 20 employees, an occupational safety and health committee comprising representatives of the employer, workers and clerical employees shall be established. It is the duty of the committee to promote safety and health at the workplace.

When necessary, the committee presents the employer with proposals for improving working conditions, developing occupational health care as well as for the arrangement of occupational safety and health training and work guidance. In addition, the committee participates in activities that aim at maintaining working ability as well as in occupational safety and health inspections at the workplace.

The employer establishes an occupational health and safety action programme in the workplace, which includes information on risks and ways of minimising them, as well as how occupational safety and health has been organised, and the assignment of responsibility. The action programme has to cover activities, which maintain the ability to work.

Annex 3 Main acts regarding sickness absence and returning or exiting work

http://www.finlex.fi/fi/

Name of the Act (English)	Name of the Act (Finnish)	Description of the Act	Stress Impact - elements
Primary Health Care Act	Kansanterveyslaki, 66/1972	Describes the arrangement of primary health care in the public sector.	- long-term absentees -mental health
Act on Specialized Medical Care	Erikoissairaanhoitolaki, 1062/1989	Describes the arrangement of specialized health care in the public sector	- long-term absentees -mental health
Sickness Insurance Act	Sairasvakuutuslaki, 364/1963	Insures Finnish resident for medical care, rehabilitation, and income compensation.	- long-term absentees -mental health
Governments decree on Sickness Insurance	Sairasvakuutusasetus, 473/1963		-complementary
Employment Accidents Insurance Act	Tapaturmavakuutuslaki 608/1948	Obliges employers to have insurance that compensates work related injuries and illnesses	-reintegration - long-term absentees -mental health
Occupational Illness Act	Ammattitautilaki, 1343/1988	Describes occupational illnesses referred to in the Employment Accidents Insurance Act	- complementary
Occupational Safety Act	Työturvallisuuslaki, 738/2002	Obliges the employer to provide a safe and healthy working environment	-mental health
Occupational Health Care Act	Työterveyshuoltolaki, 1383/2001	Obliges the employer to provide OHS for it's employees	-reintegration -long-term absentees -mental health
Act on Occupational Health Care Professionals	Laki työterveyshuollon ammattihenkilöistä, 559/1994	Describes the requirements for OHS personnel	-complementary

Governments decree on the principles of good Occupational Health Care practise, the content of occupational health care and the qualifications of professionals and experts	Valtioneuvoston asetus hyvän työterveyshuolto käytännön periaatteista, työterveyshuollon sisällöstä sekä ammattihenkilöiden ja asiantuntijoiden koulutuksesta 1484/2001	Elaborates the aims and functions of OHS, such as multidisciplinary focus and knowledge of the work context.	-complementary
The Act on Client Service Cooperation Within Rehabilitation	Laki kuntoutuksen asiakaspalveluyhteistyös tä, 604/1991 (under renewal)	Describes the relationships, functions and responsibilities of different actors within rehabilitation	- complementary
Rehabilitation Allowance Act	Kuntoutusrahalaki, 611/1991	Provide income compensation by SII during rehalinilitation back to work	- complementary
Act on Rehabilitation Arranged by SII	Laki kansaneläkelaitoksen järjestämästä kuntoutuksesta, 610/1991	SII provides vocational and discretional rehabilitation for people whose ability to work is threatened.	-reintegration -long-term absentees -mental health
Governments decree on Rehabilitation Arranged by SII	Asetus kansaneläkelaitoksen järjestämästä kuntoutuksesta, 1161/1991	Describes different forms of vocational rehabilitation covered by SII.	- complementary
Act on Public Services on Employment	Laki julkisesta työvoimapalvelusta 1295/2002	Describes the duties of the labour administration.	-reintegration -mental health
Rehabilitative Work Act	Laki kuntouttavasta työtoiminnasta, 181/2001	Obliges the municipalities to provide reintegration services for unemployed.	-reintegration -mental health
Job Alternation Act	Vuorotteluvapaalaki, 1305/2002	Promote working capacities of employees with long tenure and help transition to employment..	-reintegration -mental health
Employment Contract Act	Työsopimuslaki, 55/2001	Describes the terms of the employment relationship	-general
State Civil Servants Act	Valtion virkamieslaki, 750/1994	Describes the terms of the employment relationship	-general

Act on the Employment Relationships of Municipal Officials	Laki kunnallisen viranhaltijan palvelussuhdeturvasta, 484/1996	Describes the terms of the employment relationship	-general
National Pension Act	Kansaneläkelaki, 347/1956	Provide basic income protection for pensions.	-reintegration - long-term absentees -mental health
Employees Pension Act (and similar earnings related pension acts for different sectors of employment)	Työntekijäin eläkelaki, 395/1961	Describes the responsibilities of the workers pension system on pension and rehabilitation	-reintegration - long-term absentees -mental health
Act on the Position and Rights of a Patient	Laki potilaan asemasta ja oikeuksista, 782/1992	Describes the rights of the patient	-general
Act on the Field of Application	Soveltamisalalaki, 1573/1993	Defines the area and where different laws are applied.	-general
The Constitution of Finland	Suomen perustuslaki, 731/1999	Prohibits discrimination based on health	-general