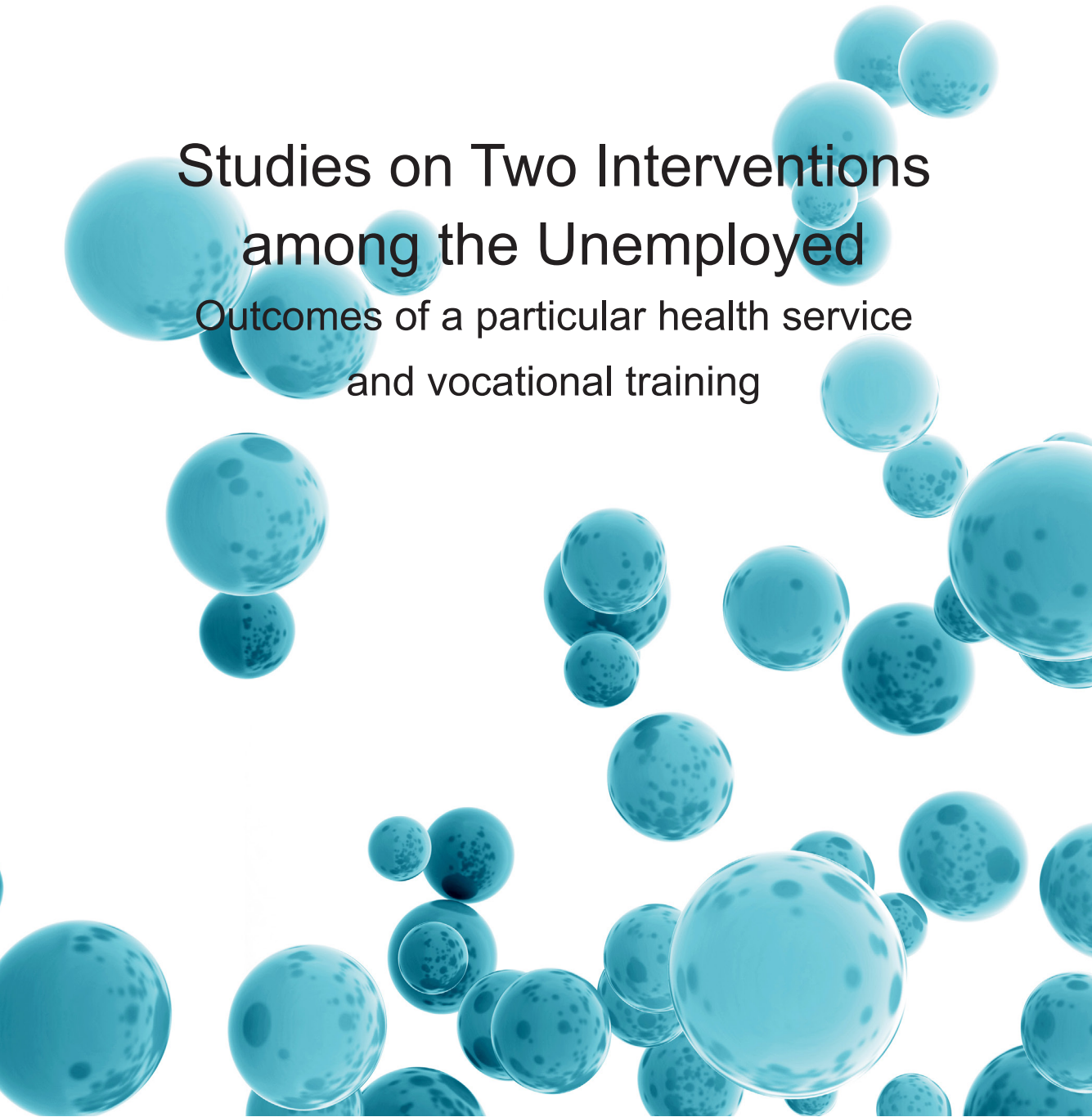


KATRI ROMPPAINEN

Studies on Two Interventions among the Unemployed

Outcomes of a particular health service
and vocational training





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ACADEMIC DISSERTATION

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KATRI ROMPPAINEN

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ABSTRACT

This dissertation consists of four empirical studies analysing two separate interventions (health service and vocational training courses) targeted at the unemployed. The study was originally intended to ascertain whether these interventions are effective in promoting re-employment or improving health and mental well-being. The study utilized a mixed methods approach in order to highlight more closely those factors which may impede or improve the desired outcomes of such interventions. The sample consisted of unemployed individuals whose period of unemployment was interrupted by an active labour market policy (ALMP) measure (Studies I, III, IV) and healthcare professionals (Study II) recruited to implement the particular health care service.

The first study examined whether the health care service implemented for the unemployed influenced their re-employment prospects compared to those not involved in the service. The results of the randomized controlled trial indicated that the health care service provided did not enhance re-employment and actually seemed to impede the re-employment of those reporting poor mental well-being.

The second study analysed qualitatively the occupational health care nurses' perceptions of the unemployed and their professional practices in the context of the new health care service. The findings of the discourse analysis revealed four overlapping discourses among the nurses: the client as a casualty of unemployment, the client as unemployed but active, the client as a deviant in the labour market and the client as a skilled user of the system. Awareness of the complexity of providing health services for the highly diverse clientele was found to be particularly important.

The third study yielded evidence of how unemployed people position themselves with regard to the health care provided as an institution aiming to facilitate their access to health care. The discourse analysis revealed six positions taken by unemployed people when encountering the service: the docile citizen, the rebel, the socially responsible citizen, the distinctive individual, the independent actor and the calculating client. These positions highlighted variation in the ways the unemployed responded to the health intervention.

The fourth study evaluated the effects of a vocational training course on the health and mental well-being of the participants, in particular whether possible outcomes varied by socioeconomic status. The analysis of variance for repeated measures indicated that there was not only distinct variation in improvements in mental well-being according to socioeconomic status, but there was also a risk that such an activation intervention maintains or even produces health differences between socioeconomic groups.

The overall findings demonstrated that the interventions examined among the unemployed at least partly failed to achieve their primary aims of increasing employment and preventing social marginalization. The findings point out the heterogeneity of the unemployed and the importance of acknowledging and considering the needs and interpretations of the unemployed as these may differ from the outcomes anticipated of interventions and activation policies. The study suggests that to ensure more effective interventions in the future, policy-makers as well as scholars should take a more holistic approach regarding activation policy measures and welfare services. Furthermore, there is a need for a better understanding of what kind of interventions are best equipped to benefit the unemployed.

Keywords: unemployment, health intervention, active labour market policy measure, mental well-being, re-employment

TIIVISTELMÄ

Tämä väitöskirja koostuu neljästä empiirisestä osatutkimuksesta, joissa tarkastellaan kahta työttömille tarkoitettua interventiota (terveyspalvelu ja työllisyyskoulutus). Väitöskirjan tavoitteena on selvittää, voidaanko valittujen interventioiden avulla lisätä työttömien työllistymismahdollisuuksia tai terveyttä ja hyvinvointia. Tutkimuksessa hyödynnetään kvantitatiivisia ja kvalitatiivisia menetelmiä. Tutkimusaineisto koostuu työttömistä henkilöistä, jotka osallistuivat tutkimusajankohtana työvoimapolitiisiin toimenpiteisiin (osatutkimukset I, III, IV), sekä terveysalan ammattihenkilöistä (osatutkimus II), jotka oli rekrytoitu tutkimusta varten perustettuun terveyspalvelukokeiluun.

Ensimmäinen osatutkimus selvitti, voidaanko työttömille suunnatulla erityisellä terveysinterventiolla vaikuttaa osallistujien työllistymiseen. Tämän satunnaistetun kontrolloidun tutkimuksen tulokset osoittivat, ettei toimeenpantu terveyspalvelu lisännyt palvelua käyttäneiden työttömien työllistymistä. Työllistymisen sijaan interventio näytti jopa haittaavan niiden työllistymismahdollisuuksia, jotka ilmoittivat kärsivänsä heikosta terveydentilasta.

Toisessa osatutkimuksessa tarkasteltiin sitä, miten erilaisin tavoin työttömien terveyspalveluun rekrytoidut työterveyshoitajat puhuivat työttömistä asiakkaistaan ja millaisia ammatillisia toimintatapoja he työssään tässä yhteydessä soveltavat. Tutkimusmenetelmänä käytettiin diskurssianalyysia, joka paljasti neljä, osin päällekkäistä työttömyysdiskurssia: työttömyyden uhri, aktiivinen työtön, poikkeava työtön sekä palveluiden ylikäyttäjä. Tutkimustulos tuo esiin työttömille tarkoitettuihin terveys-interventioihin liittyviä ongelmia ja haasteita.

Kolmas osatutkimus tarkasteli työttömille tarkoitettua terveyspalvelua sen asiakkaiden, työttömien näkökulmasta. Diskurssianalyysin avulla tarkasteltiin sitä, miten työttömille kohdistetun terveyspalvelun käyttäjät tulkitsevat palvelun hyödynnettävyyttä sekä sitä, miten he asemoivat itsensä suhteessa tarjottuun terveyspalveluun. Asemointiteoriaan perustuvan diskurssianalyysin avulla muodostettiin kuusi erilaista asemaa suhteessa tarjottuun terveyspalveluun: mukautuva kansalainen, kapinallinen, sosiaalisesti vastuullinen, omaleimainen yksilö, itsenäinen toimija sekä laskelmoiva asiakas. Tulokset korostavat niitä moninaisia muotoja, joilla työttömät tulkitsevat tarjottua terveyspalvelua.

Neljännessä osatutkimuksessa arvioitiin työllisyyskoulutuksen vaikutusta työttömien terveyteen ja hyvinvointiin ja mahdollisen vaikutuksen yhteyttä sosioekonomiseen asemaan. Toistomittausten varianssianalyysin tulosten perusteella työllisyyskoulutuksen terveys- ja hyvinvointivaikutuksissa oli merkittäviä eroja osallistujien sosioekonomisesta asemasta riippuen. Havaittujen erojen pohjalta todettiin, että työvoimapolitiittiset toimenpiteet saattavat ylläpitää tai jopa lisätä työttömiin kohdistuvaa epätasa-arvoa.

Tämä väitöskirja osoitti, kuinka tutkimuksen kohteena olevat interventiot, ainakin osittain, epäonnistuivat tavoitteissaan lisätä osallistujiensa työllisyysmahdollisuuksia sekä vähentää työttömyyteen liittyvää epätasa-arvoa. Tutkimustulokset antavat aiheen korostaa työttömien joukon moninaisuutta sekä työttömien omien tulkintojen ja toiveiden huomioimista, kun suunnitellaan heille kohdistuvia palveluja. Tutkimus tuo esille tarpeen tutkia interventioiden toimivuutta tarkemmin tavoitteena saada selville, minkälainen interventio toimii kenelle ja missä oloissa.

Asiasanat: työttömyys, terveysinterventio, työvoimapolitiittiset toimenpiteet, hyvinvointi, työllistyminen

TABLE OF CONTENTS

ABSTRACT.....	3
TIIVISTELMÄ.....	5
TABLE OF CONTENTS.....	7
LIST OF ORIGINAL PUBLICATIONS.....	9
1 INTRODUCTION.....	11
1.1 Frame of the study.....	11
1.2 Unemployment, health and mental well-being.....	13
1.2.1 Theories of deterioration of health and mental well-being among the unemployed.....	15
1.2.2 Multilevel mechanisms linking unemployment, health and mental well-being.....	17
1.2.3 Impact of re-employment on health and mental well- being.....	19
1.2.4 Concepts of health and mental well-being in the present study in light of earlier unemployment research.....	20
1.3 Interventions among the unemployed from the perspectives of health, mental well-being and re-employment.....	26
1.3.1 Concepts and definitions.....	26
1.3.2 Health interventions among the unemployed and their impact on health, mental well-being and re-employment.....	27
1.3.3 Re-employment-oriented interventions among the unemployed and their impact on health, mental well-being and re-employment.....	29
1.3.4 Need to reassess the effects of the activation policy and health and well-being interventions for the unemployed.....	32
1.4 Aims of this study.....	34
2 METHODS.....	36
2.1 Interventions, participants and procedure.....	36
2.1.1 Career Health Care (Studies I, II, III).....	36
2.1.2 Vocational training as a part of ALMP (Study IV).....	41
2.2 Measures and statistical analyses in Studies I and IV.....	44
2.2.1 Measures.....	44

2.2.2	Statistical analyses.....	47
2.3	Qualitative data collection and analysis in Studies II and III	47
2.3.1	Discourse analysis.....	47
2.3.2	Position analysis.....	49
3	RESULTS OF THE ORIGINAL STUDIES.....	51
3.1	Study I.....	51
3.2	Study II	52
3.3	Study III.....	52
3.4	Study IV.....	52
4	DISCUSSION	54
4.1	Main findings	54
4.1.1	Re-employment outcomes after the health care service	54
4.1.2	Four discourses of the unemployed as clients of Career Health Care.....	56
4.1.3	Manifold positions of unemployed people towards the targeted health care intervention.....	58
4.1.4	The differing effects of vocational training on health and mental well-being with respect to socioeconomic groups.....	60
4.2	Strengths and limitations of the study	62
4.3	Practical implications and suggestions for future research	66
	ACKNOWLEDGEMENTS.....	69
	REFERENCES.....	71
	ORIGINAL PUBLICATIONS	83

LIST OF ORIGINAL PUBLICATIONS

- Study I Romppainen, K., Saloniemi, A., Kinnunen, U., Liukkonen, V., & Virtanen, P. (2014). Does provision of targeted health care for the unemployed enhance re-employment? *BMC Public Health*, 14, 1200. doi:10.1186/1471-2458-14-1200
- Study II Romppainen, K., Jähi, R., Saloniemi, A., & Virtanen, P. (2010). Encounters with unemployment in occupational health care: Nurses' constructions of clients without work. *Social Science & Medicine*, 70(4), 605-608. doi:10.1016/j.socscimed.2009.10.052
- Study III Romppainen, K., Saloniemi, A., Jähi, R., & Virtanen, P. (2012). My health and theirs: clients constructing meanings for a health service programme for unemployed people. *Sociology of Health & Illness*, 34(6), 809-825. doi: 10.1111/j.1467-9566.2011.01429.x
- Study IV Saloniemi, A., Romppainen, K., Strandh, M., & Virtanen, P. (2014). Training for the unemployed: differential effects in white- and blue-collar workers with respect to mental well-being. *Work, Employment and Society*, 28(4), 533-550. doi: 10.1177/0950017013510761

1 INTRODUCTION

1.1 Frame of the study

Unemployment is an event with adverse consequences for those who lose their jobs. For example, numerous studies have consistently demonstrated that unemployment has a detrimental impact on the physical and mental health of individuals (Karsten & Moser, 2009; Kessler, House, & Turner, 1987; Maier et al., 2006; Paul & Moser, 2006, 2009). Research has also shown that health limitations can constitute a risk of becoming unemployed and are frequently considered a major obstacle to re-employment (Böckerman & Ilmakunnas, 2009). Thus, the relation between unemployment and health is complex and may be explained by two different mechanisms. The causation hypothesis suggests that lack of work may cause ill health in some people, and the selection hypothesis suggests that poor health probably increases the chances of becoming unemployed. Altogether, most studies support the notion that unemployed people are less healthy than employed people. This means that health and well-being interventions for the unemployed need special attention and should be more commonly addressed.

All in all, it is well known that the period of unemployment is shadowed by a fall in income and problems in well-being and health. We can conclude that unemployment is thus related to issues of inequality. Earlier research has also shown that, for example, differences in age and level of education expose differently to the risk of unemployment (McKee-Ryan, Song, Wanberg, & Kinicki, 2005). The increased knowledge of socio-economic health inequalities has put equality at the forefront of the health policy agenda. Thus, health and well-being interventions aiming to reduce health inequality among the unemployed are needed.

In fact, there is a consensus that interventions should be developed in order to be in a better position to respond to the challenges that the unemployed face (Bartley & Ferrie, 2010; Böckerman & Ilmakunnas, 2009; Harris, Webster, Harris, & Lee, 1998; Matoba & Ishitake, 1999; Vuori & Silvonen, 2005; Vuori, Silvonen, Vinokur, & Price, 2002; Ytterdahl, 1999). There is also considerable variation in the implementation of the interventions implemented in different countries. The main

tools used for dealing with the risks related to being excluded from the labour market include various forms of training, activity and subsidized work, which are called active labour market policy measures (i.e. ALMP measures). ALMP also aims to reduce the health risk of unemployment by helping to renew or maintain the human capital of the unemployed. However, the research evidence on the positive effects of participating in these programs is mixed (Card, Kluve, & Weber, 2011; Creed, Hick, & Machin, 1998; Strandh, 2001).

Although the field of interventions for the unemployed has consistently been an object of academic and political attention, we know only little about how these interventions respond to and affect the health problems of the unemployed (Harris et al., 1998). The current research and policy agenda suggest that interventions and re-employment programmes designed to decrease unemployment should be aware that the relationship between unemployment and health and well-being is complex. The complexities may be viewed from multiple angles: from the perspective of policy makers, professionals working with the unemployed and unemployed people themselves. Depending on the vantage point, the relationship is likely to be differently defined. Furthermore, little is known about how unemployed people engage in health promotion activities and integrate the health information they receive into their life context. We also need further evidence about what sort of interventions are required and whether these interventions are effective in improving health and well-being, enhancing re-employment and whether they actually reduce inequalities between employed and unemployed people.

This study aims to gain some new insights on the questions presented above. The focus is on two particular interventions, of which one was carried out in the field of health care and the other in the field of ALMP. The study investigated first the impact of the specific health care service on re-employment (Study I) and, secondly, the effects of the ALMP, in this case vocational training, (Study IV) on the health and mental well-being of the participants and whether the ALMP reduced inequality among the unemployed in terms of health and well-being.

In addition, the overall aim of this study was to find novel perspectives for understanding the challenges and barriers involved in developing interventions and to articulate how the actors involved in the health service define each other. The study therefore extends the analysis of the health care service intervention by focusing on both the health professionals involved (occupational health care nurses) and the clients (unemployed people). Thus, the aim was to ascertain how the actors involved (nurses and unemployed people) constructed meanings for the health care service and themselves (Studies II and III). In order to answer to these

four research questions, the study made use of both quantitative and qualitative research methods.

The next paragraphs of this introduction provide definitions of the key concepts, review the current research knowledge about unemployment and specify the aims of this study. The introduction begins by defining unemployment and describing the main theories related to unemployment from the viewpoint of mental well-being. Then earlier research on the impact of re-employment on health and mental well-being is reviewed. The results of earlier health and well-being intervention studies among the unemployed are also presented. The introduction ends by specifying the aims of this study.

1.2 Unemployment, health and mental well-being

According to the International Labour Organization (ILO, 1990), the unemployed are individuals who, during the reference period, meet the following three criteria: they are without work, available for paid employment or self-employment and seeking work. While the ILO criteria are based on actual behaviour, an alternative definition is based on attitudes, that is, the unemployed are those people who report themselves to be so in surveys (Pedersen & Schmidt, 2011). Paul and Moser (2006) have outlined that the concept of unemployment involves not only situational aspects (non-employment), but also a motivational (jobseeking), a medical (able-bodied for work) and legal dimensions (being available for work). To be unemployed distinguishes the unemployed from other groups of people who do not work, which usually refers to being outside the labour market. The jobseeking criterion differentiates the unemployed from those showing no active interest in employment, such as housewives and full-time students. The availability criterion distinguishes the unemployed from people who are not available to work due, for example, to reasons of health or who are legally excluded from the labour market, like children (Paul & Moser, 2006).

Defining unemployment is especially relevant when the unemployment rate and its costs are estimated. Thus, the unemployment rate can be seen as one of the most critical indicators of success or failure in economic policy. At the same time unemployment has well-known costs at the individual level in the form of loss of human capital and impaired well-being (Pedersen & Schmidt, 2011).

Unemployment is a major risk factor for health and mental well-being. Health is a complex construct with several conceptualizations. One of the most often used

definitions is from the World Health Organization (WHO, 1986). In this definition health has medical, physical, mental and social components. Traditionally, and particularly in biomedical theories, health is seen as the absence of disease or disability. It usually focuses on the causes of diseases, prevention and cure (Larson, 1999). In research and in clinical practice health is used as a generic term that is empirically approached by various indicators such as medical diagnoses, functional statuses, experienced symptoms and laboratory values. It may be assumed that lay people and medical professionals probably share a fairly similar general understanding of what constitutes health (Jylhä, 2009).

When mental well-being is the focus of research, the aim is usually to determine the absence, or a low level of distress and a high level of well-being. However, there is the same inconsistency problem in the operationalization of the well-being concept as in health (Warr, 1990, 2013). Well-being has been often defined according to the purpose of study, the sample, the setting or scope and there is no single, widely accepted definition of it (Charlemagne-Badal, Lee, Butler, & Fraser, 2014; Warr, 2013). It may be said that historically psychological distress has received far more attention in research than its positive counterpart, psychological well-being. This is also the case in research on the unemployed.

In this study health is viewed from a wide perspective covering ill health, symptoms, physical and mental state. The main focus, however, is on the mental well-being of the unemployed. In the present study the mental well-being of the unemployed is considered from four perspectives: 1) the health and mental well-being of the unemployed as a target for health care services and health policy (Study I), 2) the health and mental well-being of the unemployed as assessed by health professionals in that branch of health care (Study II), 3) how unemployed people position themselves with regard to a new health care service set up as part of an institutional strategy (Study III), and 4) the effects of ALMP (i.e. vocational training) with respect to the health and mental well-being of the participants (Study IV).

Research aiming to shed light on the relationship between unemployment and health and mental well-being has been carried out at least since the 1930s (Fryer, 2006). In order to understand this relationship, one has to look at what aspects of the unemployment situation seem to cause poor health and mental well-being. Of the theories, the two most influential psychological theories will be briefly reviewed in the next section.

1.2.1 Theories of deterioration of health and mental well-being among the unemployed

The negative effects of unemployment on mental well-being have been explained through a variety of theories. Historically, three theoretical research traditions – biomedical, sociological and psychological – have been identified (see Creed & Bartum, 2006; Janlert & Hammarström, 2009, for reviews). The biomedical tradition emphasizes the impact of physiological mechanisms in explaining the association between physical circumstances and biological phenomena. The sociological tradition focuses on material and societal circumstances with both restrictions on and opportunities for human development and an important formative environment for health and disease. The psychological tradition, in turn, concentrates on the individuals and their options (e.g., perception, learning, motivation). These traditions have subsequently been combined and formulated into more complex ones. In this study the focus is on the psychological theories.

Of the psychological theories, the latent deprivation model and the agency restriction model are perhaps the most well-known in accounting for the decline in mental well-being observed when people are exposed to unemployment. Jahoda's (1981, 1982) latent deprivation model suggests that employment provides both manifest and latent benefits. Thus, the institution of employment has not only a manifest function (associated with income) but also five latent functions (associated with psychological needs) that are important for mental well-being: time structure, social contacts, sharing of common goals, status and identity and finally activity. According to Jahoda (1982), these latent functions correspond to basic human needs and therefore have a direct impact on a person's mental well-being. Deprivation of employment leads to deprivation in both manifest and latent functions, but it is the loss of the latent functions that is especially detrimental to mental well-being.

The latent deprivation theory suggests that any job is better than being unemployed, as all jobs inevitably provide access to the latent benefits of employment. However, several studies have questioned this by arguing that unsatisfying jobs also have negative effects and may be just as psychologically damaging as unemployment (Feldman, 1996; Leach et al., 2010; Prause & Dooley, 2001). Studies have also confirmed that the latent benefits can be found in sources other than employment (e.g., Creed, Muller, & Parron, 2003). Although Jahoda's theory of latent functions of employment is useful in differentiating between unemployed and employed groups, it has been criticized for not taking account of

the total variance in the health and mental well-being of the unemployed (Creed, Muller, & Machin, 2001). It has also been shown that being unemployed, however, also brings changes that can be experienced as beneficial, for example, the opportunity to give more attention to family life (Goul Andersen, 2002). According to Jahoda (1982), although a job is not the only way to satisfy the latent functions, it is the best way as it satisfies all five latent functions.

The agency restriction model (Fryer, 1986), in contrast to Jahoda's deprivation model, emphasizes the impact of financial deprivation. Fryer considered that the main negative consequence of unemployment is the loss of income (the manifest benefits) rather than the loss of the latent benefits. He also acknowledged the role of the latent functions of employment in mental well-being, but considered these insufficient in fully explaining the decline in mental well-being experienced by the unemployed. According to this theory, the loss of income directly reduces the individual's capacity to plan and organize a meaningful and satisfying life, that is, the agency of the unemployed is inhibited. The unemployed have less money, which directly or indirectly impairs the premises for good health (Fryer, 1986; Fryer & Payne, 1986). Many unemployment studies since the Great Depression in the 1930's have provided evidence that financial hardship plays a substantial role in the lives of the unemployed (Creed et al., 2001; Elder, 2010; Rantakeisu, Starrin, & Hagquist, 1999).

Janlert and Hammarström (2009) tested seven different models (the economic deprivation model, the lack of control model, the locus of control model, the stress model, the social support model, the work involvement model and the model of latent functions) in an empirical study. Their aim was to find out which theory best explains the links between unemployment and health and mental well-being. Their analyses showed that the explanatory power differed between the models, but also between different outcomes. The model of latent functions was the most successful model, followed by the economic deprivation model. The social support and the control models were fairly good, whereas the work involvement model and the stress model demonstrated the smallest explanatory power. With regard to the outcomes, depression was the outcome best explained by the different models. Janlert and Hammarström's overall conclusion was that model development is limited to specific disciplines and that multidisciplinary theory development is rare. They suggest that there is a need to develop broader and more complex theories in order to better understand the determinants of health and mental well-being among the unemployed.

The relationship between unemployment, health and mental well-being will be discussed in the next section in more detail.

1.2.2 Multilevel mechanisms linking unemployment, health and mental well-being

The relationship between employment status and health is complicated and reciprocal: poor health can cause job loss and job loss can cause poor health. The existing unemployment research has provided a lot of evidence regarding mental well-being in the process of becoming and remaining unemployed (see reviews by McKee-Ryan et al., 2005; Paul & Moser, 2009; Wanberg, 2012). There is evidence for both causal and selective processes. The causation hypothesis states that poor socioeconomic conditions, such as unemployment, are likely to constitute risks for mental well-being and physical health problems. The selection hypothesis argues that individuals with poor health and mental well-being may be more likely to lose their jobs and find it harder to regain employment.

Olesen et al. (2013) demonstrated in their longitudinal population study that poor mental well-being is both a consequence and determinant of unemployment and the strength of each relationship is broadly consistent. Paul and Moser (2009) in their meta-analysis of longitudinal studies found evidence for selection effects supporting the assumption that there is a causal link from mental well-being to a person's employment status: a person with impaired mental well-being is more likely to lose her or his job and among the unemployed impaired mental well-being lowers the chances of re-employment. They concluded that there is a mechanism in the labour market that creates additional disadvantages for those who are already disadvantaged with regard to their mental well-being. The impact of health selection appears to be twofold: on the one hand, better health favours selection into permanent employment and, on the other hand, the unemployed undergo a repeated process of health selection when they seek employment (Böckerman & Ilmakunnas, 2009; Paul & Moser, 2009; Virtanen, Janlert, & Hammarström, 2013). To date, the causation pathway has attracted more theoretical as well as empirical research interest than the selection pathway. Nevertheless, some questions remain open.

Instead of the question of causation vs. selection, the recent unemployment research has begun to focus on possible confounding, mediating and moderating factors. One such factor is health behaviour. A number of studies have found an

increased prevalence of risky health behaviours (smoking, excessive alcohol consumption, illegal drug use, physical inactivity and overweight) among the unemployed (Fryer-Adam, Gaertner, Tobschall, & John, 2011; Hammarström & Janlert, 2003; Khlal, Sermet, & Le Pape, 2004; Montgomery, Cook, Bartley, & Wadsworth, 1998). Health behaviour change is also often the main focus for primary prevention and health promotion in the effort to reduce health risk factors and to promote health among jobseekers in health care settings. Research has generated two major hypotheses regarding the relationship between unemployment and health behaviour (Roelfs, Shor, Davidson, & Schwartz, 2011). The first, the 'latent sickness hypothesis', argues that health selection operates through health behaviour variables rather than in a direct manner. That is, if the health problems manifest, for example, in high levels of alcohol consumption and smoking only after the onset of unemployment, controlling for pre-existing health status would not effectively rule out health selection. In line with this, research has repeatedly shown that individuals with high levels of drinking and smoking are more likely to become unemployed (e.g., Janlert & Hammarström, 1992). The second, the 'coping hypothesis', suggests that unemployment causes adverse changes in health behaviour, which leads to a deterioration of health. According to this view, individuals cope with unemployment stress by changing their consumption habits in an unhealthy way and this concerns particularly individuals with low socioeconomic status. A large body of research supports the coping hypothesis (see Roelfs et al., 2011).

Although the proposed mechanisms linking unemployment, health and mental well-being offer lot of room for individual and group differences in the impact of job loss, most studies so far have treated becoming unemployed as a homogeneous event (Paul & Moser, 2009). However, it is obvious that there is wide variation among unemployed people; not all of them react to and cope with job loss in the same way; individual differences occur in the experience of unemployment and unemployment as a damaging experience does not apply to everyone (Hammarström & Janlert, 1997; Wanberg, 2012).

In addition to individual-level factors, unemployment is also generally seen as having a damaging impact on society as a whole in a number of economic, social, political and moral ways. Hence it is also important to pay attention to macro-level economic factors in the unemployment-health relationship, as national welfare and unemployment policies may play a moderating role (Bambra, 2011; Roelfs et al., 2011).

The next section provides an overview of the empirical research evidence of the impact of re-employment on health and mental well-being. After that in the following section the concepts used to describe health and mental well-being in this study are defined. Unemployment research utilizing these concepts is also introduced.

1.2.3 Impact of re-employment on health and mental well-being

Studies examining the impact of unemployment on health and mental well-being of unemployed people have a long history worldwide. The research evidence seems to be clear and univocal: several meta-analyses (McKee-Ryan et al., 2005; Paul & Moser, 2009; Roelfs et al., 2011) demonstrate that unemployed people have poorer health, particularly mental well-being, and more signs of psychological distress than do employed people. However, the effect sizes of the relationship between unemployment and decreased mental well-being vary according to the mental well-being outcome studied.

There is also ample evidence that re-employment can improve health and mental well-being. In this study re-employment is conceptualized as a transition from unemployment to employment or simply put, finding a job. According to the causation hypothesis, entering paid employment is beneficial to health and various studies have confirmed that finding a job improved mental well-being (McKee-Ryan et al., 2005; Murphy & Athanasou, 1999; Rueda et al., 2012). Positive health and mental well-being effects can be assumed according to Jahoda's (1982) theory of job deprivation. A systematic review confirms that employment is generally beneficial to health and mental well-being (van der Noordt, 2014). A review of 33 prospective studies showed that entering paid employment reduced the risk of depression (OR = 0.52; 95% CI 0.33 to 0.83) and psychological distress (OR = 0.79; 95% CI 0.72 to 0.83). A meta-analysis of 15 longitudinal studies by McKee-Ryan et al. (2005) reported significant improvements in mental well-being (effect size 0.89) and life satisfaction (effect size 3.04; $d > .80$ which is considered "large" according to Cohen).

Schuring, Mackenbach, Voorham and Burdorf (2011) in their prospective study with six-month follow-up analysed the influence of re-employment on changes in perceived health and mental well-being among the unemployed who were capable of full-time employment. Their results showed that among the re-employed participants general health, physical functioning, social functioning, vitality, mental

well-being, bodily pain and role limitations due to emotional or physical problems improved, with an effect size varying from 0.11 to 0.66. Hence re-employment had a positive influence on both physical and mental well-being. Unemployed participants with poor health and mental well-being at baseline were less likely to return to paid employment during follow-up. Another study showed that while entering employment is beneficial to health and mental well-being, unemployed people with poor health and mental well-being are less likely to engage in active search behaviour and therefore less often obtain re-employment (Butterworth, Leach, Pirkis, & Kelaher, 2011; Schuring et al., 2009). Research has also shown that the unemployed with better health and mental well-being are more likely to become employed. Based on these findings, it seems most likely that re-employment results in improved health and mental well-being

1.2.4 Concepts of health and mental well-being in the present study in light of earlier unemployment research

In this study health is viewed from a wide perspective covering ill-health, symptoms, physical and mental state. The main focus, however, is on the mental well-being of the unemployed. Mental well-being generally refers to an individual's emotional and psychological well-being, ability to function in society and capacity to cope with everyday stressors (Warr, 2013). Nevertheless, there is not a collectively agreed definition of mental well-being or distress in the literature. In this study, health and mental well-being were conceptualized with several indicators, namely psychological distress, sense of coherence, depressive symptoms, self-rated health and stress symptoms. These concepts are consistently used within the field of unemployment and health research and seem to be unequivocal with regard to their relevance to health and mental well-being.

Psychological distress

Psychological or mental distress has been often considered an instantaneous and long-term consequence of job loss. The loss may increase psychological distress in at least three ways: through stress because of involuntary loss of one's job, through effects related to being out of employment for those who do not find re-employment, and for those who find re-employment through downward job mobility (Mandemakers & Monden, 2013). Psychological distress is often – and also in this study – defined in terms of the General Health Questionnaire (GHQ)

(Goldberg, 1972; Goldberg & Williams, 1988). The GHQ is a valid screening instrument for minor psychiatric disorders, but also for general psychological distress. Its focus is on the identification of emotional symptoms, particularly those relating to anxiety, depression and social dysfunction.

The research evidence argues that unemployed people have a high level of psychological distress (Creed & Moore, 2006). However, different groups of unemployed suffer distress differently, for example, the level of psychological distress has been particularly high among the long-term unemployed. The results of Backhans and Hemmingsson (2011) are consistent with the finding by Creed and Moore: the detrimental effect of unemployment varies between groups. Backhans and Hemmingsson argued that unemployment has an independent effect on mental distress, but the association is different in different groups. Unemployed people are more distressed not only in comparison to employed people but also in comparison to other groups of people who are not in working life (such as housewives and pensioners). Tarik and Bugra (2015) studied differences in the utilization of coping strategies, social support and psychological distress among unemployed and re-employed individuals. Their results showed that unemployed participants reported higher levels of psychological distress than did re-employed participants, although social support and coping strategies also predicted psychological distress. Sociodemographic characteristics were also significantly associated with distress; being female, single, older and less educated were potential risk factors for psychological distress among unemployed individuals. Additionally, long-term unemployment was seen as a particularly risk for psychological distress.

Mandemakers and Monden (2013) investigated the impact of involuntary job loss on psychological distress and tried to ascertain whether the impact differed by level of education using a sample of unemployed men drawn from the British Household Panel Study. The results showed that the impact of job loss on psychological distress was much worse for the lower educated than for the higher educated (see also Ziersch et al., 2014). However, the educational differences in the impact of job loss diminished over time and were mainly driven by chances of re-employment.

Individuals' previous employment status may also have an impact on the relationship between unemployment and distress. Booker and Sacker (2012) in a British longitudinal panel study examined the effect of multiple unemployment spells on psychological distress. Their results indicated that distress was higher at each unemployment spell. However, previously employed and economically inactive individuals differed in their reactions to multiple unemployment spells.

Previously employed people had significantly higher GHQ scores during their first and second unemployment spells but not in the third spell. Previously economically inactive people had higher psychological distress during all unemployment spells, with significantly higher scores in the third spell than those in the first two spells. The eventual conclusion was that employed people who became unemployed coped better psychologically with each repeated period of unemployment only if they were able to regain employment in between. For those who made several attempts to re-enter the labour market following economic inactivity, mental well-being was more adversely affected at each attempt.

Sense of coherence

Sense of coherence (SOC) is described as a resource promoting the development of a positive state of health. For example, unhealthy people with a strong SOC cope better with their sickness (Eriksson & Lindström, 2005). Originally sense of coherence is a concept based on Antonovsky's (1979, 1987) health-oriented theory. According to Antonovsky's (1987) definition, SOC has three main components: comprehensibility (feeling of confidence that the stimuli, deriving from one's internal and external environment are structured, predictable and explicable), manageability (the resources are available for one to meet the demands posed by these stimuli) and meaningfulness (the demands are challenges, worthy of investment and engagement). Thus, individuals with a strong SOC see their environment as comprehensible and manageable and their lives as meaningful. SOC has been assumed to be a fairly stable disposition, but later research has shown that it is not as stable as Antonovsky (1979, 1987) assumed. Several empirical studies have confirmed that SOC changes, for example, through drastic life events such as the loss of one's job (Eriksson & Lindström, 2005; Kivimäki et al., 2002; Volanen et al., 2007).

According to Antonovsky (1987), the most overwhelming experience in working life is losing one's job. Studies have found that unemployed people have lower SOC than employed people. For example, it has been shown that those who had experienced unemployment and/or been laid off had a weaker SOC than those in continuous full-time employment across five years (Feldt, Leskinen, & Kinnunen, 2005). Also, in a Finnish cross-sectional study the unemployed had lower SOC than the employed (Volanen, Lahelma, Silventoinen, & Suominen, 2004), and in a Swedish study two years after a factory closure those employees

who were re-employed had significantly stronger SOC than those who were still unemployed (Hanse & Engström, 1999).

Having a strong SOC is assumed to be a major coping resource for maintaining good health and mental well-being. In various studies, it has been established that a strong SOC is positively associated with various aspects of health, especially with perceived mental health (Flensburg-Madsen, Ventegodt, & Merrik, 2005; Eriksson & Lindström, 2005; Kivimäki, Feldt, Vahtera, & Nurmi, 2000). SOC is thought to be a health promoting resource and important for understanding individual differences in coping with stress. Coping includes both the ability to mobilize resources in order to manage the situation (instrumental), and the ability to regulate emotions in the situation (emotional) (Lazarus & Folkman, 1984). The research findings on SOC concur with the findings of different aspects of mental well-being, for example, symptoms of depression and anxiety, psychosomatic symptoms and feelings of control (Winefield, 1995).

Depressive symptoms

Depressive symptoms (Beck, Steer, & Garbin, 1988) can be defined as a sign of negative affective state involving such characteristics as sadness, irritability, hopelessness, feeling of failure and social withdrawal. Hence depressiveness refers to a mode of reacting to challenges considered to require too much in comparison to resources. There are numerous explanations why unemployed people may suffer from depressive symptoms. The psychological cost of losing one's job is assumed to be the result of several factors ranging from loss of meaning and the need to redefine one's self-identity to the social stigma of being unemployed (Layard, Clark, & Senik, 2012).

Consistent evidence in past decades suggests that unemployment is associated with depressive symptoms (Dooley, Prause, & Ham-Rowbottom, 2000; Feather & O'Brien, 1986). In Voelker's study (2015) unemployed young adults were three times more likely to be depressed than were peers who were working. The recent meta-analysis by Kim and von dem Knesebeck (2016) of prospective observational studies suggested that unemployment was related to a significantly higher risk of depressive symptoms. The unemployed had a 19 per cent increased risk of depressive symptoms when compared with the employed. The highest ORs were found for younger unemployed people (under 40 years), while none to small risks of depressive symptoms were evident for the older age groups (40 years and over).

However, ORs were highest in studies that did not control for potential health selection effects and that ascertained prolonged unemployment.

Likewise, in their age-stratified study, Mihai, Ricean and Voidazan (2014) found that unemployment status increases depression rate particularly in vulnerable groups such as single or divorced women. Suicidal ideation, in turn, was associated with unemployment status in men living in a rural area with medium level of education. Furthermore, Stankunas, Kalediene, Starkuviene and Kapustinskiene (2006) showed that the strongest effect on increased depressive symptoms was found for long-term unemployment. It is also noteworthy that depression not only poses a serious medical problem, but may also be an obstacle to vocational reintegration among the older long-term unemployed (Liwowsky et al., 2009). A follow-up study among the unemployed showed, however, that re-employment reduced the chance of depression scores to 26 per cent and the chance of anxiety scores to 13 per cent compared to those who remained still unemployed (Clausen, 1999).

Self-rated health

Self-rated health (SRH) has also been shown to be a reliable and valid indicator of health-related well-being. It is defined as a person's global assessment of his or her general state of health (DeSalvo et al., 2006). Several meta-analyses have shown that SRH is predictive of morbidity and various objective health indicators, even mortality (DeSalvo et al., 2006; Mavaddat et al., 2014). In general practice, the one question eliciting self-rated health serves as a comprehensive screening tool for patients' health status (Jylhä, 2009). There are also reviews and meta-analyses (Gilbert et al., 2013; Kim, Subramanian, & Kawachi, 2008) reporting an overall positive relationship between social capital and health as measured by self-rated health. Self-rated health can be assumed to be an important indicator of physical and mental well-being that may influence an individual's quality of life and thus be a relevant factor to be taken into account in the assessment of unemployed people's health and mental well-being.

Several studies have confirmed the association between unemployment and poor self-rated health (Broom et al., 2006; Giatti, Barreto, & César, 2010; Minelli, Pigini, Chiavarini, & Bartolucci, 2014). Freyed-Adam, Gaertner, Tobschall and John (2011) investigated to what extent health risk factors (smoking, risky alcohol drinking, overweight, low fruit and vegetable intake, physical inactivity, illicit drug use) were associated with SRH among a large sample of jobseekers. The

associations between health risk behaviours and poor SRH were confirmed, and in comparisons to the adult general population, jobseekers lived unhealthier lives in various ways. Limm et al. (2012) showed that long-term unemployed people in particular reported poorer SRH than the general population. According to their analyses, SRH was significantly poorer among unemployed women, among people with elevated depression and anxiety scores, and in participants reporting reduced level of physical activity. Bambra and Eikemo (2009) confirmed a consistent relationship between unemployment and poor SRH in their study of unemployment and health in 23 European countries. The relationship, however, varied according to different welfare state regimes and relative inequalities were largest in the Anglo-Saxon, Bismarckian (men only) and Scandinavian regimes (women only). In terms of the Scandinavian welfare state, the relatively large inequalities between employed and unemployed women may reflect the fact that women are less likely to meet the qualification criteria for social benefits due, for example, to a less consistent employment history. Altogether, the negative relationship between unemployment and health is consistent across Europe but varies by welfare state, suggesting that levels of social security may have a moderating influence (Bambra & Eikemo, 2009).

Good SRH, instead, can also be a reliable predictor for prospects of re-employment, whereas poor SRH has been suggested to be a potential barrier to re-employment. Carlier et al. (2013) in their prospective study with 18-month follow-up among unemployed persons found that people who started in paid employment during the follow-up period were more likely to have good SRH (OR = 2.88) than were those who remained unemployed. Therefore, good health is a primary goal in health promotion programmes for the long-term unemployed (Schutgens, Schuring, Voorham, & Burdorf, 2009; Schuring et al., 2011).

Stress symptoms

Stress symptoms are considered to include a range of individual variables from cognitive to physical symptoms to account for the variation in responses to life events such as job loss (Thoits, 2010). According to Lazarus (1999), stress is a dynamic process that occurs when an individual appraises situational demands as exceeding available resources. The process of job loss itself is considered inherently stressful (Mandemakers & Monden, 2013). Within this context, job loss is a negative life event in which stress is a significant emotional outcome. The stress symptoms concept refers mainly to physical symptoms, but these are closely

related to anxiety and depression, independent of age and gender (Haug, Mykletun, & Dahl, 2004). It is thought that stress symptoms lie at the interface of the psyche and soma, therefore they are also called psychosomatic symptoms or functional somatic symptoms. They refer to symptoms such as headache, stomach ache, musculoskeletal pain, breathing difficulties, exhaustion, dizziness and fatigue. As a health outcome, stress symptoms are seen to be a predictor of health status and healthcare use (Creed et al., 2012).

Unemployment is associated with an increased likelihood of stress and psychosomatic stress symptoms (Viinamäki, Koskela, & Niskanen, 1993). A large cross-sectional study in Sweden found that stress symptoms and impaired well-being were more frequent among unemployed individuals than among employed individuals (Åslund, Starrin, & Nilsson, 2014). In a Swedish cohort study, stress symptoms were found to be significantly related to youth unemployment (Brydsten, Hammarström, Strandh, & Johansson, 2015). This was particularly true for men, after controlling for health selection, socioeconomic background, education and later unemployment. For women, there was a short-term but no long-term association and the difference from men was explained by education (see also Brydsten, Hammarström, & San Sebastian, 2016). Re-employment of unemployed people has been confirmed to be a powerful intervention to reduce stress symptoms; a longitudinal study in Norway found a positive (decreasing) effect of re-employment on somatic symptoms (Claussen, 1999).

1.3 Interventions among the unemployed from the perspectives of health, mental well-being and re-employment

This section proceeds as follows. After a short conceptual introduction, various intervention studies conducted among the unemployed will be presented from the viewpoints of health, mental well-being and re-employment. The chapter ends with a critical view of activation policy based on the findings of a few qualitative studies.

1.3.1 Concepts and definitions

According to the Oxford English Dictionary, ‘intervene’ is “to come between so as to prevent or modify a result”. To intervene is to enter from outside as an outsider and to transgress with an intent. Intervention is also a transformative act (Reus-

Smit, 2013). Intervention can be defined as any activity where an external actor with a given interest attempts to change the state or the course of affairs in a given target group.

In the present study, the target group for the interventions was unemployed people. Society can be considered to play an actor role as it is in the interests of society to preserve and promote high employment rate (i.e. workforce's employability at a macro level) by means of interventions. In this study the interventions examined were health services provided through the novel Career Health Care (CHC) and active labour market policy (ALMP) measures provided through conventional vocational training courses. Health policy as well as employment policy interventions are evidently more and less successful as regards the intended effects, that is, to promote outcomes such as health and re-employment (see Reus-Smit, 2013). Moreover, they tend to have unintended so-called side effects (for more see 1.3.4 below) that may be beneficial or detrimental. The next two sections review existing research concerning effects of interventions targeted for the unemployed. First, the focus is on health interventions and, secondly, on re-employment-oriented interventions among the unemployed.

1.3.2 Health interventions among the unemployed and their impact on health, mental well-being and re-employment

The awareness of the beneficial effects of employment on health and well-being has generated a number of health interventions and research on the topic among the unemployed. In order to improve the prospects for re-employment, improving the health and mental well-being of the unemployed may be an important aim in an intervention and one of the most relevant arguments for increased health services for them (Prause & Dooley, 2001; Thomas, Benzeval, & Stansfield, 2007). However, because of the heterogeneity of the health interventions, these measures have varying impacts on health and mental well-being and the issue of the effect on re-employment is even more unclear. Thus, previous health interventions targeting the unemployed population are diverse. The primary outcome measure seems to be improved physical or mental well-being and re-employment is often only the secondary outcome.

Nonetheless, the research evidence of the effects of health-related interventions among the unemployed is inconsistent. The meta-analysis by Paul and Moser (2009) demonstrated that intervention studies reported better mental well-being

outcomes than non-intervention studies. More specifically, those interventions programmes including some psychological components, had positive effects on mental well-being among the long-term unemployed. The effect size of such intervention programmes was medium.

In the field of health and mental well-being promotion, group-based cognitive-behavioural interventions focusing on self-efficacy beliefs have been found to effectively reduce depressive symptoms of those who are unemployed (Jané-Llopis, Hosman, Jenkins, & Anderson, 2003; Rose & Harris, 2004). Furthermore, Horns et al. (2012) in their quasi-experimental controlled study investigated the effects of a health-promotion intervention programme tailored to the long-term unemployed. The intervention combined individual sessions based on motivational interviewing and participatory group sessions including physical activity. Over a period of three months the participants of the intervention group showed greater improvement than the control group in terms of motivation for lifestyle changes towards more physical activity and healthier nutrition.

Whilst psychological interventions among the unemployed are argued to have positive effects on mental well-being, a systematic review and meta-analysis of unemployment and all-cause mortality by Roelfs et al. (2011) showed that cardiovascular screening programmes, interventions aimed at increasing awareness of behavioural risk factors and stress-management programmes may also be particularly beneficial to health and mental well-being. There are also a few studies (Gabrys et al., 2013; Schutgens et al., 2009) reporting positive results of physical activity interventions for unemployed people. According to these studies the physical health of the unemployed participants improved slightly after these health promotion programmes, but the effects on re-employment were not reported.

Less positive effects are presented in the study by Schuring et al. (2009). They implemented a randomized controlled trial with six-month follow-up among unemployed subjects ($n = 921$). The intervention consisted of training to enhance the ability to cope with health problems combined with sessions of physical activities. The health promotion programme did not show beneficial effects on physical health and mental well-being, nor on re-employment. The authors considered the possibility that the lack of integration of the intervention into regular vocational rehabilitation activities may have negatively affected the results. In the Finnish context, an evaluation study was conducted to establish the role of health care services in the process of rehabilitation, activation and re-employment of the long-term unemployed (Saikku, 2009, 2010). Empirical data were collected from 17 municipal projects established to maintain and improve the work ability of

the unemployed. The research was conducted from the perspective of process evaluation and the data consisted of surveys, interviews, case studies and physical examinations. The findings showed that the unemployed people's need for medical care exceeded rehabilitation measures. Re-employment, rehabilitation or transitions to pension were very rare among the unemployed during the three-year follow-up.

1.3.3 Re-employment-oriented interventions among the unemployed and their impact on health, mental well-being and re-employment

The main tools used and proposed to improve unemployed people's re-employment (i.e. employability at macro and micro levels, see Berntson, 2008; Forrier & Sels, 2003) have included various forms of training, activities and subsidized job placements (OECD, 2014). These measures are usually referred to as Active Labour Market Policy Measures (ALMP). ALMP can be assumed, through Jahoda's deprivation theory, to compensate for latent functions. ALMP, in a sense, resembles paid work: providing unemployed people with the opportunity to gain new skills and experiences, to meet new people and to acquire a daily structure. When participating in ALMP the participants continue to receive material earnings, the same daily allowance as during preceding unemployment, but it also contributes to psychological well-being through time structure, social contacts, collective purpose, social identity/status, and activity. Similarly, participation may counteract the restrictions on agency by providing new skills as well as steering the unemployed towards entering the labour market where further opportunities exist. This is supposed to increase competitiveness, sense of control, and confidence for the future among unemployed (Hallsten, Grossi, & Westerlund, 1999; Sage, 2013; Strandh, 2001). ALMP has been designed, perhaps primarily, to bring about positive economic outcomes, such as earnings and re-employment opportunities (Andersen, 2008; Greenberg, Michalopoulos, & Robins, 2003; Fertig, Schmidt, & Schneider, 2006). In principle, ALMP is also considered a means to reduce social inequality and enhance re-employment, which evidently improves health and mental well-being (Creed, Bloxsome, & Johnston, 2001; Paul & Moser, 2009; Strandh, 2001).

Re-employment of unemployed persons has a considerable relevance in the attempt to reduce health inequalities. Several studies have provided evidence that entering paid employment can improve health and mental well-being. However, the systematic review by van Rijn, Carlier, Schuring and Burdorf (2016) showed

that re-employment-oriented intervention studies have mainly focused on their effectiveness for vocational outcomes (entering paid employment and income level received), and the health-related outcomes have seldom been examined.

Audhoe, Hoving, Sluiter and Frings-Dresen (2010) conducted a systematic review to determine the effectiveness of vocational interventions in the work participation and mental well-being of the unemployed. The review considered all intervention studies published between 1990 and 2008 and found that only six out of 29 studies met all the inclusion criteria (related to unemployment, work participation and mental distress or minor psychological problems studied as outcomes). Of these studies, two publications included the same data. According to the authors, the methodological quality of the studies ranged from poor to good. The intervention programmes were characterized by group training techniques focusing on acquiring jobseeking skills, sustaining paid work, personal development and preparedness against setbacks during the jobseeking process. Of the five intervention studies, only one, a randomized controlled trial called JOBS II, reported a significant positive effect on re-employment (Vinokur, Price, & Schul, 1995). Concerning effects on mental well-being, American JOBS II and Finnish study “Työhön” (= to work) reported a significant effect on decreasing psychological distress (Vinokur et al., 1995; Vuori et al., 2002). The other intervention studies included in the review did not report significant effects on re-employment or mental well-being.

The findings are consistent with a more recent review by Wanberg (2012). According to that review, there is only a weak evidence to support the use of vocational interventions to improve work participation and limited evidence of reduced mental distress among the unemployed. A very recent systematic review and meta-analysis of 16 randomized controlled trials by van Rijn et al. (2016) showed that re-employment-oriented interventions had a modest (effect size 0.28) positive effect on the quality of life of unemployed people with severe mental health problems. However, there was no evidence of benefits concerning mental well-being and functioning. Re-employment was not examined as an outcome in the meta-analysis.

There has been also a change in labour market policies towards compelling unemployed people to participate in labour market programmes by means of financial sanctions. Malmberg-Heimonen and Vuori (2005) in their follow-up study with a control group investigated whether and how participation under threat of sanctions modifies the impact of job-search training on re-employment and mental well-being. The results of their study showed that such enforced participation did

not increase re-employment and, in fact, impaired the positive mental well-being effects of the programme. Self-efficacy beliefs increased among voluntary participants, whereas the outcome for those whose participation was enforced was similar to those of the control group.

However, there are studies based on a large sample register and survey data (Andersen, 2008; Korpi, 1997) that have found improved mental well-being among the participants in ALMP measures consisting of vocational training. In addition, there are studies carried out among participants in ALMP that have reported decreased psychological distress (Vuori & Vesalainen, 1999), improved sense of coherence (Vastamäki, Moser, & Paul, 2009) and self-esteem (Creed et al., 2001). Strandh (2001) studied three different types of ALMP measures, activation, vocational training and workplace participation. Of these, only involvement in workplace participation was found to have a clearly positive effect on mental well-being among the participants. Certain types of jobseeking training have been found to improve mental well-being, especially due to strengthened self-efficacy beliefs, mastery and improved financial situation due to re-employment (Vinokur & Schul, 1997; Vuori & Silvonen, 2005). The stability of the improvement, however, is not self-evident (Creed et al., 1998, 2001; Vuori & Vesalainen, 1999).

Less encouraging findings with regard to participation in ALMP have also been reported. Reine, Novo and Hammarström (2011) showed that participation in ALMP measures had no effects on mental well-being. Bredahl and Clament (2010) studied explicitly the potential of ALMP as a tool to combat marginalization. A comparison between participants and non-participants after the ALMP training programmes revealed no significant differences in the intensity of social networks, in feelings of stigmatization, or in self-esteem.

Nordlund (2011) proposed that one reason for the inconclusiveness of the results on the effectiveness of ALMP may have to do with the heterogeneity of participants, suggesting that it should be a question of who is studied and who takes part in what type of ALMP. She argued that different types of programmes generate different effects depending on the qualities and circumstances of the participants. It is also known that the experience of unemployment varies among the unemployed. While someone may be wasting his or her time in ALMP, for others ALMP can be of great help in reducing the risk of negative unemployment effects. In Nordlund's study the effects of ALMP depended on participants' age and education. The youngest showed reduced risk of labour market instability when participating in ALMP training, and the oldest reduced their risk of labour market exit and negative post-unemployment incomes when participating in ALMP

employment. In addition, those with higher education gained more in terms of labour market stability from ALMP training than did the less educated participants. Therefore, interventions should be targeted and tailored to suit the individual needs of the unemployed (Hoare & Machin, 2010).

In sum, there is some robust evidence to suggest that particular ALMP improves the health, mental well-being and even the re-employment of the unemployed. However, it has been argued that there needs to be a far better understanding of what type of ALMP is best equipped to help the unemployed. In addition to this, there is a limited amount of empirical research investigating whether ALMP and other active interventions can lead to deleterious social outcomes and even have harmful effects. The question of how socioeconomic status, for instance, is connected to the chances of utilizing ALMP has seldom been studied.

1.3.4 Need to reassess the effects of the activation policy and health and well-being interventions for the unemployed

In the field of intervention and organizational psychology research there has been increasing interest in how organizational-level occupational health interventions aimed at enhancing employee health and well-being should be planned, implemented and evaluated (Nielsen & Abildgaard, 2012; Nielsen, Taris, & Cox, 2010). The crucial question is how the effectiveness of interventions can be improved. The same interest should be focused on activation policy and health and well-being interventions targeted at the unemployed. It is known that even well-planned organizational-level interventions often fail to achieve the desired results, but the reasons for failure often remain unclear. This calls for more research to understand how and why interventions work but also for interventions appropriate to the specific group under study. For the evaluation process, organizational scholars recommend mixed methods designs (Nielsen et al., 2010).

There is no consensus on how health-related interventions can respond to and relieve the health problems of the unemployed (Harris et al., 1998). The same uncertainty also concerns ALMP. For example, the Government of Finland has increased its allocations for ALMP in order to improve the chances of the unemployed to return to employment. Despite the funds invested, its usefulness in improving the participants' labour market position has been doubted. Even though the intent behind these interventions is commendable, including empowering re-

employment, reducing health inequality by promoting easier access to health care services, as well as improving participants' self-efficacy, the strategies applied to obtain these results are not yet known.

There are also some critics arguing that ALMP, and also the processes of activation and welfare reforms more generally may actually be counterproductive. Activation and well-being interventions are a way in which the experience of unemployment is shaped by society. For example, ALMP, which enrolls participants in specific programmes and rearranges the time structure of unemployed people, may serve to improve the experience of being unemployed. The criticism, however, predicts, that ALMP and other active measures may actually exacerbate the experience of unemployment, and inflict further harm on the health, well-being and exacerbate the social exclusion of the unemployed (Sage, 2013). For instance, while activation policies recognize the various social disparities between certain groups (younger and older; men and women; those with high-level vocational qualifications and those with a low level of skills), such policies tend to consider them all in terms of the single criterion of improving vocational skills (Higuchi, 2014).

Furthermore, another critical viewpoint addressed by Eversberg (2016) argues that activation is a way to help cater to employers' needs by rendering the unemployed as 'employable' by means of intensified pressure as well as through systematic attempts to enhance their skills, competences and attitudes toward work. To participate in this activation policy is 'a compulsory choice'; the unemployed were not just forced to take part in interventions, but they were forced to choose, and penalized if they did not choose. Constant activity, flexibility and initiative are seen to be imperative and the responsibility of every unemployed person (Howard, 2012). Thus, there is a need for research to reassess the effect of these interventions in order to establish a more robust evidence base for them.

However, only a few published studies have so far described in detail the processes by which interventions targeted at the unemployed have been brought about. According to Blustein, Medvide and Wan (2012), critical analysis of interventions could examine the extent to which unemployed individuals experience and internalize the requirements of the activation policy. The qualitative research of unemployment has focused more or less on the disadvantaged positions of the unemployed, but less on why and how clients might challenge the system. An example of such a study, conducted by Patrick (2011), analysed qualitatively subjects' attitudes to the extension of work-related conditionality applied to disabled people. The findings were based on interviews with three focus

groups; two of those groups were organized with disabled participants, and one with non-disabled participants. The study found that many subjects felt that welfare reform was ill-equipped to deal with the barriers they faced. Therefore, the voices of service users themselves should be paid more attention, and in the future, this should be a key governmental priority.

Another study by Hartley (2003) examined the labour market experiences of people with multiple problems and needs (e.g., homelessness, substance abuse problems, mental health problems, physical ill-health). The study, based on 50 in-depth interviews and their discursive analysis, found that activation policies had exerted new pressures and made things worse among unemployed people with multiple problems. The normative pressures may generate a debilitating sense of self-blame that serves to compound the overwhelming nature of their unsolved problems.

Furthermore, the activation policies generally assume that clients are ‘job-ready’ and, according to Hartley (2003), there is a danger that this will lead people with multiple problems and needs to drift off without support. It should also be borne in mind that the relationship between unemployment and health and mental well-being may be viewed from multiple angles: from the perspective of the actual client and from the perspective of the health professionals advising these clients. Depending on the vantage point, the subject is perceived differently (Flores, 2008). One of the challenges for interventions is also to increase the knowledge of the health care providers and professionals, as they may be seen as gatekeepers and key actors in preventing labour market exclusion (OECD, 2014; van Rijn et al., 2016)

Considering the complex relationship between unemployment, health, mental well-being and re-employment requires insight into how the unemployed perceive targeted interventions. A better understanding of the experiences of the unemployed is furthermore highly relevant from a policy perspective. Knowing more about unemployed individuals’ motives for participating, affords more specialized tools for facilitating such policy interventions.

1.4 Aims of this study

The overall starting point of this study was to enhance the understanding of the effects of two specific interventions, a specific health care service (CHC) and vocational training as an active labour market policy measure (ALMP), among the unemployed. Firstly, the aim was to examine the effects of the CHC intervention

on re-employment. The second aim was to increase the understanding of the nature of the CHC intervention from the viewpoint of the occupational health professionals and, thirdly, from the viewpoint of the unemployed as subjects of the intervention. Fourthly, the effects of vocational training as a part of ALMP on the health and mental well-being of the unemployed were investigated.

The specific research questions were as follows:

1. Does the specific health service enhance re-employment of the unemployed and do the possible effects on re-employment depend on the self-perceived health and mental well-being of the unemployed? (Study I)
2. How do the occupational health care service professionals perceive and define the unemployed as a new clientele of targeting health services? (Study II)
3. How do the unemployed position themselves with regard to a new health care service? (Study III)
4. Did the active labour market policy measure (vocational training) have effects on the health and mental well-being of the unemployed and did the benefits vary with socio-economic status? (Study IV)

2 METHODS

2.1 Interventions, participants and procedure

2.1.1 Career Health Care (Studies I, II, III)

Career Health Care (CHC) was an intervention which was modified from the Finnish occupational health care services (OHC), with the difference that the clients were recruited from the unemployed participating in ALMP measures. The CHC adopted the principles of existing OHC and was carried out by OHC professionals (Taskinen, 2004) to serve the unemployed in an attempt to enhance their re-employment. Instead of workplace-related health problems, the service aimed to tackle the problems and risks related to unemployment. The OHC-CHC setting was chosen in order to reduce the transfer problem of an evidence-based intervention from research settings to real contexts.

The CHC was organized in three localities in southern and central Finland (the towns of Seinäjoki, Nokia, Tampere) by contracting established providers of OHC. A total of six nurses carried out the work with the clients. The main focus of CHC was on health promotion and primary prevention, managed with a specific 'health plan' adopted from OHC (Taskinen, 2004). The service consisted of three scheduled health check-ups at the beginning and at the end of the ALMP measure, when three years had elapsed since the beginning. The check-ups consisted of three kinds of physical performance tests (a repetitive lift test, repetitive sit-ups and squats) and measurements of weight, blood pressure and pulse. The topics of health promotion and health counselling were 'classic' such as smoking cessation, excess alcohol consumption, diet due to high cholesterol, diabetes or obesity, physical exercise and psychosocial conditions. Moreover, the activities also included health screenings, assessments of the client's working ability and counselling, emphasizing in particular the health-related risks and problems during the unemployment spell.

The need for regular laboratory screenings or consultations with a physician was elicited individually, and the clients received referrals and guidance to the

appropriate health services if needed. The clients could also make control visits to CHC, for instance, to measure blood pressure. In addition to this, the clients were offered an opportunity for spontaneous contacts if needed. There were no specific procedures for the encounters, and the nurses were advised to conduct the encounters as they usually did in their everyday work. The instructions for organizing the check-ups were left relatively open, and the nurses were encouraged to vary and develop the encounters.

Study I

The participants of Study I took part in CHC. They were recruited from those unemployed people whose period of unemployment was interrupted by one of three active labour market measures (ALMP): 1) vocational training (consisting of classroom and practical training providing a formal qualification or part of a higher education degree), 2) subsidized employment in the public sector (subsidy paid to a public institution which employs an unemployed individual) or 3) participatory training for entering the labour market (offering basic skills needed in job-seeking). The participants were unemployed in the sense that they received their income through the labour market programme, but employed in the sense that they participated daily in these measures. Thus, the service was focused on those who were actively taking part in labour market policy measures and actively seeking work. From the employment policy perspective, the participants represented jobseekers whose re-employment difficulties were regarded as substantial enough to warrant such intensive measures. However, they were not too sick or marginalized as to be unable to participate in these measures, which required daily full-time participation and lasted from three to 24 months. The selection process for ALMP was carried out by the local labour administration. Note that at the time of data collection, the years between 2000 and 2006, the Finnish economy grew with organizational upsizing and relatively low unemployment rates.

The participants for the study ($n = 539$) were recruited from volunteers at the beginning of each ALMP measure. The researchers visited a lesson and informed the participants about the study, including access to CHC. The participants in the subsidized employment and training for entering the labour market received also written information about the opportunity to participate in the study. Participation or refusal to participate in the study did not affect financial benefits. Of the total 539 unemployed people who participated in the study, 342 were enrolled from

vocational training, 140 from subsidized employment, and 57 from preparatory training for entering the labour market in 2002 and 2003.

Participants were randomized at an individual level at the recruitment occasion. The intervention group ($n = 265$) had access to CHC, whereas the control group ($n = 274$) could use the regular municipal health centres. Baseline data were collected in the period 2002-2003 (Time 1) with questionnaires at the beginning of the ALMP programmes. The intervention consisted of three health check-ups and on-demand health services. A follow-up was conducted three years later (Time 2). The participants of the intervention group completed questionnaires at the health check-ups, and the control group returned the questionnaires by post. Thus, a three-year follow-up, controlled design was used. The design of the CHC trial in Study I is presented in Figure 1.

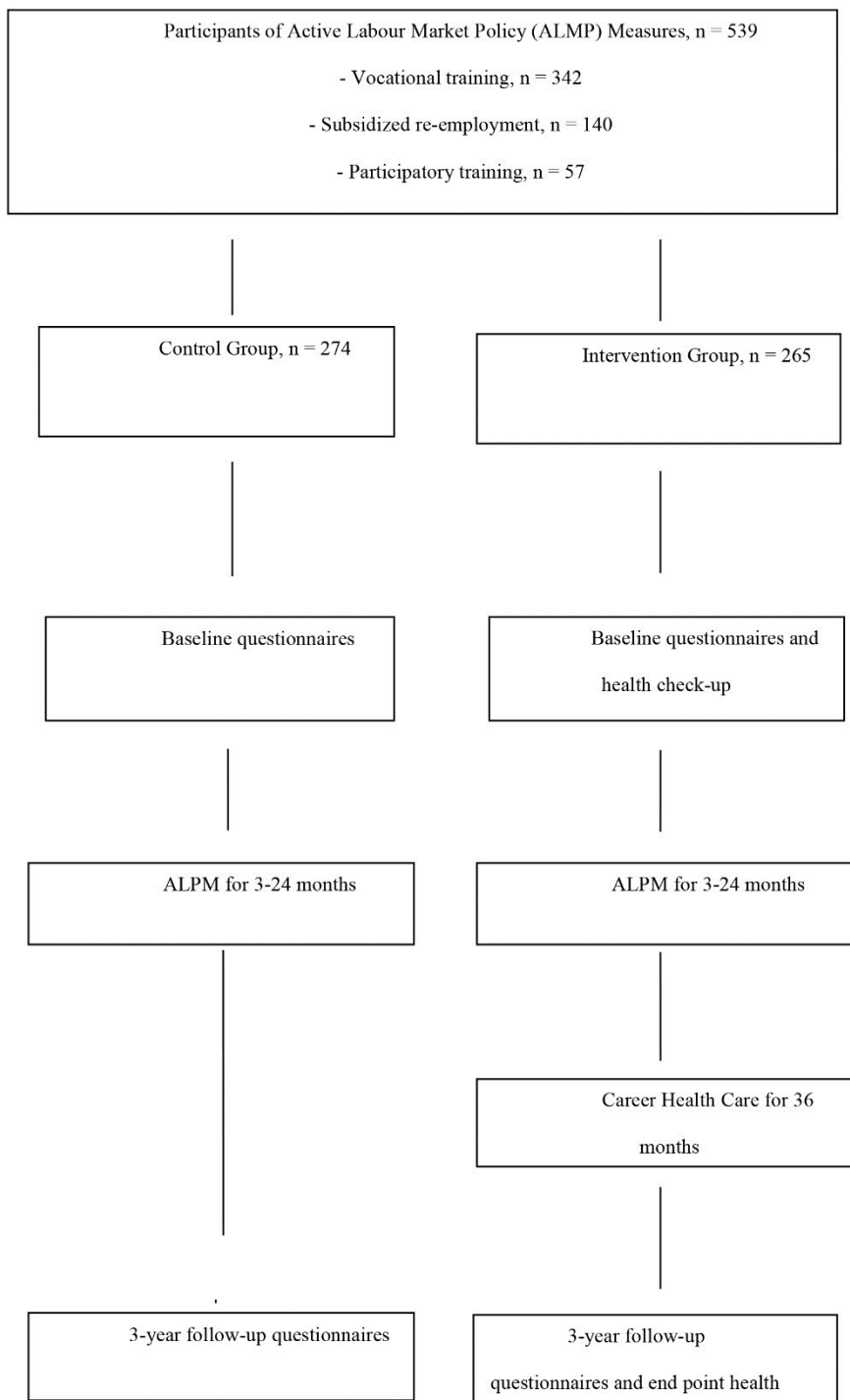


Figure 1. Design of the Career Health Care trial (Study I) (see Romppainen et al., 2014)

Of the original sample, 322 (60%) participated in the follow-up. Dropouts were more common in the intervention than in the control group (49% vs. 31%) and more men than women were lost to follow-up. At follow-up, there were fewer women in the intervention group than in the control group (64% vs. 71%). Mean age was around 39 years in both groups. Around one in three had basic education and one in five had tertiary level education. The unemployment spell had lasted less than one year for about 70 per cent and one year or more for around 30 per cent. Suboptimal self-rated health was more common (30% vs. 23%) in the intervention group, otherwise the two groups did not differ statistically in baseline variables.

Study II

The qualitative data for Study II comes from interviews with six nurses who were recruited for the CHC and who carried out the work with the clients. They were occupational health nurses from established OHC providers in three localities in southern and central Finland, which were contracted to provide a three-year health care service in nurse-led clinics. The nurses were interviewed face-to-face by two researchers (KR, AS) using a thematic format. The three main themes were the clientele, the professional practices and assessment of the CHC experiment. The interviews lasted between 30 and 90 minutes and were tape-recorded and professionally transcribed.

Study III

In Study III qualitative data were collected among 28 unemployed individuals participating in the CHC intervention group. A combined consecutive and purposive sampling strategy was used to achieve detailed coverage that took into account the employment policy intervention, gender, age and educational background of the participants. Data were collected through semi-structured and face-to-face interviews with the participants. The interviewers (KR, RJ, AS) presented themselves as academics with a particular interest in understanding how CHC benefits its clients. The duration of the interviews varied from 20 to 70 minutes. The interviews were audio-recorded and transcribed verbatim.

2.1.2 Vocational training as a part of ALMP (Study IV)

The vocational training studied here as a part of ALMP was intended for individuals aged 20 or older and who were unemployed or at risk of losing their jobs. The aim was to help unemployed individuals accumulate or maintain human capital in the form of conventional training and skills improvement. More specifically, taking into account former education and expertise, the objective of the courses was to re-educate the unemployed for new occupations. The vocational training was funded by the national labour administration, organized by local employment authorities and was available free of charge to the participants. During training the participants received a sum equal to their unemployment benefit together with a daily subsistence allowance.

The participants ($n = 342$) of Study IV were selected from those unemployed who had applied for the courses. The vocational courses, altogether twenty-six, were chosen purposefully in order to obtain approximately equal numbers of men and women, and also to include in the study participants with a range of educational levels. The duration of the vocational training varied between three to twenty-four months. Four courses (advanced courses in sales, marketing, IT technology and project management) aimed to improve and expand the expertise and qualifications of white-collar professionals, while the majority of the courses offered vocational training in blue-collar occupations (e.g. sales, logistics, construction and electrical installation). The sample of the participants turned out to be relatively representative regarding gender, age and educational background when compared to the participants on such courses in general (Aho & Koponen, 2007).

The researchers visited a lesson at the beginning of the course (Time 1) and informed the participants about the study. Those who were willing to participate completed a questionnaire. Information on gender, year of birth, marital status and pre-course unemployment spells were collected as part of the questionnaire. Follow-up questionnaires were distributed during lessons at the end (the time varied from three to 24 months) of each course (Time 2). A total of 212 (62%) participants responded to the follow-up questionnaires. One course (security guards) collectively refused to participate, otherwise non-participation was mainly due to absence. Dropout was more common among men, among the less educated and on courses in blue-collar occupations.

The final sample was female-dominated (61% vs. 39%) and participants' mean age was 36 years. Of the participants, 28 per cent had basic education and 26 per

cent had tertiary level education, and the majority of the participants were attending a blue-collar course. The unemployment spell preceding the course had lasted less than half a year for 44 per cent, and more than a year for 29 per cent of the participants. Of the participants, 40 per cent reported poor prospects of re-employment at the end of the courses, and 32 per cent reported high prospects of re-employment.

Table 1 summarizes the sample, design, data collection and data analyses of each sub-study. Next data collection and analyses are described separately in the quantitative (Studies I and IV) and qualitative (Studies II and III) sub-studies.

Table 1. Summary of Studies I-IV.

Study	Participants	Study design	Data collection	Data analyses
Study I	<p>Unemployed people participating in ALMP</p> <p>Intervention group at baseline $n = 265$, at end $n = 134$ (51%) Control group at baseline $n = 274$, at end $n = 188$ (69%)</p>	<p>Randomized longitudinal study with an intervention and a control group</p> <p>Intervention: three health check-ups and on-demand health service for the intervention group and usual care for control group</p>	<p>Questionnaires at the beginning (T1) and after three years (T2)</p> <p>health questionnaires (T1): Health status (SHR) Psychological stress (12-GHQ) Depressive symptoms (BDI) Sense of Coherence (SOC) employment status (T2)</p>	<p>Logistic regression analysis</p>
Study II	OHC nurses recruited to CHC ($n = 6$)	Discursive study	Semi-structured interviews	Discourse analysis
Study III	Unemployed people participating for ALMP and recruited for clients of CHC ($n = 28$)	<p>Discursive study</p> <p>A combined consecutive and purposeful sampling strategy was used to achieve detailed coverage</p>	Semi-structured interviews	Analyses which combined ideas from discursive psychology and positioning theory

Study	Participants	Study design	Data collection	Data analyses
Study IV	Unemployed people participating for vocational training courses in ALMP at baseline <i>n</i> =342, at follow-up <i>n</i> = 212 (62%)	Longitudinal study Intervention: vocational training as an active labour market measure (length 3-24 month)	Questionnaires at the beginning (T1) and the end of vocational training course (T2) Questionnaires: Stress symptoms Psychological distress (12-GHQ) Sense of Coherence (SOC)	Analysis of variance (ANOVA)

2.2 Measures and statistical analyses in Studies I and IV

2.2.1 Measures

The data were collected by questionnaires which included the following measures. Study I utilized four measures to assess the health and mental well-being of the participants at baseline: psychological distress (GHQ), sense of coherence (SOC), depressive symptoms (BDI) and self-rated health (SHR). In Study IV the health and mental well-being of the participants were studied at baseline and at follow-up with three measures: GHQ, SOC and stress symptoms. In addition, in both studies at follow-up participants were asked to report their employment status or assess their perceived employment prospects.

Psychological distress (GHQ)

Psychological distress was measured (Studies I and IV) by the 12-item version of the General Health Questionnaire (GHQ; Goldberg, 1972). The GHQ is a short and well-validated measure of psychological distress. It is probably the most widely used screening scale for mental disorders in the areas of depression and anxiety. It aims to provide information through the identification of distressing symptoms rather than providing a psychiatric diagnosis (Tait, Hulse, & Robertson, 2002). The validity and reliability of the GHQ-12 have been widely demonstrated (Goldberg et al., 1972, 1997). Responses to the 12 items on experienced symptoms (e.g., “Have you recently felt you could not overcome your difficulties?”) were scored on a four-point scale (1 = not at all, 2 = not more than usual, 3 = rather more than usual or 4 = much more than usual). Those reporting 3 or 4 in at least four items of the total measure were identified as distressed (Goldberg, 1972).

Sense of coherence (SOC)

Sense of coherence (SOC) was assessed (Studies I and IV) using the 13-item version of the Orientation to Life Questionnaire devised by Antonovsky (1987, 1993). SOC describes coping resources and health-protective life orientation with three inter-related dimensions: comprehensibility, manageability and meaningfulness (Antonovsky 1987, 1993). The respondents are asked to report their level of agreement with the items on a seven-point semantic differential scale with two anchoring phrases. The scale has five items about comprehensibility (e.g., ‘Do you have very mixed-up feelings and ideas?’ 1 = very often to 7 = very seldom or never), four about manageability (e.g., ‘Has it happened that people whom you count on disappointed you?’ 1 = never happened to 7 = always happened) and four about meaningfulness (e.g., ‘Do you have the feeling that you don’t really care about what goes on around you?’ 1 = very seldom or never to 7 = very often). In both studies SOC was used rather as an indicator of mental well-being than an overall coping resource and the score was dichotomized at the median: low SOC (0) vs. high SOC (1).

Depressive symptoms (BDI)

In Study I the Beck Depression Inventory (BDI, Beck et al., 1961) was used in order to screen for depressive symptoms at baseline. The BDI is a widely used and established (i.e. valid and reliable) method for detecting depressive symptoms both in research and in clinical practice. The measure contains 21 self-rating items and

assesses the cognitive, affective, behavioural and somatic areas of depression. The items (e.g., “I often feel sad”) were rated on five- to six-point scales. The BDI score was dichotomized into two categories: a total BDI score of less than 10 points was considered to indicate not depressed/mildly depressed (0) and a score of 10 points and over cases with depression (1) (Beck, Steer, & Garbin, 1988).

Self-rated health (SRH)

Self-rated health (SRH) was measured in Study I at baseline by asking participants to rate their overall health with a single-item question: “How do you rate your health compared with your age peers?” The question was rated with a five-point scale, ranging from 1 = good, 2 = fairly good, 3 = average, 4 = rather poor and 5 = poor. In Study I the variable was dichotomized to optimal (1-2) and suboptimal (3-5).

Stress symptoms

Stress symptoms were assessed in Study IV (at baseline and again at follow-up) with a list of 18 symptoms (e.g., headache, stomach ache, dizziness). The participants were asked: ‘Have you had some of the following symptoms during last year and how often?’ The replies were given on a scale from 1 (never or seldom) to 4 (often or all the time) and were summed up to form a Stress Symptom Score ranging from 18 to 72.

Employment status and prospects

In Study I at follow-up, employment status was elicited with one question: “Are you employed?” The response options were: 1 = yes, 2 = no. In Study IV employment prospects were elicited at the end of the vocational training course with a question about the probability of obtaining a job. The replies ‘highly probable’ and ‘probable’ were recoded as ‘high’ (= 3), the reply ‘cannot say’ as ‘intermediate’ (= 2), and the replies ‘improbable’ and ‘highly improbable’ as ‘low’ (= 1) employment prospects.

2.2.2 Statistical analyses

Frequencies, means, standard deviations and cross tables were used in basic descriptions of the variables in both Studies I and IV. In Study I logistic regression analyses were used to obtain the odds ratios of the intervention group versus the control group for being re-employed at follow-up. In order to investigate whether the re-employment effects of CHC depended on baseline health status, the analyses were made separately for those reporting good and poor self-rated health. The significance for the interaction term from the fully adjusted regression models was used to assess whether those reporting poor health differed from those reporting good health with respect to the re-employment effects of the CHC.

In Study IV changes in health and mental well-being from baseline to follow-up were studied using analysis of variance for repeated measures. Similar multivariate models were made for the whole sample and separately for sub-groups determined by education (tertiary level, $n = 55$; upper secondary level, $n = 98$ and basic level, $n = 59$) and by the socioeconomic status of the subject's occupation on the course (white-collar occupation, $n = 34$; blue-collar occupation, $n = 178$). The analyses of variance for repeated measures were adjusted for gender, age and pre-course unemployment, marital status and employment prospects were added into the model. Statistical Package for the Social Sciences for Windows (SPSS) software, version 15.0 was used in these analyses. A more detailed description of the statistical analyses is provided in the original articles.

2.3 Qualitative data collection and analysis in Studies II and III

2.3.1 Discourse analysis

The discursive approach offered a methodological frame for Studies II and III. The discursive approach was chosen in order to understand in more detail the intertwined relationship between the health intervention (CHC), and its actors, namely health care professionals (Study II) and the clients (Study III). It helps in analysing collective meaning constructions on a socially shared level. In general, the discursive approach emphasizes the study of language, talk and texts and how they are used to perform actions. It is based on an assumption that reality is socially constructed through talk and offers a way to examine collective and shared

accounts, not individual experiences (Burr, 1995; Potter & Wetherell, 1987). Discursive analysis is concerned not only with understanding, but also with action. Discourses are not only words; they also do things and have a profound effect on how people perceive, react and act (Potter, 2003; Potter & Edwards, 2001).

There are various types of discursive approaches, deriving from different methodological principles and involving different conceptions between language and the social world (Potter, 2000). Discourse-oriented research has analysed among other things the concept of health and illness and the role of the patient in the health promotion process (Willing, 2000). In Studies II and III the chosen approach was embedded in the field of discursive approaches utilizing in particular the ideas of critical discursive psychology (Harré et al., 2009; Wetherell 2007). Critical discursive psychology pays attention to micro-level details, which are supplemented with a macro-level layer of analysis. It emphasizes the significance of social and cultural resources as sources for individual meaning construction and subject positions. It strives to move away from attempts to categorize and label individuals and phenomena towards an understanding of the functions of statements in discourses for the individual embedded in the wider social and ideological context (Abell & Myers, 2008).

In Study II the interviews were conducted by the research team participants. A semi-structured interview schedule was followed, covering the clientele, the professional practices, and the assessment of the CHC experiment. The interviews served as material for a discourse analysis which focused on client constructions and the implications for professional practices to these constructions give rise. At the first phase of the analysis the data (interviews with the six CHC nurses) were re-read through for the author to become familiar with the content. Secondly, how the OHC nurses defined the unemployed as clients of CHC was identified and then how they assessed the suitability of their own professional skills in dealing with these new clients. The further analysis process involved discussions between the researchers, re-reading the data and finding similarities and differences in the nurses' accounts. Extracts from the transcribed interviews were coded into categories and the categories were grouped into themes. The iterative process included searching, defining, grouping and naming the initial themes. As a consequence, these discourses offer internally coherent ways of talking about and understanding the unemployed as clients of CHC, and making it understandable in a particular community, i.e. the occupational health care service (Potter & Wetherell, 1987).

2.3.2 Position analysis

The analysis method in Study III drew on discursive psychology but on from positioning theory (Harré et al., 2009; Potter & Wetherell, 1987; Wetherell, 2007). By combining these two approaches Study III could show the process of participating in the health service and the dynamics of the associated position production. The focus was not on linguistic issues but rather on the use made of language; how the unemployed recruited for the study perceived the mode of health care delivery developed for the study (its meaning and its nature) and how the positions of its clients, including themselves, were justified. The aim was to understand the kinds of subject positions constructed in general, not particular identities as constructed within different discourses.

The position theory approach was chosen because positioning helps to take into account the agency and the generation of reality in social interaction. Additionally, positioning seems to be a very effective method for uncovering personally relevant and more abstract goals related to a given behaviour. In conversation, participants offer, accept or reject subject positions that are made available through their own and others' discourse. The upshot of the assumed position may be positive or negative, supporting or denying a claim, demanding or refusing the assignment of a duty (Harré et al., 2009). Following Harré, it is possible to specify first-order and second-order positions. These positions are mutually challenged and negotiated: first-order position refers to the way people locate themselves and others within an essentially moral space, and second-order positions occur when the first is not taken for granted. In terms of analysis the first-order position has a so-called candidate status and the second-order has, either implicitly or explicitly, an acknowledged status (Harré et al., 2009). The analysis also included categories of theoretical interest derived from positioning theory, such as storyline, rights and duties associated with a position (Harré & Van Langenhove, 1999; Potter & Wetherell, 1987). Positions are related to different storylines that unfold in an encounter. The storylines are linked to different moral orders, with different sets of norms about what counts as right, legitimate and appropriate behaviour.

In Study III data were collected through semi-structured interviews with the participants. The questions were broad and focused on experiences and opinions concerning the three-year CHC process in general, and on participants' perceptions as to how they had benefited from the service. The analysis in Study III was a process which entailed reading the data in the research team. The team compared and contrasted the discourses and positions as part of an iterative analytical

process, initially looking at sequences where elements of participation discourse were identifiable. On the basis of the themes emerging from the interviews, a coding framework was established. The analysis progressed on a cross-case basis, meaning that the sequences were searched for both within and across interviews. This is characteristic in particular of critical discursive psychology, where the unit of analysis is usually a discursive practice, rather than an individual actor (Wetherell, 2007). After close re-reading and consequently extracting all the sequences, the data were coded and thematized. This was systematic and careful sorting to ensure that all the data were considered. The themes were compared using analytical tools, i.e. the first-order and the second-order positions. The aim of this analysis phase was to identify the boundaries and overlaps between these preliminary positions. Thus, the final positions could be identified as representing differently organized ways of talking about a specific health care service and its clients.

3 RESULTS OF THE ORIGINAL STUDIES

3.1 Study I

The first study aimed to examine whether a specific health care (CHC) intervention among unemployed people had an impact on their re-employment prospects compared to those not included in the service (i.e. the control group). We also investigated whether the possible effects depended on reported health and mental well-being of the unemployed individuals. The analysis showed that the health care service provided, consisting of health check-ups, did not enhance re-employment: 50 per cent from both the intervention group and the control group were employed at follow-up. When regressed for background factors (gender, age, level of education, duration of unemployment), the odds ratio for unemployment in the intervention group was 0.92 (95% CI 0.57 to 1.49).

In order to investigate whether the re-employment effects of CHC depend on baseline status, health-related differences were assessed through the significance of the interaction in the regression analyses. Among the participants reportedly in good health, the intervention did not increase re-employment, nevertheless, the odds ratios tended to show higher re-employment among those with good mental well-being best in terms of sense of coherence and depressive symptoms. Among those reporting poor mental well-being, re-employment in the intervention group tended to be lower than in the control group. Regarding sense of coherence (OR = 1.79; 95% CI 0.90 to 3.58 for higher SOC vs. OR = 0.72; 95% CI 0.36 to 1.47 for lower SOC) the difference was nearly statistically significant (p -value for interaction .064), while the interaction with depression was non-significant (p = .133). In sum, re-employment tended to be more prevalent among participants with good health and well-being in the intervention group and the health intervention actually seemed to disadvantage those people's re-employment who were in need of health care. It is worth noticing that the differences were, however, statistically non-significant.

3.2 Study II

The aim of the second study was to ascertain how the six occupational health care nurses perceived and defined the unemployed as a new clientele in the context of the health care intervention. The discourse analysis revealed four overlapping discourses with regard to clients; the client as a casualty of unemployment, the client as an active unemployed person, the client as a deviant in the labour market and the client as a skilled user of the system. Each discourse had implications for professional practices.

The findings point out the risk of negative stereotyping and consequent exclusion from services and the need for critical awareness of the discourses and assumptions regarding the new client group. The study also stresses the complexity of providing health services that match the increasing diversity of the unemployed.

3.3 Study III

The aim of the third study was to analyse how unemployed people positioned themselves with regard to a new health service provided as part of an institutional strategy for delivering and enabling their access to health care. On the basis of positioning theory, the focus was on the ways the unemployed people established their positions through discourse, and the range of factors coming into play in determining those positions.

The analysis revealed three dominant interpretative discourses: the institutional, the other unemployed and the private and six positions unemployed people used when encountering the health service: the docile citizen, the rebel, the socially responsible citizen, the distinctive individual, the independent actor and the calculating client. These positions and associated discourses displayed the different sets of rights and duties of the client and simultaneously defined their positions vis-à-vis the service. The findings describe the variation in the ways the unemployed people responded to the institutional context of the health intervention provided.

3.4 Study IV

The aim of the fourth study was to investigate the effects of vocational training as part of the ALMP on the health and mental well-being of the unemployed. We also

examined whether the potential effects varied with socio-economic status. The results showed that among the training participants health and mental well-being remained almost unchanged, while stress symptoms tended to decrease and sense of coherence tended to improve towards the end of the training course. All changes, however, were statistically non-significant.

When the analyses were carried out separately by socio-economic status, they revealed significant variation in the development of health and mental well-being (stress symptoms, psychological distress, sense of coherence). For the white-collar participants, the training was largely accompanied by improvements, whereas for the blue-collar participants the change tended to be negative. The trends were similar whether the socio-economic status was defined in terms of the level of education or occupation. Thus, there were greater improvements in health and mental well-being among those belonging to upper-level occupations.

4 DISCUSSION

The purpose of this study was to enhance the understanding of the effects of two particular interventions, the Career Health Care service (CHC) and vocational training as part of an ALMP measure targeting the unemployed. More specifically, the aim was to examine the effects of the health service intervention on re-employment (Study I) and the effects of vocational training on the health and mental well-being of the unemployed participants (Study IV). In addition, the aim was to ascertain how the actors involved (nurses and unemployed people) in CHC constructed meanings for the health care service and themselves (Studies II and III). The starting point for the study as a whole was an existing consensus that there is a need to develop interventions in order to be in a better position to respond to the well-known challenges the unemployed face (Bartley & Ferrie, 2010; Böckerman & Ilmakunnas, 2009; Harris et al., 1998; Matoba & Ishitake, 1999; Vuori & Silvonen, 2005; Ytterdahl, 1999). Thus, the overall aim of the whole study was to find novel perspectives for understanding the challenges and barriers involved in developing interventions for the unemployed.

4.1 Main findings

4.1.1 Re-employment outcomes after the health care service

Study I examined the re-employment effect of the specific health care service, Career Health Care (CHC), established for the purpose of the study. The new service was a variant of occupational health care, the difference being that the clients were recruited from among the unemployed. The results revealed that CHC was not effective enough to increase re-employment; at follow-up 50 per cent of both the intervention group and the control group were at work. Further analyses revealed that the intervention tended to improve re-employment among participants with good health and mental well-being, whereas an opposite tendency

was seen among those with poor mental well-being. The differences were, however, statistically non-significant.

In the light of earlier unemployed studies (Harris, Rose, & Ritchie, 2009; Henderson, Muller, & Helmes, 2013), the health care service can promote primarily health and well-being, particularly among those with poor health. According to the findings of this study, the health care service implemented seemed, in fact, to impede re-employment rather than to benefit those in particular need of health care. One plausible explanation for the contradictory result may lie in the health-related selection at recruitment. Even though participation was voluntary, the intervention and control groups may have differed with respect to their motives for participating. In other words, the participants with suboptimal health in the intervention group may have had relatively severe health problems concerning re-employment. Indicatively, self-rated health was more commonly poor in the intervention group. As earlier research has shown, self-rated health is a reliable predictor for one's overall health and health-related well-being (Gilbert et al., 2013; Kim et al., 2008) and poor self-reported health is seen as a barrier to returning to employment (Carlier et al., 2013).

An alternative explanation for not finding any effect on re-employment is the possibility that this kind of health care is not able to primarily promote health and mental well-being and consequently to have so-called side effects on re-employment. It may also be assumed that the service model adopted from occupational health care does not work in the context of unemployment. The research so far has not been able to demonstrate consistently that one type of intervention is superior to others in terms of improving the health and mental health or re-employment of the unemployed. The qualitative study of Patel, Greasley and Watson (2007) has suggested that multidisciplinary approaches should not only be concerned with medical and psychological issues, but also address the obstacles to re-employment as seen by the client.

As a conclusion, it might be argued as by Starfield (2007) that even when tailored to meet the assumed needs of a specific client group, the health care service mobilizes them only partly, and not all of them benefit from it. To learn more about effective interventions for the unemployed attention should be paid explicitly to the orientation and contents of the interventions as well as to the role of its actors. In this connection they are the health professionals and the unemployed as clients. Studies II and III show how several logics are present in CHC and give some insights on why the context of CHC does not seem to match the increasing diversity of the unemployed.

4.1.2 Four discourses of the unemployed as clients of Career Health Care

The prevalence of health problems among the unemployed has given rise to recommendations concerning their health care (Harris et al., 1998; Matoba & Ishitake, 1999; Ytterdahl, 1999). At the same time, the role of occupational health care services among employed people has been cited as an important future challenge in the changing labour market (Felton, 2000). In case of atypical employment or unemployment individuals are disadvantaged in terms of access to occupational health care (OHC) (Virtanen, Kivimäki, Vahtera, & Koskenvuo, 2006). Study II focused on health professionals', that is, OHC nurses', perceptions of the unemployed as clients and their professional practices in the context of CHC.

The analysis of Study II revealed four overlapping discourses among the OHC nurses with regard to the unemployed as clients. Each discourse had also implications for professional practice. The discourses were named as follows: the client as a casualty of unemployment, the client as unemployed but active, the client as a deviant in the labour market and the client as a skilled user of the system. The client as a casualty of unemployment represents clients as having multiple problems due to their unemployment and being helpless to resolve them. The nurses assumed that such 'casualties' lacked the capacity to deal with to health problems and they opted not to speak of health promotion. The client as unemployed but active identifies the client as an actor who has succeeded in integrating unemployment into her or his personal life. These clients co-operate actively and competently in the context of professional-client interaction and the nurses could trust and communicate with them. The client as a deviant in the labour market was portrayed as differing from the mainstream of the labour force. They were perceived as lacking the potential to develop or to change. Their ability to hold down a job was deemed as permanently poor, and consequently health promotion was also considered unnecessary. The client as a skilled user of the system refers to those clients who were also constructed as active, but their activity was aimed at exploiting the service system to the full. They were seen as heavy users of the health care services and the nurses felt as if they had to control and act as gatekeepers to access to health care services. In this context, the confidence gap decreased opportunities for successful collaboration.

The four discourses analysed were produced in a context where the OHC nurses were exposed in a professionally unusual situation. The nurses perceived that the unemployed clients did not fit into the routines and culture of

occupational health care and observed that their previous training and experiences did not equip them for the challenges they faced with the CHC clients. However, the discourses reflect socially shared constructions of unemployed people rather than nurses' individual prejudices and the associated stereotypes. The discourses also served as resources with which the nurses felt able to conduct the encounter properly.

The difficulties in carrying out the CHC intervention for the unemployed in the context of OHC could mostly be explained by the lack of appropriate practices. The main purpose of OHC is to prevent work-related illnesses and to protect and promote employees' health and work ability. The CHC nurses reported feeling challenged by their unemployed clients. A potential reason for this is that the nurses were more familiar with practices related to workplace-problems and may thus have had limited experience of the challenges which the unemployed often face. It can also be speculated that as the instructions for carrying out the CHC were left relatively open, the responsibility born by the nurses was unnecessarily heavy.

However, the problem is, perhaps, more widespread. Parallel gaps between ethical principles and practices have been identified in interaction studies in medical settings. Jones et al. (2004) in their qualitative study of general practitioners in the UK found that there were clear distinctions between ethical principles and the interpretation and implementation of these in practice. Earlier research has also shown that the patient-practitioner relationship is an important determinant of successful co-operation (Anema et al., 2002; Peebles & Moore, 2000). Health care professionals may therefore be seen as very powerful sources of social change agents and key actors in preventing labour market exclusion (OECD; 2014; van Rijn et al., 2016). It can also be speculated that the wide institutional and social context of OHC, and in health care more generally (Pilnick & Dingwall, 2011) furthers the nurses' choice to construct the clients as 'deviant' from the mainstream clientele. There does appear to be reluctance among health professionals in the front line of occupational health care to see these new clients as employable and rather to view them as permanently unemployed. Although this is a tentative explanation, this constructing was especially important as regards stigmatization.

Thus, in medical interaction, professionals' attitudes, beliefs and expectations can lead to social compartmentalization of the clients. Such situations have been studied in the context of social judgement theory (Dovidio et al., 2008; Thompson, Foster, Cole, & Dowding, 2005). Due to a lack of studies on health care services among the unemployed, it is difficult to evaluate if the accounts are typical, for

example, of primary health care. Despite several theoretical discussions of health interventions and the unemployed, this setting was the first in the context of OHC. The findings of this study show that it is important to be aware of the discourses and assumptions concerning new client groups that tend to break the patterns in which health care professionals and providers operate. The results also supported the view presented by Starfield (2007) that even when carefully tailored, the health care service does not enable all clients to use and benefit from it.

4.1.3 Manifold positions of unemployed people towards the targeted health care intervention

Research on the unemployed has so far shown that interventions are not always able to respond sensitively and adequately to the needs of unemployed individuals. Health policy as well as activation policy interventions have been more or less successful as regards the intended effects (Reus-Smit, 2013). Concerning health promotion (Davies, Macdowall, & Bonnell, 2006), planning and organizing services for the unemployed requires a thorough understanding of their motives for participating. However, the information about the initial motivation of unemployed people to participate in health service delivery is limited. In Study III the main focus was on analysing how the unemployed people recruited for the CHC intervention perceived the mode of health care delivery.

The findings, based on positioning theory, showed how the unemployed individuals constructed their interaction with the CHC. The analysis revealed three dominant interpretative discourses – the institutional, the other unemployed, the private – and six associated positions: the docile citizen, the rebel, the socially responsible citizen, the distinctive individual, the independent actor and the calculating client, which the unemployed people used when encountering the health care intervention studied. The different positions and associated discourses displayed the different sets of rights and duties of the client and simultaneously defined the positions of the CHC service.

In the institutional discourse, the unemployed constructed CHC as part of the system that society has developed to take care of the health of its members. It adopted a broad societal perspective to promote the health of the unemployed and it carried a mandate to activate unemployed people by making them feel responsible for their health and simultaneously improve their employability. Within this discourse the clients positioned themselves as docile citizens. Docile citizens

are aware of what is expected of them from the point of view of overall health policy and by the medical regime. In taking up this position the clients showed that they were morally competent members of society who are looking after their health. The institutional discourse and its positions prevailed throughout the entire data corpus and were presented more widely than the others. This may be seen to confirm with today's general health agenda and activation ideology, which asks unemployed people to improve their health and employability (Lahausen, 2009; Taylor-Gooby, 2008; Vallgård & Lehto, 2009). More broadly, health has become an issue of individual responsibility (Crawford, 2006; Rose, 2001).

Another unemployed discourse committed itself to the stereotype of unemployed people as a homogeneous group and unemployment is thus reified as a set of disadvantageous experiences. This discourse can be used to express interpersonal relationships, such as empathy and other kinds of interaction with peers. By occupying the position of the socially responsible citizen, the clients fulfilled the duty of responding to the request to help the reference group, the other unemployed, and simultaneously proclaimed themselves as survivors. This position corresponds to social identity theory and group engagement models by arguing that the experience of stereotyping and prejudice within a group may lead members to maintain a psychological distance between their own identity and group membership (Tyler & Blader, 2003). The other discourses and their positions were identified in all the interviews, but instances were often short and embedded in several discussion themes.

The private discourse consisted predominantly of biographical talk and personal stories. It related to the clients' personal experiences and described personal motivations and values. Consequently, this discourse dealt with how the client can benefit in person from the health care service. Within this discourse the unemployed adopted the independent actor position, appearing as rational decision-makers seeking control over their health and giving priority to the individually driven motives and contests and even questioning the legitimacy and the agenda of the institution.

The results highlight the variation in the ways people respond to institutional contexts. This finding can be interpreted to suggest that although conventional unemployed research views unemployment as a homogeneous event (Paul & Moser, 2009), the analysis describes how unemployed individuals take manifold positions, and consequently their relationship with health interventions contains different facets. Furthermore, the study showed that participants at the receiving end of a health policy initiative were also involved in an interpretative process that

constructed various positions. The results supported the view of a wide variability among the unemployed and individual variety exists in the experience of unemployment (Hammarström & Janlert, 1997; Wanberg, 2012).

These positions also have an impact on the way clients construct the health care service and, consequently, on assumptions about appropriate health promotion. In practice, health promotion may be less likely to shape behaviour among clients who do not share the organization's values or who do not belong to a group with a set of shared values (Blader & Tyler, 2009). The diversity of unemployed experiences, when encountering the health service, challenges the health policy interventions recommended by unemployment studies (Harris et al., 1998; Matoba & Ishitake, 1999; Ytterdahl, 1999) or at least their universal and uniform model. In all, this study supports the view that the diverse nature of experiences among people who are unemployed greatly complicates intervention planning and delivery.

4.1.4 The differing effects of vocational training on health and mental well-being with respect to socioeconomic groups

Study IV investigated the effects of vocational training as part of an ALMP measure on its participants' health and mental well-being and how these effects were connected with socioeconomic status. This latter question is seldom discussed (see Nordlund, 2011). However, there are theoretical considerations for anticipating a class-based split of benefits among the recipients of ALMP measures. As regards latent functions (Jahoda, 1981), there is research showing that the psychosocial need for employment varies substantively. For example, when people are dependent on a job to fulfil their economic and psychosocial needs, mental well-being is markedly poorer when they are unemployed than when they are employed. This variation is of importance for understanding the differentiation in the effect of unemployment on mental well-being (Nordenmark & Strandh, 1999; Rantakeisu & Jönsson, 2003).

Study IV analysed the effects of vocational training on health and mental well-being consisting of psychological distress, the sense of coherence and stress symptoms. The results showed that vocational training was accompanied by improvements in mental well-being among the participants with higher socioeconomic status, whereas for blue-collar workers the changes were neutral or even detrimental. It is noteworthy that when the participant group was studied as a whole, there were no effects. In this latter respect, the results are partly in line with

those of earlier studies (Breidahl & Clement, 2010; Reine et al., 2011; Strandh, 2001) on ALMP participation and mental well-being. Reine et al. (2011) in their 14-year follow-up study among a northern Swedish cohort found higher scores on psychological symptoms in general among those who participated in ALMP programmes than among those not participating in ALMP. In the study by Reine et al. (2011), participation in ALMP programmes was not analysed in respect of different types of ALMP. Strandh (2001) in a longitudinal and nationally representative survey of 3,500 unemployed Swedes found neither generally positive effects of participation in vocational training on mental well-being. Only involvement in workplace participation as a part of ALMP measures had a clearly positive impact on mental well-being in the study by Strandh (2001). The study by Breidahl and Clement (2010) in Denmark identified that there are groups that do not benefit fully from participation in ALMP (in Denmark ALMP covers vocational courses or continuing education, practical training in a firm, or wage compensation) and that their outcomes were similar to those who did not participate. In contrast to these, there are, however, studies concluding that ALMP has a positive effect on the mental well-being of the participants. Strandh (2015) found that a considered and consistent activating labour market policy (such as activation, education and training) directed particularly at young people could potentially reduce the short- and long-term mental well-being costs of youth unemployment. Andersen (2008) and Creed et al. (2001) also reported improved mental well-being among participants attending vocational training as a part of ALMP. The differences between the mixed results may well be attributable to differences in the settings and samples of the studies.

However, when the analyses were carried out separately by socioeconomic category, significant variation in the development of health and mental well-being was shown. Parallel results have been reported in studies by Auer, Efendioglu and Leschke (2005) and Nordlund (2011) indicating that participants with the best resources benefit more from the measures. The same kind of socioeconomic health gradient is also found in the field of health care services: those who benefit most tend to come from higher socioeconomic positions (Virtanen et al., 2006). The study results also support the view that participation in vocational training as a part of ALMP measures compensates for Jahoda's (1981) latent functions of work more adequately among the more educated. Although the findings do not enable ranking of the five functions in this respect, the hypothesis is that the socioeconomic difference may appear predominantly in the areas of social contacts, collective

purpose and social identity. In the frame proposed by Fryer (1986), vocational training emancipates agency more extensively among the more highly educated.

The results raise the question of ALMP as a moderator of inequality in general. In the frame of unintended or so-called side-effects of the interventions, the findings indicated that the public policy intervention studied was unable to reduce the health and mental well-being inequalities based on social class (see also Mackenbach, 2012; Tarkiainen, Martikainen, Laaksonen, & Valkonen, 2012). The results of Study IV show that no matter how commendable the intent behind the designed policies themselves may be, in terms of equality they are failing, and even may induce discrimination in the context of the Finnish highly segregated labour market. Hence it is obvious that the 'same-size-fits-all' logic is no longer valid for tailored and implemented activation policy and interventions for the unemployed.

4.2 Strengths and limitations of the study

This study has strengths and limitations that are important to take into account when interpreting the findings. The most important of these are discussed next.

One of the main strengths of the study is a mixed methods approach: both quantitative and qualitative analysis methods were used and different kinds of methods (questionnaires and interviews) complement each other. The mixed methods approach was chosen for practical reasons. In addition, it is known that mixed methods are highly relevant particularly in the area of health research (O'Cathain, Murphy, & Nicholl, 2007) and organizational-level intervention studies (Nielsen et al., 2010). A qualitative approach helps to address and understand the complexities of health care services, and bring in the voices of service users and service providers. It also perhaps helps to better understand why the health intervention did not enhance re-employment. In Studies II and III qualitative methods were used for developing, marketing and managing policies and services for the unemployed. The discursive method produced different insights into a different facet of experience of the unemployed and the health care professionals and led to a more profound understanding of how best to serve these diverse groups. Mixed methods also provided more detailed information for planning new interventions in the future. Applying qualitative methods to elaborate analysis made it possible to examine more closely factors inhibiting facilitating desired outcomes of such an intervention. Study I showed that the health intervention implemented (CHC) did not serve to improve re-employment among the unemployed. The

interviews conducted for Studies II and III among the unemployed and health care professionals revealed factors possibly underlying the unexpected outcomes of the intervention.

The second strength of the present study is its potential for large-scale practical implications (Studies I, II, III). It aimed at implementing an intervention reminiscent of what is habitually done in occupational health care and this was chosen in order to reduce the transfer problem of an evidence-based intervention from research settings to real contexts and populations. The study design was also integrated into routine occupational health care practice conducted by ordinary health care professionals (nurses) in order to ensure and pilot its applicability in a routine care setting. Pragmatic trials have been proven to have greater generalizability of the results than explanatory studies, but the reliability of the results may instead be lower (Godwin et al., 2003). The third strength of this study is the randomized controlled trial design in Study I: a longitudinal design with quite large intervention and control groups and reasonably small sample attrition. The targeted health care intervention had also a good outreach among the unemployed, who are usually difficult to engage in health promotion activities.

Despite these strengths, however, the study has several limitations that should be taken into consideration when contemplating the findings. The first and perhaps the most notable limitation relates to the generalizability of the results. Three of the studies (I, III, IV) concentrated on the same sample, namely the unemployed people participating in ALMP. The sample for Studies I, III and IV was chosen in order to obtain a roughly equal number of participants from both sexes and a range of educational levels. According to a register data study of ALMP participants by Aho and Koponen (2007), the sample turned out to represent the participants well in ALMP measures in general regarding gender, age and educational background. The attrition rate is crucial regarding the reliability of a survey-based follow-up study. In Studies I and IV the attrition was at a reasonable level, taking into account that it consisted of both non-response and dropout during the interventions. The loss of participants did not severely bias the sample.

Although the heterogeneity of the sample adds to the generalizability of the findings, generalizing the results among the unemployed more widely should be done with caution. For example, the expectations and needs for well-being interventions may well be different among the long-term unemployed. Also, the definition of who is unemployed is not entirely clear: the participants' period of unemployment was actually interrupted by activation policy. Thus, they were unemployed in the sense that they received their income through the labour market

programme, but employed in the sense that they participated daily in these measures. It is also noteworthy that the participants of this study were also likely to represent fairly healthy unemployed people; they were not so sick or marginalized as to be unable to participate in ALMP, which required daily full-time participation and lasted from three to 24 months. Therefore, the target group represented less a severely marginalized group of the unemployed than in some earlier research (Gabrys et al., 2013; Schuring et al., 2009), which is why only tentative inferences can be drawn regarding, for example, the more disadvantaged unemployed. Thus, the results from the study may not be directly generalized to populations other than unemployed people participating in ALMP. A general limitation is also that intervention studies tend to be inherently national. Generalization to other countries should be made with an understanding of differences, for example, in employment and health policy.

Secondly, the study designs also set some limitations to be considered. In Study I the baseline variables were adjusted for controls in the analysis, but there may have been other variables that influenced re-employment and were not included in the analysis, for example, personal characteristics and motivation to return to paid employment. One of the limitations is that Study IV did not have a control group. Lack of a control group in this context was not seen as crucial, because the main focus in Study IV was not on changes in the well-being of ALMP participants compared with non-participants. Instead, the focus was on differences in the changes between different sub-groups of ALMP participants. Still, without a control group it is not possible to guarantee that the differences observed between the groups were not the result of stratified processes that would have occurred over time without the ALMP intervention. To demonstrate this would have required a randomized controlled trial, but for both practical and ethical reasons such interventions were not feasible.

The third limitation concerns the methodology and measures used in this study. Studies I and IV were based on questionnaire data, which are subject to the well-known limitations associated with self-report and same-source bias. Health and mental well-being was conceptualized with several indicators which are consistently used within the field of unemployment and health research, and seem to be unequivocal with respect to their relevance to mental well-being. The established indicators also reflect different aspects of health mental well-being. In the case of Study IV and from the point of view of the ALMP intervention, certain notions about these indicators are still open to conjecture. The GHQ score reflects actual mental well-being and is quite sensitive to changes in life conditions (Goldberg &

Williams, 1988). Therefore, the changes observed in this outcome may also be due to other changes in life (such as changes in social status) among the unemployed than to the actual participation in ALMP. As to the sense of coherence, SOC theory states that it stabilizes in early adulthood in the form of a personality trait that is resistant to stressful life events (Antonovsky, 1987). Although empirical research has questioned the stability of the sense of coherence (Feldt, Leskinen, & Kinnunen, 2005; Volanen et al., 2007), it is evident that it reflects an individual's relatively permanent global orientation and feeling that the environment is comprehensible, manageable and meaningful. Changes in the sense of coherence during vocational training may thus mean that the effects on mental well-being are relatively profound.

Studies II and III used discourse analysis. In terms of validity and reliability the evaluation criteria of qualitative research are different. The results of discourse analysis are not directly repeatable, but context-sensitive and the plausibility of the finding, for example, can be evaluated (Peräkylä, 2004; Phillips & Hardy, 2002). An important way to improve the plausibility of the findings is to describe the research process as transparently as possible. Another way to consider the plausibility of the analytic scheme is related to make sense of new kinds of discourse and to generate novel explanations (Potter & Wetherell, 1987). In this study, the discourse analysis built on earlier research in order to offer some novel, and perhaps unconventional perspectives for traditional research on the unemployed.

Fourthly, the study was conducted during the period 2000-2006, during which favourable macroeconomic conditions prevailed. There is a danger that the findings may be somewhat outdated; at least the economic circumstances have changed since then. However, the study by Novo, Hammarström and Janlert (2000) and that by Virtanen, Hammarström and Janlert (2016) showed that the unemployed did not show any significant differences in physical or psychological symptoms during an economic boom compared to an economic recession. Nevertheless, there remains a need to corroborate the findings under different more recent economic circumstances.

The fifth limitation concerns the adequacy of the health care service (CHC) implemented. It may be assumed that CHC was not effective enough in its form. Ideally such an intervention should enhance employability and re-employment, and therefore – as re-employment promotes health and mental well-being – reduce health inequality. One may ask hypothetically whether a more intensive intervention of shorter duration may be more effective than a less intensive intervention with a longer duration. However, the evidence-based research on

interventions to enhance re-employment is relatively sparse or the results are mixed. It has been found that effective interventions in general are complex and many factors may influence whether they succeed or not (Egan, Bambra, Petticrew, & Whitehead, 2009; Murta, Sanderson, & Oldenburg, 2007). Among the employed it has been shown that shorter stress management interventions are more effective than longer ones in terms of such psychological outcomes as stress and anxiety (Richardson & Rothstein, 2008). Concerning vocational training as an intervention in Study IV, willingness to participate in training has been identified as an important motive for both employed and unemployed people (Banks, 1990). A desire to change and active participation in training have also been prerequisites for a successful intervention (Black, 1996). Although the participants in Study IV were volunteers, they were not explicitly seeking to improve their health and mental well-being. As the Study III findings revealed, the perceptions and participatory motives for the interventions should be addressed as they are seen by the client (see also Patel et al., 2007).

4.3 Practical implications and suggestions for future research

Interventions for the unemployed have been carried out mainly on the basis of two arguments: increasing re-employment and preventing social marginalization, which obviously promotes health and improves mental well-being (Paul & Moser, 2009). However, the present study showed that the CHC intervention and vocational training as a part of ALMP actually at least partly failed to achieve these goals, thus there is a need for further empirical study to reach a better understanding of what kinds of interventions will help the unemployed most. As this study indicated, it is worthwhile to acknowledge and consider the needs and interpretations of the unemployed as these may differ from the official goals imposed on participants by interventions and activation policies and the response they expected from the participants.

In terms of activation policy, the present study showed that unemployment studies need to be better incorporated into the understanding of socioeconomic inequality and the medicalization of unemployment. Although the universalistic services of the Nordic model may be superior in contributing to improved population-level welfare (Dragano, Siegrist, & Wahrendorf, 2011), it seems that they are not good enough at maintaining equality in the distribution of improvements in health and mental well-being among the unemployed

(Mackenbach, 2012; Tarkiainen et al., 2012). The persistence of the socioeconomic health gradient may partly be due to the medicalization of unemployment. As Holmqvist (2009) argues, when a social position, such as unemployment, turns out to be a personal problem, it has profound implications for policy. If individuals are labeled as disabled as a result of unemployment, there is a risk that they will be placed in interventions that are neither helpful nor cost effective, and may even impair their re-employment prospects. Health and well-being interventions for the unemployed may also blur the importance of the social and economic flaws that underlie unemployment (Conrad, 2007; Holmqvist, 2009). The challenge is to develop and implement de-medicalizing and equal interventions and services free of stigma, labelling and socioeconomic discrimination. A more realistic goal would be to increase the awareness of these side-effects and the complex links between the interventions and their effects among the unemployed.

The present study also points out the heterogeneity of the unemployed. At the completion stage of this study at least one thing has become clear: interventions for the unemployed have various outcomes and meanings. Each study (I, II, III and IV) offers a different angle on interventions. It was evident that the unemployed people, like consumers and clients in any service in general, actively positioned themselves and others over the course of the encounter. The health care intervention studied here was designed to have an impact on individuals' health and mental well-being and thus to enhance re-employment. The qualitative analysis showed that the intervention may have matched with people's real-life situation only poorly. Similar findings were found in a study by Corden and Nice (2007).

Regarding the distributive dilemma of who should benefit from the help and resources of society (Prottas, 1978), the overall findings raise a crucial problem: the studied interventions rather accentuates inequalities and the unemployed as clients of health care intervention seem not to be individuals in need of the services offered. On the basis of this study, it is obvious that the perspective of the unemployed as social actors must be taken into account when various actions are taken on a societal level. The same phenomenon has also been recognized in the field of health service research by arguing that clients who had an active role in the encounter show a greater reduction in health concerns and problems relative to clients reporting less involvement (Lerman et al., 1990). Unemployed people should no more be seen only as victims, which may lead to a more satisfactory balance between enhancing personal resources and providing social resources. The services may also strengthen the negative stigma, but ideally, they can play an important role in building trust in society and its institutions and minimizing

feelings of exclusion (Kieselbach, 2007). Thus, implementation strategies including individual as well as social dimensions require changes in the institutions which are in contact with unemployed people (Kieselbach, 2003). As the results of Study II suggest, health care professionals are in a key position within health care service interventions and therefore have the responsibility of being aware of the possibility of stigmatization. One of the challenges is to improve the knowledge of the health care professionals and other activation practitioners as they are the important actors in preventing labour market exclusion.

Instead of concluding, on the basis of this study, that an intervention is ineffective or stating that interventions are unsuccessful in attempting to reach their targets, future research on the unemployed should include the more specific evaluation of intervention processes. One important issue is also to match available services to the individuals in need of those services. There is still little evidence of and a need for research on which elements may actually be important to ensure the effectiveness of an intervention, but also to evaluate what kind of well-being intervention works for whom, why, how and under what circumstances (Nielsen & Abildgaard, 2012; Wanberg, 2012). In this development work identifying those who benefit most from the intervention in question would be important. This could be done by searching, for example, mental well-being trajectories across the follow-up time and what ascertaining factors predict these trajectories (see Hättinen et al., 2009). Study of the unemployed would also benefit from greater attention to qualitative studies on the intervention processes. Such an approach would not only provide a more complete understanding of the health and well-being of the unemployed, but would also enhance the broader field of research on the factors affecting the outcomes of interventions. Whatever approach is adopted, it is important to be clearly aware of both the complexity of unemployed people's needs and attitudes and the challenges currently facing interventions. This research makes a contribution to this goal.

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ORIGINAL PUBLICATIONS

RESEARCH ARTICLE

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Does provision of targeted health care for the unemployed enhance re-employment?

Katri Romppainen^{1*}, Antti Saloniemi², Ulla Kinnunen³, Virpi Liukkonen⁴ and Pekka Virtanen⁴

Abstract

Background: There is increasing pressure to develop services to enhance the health of the workforce on the periphery of the labour market. Health promotion among unemployed people may improve their health but also to increase their employability. We tested whether re-employment can be enhanced with a health care intervention targeted at the unemployed.

Methods: A 3-year follow-up, controlled design was used. The data were collected among unemployed people ($n = 539$) participating in active labour market policy measures. The baseline survey included established habitually used health questionnaires. The intervention consisted of three health check-ups and on-demand health services. Logistic regression analyses were used to obtain the odds ratios of the intervention group versus control group for being re-employed at follow-up. Health-related differences in the re-employment effects of the intervention were assessed through the significance of the interaction in the regression analyses.

Results: The intervention did not serve to improve re-employment: at follow-up 50% of both the intervention group and the control group were at work. In further analyses, the odds ratios showed that the intervention tended to improve re-employment among participants in good health, whereas an opposite tendency was seen among those with poor health. The differences, however, were statistically non-significant.

Conclusion: The experimental health service did not show any beneficial effects on re-employment. Nevertheless, rather than considering any particular health care as unnecessary and ineffective, we would like to stress the complexity of providing health services to match the diversity of the unemployed.

Keywords: Health services, Access to health care, Unemployment

Background

Unemployment is associated with poor mental and physical health independent of time and place [1,2]. It is well understood that the antithesis 'selection or causation' is false [3]. Both selective and causal processes are therefore relevant in considering the preventive and the illness-related health services for the working aged population. Policymakers and health service researchers also consider health care for the unemployed a major challenge, but there are concerns about appropriate arrangements and the consequent effectiveness and efficiency of the service.

Implementing a service always takes place in national structures and is actualised in different contexts. The

present study reporting a health care intervention among the unemployed was conducted in Finland, where unemployment entails a specific risk of being excluded from health care [4]. The reason for this is the structure of the primary health care service for working aged people, which largely relies on occupational health care services (OHC) [5]. OHC is provided by law for all waged and salaried employees, and has developed beyond worker protection and occupational medicine into a comprehensive system of illness-related and preventive general health care [6]. About 90% of the employed population has access to this service [7] which, however, is lost together with the job. In the other words, as a consequence of unemployment the citizen also loses part of his/her health service system and the available service is limited mainly to communal Health Centres. Therefore there is a particular pressure to develop services to

* Correspondence: katri.romppainen@uta.fi

¹P.O Box 607, 33014 Tampere, Finland

Full list of author information is available at the end of the article

cater for the workforce on the periphery of the labour market. Extensive development projects have been piloted in order to find ways to implement health services for the unemployed [8], and under the amendment to the Health Care Act of 2011 municipalities are obliged to provide health promotion and check-ups for the working aged who do not have access to OHC. Research evidence of the impacts of such a service is still lacking. Also internationally, publications tend to write about the state of affairs and recommend novel services [9-12], whereas studies concentrating on the provision and effects of the services are scarce [e.g. 13-15].

Although the ultimate and explicit aim of health care interventions is to prevent prolongation of the unemployment, to the best of our knowledge there are no studies with re-employment as the outcome of the service. The opposite phenomenon, i.e. the 'indirect effects' [16] of employment policy interventions on health, has been studied more extensively. The evidence that the interventions are able to promote health is limited, and they seem to be relatively ineffective even with respect to work participation [17]. With these research defects as the starting point, we ask in the present study if the re-employment effect of active labour market measures could be improved by accompanying health services.

The idea was to apply the existing Finnish OHC as a health service for unemployed people participating in active labour market policy (ALMP) measures. We wanted to carry over the principles and professionals of OHC to serve the unemployed in an attempt to enhance their employability. The OHC-ALMP setting was chosen in order to reduce the transfer problem of an evidence-based intervention from research settings to real contexts and populations. The aim of our trial was to investigate whether a health intervention among unemployed people enhances their re-employment prospects compared to those left without the service. In particular, we were interested in studying whether the possible effect depends on the self-perceived health of the unemployed individuals.

Methods

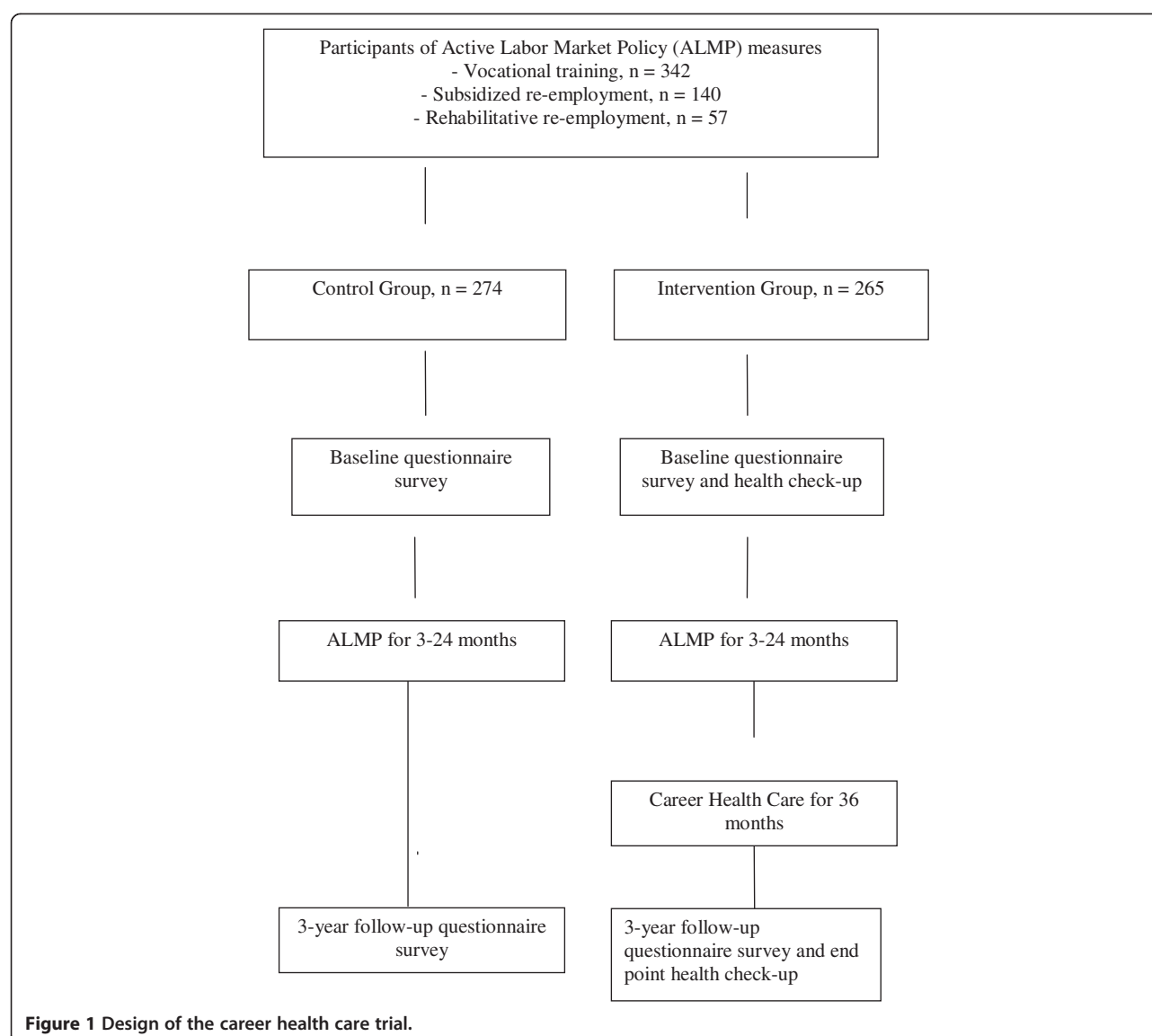
Career Health Care (CHC) was an intervention resembling Finnish OHC services, except that the clients were recruited from jobseekers participating in ALMP measures (vocational training courses, subsidized employment, and participatory training for entering the labour market). Adopting the logics of OHC, CHC aimed to tackle the problems and risks inherent in unemployment. Six occupational health nurses from established OHC providers in three localities in southern and central Finland were recruited for the client work. The CHC service consisted of three health check-ups by the nurses at the beginning and end of the ALMP measure,

and when three years had elapsed since the beginning. Main focus of CHC was on health promotion and primary prevention, managed with a specific 'health plan' adopted from OHC [6]. The activities consisted health screenings, assessment of client's working ability and individual health promotion-oriented guidance and counselling, emphasising in particular the health-related risks and problems during the unemployment spell. The instructions for organising the check-ups were, however, left relatively open, and nurses were encouraged to vary and develop the encounters (see [18] for more details).

In addition to personal interviews, the nurses received information through the questionnaires that the clients returned at the check-up. Moreover, the encounter included three kinds of physical performance tests and measurement of weight, blood pressure and pulse. Regular laboratory screenings or physician consultations were not routinely included in CHC, but the needs were assessed individually and the clients received referrals and guidance to appropriate health services. The nurses could also book control visits in CHC, for instance for checking the blood pressure. The most common topics of health promotion and health counselling were 'classic', such as smoking cessation, excess alcohol consumption, diet due to high cholesterol, diabetes or obesity, physical exercise and psychosocial conditions. In all, the idea of CHC was to provide the clients an opportunity to use health care in maintaining their workability of and boosting their re-employment; therefore no co-work systems with social or employment services, for example, were established but the clients were encouraged to use them if needs were detected.

In addition to the scheduled encounters, the participants had throughout the three-year CHC-clientship an opportunity to spontaneous illness related contacts with the nurse and, if needed, with a physician. During the encounters, the participants also discussed their background health status in light of their employment histories and vocational goals.

The design of the CHC trial is presented in Figure 1. The sample of this study consisted of 539 unemployed individuals who were enrolled in ALMP in 2002 and 2003. The participants were 'healthy' unemployed and possible disability was not used as criterion in selection. The vocational courses were chosen purposefully in order to obtain roughly equal amount of men and women, as well as to include in the study participants with a range of educational levels, to the intervention and the control group. Participants of the subsidized employment and participatory training were randomized at individual level at the recruitment occasion. The intervention group had a privilege to extra health service targeted for the unemployed (CHC), whereas the control group only could use the regular communal Health



Centres. The intervention group ($n = 265$) with access to CHC and also the control group ($n = 274$) was recruited from among voluntary participants at the beginning of the ALMP measures. The researchers visited a lesson at the beginning of the vocational training courses and informed the participants about the study. Those who consented filled out a questionnaire. Participants of subsidized employment and participants in training for entering the labour market got a written information about opportunity to join the study, and those who consented were randomized. Baseline data were collected in the period 2002–2003 (Time 1) with questionnaires at the beginning of the ALMP programmes. A follow-up survey was conducted three years later (Time 2): the participants of the intervention group completed the questionnaire at the health check-up; participants of the control group returned the questionnaire by post.

The study had a steering group consisting of representatives of the Ministry of Labour and Ministry of Social Affairs and Health. At recruitment all participants received spoken and written information about the study, where it was made explicit that enrolment was voluntary and not a condition for participation in ALMP and the associated benefits. At the time of planning and implementation of the study, the Medical Research Act about Ethics Committees had not yet been enacted in Finland. There were Ethic Boards which, however, were oriented narrowly to biomedical experiments, and this kind of studies on health promotion services were not subjected to external ethical assessment. We asked the Ethics Committee of Pirkanmaa University Hospital District to assess retrospectively the study plan, and the committee stated that a study with corresponding design would be approvable (ETL-code R13024).

The baseline surveys included established questionnaires of perceived physical and mental health and well-being. The present study utilised four health indicators. Self-rated general health (SRH) was elicited with the response options 1 = good, 2 = fairly good, 3 = average, 4 = rather poor or 5 = poor and dichotomised to optimal (1–2) and suboptimal (3–5). Psychological distress was measured with the General Health Questionnaire (12-GHQ, case vs. not, cut-off value 3/4) [19]. Depressiveness was evaluated using the Beck Depression Inventory (BDI) [20] and dichotomised to not/mildly depressed (cut-off value 4/5). The fourth indicator was Sense of Coherence (SOC), which was measured with a 13-item questionnaire [21] and dichotomised at the median. One question about current employment status (employed vs. not) was added into the 3-year follow-up questionnaire.

All statistical analyses were conducted using SPSS (version 19) for Windows. The level of statistical significance was set at 0.05. We used binary logistic regression analyses to obtain the odds ratio of the intervention group vs. control group for being re-employed at follow-up. The group \times health interaction term of the regression analyses was used to assess the health-related differences in the re-employment effects of the intervention. Gender, age, level of vocational education and length of unemployment prior to entering the ALMP measure were controlled for as background factors.

Results

Of the original sample ($n = 539$), 322 (60%) participated in the follow-up survey (Table 1). Drop-out was more

common in the intervention than in the control group (49% vs. 31%). More men than women were lost to follow-up, otherwise participation was not related to the baseline variables. Among the participants at follow-up there were fewer women in the intervention group than in the control group (64% vs. 71%), whereas the groups did not differ in educational level, age and length of unemployment at baseline. Suboptimal self-rated health was more common (30% vs. 23%) in the intervention group. All mentioned differences were non-significant.

Table 2 describes those who participated at the end by the group and by the four indicators of health. According to all indicators, suboptimal health was slightly more common in the intervention group.

In the intervention group, 50% were employed at follow-up. The percentage was exactly the same in the control group. When regressed for background factors (gender, age, level of education, duration of unemployment), odds ratio for unemployment of the intervention group was 0.92 (95% confidence interval 0.57–1.49).

In order to investigate whether the re-employment effects of CHC depend on baseline health status, we analysed separately those with reportedly good (Table 3) and with poor (Table 4) health. Among the participants reportedly in good health, the intervention did not increase re-employment although the odds ratios with all four health indicators tended to show higher re-employment (Table 3). In the corresponding analysis of those with reportedly poor health (Table 4), the re-employment in the intervention group was lower than in the control group. However, the differences were statistically non-significant

Table 1 Descriptive statistics of the intervention group and the control group at baseline and at the end of the career health care experiment

	Intervention group		Control group	
	Recruited at baseline ($n = 265$)	Participated at end ($n = 134$)	Recruited at baseline ($n = 274$)	Participated at end ($n = 188$)
Gender				
Men	41%	36%	35%	29%
Women	59%	64%	65%	71%
Former education				
University or college	20%	21%	18%	21%
Vocational school	42%	43%	43%	45%
ALMP course or none	38%	36%	39%	34%
Unemployment at baseline				
Less than 1 year	67%	66%	67%	69%
1 year or more	33%	34%	33%	31%
Mean age at baseline	38.0	39.6	37.6	38.5
Self-rated health at baseline				
Optimal	68%	70%	76%	77%
Suboptimal	32%	30%	24%	23%

Table 2 Health of the participants of the intervention group and the control group in the beginning of the follow-up

	Intervention group		Control group	
	Optimal	Suboptimal	Optimal	Suboptimal
Self-rated health	91 (70%)	39 (30%)	137 (77%)	42 (24%)
Depressiveness	96 (76%)	31 (24%)	135 (77%)	40 (23%)
Psychological distress	105 (82%)	23 (18%)	152 (85%)	26 (15%)
Sense of coherence	57 (45%)	69 (55%)	95 (54%)	81 (46%)

both among those reporting good and those reporting poor health.

Finally, we analysed the complete study population and utilised p-values for interaction from the fully adjusted regression models to assess whether those reporting poor health differed from those reporting good health with respect to the re-employment effects of the CHC. Regarding sense of coherence (OR 1.79 for higher vs. OR 0.72 for lower SOC) the difference was nearly significant (p-value 0.064), while the p-values for SRH (0.197), for psychological distress (0.874) and for depression (0.133) were non-significant.

Discussion

Earlier studies and scholars have usually taken as the starting point the idea that it is possible to enhance employment by improving the health of the unemployed [e.g. 22,23]. The setting of our study was in line with this

Table 3 Odds ratios with 95% confidence intervals for being employed at the end of the career health care experiment in cohorts with optimal self-rated overall health, optimal mental health (GHQ), optimal mood (BDI) and high sense of coherence at baseline

	Employed	Model 1	Model 2
Optimal self-rated health			
- Control group	53%	1	1
- Intervention group	59%	1.28 (0.75-2.19)	1.38 (0.78-2.42)
Low psychological distress			
- Control group	54%	1	1
- Intervention group	51%	0.90 (0.55-1.49)	1.07 (0.63-1.83)
No depressive symptoms			
- Control group	51%	1	1
- Intervention group	55%	1.18 (0.70-1.99)	1.30 (0.74-2.28)
High sense of coherence			
- Control group	49%	1	1
- Intervention group	58%	1.47 (0.78-2.80)	1.79 (0.90-3.58)

Model 1: Unadjusted.

Model 2: Adjusted for gender, age, vocational education and length of unemployment at entry to the experiment.

Table 4 Odds ratios with 95% confidence intervals for being employed at the end of the career health care experiment in cohorts with suboptimal self-rated overall health, suboptimal mental health (GHQ), suboptimal mood (BDI) and low sense of coherence at baseline

	Employed	Model 1	Model 2
Suboptimal self-rated health			
- Control group	41%	1	1
- Intervention group	28%	0.58 (0.23-1.47)	0.56 (0.20-1.54)
High psychological distress			
- Control group	35%	1	1
- Intervention group	39%	1.21 (0.38-3.89)	0.90 (0.23-3.58)
Depressive symptoms			
- Control group	53%	1	1
- Intervention group	36%	0.50 (0.19-1.30)	0.42 (0.14-1.30)
Low sense of coherence			
- Control group	52%	1	1
- Intervention group	44%	0.72 (0.37-1.40)	0.72 (0.36-1.47)

Model 1: Unadjusted.

Model 2: Adjusted for gender, age, vocational education and length of unemployment at entry to the experiment.

general emphasis. Yet it is not guaranteed that changes in health lead to changes in employment as well. Therefore the direct outcome of our intervention was re-employment, i.e. at this time health care was treated as an instrument which, by definition, promotes health, in particular among those with poor health. On the other hand, we are aware of the fact that, at least in the work-site interventions, the health impacts have turned out at best very modest, and the results are mixed [24,25].

We aimed to investigate whether re-employment can be enhanced with a health care intervention among the unemployed. No such enhancement was found: in three-year follow-up the difference in re-employment between the intervention group and the control group was insignificant. When participants with optimal and suboptimal baseline health were analysed separately, re-employment tended to be more prevalent among participants with optimal health in the intervention group, whereas among the participants with suboptimal health re-employment tended to be lower in the intervention group. However, these differences were not statistically significant.

Different interpretations may be made on the result, which tended to contradict rather than support, the expected improvements in the re-employment. How is it possible that the intervention seemed to harm rather than to benefit those in particular need of health care, i.e. those with poor health? One explanation may be in the health related selection at recruitment. Indicative of this, self-rated health was more commonly poor in the

intervention group. Moreover, as participation was voluntary, the groups may have differed with respect to their motives to participate. In other words, in the intervention group the participants with suboptimal health may have had relatively severe health problems as regards employability. An alternative explanation is that this kind of health care is not able to improve health and consequent re-employment. As we have reported elsewhere [18,26] several logics are present in CHC, and this is why the service model adopted from occupational health care does not seem to work in the context of unemployment. Moreover, it is possible that the intervention maintained and strengthened elements of the sick role, instead of enhancing the role as a capable job seeker.

OHC is obliged to support employees with impaired work ability to cope at the workplace, in other words, to prevent health related selection out of work. Analogously, CHC should succeed in promoting re-employment in particular among the unemployed with impaired employability. In this respect, the result of our trial was discouraging. We would like to agree with the view [27] that, even when tailored to meet the assumed needs of a specific client group, the health service mobilizes them only partly, and not all of them benefit from it. To provide a service that matches the increasing diversity of contemporary labour market trajectories is complex. In addition to mere 'guaranteed access' to existing or novel service systems, attention should be paid explicitly to their orientation and contents. Our intervention was carried out in the frames of an established OHC service. If the results had been more promising, it would have been possible to conclude that it is not too problematic to transfer and adjust the model for participants in ALMP measures.

The design with a long follow-up time, large intervention and control groups with reasonable sample attrition may be considered to be among the strengths of this study. The established health indicators also reflected different aspects of mental well-being. Although stratification of the participants by baseline health did not reveal statistically significant differences, it deepened the analysis into potential effects that would have otherwise gone unnoticed. A general (level) limitation is that such intervention studies tend to be inherently national and particular with respect to the participant groups and details of the intervention. With respect to earlier research [14,28], the target group of this study represented less severely marginalised group of the unemployed. Moreover, participation in the study was voluntary, e.g. not related with unemployment benefits.

It is evident that existing, more or less universal service systems do not guarantee adequate health promotion for the unemployed. Therefore, 'positive discrimination' of the unemployed with regard to improving their health, and

consequent re-employment, will continue to be central to the public health and policy agenda in future years. The present study provides research evidence for the choice of policy instrument. Both health services and employment policy services are important for the well-being of the disadvantaged, but they are probably not interchangeable.

Parallel results from Finland and the Netherlands [15] about the ineffectiveness of health services for the unemployed do not justify the conclusion that any service would be ineffective. Rather, there is a need to develop innovative service contents and models in this field in different national contexts. Alternatively, any particular service tends to stigmatize the client group, and an appropriate direction might rather be to concentrate on developing universal health care and the skills of all professionals with respect to unemployed people.

Conclusions

The experimental health service did not show any beneficial effects on re-employment. Nevertheless, rather than considering any particular health care as unnecessary and ineffective, we would like to stress the complexity of providing health services to match the diversity of the unemployed.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

KR drafted the manuscript and analysed the data, AS contributed to design of the study and writing, UK and VL contributed to writing, PV is principal investigator of the Career Health Care -project. All authors read and approved the final manuscript.

Author details

¹P.O Box 607, 33014 Tampere, Finland. ²Department of Pori, School of Social Sciences and Humanities, University of Tampere, Pori, Finland. ³School of Social Sciences and Humanities, University of Tampere, Tampere, Finland. ⁴School of Health Sciences, University of Tampere, Tampere, Finland.

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Short report

Encounters with unemployment in occupational health care: Nurses' constructions of clients without work

Katri Romppainen ^{a,*}, Rita Jähi ^a, Antti Saloniemi ^b, Pekka Virtanen ^a^a Tampere School of Public Health, University of Tampere, P.O. Box 607, 33014 Tampere, Finland^b Department of Pori, University of Tampere, P.O. Box 181, 28101 Pori, Finland

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ABSTRACT

This study explores occupational health nurses' encounters with unemployed clients in Finland. It involved setting up and evaluating a new service, Career Health Care, that resembled occupational health care, except that clients were recruited from among job seekers who were participating in one of three active labour market policy measures: vocational training, subsidised employment in the public sector, or participatory training for entering the labour market. Our main interest focused on nurses' perceptions of the unemployed and their professional practices in the context of Career Health Care. The analysis revealed four overlapping discourses with regard to clients: the client as a casualty of unemployment, the client as unemployed but active, the client as a deviant in the labour market, and the client as a skilled user of the system. Each discourse had implications for professional practice. The risk of negative stereotyping and consequent exclusion from services is discussed here. In conclusion, we stress the complexity of providing health services that can match the increasing diversity of contemporary labour market trajectories.

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Introduction

The frequency of health problems among the unemployed has raised questions and recommendations concerning their health care (Harris, Webster, Harris, & Lee, 1998; Matoba & Ishitake, 1999; Ytterdahl, 1999). Moreover, utilisation of health services seems to be suboptimal during unemployment and periods of atypical employment (Virtanen, Kivimäki, Vahtera, & Koskenvuo, 2006). Health services should be able to respond to this inequality in care, and also to provide preventive services (e.g. Åhs & Westerling, 2006; Perkins, 2007; Rose & Harris, 2004). In addition, the role of occupational health services (OHS) in the changing labour market has been cited as an important future challenge (Felton, 2000). Nevertheless, only a few studies have concentrated on provision of these services (e.g. Buchanan, Evens, Buckley, & Friedman, 2008). In particular, little attention has been paid to the role of health professionals within this context. Typically, studies of health professionals focus on professional–client interaction and medical decisions. There are also numerous examples of how marginalised individuals experience stigmatisation and social inequality in health services (van Brakel, 2006; Link & Phelan, 2006; Link, Castille, & Stuber, 2008). Our study was also motivated by the idea that the unemployed are disadvantaged in terms of access to and quality of health care. However,

instead of concentrating on interaction we studied health professionals in the context of a trial that was based on the idea of delivering health services to unemployed persons taking part in programmes of active labour market policy measures. Nurses had a crucial role in the implementation of this Career Health Care (CHC) service. In this report, we focus on information obtained from the nurses who faced new professional challenges during the trial.

According to 'the inverse care law', the availability of good medical care tends to vary inversely to the need for it in the population served (Hart, 1971). Thus, health care would tend to maintain and perpetuate, or even widen, the health gradient between the employed and the unemployed. In addition to unemployment, the increase in atypical employment has revealed that Occupational Health Care (OHC) represents a potential source of health inequality. In fact, OHC is an example of the welfare institutions of Western economies that have been developed on the premise of lifelong full-time employment. In Finland OHC is provided by law for all wage and salary employees, and it has developed beyond worker protection and occupational medicine into a comprehensive system of illness-related and preventive general health care (Taskinen, 2004). About 90% of the employed population has access to this service (Kimanen et al., 2008).

Unemployment can be viewed as an extreme form of atypical employment which challenges OHC to develop both its organisation and its underlying paradigm. If atypical work is associated with inadequate or low benefit levels, poor and insecure income and

* Corresponding author. Tel.: +358 503451626; fax: +358-3-35516057.
E-mail address: katri.romppainen@uta.fi (K. Romppainen).

powerlessness in influencing working conditions (Letorneux, 1997; Menéndez, Benach, Muntaner, Amable, & ÓCampo, 2007; Paoli & Merllié, 2001), it is an obvious risk to well-being and health. In Finland atypical employment also means irregularity, in other words 'atypicality', in OHC contacts (Virtanen et al., 2006). Therefore the question of work-related strategies for reducing social inequalities in health (Siegrist, 2002) is especially linked to the labour market positions of the employees. How should the service structure be changed in order to favour the workforce on the periphery of the labour market? What kinds of tools are needed in health care when working with unemployed clients? In this report we focus on nurses' experiences while practising CHC, and particularly the way in which they define the new clientele and assess the suitability of their own professional skills in dealing with these clients.

Setting and methods

The Career Health Care service

The CHC project was carried out in 2002–2005. The new service resembled OHC, but instead of workplace-related health problems, the service aimed to tackle the problems and risks related to unemployment and atypical work. Occupational health nurses from established OHC providers in three localities in southern and central Finland were recruited. A total of six nurses carried out the client work. CHC was built on nurse-led clinics focusing on health promotion and primary prevention with a specific 'health plan' adopted from OHC (Taskinen, 2004) and an assessment of clients' working ability. The clients were invited to three health screenings: at the beginning and end of the measures and three years after the first contact. In addition, the clients were offered an opportunity for spontaneous contacts when required. Instructions for organising the encounters were left relatively open, and nurses were encouraged to vary and develop the checkups which examined clients' labour market status, their personal and employment history, and perspectives regarding re-employment and vocational training. Laboratory screenings or physician consultations were not routinely included in CHC.

A total of 265 clients participated in CHC. They were job seekers who were participating in one of three different active labour market policy measures: vocational training, subsidised employment in the public sector, or preparatory training for entering the labour market. Thus, they were unemployed in the sense that they received their income through the labour market programme, but employed in the sense that they participated daily in these measures. From the employment policy perspective they represented job seekers whose re-employment difficulties were assessed to be substantial enough to warrant such intensive measures. On the other hand, they were not so sick or marginalised as to be unable to participate in these measures, which required daily full-time participation and lasted from 3 to 24 months. Participants' age ranged from 18 to 58 years (mean age 37), 59% were women and 36% had white collar occupation. Unemployment had lasted less than one year in 58% of the participants.

The study followed conventional ethical rules of scientific research and especially those applicable to health research. According to the national practices at the time of field work no processing of the ethical committee was required of this kind of health services research. The study had a steering group consisting of representatives of Ministry of Labour and Ministry of Social Affairs and Health.

Interviewing career health care nurses and analysing data

The data comes from interviews with all six nurses who were recruited to the CHC. A semi-structured interview schedule,

covering the clientele, the professional practices, and the assessment of the CHC experiment, was followed. The interviews were conducted by the authors (KR, AS). Interview sessions lasted between 30 and 90 min and were tape-recorded and professionally transcribed. These interviews served as material for discourse analysis which focused on client constructions and the implications for professional practices these constructions warrant. Our methodological choice, that of discourse analysis, is based on social constructionist premises (Burr, 1995). Discourse both constrains and enables, and can also be used as a resource for reproducing the practices (Nikander, 2008; Potter & Wetherell, 1987). In practice, each interview was read with the aim of identifying sections relating specifically to CHC clients. Extracts from the transcribed interviews were coded into categories and the categories were grouped into themes. The research team compared and contrasted the discourses as a part of an iterative analysis process.

Findings

Client discourses and implications for nurses' service practices

The client as a casualty of unemployment

N2: Mental health problems are certainly one of the things that emerge quite strongly. Another thing is substance abuse problems. (...) And, of course, last but not least, musculoskeletal disorders, which are also very common. (...) I'm pretty certain that nearly half of them will never get a job.

N2: But it is true that it [unemployment] often characterises the way these people think, I mean they are not... they tend not to plan ahead. And this of course includes their health.

The perception of the client as a casualty of unemployment identifies clients as having a problematic status which entails the inevitable accumulation of multiple problems and a helplessness in resolving them. The nurses draw on this discourse to construct their new clients as individuals sharing a number of cognitive, social, emotional and behavioural characteristics due to their unemployment. An "unemployed person" was constructed as someone having a short attention span, a lack of foresight and self-confidence and low motivation for health-promoting behaviour. The inability to take control of one's life leads to passivity and helplessness, and there is no capacity for change.

Nurses assume that such 'casualties' do not have the capacity to pay attention to health promotion. They take the view that there are far more urgent problems to solve than health issues, and they opt not to speak of health promotion although they see that clients lack basic knowledge about health risks. Also health is not considered as important in itself, it is simply a means of contributing to clients' employability.

In the casualty discourse, nurses emphasise their sympathy with the client. In their opinion, it is their duty to provide supportive empathy and advocacy for clients, rather than pay attention to health problems or their prevention. Nurses are uncomfortable with these clients because they do not have access to a real workplace and the social network it provides, as is the case in the everyday work of nurses.

The client as unemployed but active

N6: Some of them are in really good shape, they've kept themselves fit and even enjoyed being out of work, being able to exercise and concentrate on their hobbies. There really are people who have actually said that it's wonderful, for once, to be able to just take it easy and live for oneself.

The activity discourse represents the clients more as actors than as casualties. Even when unemployed, they have capacity for adaptation and are motivated to do something with their lives. They have succeeded in integrating unemployment into their personal lives. Although nurses view them as victims of circumstance, they are also seen as potential survivors. The discourse indicates relatively balanced and trustworthy clients who are predominantly in good physical and mental condition. There may be hardships, such as financial difficulties, but these problems do not dominate their thoughts.

N1: There are people who are in pretty bad shape physically as well, but they are so eager to work that they'd rather go to work than stay at home, even with back pain or something.

There is, therefore, a somewhat different way of depicting those who are unemployed but active. Activity can refer to the “decent unemployed” who are maintaining their employability by taking care of their physical and mental health. They are highly motivated to get a job, to the extent that they are even prepared to risk their own health in order to find re-employment.

Instead of being passive recipients of care, these clients co-operate actively and competently. Nurses trust the ability of these clients to make decisions and take care of their health. In fact nurses consider that some clients are already so well-informed that they do not need any further advice. Nurses do not feel alienated from these kinds of clients' life situations and can trust and communicate with them. The context thus enhances mutuality and trust in the professional–client interaction.

The client as a deviant in the labour market

N1: ...Well, you know, I'm not a novice anymore...it doesn't take much to see that it's not just about a person's formal qualifications, it also depends a lot on what kind of personality you have. I've seen barriers that are clearly related to individual personality characteristics.

N6: ...It is doubtful whether some of these people will ever change. They will have a hard time for the rest of their lives, unless, by some stroke of luck, they happen to find a workplace that appreciates diversity. In this sense I can say that I've come across a few persons who are, how should I put it, rather deviant personalities.

The deviants are thought to differ from the mainstream of the labour force. They are portrayed as lacking the potential to develop or to change, and seen as doomed to marginality. The deviant discourse perceives the client's personality as the cause of the problems. Deviants are assumed to lack social skills and the ability

to observe codes of behaviour. Their inability to engage in reflective behaviour is seen as leading to maladjustment, particularly in the workplace.

The deviants are portrayed by nurses as being particularly challenging and difficult to work with. As the prospects for change are deemed limited, it is not easy for the nurses to come up with solutions to client problems. The complexity of the situation leads the nurses to talk about the negative traits and poor introspection skills of the deviants, rather than focusing on health. The deviants' ability to secure a job is deemed as permanently poor; the nurses did not believe that they could be helped by any services or professionals. Consequently, health promotion was also considered unnecessary, at least with regard to improving the employability of the clients. If the deviants are regarded as being beyond help by health services or any other services, they are left alone to bear the responsibility for improving their situation.

The client as a skilled user of the system

N4: ...Some persons have sort of gotten involved in the system and have, for one reason or another, had many dealings with professionals from different fields. You can rightly say that in a way they have turned into professionals of some sort.

These clients are also constructed as active, but instead of re-employment or health promotion, as with the unemployed but active discourse, their activity is aimed at exploiting the service system as fully as possible. They are commonly characterised as being well aware of social benefits and individual rights to services. Nurses consider that these clients may even overuse services, partly because of the complex structure of health services and informal promises made by the system, which in a way entitle people to utilise them. These ‘skills’ have emerged from the interaction between the individual and system.

In this discourse nurses may suspect these clients of arrogance and insincerity. In this context, mistrust between the client and the nurse is obvious and the resulting confidence gap decreases opportunities for successful collaboration. Nurses perceive the mistrust as mutual: the ‘skilled ones’ are seen as assertive, knowledgeable and demanding manipulators who, on the other hand, are wary of professionals and institutions. Nurses talked as if they had to control these clients and act as gatekeepers for access to health services.

Table 1 summarises the main findings of the analysis. In addition to basic characterisations, the table presents corresponding interpretations regarding the cause of the problems, the implications for nurses' work, and the nature of the health promotion practices.

Table 1

Client characteristics, causes of the problems, implications for nurses' work and health promotion in practice according to client discourse in CHC nurses' speech.

	Discourse of the client			
	Casualty of unemployment	Unemployed but active	Deviant in the labour market	Skilled user of the system
Client characteristics	Helplessness Passivity Social exclusion Multiple problems	Adaptation Emancipation Survivor	Unlike most other people Misfit	Demanding player Overuse of services
Cause of problems	Lack of work	Lack of work	Personality	Flaws in the healthcare system
Implications for nurses' work	Empathic support	Practical support	Withdrawal, minimal intervention	Confidence gap, control
Health promotion in practice	Scarce due to overwhelming socioeconomic troubles and health problems	Easy due to mutual understanding	Pointless due to poor re-employment prospects	Difficult due to mutual mistrust

Discussion

The studied discourses were produced in an experiment where the nurses were exposed to a professionally unusual situation. In contrast to their ordinary activity, the nurses received clients who did not expect their labour market position to entitle them to specific health services. In this situation nurses perceived that the new clients did not fit into the routines and culture of occupational health care, and their previous training and experiences did not equip them for the challenges they faced with CHC clients.

When asked to characterise the CHC clients, the nurses commonly replied “*it's impossible to generalise*”. Nevertheless, in their further accounts nurses relied on a repertoire of stereotyping. In the course of analysis we were able to identify four major client discourses. Rather than nurses' individual prejudices and associated stereotypes, the discourses reflect socially shared constructions of unemployed people and their living conditions. These constructions served as resources with which the nurses felt able to conduct the client encounter properly. The findings highlight the need for critical awareness of the discourses and assumptions towards new client groups that tend to break the patterns in which nurses and other healthcare providers operate.

The contradictions described above are mostly explainable by the lack of appropriate practices, but the problem is more general. Parallel gaps between ethical principles and practices have been identified for instance as a result of time shortage or economic limits (Jones et al., 2004). Moreover, when situational demands are unclear or norms for appropriate actions are weak, the risk of stereotyping, and even of discriminatory actions, is increased, as demonstrated by Dovidio and Gaertner (2004). In medical interactions, professionals' attitudes, beliefs, and expectations can lead to social categorisation of the clients. Therefore, health professionals do not always make decisions in the way they think. Such situations have been studied in the context of social judgement theory. (Dovidio et al., 2008; Thompson, Foster, Cole & Dowding (2005). A further angle can be identified from research traditions that have adopted the ‘deviance’ or ‘othering’ concepts (Browne, 2007; Scambler & Paoli, 2008): in our case the larger institutional and social context furthers the nurses' choice to construct the clients as ‘deviants’ from the mainstream clientele. In this process, even policies and institutional practices have critical relevance (Link et al., 2008). Thus, we can agree with the conclusions of Östberg and Lennartsson (2007) suggesting that it is difficult to predict the relative importance of different types of interventions needed in a specific population.

Our results supported the views presented by Starfield (2007), that even when tailored carefully, the health service does not enable all the clients to use and benefit from it. In other words, the CHC experiment represents one way of organising and providing the services, and we do not recommend it as a universal solution for linking OHC more flexibly with the needs that vary according to labour market situation.

While the economic and structural conditions of health care can change relatively quickly, changes in social practices are more difficult and take longer. Our findings stress the importance of perceptions about the unemployed; the services they use may strengthen the negative stigma, but ideally they play an important role in building trust in society and its institutions and minimising feelings of exclusion (Kieselbach, 2007). The development of health services is important, but, as Fryer (1999) argues, most mental health problems among the unemployed are socially caused and can only be socially resolved.

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My Health and Theirs: clients constructing meanings for a health service program for the unemployed

Katri Romppainen¹, Antti Saloniemi², Rita Jähi¹ and Pekka Virtanen¹

¹Tampere School of Public Health, University of Tampere, Finland

²School of Social Sciences and Humanities, University of Tampere, Finland

Abstract

Health care research has been more interested in identifying reasons why people do not participate in health interventions than in trying to understand the reasons why they do. This study examined how the unemployed position themselves with regard to a new health service which was set up as part of an institutional strategy for delivering and enabling their access to health care. Positioning theory was used as a methodological framework to analyse participants' responses to the novel health service. The focus was on two main issues: the way clients' positions are established through discourse, and the range of factors that come into play in determining those positions. The analysis revealed six positions the unemployed use when encountering the studied service: the docile citizen, the rebel, the socially responsible citizen, the distinctive individual, the independent actor, and the calculating client. These positions and associated discourses display the different sets of rights and duties of the client and simultaneously define the positions of the service. While illustrating how a health service engaged with the ideology of equality is integrated into the value framework of the clients, the findings contribute to the ongoing debate on need of particular health service for the unemployed.

Keywords: positioning theory, unemployment, health services research

Introduction

Social security and welfare services are not always able to respond sensitively and adequately to the needs of unemployed citizens. In particular, there seems to be a worrying degree of marginalisation and inequality regarding access to health services (Virtanen et al. 2006, Virtanen 1993). This inequality can be reduced only partly by increasing the universal availability of these services because, for instance, dropping out of health interventions correlates strongly with unemployment (Surakka et al. 2004). The life situations and labour market positions of the unemployed are diverse and particular, and their involvement in health care obviously takes place in diverse and particular ways. Should health services be reassessed in the light of enduringly high unemployment rates?

It is well documented that the unemployed commonly experience problems in physical and mental health. Irrespective of the theoretical assumption how unemployment leads to poor health (Janlert and Hammarström 2009), including the selection/causality debate, studies tend to recommend targeted policy interventions, but only in very general terms (Harris et al. 1998, Matoba and Ishitake, 1999, Ytterdahl, 1999). In addition, there is a strong interest among policy makers and in the media for health service programmes for the unemployed. In this context health may be valued instrumentally: improved health is associated with improved employability and increased opportunities for re-employment. However, we do not know exactly how the health system can respond and affect the health problems of unemployed people (Harris et al. 1998). The present study is strictly concerned with the question of extra health services for unemployed.

As regards health promotion (Macdowall et al. 2006), planning and organising services for the unemployed requires a thorough understanding of their motives for participating. Recent research has shown that clients who perceive that they have an active role in the encounter show greater reductions in health concerns and problems, relative to clients who report less involvement (Lerman et al. 2004). However, information about clients' initial motivation for taking part in health service delivery is limited. Participation in the service can yield benefits, but we do not know how and when these benefits are experienced. Our previous field work (Kaukiainen et al. 2001, Virtanen et al. 1997) indicates that it is not easy to assess how much of this involvement is simply token participation. Furthermore, little is known as to how clients engage with the health promotion and integrate received health information into their life contexts.

This Finnish study evaluates a novel health service for the unemployed. Aware of the contextual challenges and particularly the complexities that arise from arranging such services, we are interested in clients' experiences when encountering the service and in the actual utilisation of that service. The main focus is on analysing how the unemployed clients recruited for the study perceive the mode of health-care delivery we had developed. In analysing the interview data, we examine the way in which the clients define the service and the kinds of positions they construct for the service's target group, including themselves.

Materials and methods

The context of data collection: a health service for the unemployed

The service, Career Health Care (CHC), was based on the idea of experimenting with the Finnish model of occupational health care (OHC) among the unemployed. National regulations guarantee OHC for all wage and salary employees, and it has developed beyond worker protection and occupational medicine into a comprehensive system of illness-related and preventive general health care (Taskinen, 2004). About 90% of the employed population has access to this service (Kimanen et al. 2008).

CHC was organised in four localities in southern and middle Finland. Local OHC agencies were contracted to provide a three-year service in nurse-led CHC clinics. There were three scheduled health check-ups, one at the beginning, one on the average after one year, and one at the end of the clientship. In addition, spontaneous contacts initiated by health problems were available. The main activities of CHC were health screenings, assessment of each client's working ability and individual health promotion-oriented guidance and counseling, emphasizing in particular the health-related risks and problems in the employment career.

The clients were recruited from among job seekers whose period of unemployment was "interrupted" by one of three active labour market policy measures: vocational training, subsidised employment in the public sector, or participatory training for entering the labour market. The 265 participants were aged from 18 to 58 years (mean=37), of whom 59 per cent were women and 36 per cent had had white collar occupations. Thus, the service was focused on those who were actively taking part in labour market policy measures and actively seeking work. From the employment policy perspective the participants represented job seekers whose re-

employment difficulties were regarded as substantial enough to warrant such intensive measures. On the other hand, they were not so sick or marginalised as to be unable to participate in these measures, which required daily full-time participation and lasted from 3 to 24 months.

Data were collected through semi-structured interviews with the participants. A combined consecutive and purposeful sampling strategy was used to achieve detailed coverage that took into account employment policy intervention, gender, age and educational background. A total of 28 clients were interviewed by three researchers (KR, RJ, AS). Both genders were represented among the interviewees and the interviewers. All participants and interviewers were native Finnish, due to ethnic homogeneity of the labour force in Finland. The interviewers presented themselves as academics with a particular interest in understanding how CHC benefits its clients. The questions were broad and focused on experiences and opinions concerning the three-year CHC process in general, and on clients' perceptions as to how they benefited from the service. The duration of the interviews varied from 20 to 70 minutes; the sessions were audio-recorded and transcribed verbatim.

Positioning theory as the theoretical and methodological framework

Our study is embedded in the field of discursive approaches (Potter and Wetherell, 1987), utilizing in particular the ideas of discursive psychology (Wetherell, 2007, Harré et al. 2009) which regard reality as socially constructed through talk. It sees discourses as action-oriented, situated and constructive and focuses in detail on interaction (Harré and van Langenhove 1999). This perspective is used here to examine how participation in the health service for the unemployed is constructed within the interview conversation.

Discursively-oriented research has, among other things, analysed the concepts of health and illness and the role of the patient in the health promotion process (Willing 2000). However, it is still largely unknown why people visit services in general and take part in health promotion programs in particular. In order to analyse this aspect of the encounter, we employ the theory of positioning and subject positions (Harré et al. 2009, Harré and van Langenhove 1999.)

Davies and Harré (1990) propose that the notion of role should in several instances be replaced with the more dynamic notion of position. Positioning helps to take into account in an adequate manner the agency and the generation of reality in social interaction. Moreover, it can be used in elaborating the social effects of speech acts. Participants in a conversation offer,

accept or refuse subject positions that are made available through their own and others' discourse. The upshot of the assumed position can be positive or negative, supporting or denying a claim to a right, demanding or refusing the assignment of a duty. (Harré et al. 2009.)

Positions are related to different storylines that are unfolded in an encounter. The storylines are linked to different moral orders, with different sets of norms about what counts as right, legitimate, and appropriate behaviour. Every social milieu incorporates multiple subject positions "which people can adopt, strive to locate themselves or others in, can resist being positioned, and can reposition themselves" (Davies and Harré 1990). Social constructionists emphasise the importance of institutional settings, such as a judicial court or a workplace, and the tension between the structuring force of the situation and the contingent repertoires of the speaking subject (Harré and Gillet 1994, Potter and Wetherell 1987). According to Wetherell (1998), in constructing a subject position, accountability and context are even more important than the discourses used. How one positions oneself or is positioned by others occurs in and throughout discourses at a situational, institutional and societal level. Consequently, positions are always relational, either to an audience or to other positions (Harré and Moghaddam 2003). Following Harré, it is possible to specify first-order and second-order positions. These positions are mutually challenged and negotiated: first order refers to the way people locate themselves and others within an essentially moral space, and second-order occurs when the first is not taken for granted. In terms of analysis the first-order position has a so-called candidate status whereas the second-order has, either implicitly or explicitly, an acknowledged status. (Harré et al. 2009.)

The present study investigates specifically the discursive markers of positioning. We are seeking the elements in the discourse of participants that elicit the positions they occupy as clients of CHC. Moreover, we elicit the positions of the CHC that associate to these client positions. Therefore, the position of CHC varies according to client position. In sum, we examine how participants construct their own meanings about this service, with reference to factors inherent in their environment and their own personal experience. Clients' statements about CHC are not taken as an expression of their inner thoughts on the subject but rather as a mobilisation of culturally available explanations. These accounts are mobilised at different points in the interaction to serve particular purposes in a flexible and even contradictory manner. Nevertheless, they are subordinate to the client positions.

The procedure

The method of analysis draws on ideas from discursive psychology and positioning theory. By combining these two approaches, we attempt to show the process of participating in the health service and the dynamics of associated position production. The analysis process consisted of a reading of the data and sessions with a research team (KR, AS, RJ, PV). The authors compared and contrasted the discourses and positions as part of an iterative analysis process. The analysis began by looking at sequences where elements of participation discourse were identifiable. Based on the themes that emerged from interviews, a coding framework was established. In addition to emergent categories, the study also included categories of theoretical interest derived from positioning theory, such as storyline, rights and duties associated with a position. (Harré and van Langenhove 1999, Potter and Wetherell 1987).

The section on findings illustrates and explicates identified discourses and positions. Here, individuals' positioning towards institutional policy orientations is discussed. Finally, we consider the implications of our findings for policy makers.

This study followed conventional ethical rules concerning scientific research and especially those applicable to health research. The study had a steering group consisting of representatives from the Ministry of Labour and the Ministry of Social Affairs and Health.

Findings

Our analysis resulted in the identification of three dominant interpretative discourses (the institutional, the other unemployed, the private) and six positions (the docile citizen, the rebel, the socially responsible citizen, the distinctive individual, the independent actor, calculating client). The discourses were present to a greater or a lesser extent in all the interviews, but mainly as indirect and delicate references to dominant cultural categories. The institutional discourse and its positions prevailed throughout the entire data corpus and were therefore presented more widely than the others. Nevertheless, the other discourses and positions were also identified in all the interviews but instances were often short and embedded in several discussion themes. Figure 1 illustrates how the discourses make up a continuum in which 'the other unemployed' discourse overlaps partly with the private and the institutional discourses.

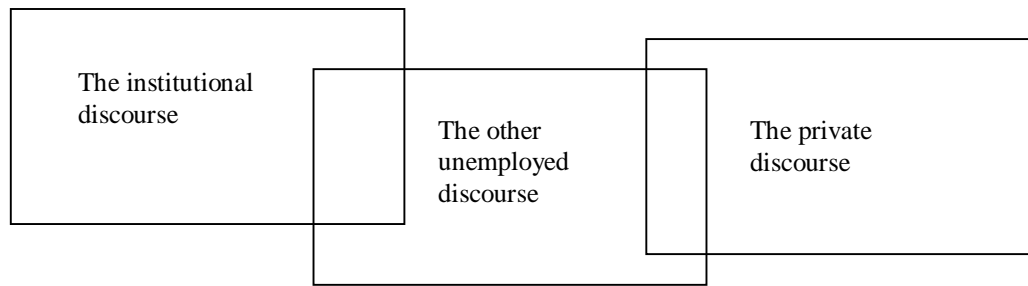


Figure 1. The discourse continuum

The institutional discourse and associated positions

The client and the institutional discourse

In drawing on the institutional discourse the clients constructed CHC as part of the system that society has developed to take care of the health of its citizens. This discourse embodies the guidelines that optimally benefit the average population. It specifies healthy and unhealthy modes of conduct, appropriate and inappropriate ways of behaving and offers up particular ways of acting and relating to the self. Although the focus is on individuals' ability, performance and activity, the interviewees tend to use depersonalising and abstract formulations and rarely use the first person singular pronoun.

This discourse adopts a broad societal perspective to promote the health of the unemployed. It carries a mandate to activate unemployed people by making them feel responsible for their health and simultaneously boost their employability. The questions concern institutional priorities and the clients' knowledge of these and their attitude towards them. In broad terms, health has become an issue of individual responsibility (Crawford 2006, Rose 2001). This is in line with today's general agenda, which asks unemployed people to improve their health and employability. Thus, the logic is in accord with the general activation ideology that pervades employment policy (for example, Lahausen 2009, Taylor-Gooby 2008, Vallgård and Lehto 2009).

In their accounts the interviewees predominantly drew from the institutional discourse, focusing on aspects of health promotion, health risks and preventive benefits, although the frame of the interviews was set quite freely.

Extract 1

Interviewer: What do you think about this [CHC] as a whole (.)? What impact does it have on your health or well-being? Or (.) if you think about it in general, well, getting a job or other things (...) in general?

Interviewee: (...) well, I've started to think about myself a bit more (.) my health and I've started to take care of my health on my own. (.) You don't always watch, when you're shopping, what you're buying (.) and I cook and check salts and fats and everything. And then (.) I have also noticed that exercise is really important. Without that (.) you're totally stuck, you can't move at all. Well (.) it has brought me a lot of positive things. I've been able to think for myself about my health and health services. (Woman, age 56)

Although apparently personal and self-evaluative, implicit in this extract is the client's willingness to demonstrate her awareness of the institutional discourse and to attach it to her motivations and values. On the other hand, there are also moments in which she seems to negotiate between her own health behaviour and the pressure of the discourse. The switches from 'I' to 'you' demonstrate the change in her health practices as a subsequence of routine 'bad' health practices that are generalised. This kind of discursive work represents an example of the institutional discourse being employed to construct the interviewee as a credible person and, consequently, a competent member of society.

In the following section, we describe two positions which occur within this discourse: one is described as a first order position and the other a second order position.

The first-order position: the docile citizen

Within this discourse the interviewees adopt the first-order position that we have dubbed 'the docile citizen' (Figure 2). Docile citizens know what is expected of them from the point of view of overall health policy and from the medical regime. In taking up this position the clients show that they are morally competent members of society who are looking after their health. Thus, taking care of one's personal health is considered a desirable social practice rather than something that is in one's own interest.

Extract 2

Interviewer: Well, could you tell what made you to participate in it [CHC]?

Interviewee: Actually, I probably took part because I couldn't recall when I'd last been for a health check. I thought that it would be a good thing to do (...) and I really wanted to know what would be said.

Interviewer: Yeah, well did you benefit from these three visits?

Interviewee: (...) I did get from both visits a kind of good feeling, that I know I am in the sort condition I thought I was in. (...) Although, in a way I can know myself that I am healthy, but well, if a professional tells you that, it is better still ... for me. (Man, age 36)

In Extract 2 the client presents an interpretation of CHC that affirms the institutional discourse. In utilising opportunities to check his own health regularly, he expresses compliance with the institution and justifies his status as a docile citizen. During the course of the interview this client mentions that he is actively taking an interest in fitness in order to maintain his healthy condition. Nevertheless, he wishes to have his health confirmed by a professional authority. Within the institutional discourse, our interpretation of the reason for participation is willingness to conform the system, and here is the source of 'good feeling'. The position of the client is presented merely as a recipient of health information: whilst the interviewee may actually be seen as an active agent here (he has decided to have his health checked), the point is that he constructs himself as a medical object rather than a social subject. At the end of the extract the client admits that he already knew the result of the health check-up; in fact, this standpoint legitimates the importance of professional knowledge.

However, there are multiple ways to construct oneself as a docile citizen. The clients did not approach CHC solely as a health service but also as a scientific project in which the participant has a duty to offer a contribution to the common good. In Extract 3 the client demonstrates this aspect of the position.

Extract 3

Interviewer: ... so what made you join this kind of experiment?

Interviewee: Don't know. Maybe some kind of curiosity or maybe I kinda thought that if

somebody wants to research something, it's OK. It's impossible to do research if there's no material." (Woman, age 45)

This position gives CHC the right to gather health-related information on its clients. More generally, a characteristic of a docile citizen is to respond to research initiatives. Thus, what is an obligation for the client becomes a right for CHC.

When choosing this position, the CHC client expresses a degree of liability as regards social definitions and modes of conduct. However, the clients walk a fine line regarding how their behaviour is viewed; that is, in addition to avoiding being labelled as unmotivated clients they have to find a balance between excessive compliance and agency. This position may also incur a moral dilemma. It may be enabling in some respect, but may also narrow the ways in which unemployed people relate themselves to others. They inadvertently create a moral hierarchy in which there are good citizens and those who fail to act adequately. In asserting their survivor attitude, they actually define others as incapable and indolent. These 'others' can even be seen as a threat to the responsible unemployed. Thus, to take a docile position may unwittingly lead to stigmatisation (also Holmqvist 2009).

The second-order position: the rebel

Like the docile citizens, the rebels accept that CHC is in the interests of society but they signal non-compliance and non-obedience in the institutional context. Thus, within the institutional discourse it is possible to take a position as a client who does not assume the aspects of a docile citizen.

As rebels, clients do not take institutional duties and obligations for granted. Instead, they adopt a reflexive and critical position in relation to them. They suspect the effectiveness of intervention and present ethical concerns about providing special health services for unemployed people. Rather than adopting an affirmative interpretation of CHC the rebels distrust everything that comes from above although their sceptical questions are rarely made explicit. Nevertheless, the role of public institutions in controlling individuals was mentioned. They were irritated by the fact that some are interested in having their health checked. In taking this position, the clients oppose a culture of being responsible for maintaining one's own health, and resist being controlled – an attitude demonstrated in Extract 4.

Extract 4

Interviewer: So could you first tell me about the process of how you came to join this project?

Interviewee: ... they gave me the papers and said that this is now the kind of thing that you must take part in.

Interviewer: Must take part?

Interviewee: Yeah.

Interviewer: So you thought that you had to do it then?

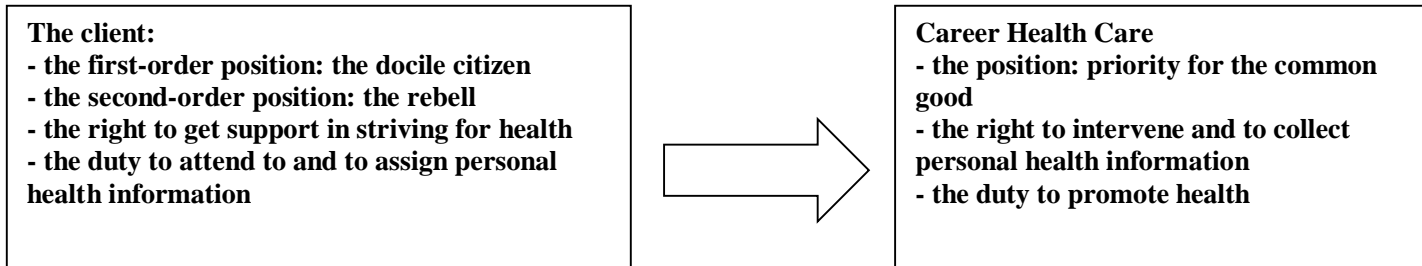
Interviewee: Well, it's usually like that. What the state says, it has to be done, so ... Like donating blood in the army is voluntary. (Man, age 52)

When the interviewer asks the client how he came to take part in CHC he responds that it was obligatory and makes a reference to military service. In taking an ironic tone about not having a choice, the client places himself in opposition to the obligations imposed by the medical regime. While the docile client argues that there are no choices, the rebel sees that there may be choices, but ultimately not in the specific case of CHC. By adopting a rebel position, the client submits to the legitimacy of health policy but simultaneously reflects critically upon it. This position indicates that the CHC unit has not succeeded in clarifying its focus and relevance to the new clientele. The client's complaint that 'you must take part' can be read as indicating shortcomings both in voluntary nature of the project and in its benefits.

This position invokes the issue of heresy, coupled with an overarching request for citizens to take care of their own health. Opposing accounts do not necessarily challenge regulatory systems, but they do confirm that authoritative knowledge is rarely able to exert totalising control, and that clients always have some leeway as to how they respond to a given situation. CHC is portrayed here as giving higher priority to the interests of society than to those of the individual. Whereas the docile citizen position maintains compliance, here the client impugns the motives of CHC. The rebel position challenges the traditional institutional discourse and represents the client more as an active subject.

The institutional discourse and associated positions are summarised and demonstrated in Figure 2. Both client positions define CHC as a place where priority is given to

the common good. CHC is based on the right to intervene and to collect health information, and on the duty to promote health.



Discourse: institutional

Storyline: health policy

Figure 2. Client positions and consequent position of the Career Health Care according to the institutional discourse.

The other unemployed discourse and associated positions

The client and the other unemployed discourse

This discourse and storyline are based on the assumption that despite variations in interests and opinions unemployed people share a social and cultural reality with similar values. The other unemployed discourse commits itself to the stereotype of unemployed people as a homogeneous group. Unemployment is thus reified as a set of disadvantageous experiences. By using expressions such as 'decline', 'go to pieces' and 'one worry less' when talking about 'those unemployed people' this discourse emphasises what happens when you become unemployed. The consequences of unemployment are presented as something unavoidable that occurs by virtue of being a member of this group; in fact, very few resources are allowed for autonomous action. Moreover, the other unemployed discourse can be used to express interpersonal relationships, such as empathy and other kinds of interaction with peers. These features are illustrated in Extract 5.

Extract 5

Interviewer: (...) So, our focus is on how this kind of system and how the service works, particularly when someone has an uncertain career (...) We are interested in people's experiences.

Interviewee: Well, I don't know. But I do believe that this has given something to some people. ... I do believe, that it's anyway a good thing, I mean health and work, they go hand in hand, so it is good to follow one's own health all the time, and normally, when you are unemployed you don't follow your health much. So, especially if you've been unemployed for a long time, you decline in a way, so your own health is not the first thing you think about. And a lot of people, like many unemployed friends, have gone to pieces. Like good men have become ... become something like that.
(Man, age 27)

The first-order position: the socially responsible citizen

By occupying this position the clients fulfill the duty of responding to the request to help the reference group, the other unemployed. They engage morally with this responsibility, projecting a socially responsible and altruistic image. This position corresponds to the group engagement models (Tyler and Blader 2003) which suggest that individuals whose self-concept is integrated with the reference group are inherently concerned for their group's welfare and are likely to behave on behalf of their group's interests. The socially responsible position brings with it the right to emphasise the needs of others (Extracts 6 and 7) and, in addition, it offers the opportunity to underline one's own resilience.

Extract 6

Interviewer: (...) How did the people in your training course get along with this? What was the attitude towards this in general?

Interviewee: Well, there is some sense in this, at least a little, in a way, if there are benefits for somebody, from what we've done." (Man, age 49)

Extract 7

Interviewer: (...) What do you think in general (...)? Could this kind of health service (...) have any significance?

Interviewee: You mean, in creating a new system?

Interviewer: Yeah, I mean we should supplement the old one in some way, so that the person who becomes unemployed does not lose, along with the job, access to occupational health service.

Interviewee: For many people, although I don't worship money, but there will be economical difficulties, if one works on short term contracts without any feeling of perseverance, of building up one's life ... So in my opinion, if you think about young people and life as such, well it isn't like the world I was born into, there was always plenty of work. Yes, I really feel sorry. They deserve all possible support – also from this project. This is what I felt right away. Then there would be one worry less... In my opinion it [health care of unemployed people] would support people a great deal. (Woman, age 58)

In fulfilling the duty to help and sustain others the socially responsible clients are proclaiming themselves as survivors. In addition, this position grants others the right to seek health intervention. The socially responsible position is a move up from the passivity of the docile citizen position, but it is still within the limits of the health regime. In this respect, it includes some elements of docility, although it allows more space for autonomous action. On the other hand, it suggests a certain compatibility between the docile citizen and the independent actor (to be presented subsequently).

The second-order position: the distinctive individual

In the distinctive individual position clients place themselves in opposition to the image which categorises all unemployed people as a uniform type characterised by passivity and disadvantage. In this position clients separate themselves to some extent from their co-unemployed. However, in emphasising the difference they happen to define themselves as a member of the group. In fact, by doing so, they underline the stigma of unemployed people. Although the other unemployed are present in these clients' accounts of their own lives, they clearly disclaim the identity of an unemployed person, playing down the impact that unemployment has on them. As a result, they are challenging and disclaiming in their own case the need for health intervention.

Extract 8

Interviewer: Okay. What do you think of this health project which we contacted you about, tell me what you think of this kind of activity?

Interviewee: ... it's good, and for a person who needs something ... like more of these services, it's even better, but I haven't had anything, no need. (Woman, age 45)

Extract 9

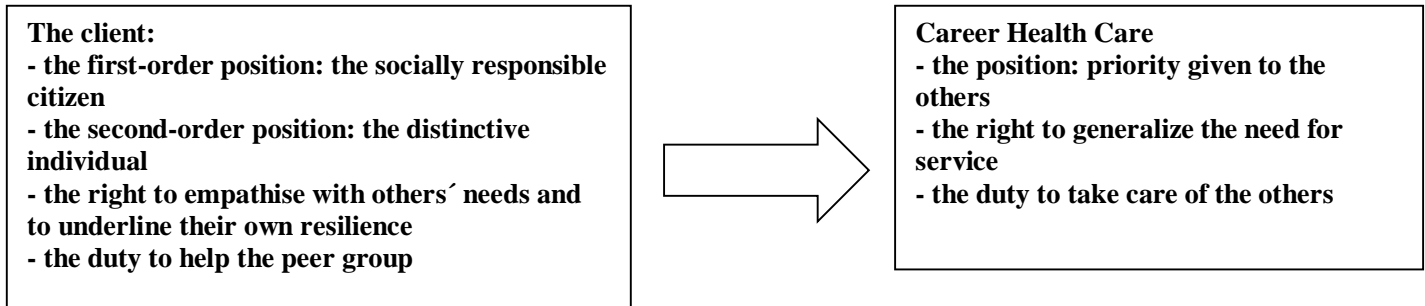
Interviewer: What do you think (.) what kinds of expectations did you have? Or concerning the health check-ups, did you hope that special attention would have been paid to something?

Interviewee: ... I was thinking that I'd check this out because I promised. Maybe this will help people. I didn't feel like it was giving anything to me. (...) but I was thinking that I'm helping now. (Man, age 49)

In the extracts 8 and 9 the interviewees present two more or less separate aspects concerning the need of CHC; they empathise its usefulness for the others, however, at the same time they underline their own resilience from the average crowd of unemployed. By these separations these clients simultaneously draw on negative images regarding those who are unable to cope with unemployment and maintain a healthy lifestyle, trying to reinforce how well they were getting on. The distinctive position is linked with a fear of becoming merged with the disadvantaged by participating in CHC; in other words, these people are concerned that group membership may have unwanted consequences. The situation conforms to social identity theory which argues that the experience of stereotyping and prejudice within a group may lead a member of that group to maintain a psychological distance between their identity and group membership (Tyler and Blader 2003). The distinctive individuals avoid expressing direct comparisons, emphasising instead their unlikeness and their own ability and luck. Moreover, they count themselves among the majority and are thus able to define unemployed people as others (see also Furåker and Blomsterberg 2003).

The other unemployed discourse and associated positions are summarised and demonstrated in Figure 3. Both client positions define CHC as a place where priority is given to

others. CHC is committed to the right to generalise the need for service, and to the duty of taking care of the others.



Discourse: the other unemployed

Storyline: uniform conditions

Figure 3. Client positions and consequent position of the Career Health Care according to the other unemployed discourse.

The private discourse and associated positions

The client and the private discourse

Compared to the institutional and the other unemployed discourses, the private discourse of CHC encounters consists predominantly of biographical talk and personal stories. This discourse is used to express aspects of self-perception and person-level interactions. 'Private' refers here to a variety of expressions that are actually not related to health care, institutions or to group level identities. The discourse relates to clients' personal experiences and background without reference to the institutional agenda. Private discourse concerns individual aims and describes personal motivations and values with concrete examples that may include evaluations, opinions or affective talk. Consequently, this discourse deals with the topic of how the client can benefit from the health service in person.

Extract 10

Interviewer: Could you tell me a bit about the experience of how you were when you went for

that health check?

Interviewee: I was just fine, that I (.) well, there were tiny things which I hadn't complained about to anyone [laughing] so it's good that there's someone (.) you can tell (...)

Interviewer: Can you say what made you to go for it? I mean, it requires you to enroll for it and go there.

Interviewee: Well, just the fact that I've spoken to someone ... because I'm the kind of person who needs to discuss everything with others, then I understand it better even myself. Just like that (.) Like that (.) so I can speak to someone [laughing]."

(Woman, age 38)

In Extract 10 the client emphasises that the discussion with the health professional as such was the essence of the intervention. In this discourse CHC was constructed as a forum for psychological concerns.

The storyline of this discourse highlights individuality; the clients suggest health as an issue that has to do with the self rather than the institution. They see that psychological qualities such as personality, capability and attitude are significant determinants of their own health and of coping with unemployment.

The first-order position: the independent actor

Independent actors appear as rational decision makers who desire control over health and their lives in general. Underlining the significance of the personal, independent actors maintain an individual attitude; they are concerned about what they are capable of achieving, and stress their own competencies, choices and responsibilities. This contrasts with the docile citizen position which, as a rule, attaches to organisational motives and values. By occupying an independent actor position, the client gives priority to the individually driven motives and contests the agenda of the institution, and even questions its legitimacy.

Extract 11

Interviewer: Would you tell me a little about what kind of experience it was, when you went for your health check-up?

(...)

Interviewee: I was worried about my weight [laughs] then I got support (.) but about the weight thing there should be more like that. I can't handle it if there isn't somebody [supervising] a bit (.) more closely...

Interviewer: So did you get any help with the weight loss? Do you feel like you gained something from the visit?

Interviewee: Well, I didn't. It has to start in your own head. (Woman, age 38)

Here the client seeks to include health professionals as co-constructors of knowledge rather than experts who possess the knowledge within the frame of an institutional discourse. Being overweight is presented as the client's personal and intentional concern rather than a concern for the institution only. The client not only defines the agenda, she also introduces the topic of personal interest that was not raised by the CHC nurse. In doing this, the client gives priority to her personal concerns, constructing herself as a consumer who needs to control her weight. The private discourse creates space for a personal sense of her condition, which may even open up alternatives that are not predicted by the medical regime.

The second-order position: the calculating client

For the subject, the use of the calculative position implies to a degree an egoistic mode of conduct. This position renders the client more critical than is the case with the independent actor. The institutional surveillance and associated compliance are assessed purely on the basis of whether they deliver personal benefits: is the health service to the user's advantage or not? While the independent actor position, as described above, constructs objective personal benefits related to health and well-being, the calculative position articulates personalised risks and benefits. The calculations regarding, for example, the timing, the reliability and the trustworthiness of the service emerge from experiences of participation in CHC. In the calculative position the clients do not dismiss the significance of CHC: there may be those who find ways to make use of it but, for them, the benefit is almost nil. They have chosen a standpoint where health issues are seen as a means of exchange on the health service market. Consequently, the calculative position resists institution-driven standardisation of health and advocates an individualistic concept of health.

Extracts 12 and 13 show how the position ephemerally shifts from that of the independent actor position to the calculative position.

Extract 12.

Interviewer: Okay, well, what do you think about this, this thing that has been offered [CHC]?

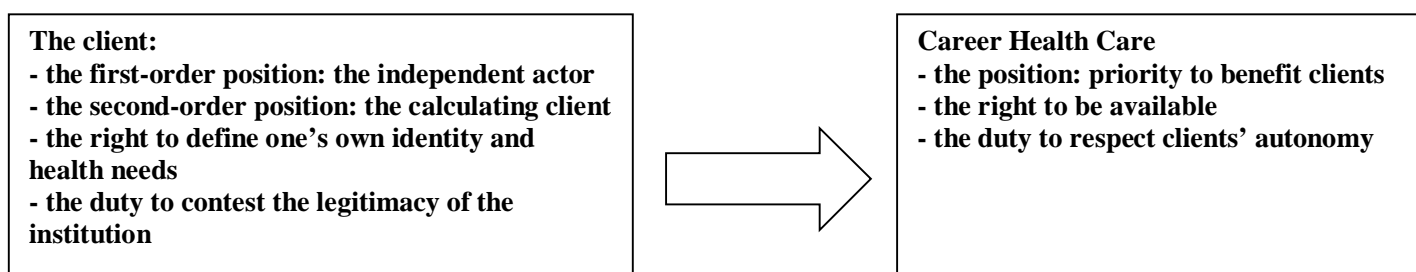
Interviewee: Well I don't know, it wasn't any kind of burden, so well, it has been always in the school time. (..) but I can't see any money value in it. (Man, age 52)

Extract 13.

Interviewer: (...) you know, people usually have some reason to participate, because all this is totally voluntary as you see.

Interviewee: It didn't bother me like that ... But just this morning I was cursing myself that I'd promised to come here, that you called, you called when I'd just woken up and then I was a bit confused. So I was cursing, saying that you're the last one, you're going to have to do the interview without me! (Man, age 49)

The institutional discourse and associated positions are summarised and demonstrated in Figure 4. Both client positions define CHC as a place where priority is given to client benefit. CHC is bound to the duty to be available, and to respect the client's autonomy.



Discourse: private

Storyline: individualism

Figure 4. Client positions and consequent position of the Career Health Care according to the private discourse.

Discussion

As a rule, research has been more interested in identifying reasons why people do not participate in health interventions than in trying to understand the reasons why they do. In this study of an experiment with CHC we have revealed the multiple mechanisms that individuals use when encountering the services. Employing Harré and van Langenhove (1999) and Harre et al's (2009) positioning theory we describe three first-order positions (the docile citizen, the socially responsible citizen and the independent actor) corresponding to three second-order positions (the rebel, the distinctive individual, and the calculating client). These six positions and associated discourses display the different sets of rights and duties of the client. Simultaneously, they define the positions of the CHC service, as described in Figures 1 to 4.

Our analysis describes how unemployed people take manifold positions, and consequently their relationship with health interventions assumes different facets. While organising CHC we caused a shift in the services available to them, and they had to decode and reconstruct the situation and resolve potential conflicts in a fluent, coherent and consistent way. In short, as subjects at the receiving end of a health policy initiative, the participants were also involved in an interpretative process that constructed various positions.

The organisational context of a health service tends to rationalise its clients as a certain homogenous group. However, it is evident that unemployed people, like health care consumers in general, actively position themselves and one another over the course of the clinical encounter. Furthermore, this positioning has an impact on the way clients construct the health service and consequently on assumptions about appropriate health promotion.

Our analysis illustrates how unemployed people were called into a continuing dialogue through the project. Building on Halford and Leonard's (2006: 20) notion that employees are increasingly expected to 'identify and conceive of their interests in terms of the organisations' words and images', our analysis argues that clients shift between the personal and the institutional, and synthesise the public and the private domains in their discourses. This is crucial for their success in identifying themselves as individuals aware of corresponding cultural categories. These categories imply that the focus is not actually on the individual but on a norm-like unemployed person. In fact, interviewing people within the context of 'a health care service for unemployed clients' also invited such talk.

The result highlights the variation in the ways people respond to institutional contexts. Unemployed people do not always act accord the general norms. While fluctuating between the first-order and second-order positions of unemployment and CHC they both support and challenge the knowledge that underpins the practices of medical and health care institutions. Health promotion may also be less likely to shape behaviour among clients who do not share the organisation's values or who do not belong to a group with a set of shared values (Blader and Tyler 2009).

Overall, CHC cannot avoid questions about the medicalisation of unemployment. Holmqvist (2009) argues that the individualisation of a social position, such as unemployment, into a personal problem has profound implications for policy. If individuals are labeled as disabled as a result of unemployment, there is a risk that they will be placed in welfare programmes that are neither helpful nor cost-effective, and may even reduce employability. Health interventions for unemployed people may also blur the importance of the social and economic opportunities that underlie unemployment. (Conrad 2007, Holmqvist 2009.) We are not saying that it is not useful to try to reduce the destructive effect of unemployment with help at an individual level (see, for example, Cole 2008, 2007). The challenge is to develop and implement demedicalising health programmes and services, free of stigma and labelling. Moreover, the diversity of the unemployed clients challenges conceptions of universal models of health promotion and intervention among unemployed people. There is a need for studies that examine not only the individual level, but also the structural level to better understand the culturally complex realities faced by unemployed people.

Policy reconstruction: can a specific health service like CHC promote health among unemployed?

So far we have two conclusions. Firstly, we have shown that a health service encounter for unemployed people is a dynamic and fluctuating process, far from a simple, normative service for a homogenous group. Clients' individual positionings are neither univocal nor unitary. Alignment is not always a sign of congruity between the interests of unemployed people and the interests of the health policy institutions. The findings provide insights both into the experience of unemployed people and into the question of organising health services for any particular group.

We were able to illustrate how a health service engaged with the ideology of equality (Häkkinen 2005) is integrated into the value framework of the clients. Regarding the distributive dilemma of who should benefit from the help and resources of society (Prottas 1978), our findings raise a crucial problem: the positions that CHC clients occupy clearly do not always present them as individuals in need of the services offered.

Secondly, we conclude that the social construction of CHC is related to the construction of positions. The significance of clients' own views is revealed in terms of positioning theory: that is, it is possible to recognise more precisely the scope and content of both rights and duties. What kind of position is constructed or offered to the client depends on the settings of the encounter. It is important to note that such encounters may be uncomfortable for clients. This situation can be handled by repositioning. The design of the present study does not allow us to conclude how this repositioning could be accomplished. What we do know is that the perspective of unemployed people as social actors must be taken into account, when various actions are taken on a social level. One obvious direction is to abandon the reductionist view of unemployed people as victims; which may lead to a more satisfactory balance between enhancing personal resources and providing social resources. Thus, implementation strategies including individual as well as social dimensions require changes in institutions which come into contact with unemployed people. (Kieselbach 2003.)

Harré's theory of positioning provided us with a lens through which to view more closely what is happening behind health service interventions. What is essential are the ways in which the position of the client sits within the positioning structure. It is reasonable to argue that successful models of intervention allow the clients to become part of the discourse community. Ideally these discourse communities are dialogic, inviting all participants to engage by allowing questions, diversity and new ideas. This requires mutual respect, trust and concern. Clients' actions in personal-institutional and private-public dimensions require from health professionals the ability to synthesise discourses in order to resolve potential tensions. Awareness of one's own contribution to the construction of the relationship within the health care encounter should be part of the reflexivity required in professional practices (Romppainen et al. 2010).

We have demonstrated in this study how the perspective of positioning theory can be used to define the meanings of a health service, not simply at individual and group levels but also at the structural level. This perspective offers a novel understanding of the human problems

and resources involved in intervention, which can in turn be helpful both in health-related research and in policy making. In the case of CHC, the tailored health intervention turned out to be heavily constrained, due to the differing contextual realities of the clients.

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Training for the unemployed: differential effects in white- and blue-collar workers with respect to mental well-being

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Antti Saloniemi

University of Tampere, Finland

Katri Romppainen

University of Tampere, Finland

Mattias Strandh

University of Umeå, Sweden

Pekka Virtanen

University of Tampere, Finland

Abstract

In this study we investigate the effects of active labour market policy measures on health and well-being and how these effects are connected with socioeconomic status. The data were collected among the participants ($n = 212$) in 24 conventional vocational training courses in Finland. According to the results, training was accompanied by improvements in health and well-being among participants with a higher socioeconomic status, whereas for blue-collar workers the changes were neutral or even detrimental. The results raise questions about the role of active labour market policy measures as a public service. There seems to be a risk that these types of measures maintain or even produce health differences between socioeconomic groups.

Keywords

active labour market policy, Finland, health inequality, interventions, mental health, unemployment, vocational training

Corresponding author:

Antti Saloniemi, University of Tampere, P.O. Box 181, FI-28101 Pori, Finland.

Email: antti.saloniemi@uta.fi

Introduction

Health in All Policies was adopted as the main health theme during Finland's EU Presidency in 2006 (Puska, 2007; Ståhl et al., 2006). The aim of the slogan was to address health determinants that are mainly controlled by policies of sectors other than health. It also referred to the common situation that decisions in these policy fields seldom take health impacts into consideration – not to speak of the lack of systematic health impact assessments. Moreover, pointing out societal determinants of health and disease was considered as a strong tool for reducing inequalities in health, which is a major concern in most European countries.

In the spirit of Health in All Policies, there is reason to dissect all public services with an eye for their potential contribution to the health of clients. The service analysed in the present study is the active labour market policy (ALMP) measures for the unemployed: do these measures have any impact on the health of the participants, and if so, is the impact equal in all socioeconomic strata?

Unemployment and policy responses

Since the mid-1970s, unemployment has been a major problem in Western societies. In contrast to previous, mostly cyclical unemployment, current unemployment is characterized by a structural mismatch between the qualities of the work force and the requirements of the employers. The major driver of this change has been the collapse of the old structures, based on manufacturing employment. Policy reactions to this post-industrial employment challenge have been threefold: market-based adjustment by labour market deregulation; reduction of the labour supply (incentives to leave the labour market for older workers, especially in declining industries, and for women); and active labour market policy (Bonoli, 2009). These policies may be seen to correspond, respectively, to the classification of welfare-state regimes into liberal, conservative and social-democratic (e.g. Eikemo and Bambra, 2008).

The welfare-state regimes also reflect different attitudes towards socioeconomic inequality with respect to income and to the opportunities for higher education (Sachweh and Olafsdottir, 2010). These are examples of areas where a certain degree of difference is seen as acceptable and beneficial even in universalistic societies. On the other hand, there are areas, typically health, where inequality is not considered as acceptable. More equal distribution of health is, however, difficult to attain. The socioeconomic health gradients seem to persist even in the societies that have assumed an equality-labelled social-democratic regime (Mackenbach, 2012). Nevertheless, the 'health in all policies' slogan should in fact be specified as 'socioeconomic equality of health in all policies'.

Returning to unemployment, there are two major explicit policy goals for ALMP: to reduce the number of the unemployed; and to limit the negative consequences of unemployment in terms of, for example, poverty, marginalization and fading social cohesion (Furåker, 2009). The key idea of ALMP is to expand employment by maximizing the chances of people finding a paid job and being (re)inserted into the labour market. That is to say, it highlights policies that improve people's capacity and resources to assume

control of their own lives, in particular enabling them to take part in economic activity and be self-sufficient.

In principle, there are good reasons to consider ALMP as a means to reduce social inequality and its consequences for well-being and health. Re-employment, spontaneous as well as by virtue of ALMP, evidently increases well-being and improves mental health (Paul and Moser, 2009). Evidence about corresponding improvement during ALMP is limited, although participation in the measure could affect well-being by fulfilling social and psychological needs. Assuming that there is improvement, ALMP measures meet the 'health in all policies' criteria in general and also reduces health inequalities between the employed and the unemployed.

Still, the problem of 'socioeconomic equality of health in all policies' is relevant. Is the overall effect of ALMP maintenance or even the reproduction of socioeconomic health differences among the unemployed? The question is becoming increasingly timely when a growing share of the unemployed come from white-collar occupations. This is not to suggest that the high risk of unemployment of wage earners in relation to salary earners is disappearing; rather it is the growth of the salariat which means that a considerable number of unemployed come from among them (Goldthorpe and McKnight, 2006).

Due to the fact that unemployment has extended to new occupational groups, the clientele of employment services has expanded, which means that the objectives of the measures have to change as well. Advanced and flexible combinations of ALMP and unemployment benefit systems are more often required and enforced. As a consequence of these changes, the question of socioeconomic differences and the possible inequality of the effects of ALMP has become more relevant. In fact, ALMP is facing the problem inherent in all universal public services: are they advancing equality, or are they becoming a platform where privileges and benefits accumulate for those with the most advantages, for example, in terms of education (see Auer et al., 2005)?

Socioeconomic stratification and the unemployed

To attempt to stratify the unemployed according to socioeconomic position one can look at the basic assumptions of the standard indicators, that is education, occupation and income. Regarding income, facing unemployment tends to reduce higher incomes relatively more than low, even if the benefits are usually more or less earnings related. Occupation is more or less related to the past job in the form of 'job-seeking occupation' recorded by employment officers. Education is also a key factor in the most commonly used class schemes (e.g. EGP; Erikson and Goldthorpe, 2002). As education is not lost with the job, it would be the most appropriate basis for socioeconomic stratification of the unemployed.

As the unemployed have become more heterogeneous, we have to take into account the fact that there are systematic class-based differences not only in the income level, but also in the degree of income security, in short-term income stability and in longer-term income prospects. These future-oriented aspects constitute an essential difference between wage-earners and the salariat (Goldthorpe, 2012). In the case of unemployment, at least the promise of security and short-term income stability collapses, regardless of the class. Still, individuals in different class positions could in fact be seen as living in quite different economic worlds, 'not just as regards their levels of material

welfare but, further, as regards the whole range of economic life-chances – of risks and opportunities – that they face’ (Goldthorpe and McKnight, 2006: 129). As a rule, education is an essential resource in the production and reproduction of the different places in the process of stratification.

The participants in ALMP measures are in an ambiguous situation. Unemployment means economic insecurity, the possible re-employment may take place in the old or in a new occupation, and re-education may change even the major socioeconomic status from white to blue-collar or – less commonly – vice versa. This ambiguity requires new standpoints for the analyses of the relationships between unemployment, public policy measures and health. There is no reason to suspect that the general rule that health problems tend to concentrate on the lower social strata (Lahelma, 2009) is true also among the participants in ALMP measures. Concerning the direction of the causation, those with poor health may be selected to measures that speed up downward social mobility, whereas the opposite, that is deterioration of health due to unemployment, may be slowed down by the measure. It is also relevant to ask whether the effects of ALMP are related to socioeconomic status, in particular as indicated by education.

ALMP interventions and their effectiveness

Overall, the objective of ALMP is to increase participants’ employability and to avert marginalization. Bonoli (2009) compresses the orientation of ALMP into three major areas: investing in human capital; removing obstacles to employment; and preventing the depletion of human capital.

Initially, the measures were framed in Sweden in the 1950s and the 1960s as a response to the fast-growing demand for a more highly and differently skilled labour force. Persistent high unemployment since the 1970s has shifted the focus of ALMP towards measures that explicitly treated unemployment (Bonoli, 2010).

According to Bonoli (2010: 446), the key idea of current ALMP is to provide ‘occupation, which does not really aim to put jobless people back into the labour market but is designed to keep them busy and slow the deterioration of human capital associated with unemployment’. Since the mid-1990s, ALMP has been more aimed at activation and re-employment into the labour market. The idea of this third phase was to combine incentives and compulsions for social assistance recipients to move from welfare dependency into employment (Bonoli, 2009).

The effectiveness of this has been questioned regularly. Still, a recent meta-analysis came to the conclusion that there seems to be at least a modest positive connection between participation in ALMP measures and re-employment. Consistent with earlier summaries, the analysis found subsidized public-sector employment relatively ineffective, whereas job-search assistance and related programmes generally have favourable impacts (Card et al., 2011).

Well-being as a side effect of ALMP measures

The vast majority of the research literature concerning the effects of ALMP has been focused on re-employment or earnings. The scope of the goals of ALMP nevertheless

cannot be reduced to these topics only (e.g. Audhoe et al., 2010; Wulfgramm, 2011). For instance, Furåker (2009: 33) calls for more studies on 'the wider social and psychological consequence' of ALMP measures, assuming that participating in a programme 'is perhaps better' in terms of well-being than just receiving cash benefits. In other words, ALMP should prevent marginalization and exclusion through the 'indirect employment effects' (IEE) (Andersen, 2009). This shifts into the focus the effects on participants' mental health, well-being, self-esteem and attitudes to work, for example.

The IEE concept expresses reliance on the logic of removing obstacles to employment. The link between poor mental health and unemployment is well documented (Paul and Moser, 2009), as well as the positive correlation between subjective well-being and the probability of re-employment (Andersen, 2008). Previous research has indicated that participation in many forms of activity, from leisure pursuits to voluntary work (Fryer, 1986; Muller et al., 1996), is better for the mental health of the unemployed than no activity at all. Reasons for the effects have often been sought in deprivation theory (Jahoda, 1982) which assumes that, in addition to the manifest material earnings, work contributes to psychosocial well-being through five 'latent functions', or 'unintended by-products' (Jahoda, 1981: 188): time structure; social contacts; collective purpose; social identity/status; and activity. Job loss leads to deprivation of the manifest as well as the latent functions, but it is primarily the deprivation of the latent functions that causes distress. In addition, Fryer (1992) identifies two central restrictions on agency in the unemployment situation: limitations on the future and on the ability to plan ahead or even anticipate what the future might be; and the limitations derived from poverty.

An ALMP measure can be assumed to compensate for the latent functions, as the participants continue to receive the same daily allowance as during preceding unemployment. Similarly, participation could counteract the restrictions on agency by providing new skills as well as steering the unemployed towards occupations and branches of industry where opportunities exist. This should increase competitiveness, sense of control and confidence for the future (Hallsten et al., 1999; Strandh, 2001). Altogether, these characteristics of ALMP participation suggest positive effects also on mental health (Creed et al., 2001; Strandh, 2001).

The number of longitudinal studies on IEE is minor in comparison to studies on direct employment effects, but the overall results are not fundamentally different. For their systematic analysis Audhoe et al. (2010) found 29 potentially relevant publications, but only five of them could be accepted as part of the final phase of the analysis. As a conclusion, the authors found only weak evidence to support the use of vocational interventions to reduce mental distress for the unemployed. In three of the accepted studies, the intervention consisted of improvement of general working-life skills and work-seeking techniques, and in two studies traditional vocational training was combined with that type of activity. A significant decrease in psychological distress was found in two studies (Vinokur et al., 1995; Vuori et al., 2002). The effects on re-employment were also scarce (only in the study by Vinokur et al., 1995).

Still, there are studies based on large-scale register and survey data (Andersen, 2008; Korpi, 1997) that have found improvement in subjective well-being among participants in ALMP measures consisting of vocational training. In addition, there have been studies carried out among participants in particular courses that have reported decreased

psychological distress (Vuori and Vesalainen, 1999) and improved sense of coherence (Vastamäki et al., 2009) and self-esteem (Creed et al., 2001). The permanency of the improvements is, however, not self-evident (Creed et al., 1998, 2001; Vuori and Vesalainen, 1999).

However, less optimistic findings with regard to IEE have been obtained. Strandh (2001) investigated IEE in the contexts of vocational training, activation and workplace participation. Only the last turned out to have clearly positive effects. Breidahl and Clement's (2010) study explicitly focused on the possibilities of IEE as a tool against marginalization. Comparison of participants and non-participants after the studied ALMP training programmes did not reveal significant differences in the intensity of social networks, in feelings of stigmatization, or in self-esteem. According to Reine et al. (2011), participation in ALMP measures had no effects on mental health.

Who benefits?

The question of how socioeconomic status, for instance, is connected to the chances of utilizing ALMP services is seldom discussed. However, according to Nordlund's (2011) study, 'the lucky ones' in the ALMP system are most often participants with a higher level of education; the measures seem to offer them a springboard towards further educational investment. The outcomes depicting the situation in Finland in the 1990s are parallel (Tuomala, 2002). The results give reason to further investigate the stratification logic within ALMP. Instead of protecting and supporting the most vulnerable groups in the labour market, ALMP seems to lead to a situation where the participants with better resources are provided with an edge over the others in the labour market.

Reports directly concerning the distribution of IEE according to participants' background are few and their findings are contradictory. The study by Machin and Creed (2003) of an ALMP measure among the young unemployed revealed that the participants who had the lowest general self-efficacy and the highest levels of psychological distress at the beginning benefited most from the measure. The results in a way paralleled a previous study that did not have a specific age definition (Creed et al., 2001), where participants with higher levels of self-esteem at the beginning declined over the period of training. That is to say, for participants with high self-esteem, ALMP measures may even be 'toxic'. A sort of detrimental effect was also uncovered by Malmberg-Heimonen and Vuori (2005) who find that the positive effects on mental health of a job-search training programme are impaired if the participation is enforced. Furthermore, enforced participation decreases re-employment among the long-term unemployed.

There are, in addition, theoretical considerations for anticipating a class-based split of benefits among the recipients of ALMP measures. Looking at the latent functions, there is research that shows the psychosocial need for employment varies substantially among the unemployed, and that this variation is of importance for understanding the differentiation in the effect of unemployment on mental health (Nordenmark and Strandh, 1999; Rantakeisu and Jönsson, 2003). Furthermore, we know that in a Nordic setting, there is a clear class structure in non-financial work orientation. White-collar workers, the salariat, have substantially higher levels of non-financial commitment to employment (Svallfors et al., 2001) than blue-collar workers. Together with previous findings that

unemployment has a greater impact on the mental health of white-collar workers (Andersen, 2009), the evidence suggests that the benefits of participation in ALMP would be most visible among them. The logic may be that white-collar workers have more to lose from unemployment – but perhaps more resources to utilize ALMP measures.

Aim of the study

The aim of the present study is to demonstrate the potential effects of ALMP (vocational training) with respect to the mental well-being of the participants.

Based on previous research and current policy level concerns, we assume that ALMP measures reproduce socioeconomic health inequalities; that is, we test the hypothesis that the benefits of the measures are more pronounced among better-educated white-collar professionals.

Setting and methods

ALMP in the Finnish context

Regarding the regime logic, Finland is classified as a representative of the Nordic model. Yet the position is somewhat unclear. As a latecomer the structures of the welfare state have always been weaker than in, for example, Sweden. Furthermore, in the contemporary situation, it is in many respects more market-driven than the clean-cut Nordic model (Ferragina and Seeleib-Kaiser, 2011). This situation is illustrated in the uses of ALMP. After the deep recession in the first half of the 1990s and during the long period of economic upswing, the share of ALMP spending in GDP has also risen in Finland but it still contrasts with the high ratios in Norway and Sweden. In rough terms, the Nordic countries represent societies where investments in ALMP exceed the OECD average, but in Finland the ALMP expenditures in 2003 were lower (0.91% of the GDP) than, for example, in Denmark (1.74%) or in Sweden (1.28%). However, a special feature in Finland is the relative weight of training measures compared to the other Nordic countries (Furåker, 2009).

In the first decade of the 21st century, the unemployment rate in Finland hovered between seven and nine per cent, which is higher than in the other Nordic countries. The need for ALMP measures has not disappeared, but rather changed as the clientele of employment services has become more heterogeneous, and the measures are evolving towards a more permanent policy instrument for managing the changes in the labour market (Auer et al., 2005).

Data and statistics

The sample of this study consisted of 342 unemployed individuals who were enrolled in various vocational training courses in 2002 and 2003. The target groups of all courses were ‘healthy’ unemployed, in other words, possible disability was not used as a criterion in selecting the participants. The participating courses were chosen purposefully in order

to obtain a roughly equal number of men and women, as well as to include in the study participants with a range of educational levels. The actual goal was, therefore, not to get a representative sample, but still the group turned out to represent the participants in such courses in general relatively well regarding gender, age and educational background (Aho and Koponen, 2007).

The researchers visited a lesson at the beginning of the course (T1) and informed the participants about the study. Those who consented filled out a questionnaire. Follow-up surveys took place during lessons at the end of each course (T2). A total of 212 of the 342 participants (62 per cent) replied in the follow-up survey. One course (security guards) collectively refused to participate in the follow-up survey; otherwise non-participation was mainly due to absence.

Following the normal practice, the courses were organized and recommended by employment authorities and participants were selected from among those who applied. The participation or refusal did not affect benefits. The objective was to train the unemployed in new occupations, taking into account their former education and expertise. The subjects of this study were recruited from 26 courses lasting from three to 24 months. Four courses (advanced courses in sales, marketing, IT and project management) aimed to improve and expand the expertise and qualifications of white-collar professionals, while the majority of the courses were offering vocational training in blue-collar occupations (e.g. sales, logistics, construction and electrical installation). These occupations were used as the basis for designating the courses as 'white-collar' and 'blue-collar'.

The former education of the participants was elicited in the T1 questionnaire and was classified as 'basic', 'upper secondary' and 'tertiary'. Information on gender, year of birth, marital status and pre-course unemployment spells were also collected as part of the questionnaire.

The well-being of the participants was studied with three different indicators of mental health at T1 and again at T2. Psycho-physiological stress was assessed with a list of 18 symptoms which were rated on a Likert scale from one (never or seldom) to four (often or all the time), and the replies were summed up in a Stress Symptom Score variable ranging from 18 to 72. Psychological distress was measured by the simple sum of the 12-item version of the General Health Questionnaire (Goldberg, 1972). The third outcome was sense of coherence. According to Antonovsky (1987), a high sense of coherence means good stress resistance resources, or the ability to stay healthy in spite of stressful life events, due to perceived manageability, comprehensibility and meaningfulness of the social environment. The 13-item version of the questionnaire was used to assess participants' sense of coherence.

Employability after completing the vocational training was elicited at T2 with a question about the probability of obtaining a job. The replies 'highly probable' and 'probable' were recoded as 'high', the reply 'can't say' as 'intermediate', and the replies 'improbable' and 'highly improbable' as 'low' employability.

Changes in the indicators of mental well-being from T1 to T2 were studied with analysis of variance for repeated measures for the whole cohort and for the sub-groups defined by former education and by the socioeconomic status of the subject occupation of the course. The analyses were univariate when changes in the whole cohort and in the

sub-groups were studied separately. Between-sub-group differences in the changes were assessed by the statistical significance of the interactions 'time*education' and 'time*socioeconomic status' from multivariate models that included gender, age, pre-course unemployment spells and employability.

Results

Descriptive data of the participants in T1 and T2 are presented in Table 1. Attrition of the original sample was more pronounced in men, among the less educated and in courses in blue-collar occupations, but did not depend on the length of the course (on average 35 weeks for participants and 37 weeks for dropouts).

The final cohort was somewhat female-dominated, around one in three had basic level and one in five tertiary level education, and the majority of the participants attended a blue-collar course. The unemployment spell preceding the course had lasted less than half a year for 44 per cent, and more than a year for 29 per cent of the participants. At the end of the courses (T2), almost half of the participants reported poor prospects of re-employment (in other words, assessed that their unemployment would probably continue when the course was over), and one in three reported high employability (Table 1).

Looking at the overall effects of ALMP participation on mental health (Table 2), we see that psychological distress remained almost unchanged, while stress symptoms tended to decrease and sense of coherence tended to improve towards the end of the course. All changes were, however, statistically non-significant.

This 'neutral' picture was changed when the analysis was broken down by level of former education and by social class within the subject occupation, as seen in Tables 3 and 4. At the beginning of the training (T1), the sub-groups with tertiary education and attending white-collar courses reported the highest psychological distress (p -values 0.01 and 0.06 respectively), while corresponding differences in stress symptoms and sense of coherence were statistically non-significant (Tables 3 and 4).

Among the sub-groups by education (Table 3), a significant decrease appeared in psychological distress of the tertiary-level educated and, correspondingly, the distress increased significantly in the basic-level educated. In all, the changes in psychological distress depended on level of education (p -value for interaction 0.017). The changes in stress symptoms were non-significant in all sub-groups. The sense of coherence improved significantly among the tertiary-level educated, but here the between-sub-group difference was non-significant. When employability was added to the models, the interaction on psychological distress remained significant whereas the p -value of the interaction on stress symptoms was increased above the level of significance.

We continued the analysis by splitting the data according to the subject occupation (Table 4). When analysed separately, the participants with prospective white-collar positions showed significant improvements in all indicators of mental well-being, whereas the well-being of blue-collar participants remained unchanged (Table 4). The between-sub-group difference turned out to be statistically significant for stress symptoms ($p = 0.027$) and psychological distress ($p = 0.019$) but not for sense of coherence.

Finally, in Table 5 we selected the participant group with tertiary-level former education and analysed their mental well-being according to the subject occupation of the

Table 1. Descriptive statistics of the participants in the beginning (T1) and in the end (T2) of the vocational training courses.

	T1 (n = 342)	T2 (n = 212)
Gender		
men	47%	39%
women	53%	61%
Mean age (years)	36	36
Level of former education		
tertiary level	22%	26%
upper secondary level	45%	46%
basic level	33%	28%
Socioeconomic status of subject occupation		
white-collar	11%	16%
blue-collar	89%	84%
Employability		
high		32%
intermediate		28%
low		40%
Duration of pre-course unemployment		
0–6 months		44%
7–12 months		27%
> 12 months		29%

Table 2. Mental well-being of the students (n = 212) in the beginning (T1) and in the end (T2) of the vocational training courses.

	T1	T2	Change from T1 to T2 (I)
Stress symptom score	27.5	26.9	$p = 0.090$
Psychological distress	22.8	23.0	$p = 0.698$
Sense of coherence	65.0	65.9	$p = 0.157$

Note: (I) Analysis of variance for repeated measures.

course. Such participants were particularly common in female-dominated courses that prepared people for office and retail occupations. The 33 participants were distributed across 10 courses lasting from five and a half to 13 months. It appeared that highly educated participants benefited, at least in terms of decreasing psychological distress and improved sense of coherence, from training in a new occupation even in the cases where this represented downward social mobility.

Discussion and conclusions

This study investigated the effects of active labour market policy measures with a focus on mental well-being outcomes, or to be more precise we analysed the effects of

Table 3. Mental well-being in the beginning (T1) and in the end (T2) of the vocational training courses in sub-groups defined by the level of former education of the participants (tertiary level, n = 55; upper secondary level, n = 98; basic level, n = 59).

	T1	T2	Change from T1 to T2 (1)	Time*sub-group interaction	
				Model 1 (2)	Model 2 (3)
Stress symptom score				<i>p</i> = 0.331	<i>p</i> = 0.361
tertiary level education	27.3	26.4	<i>p</i> = 0.125		
upper secondary level education	28.5	27.5	<i>p</i> = 0.065		
basic level education	25.9	26.5	<i>p</i> = 0.372		
Difference by education	<i>p</i> = 0.074				
Psychological distress				<i>p</i> = 0.056	<i>p</i> = 0.017
tertiary level education	23.9	22.2	0.014		
upper secondary level education	23.3	23.5	0.763		
basic level education	21.2	23.0	0.014		
Difference by education	<i>p</i> = 0.010				
Sense of coherence				<i>p</i> = 0.802	<i>p</i> = 0.432
tertiary level education	65.5	67.9	0.019		
upper secondary level education	64.7	64.7	0.983		
basic level education	65.4	66.2	0.531		
Difference by education	<i>p</i> = 0.605				

Notes: (1) Analysis of variance for repeated measures, unadjusted. (2) Analysis of variance for repeated measures, adjusted for gender and age and pre-course unemployment. (3) Analysis of variance for repeated measures, adjusted as (2) and change in marital status and employability at T2.

vocational training courses on psychological distress, sense of coherence and stress symptoms. We combined participants from 26 courses and found, on average, this kind of ALMP measure to be ‘mental health neutral’, but we obtained support for the hypothesis of the importance of social strata. The effects are more positive among longer educated white-collar professionals than among less educated blue-collar ones. In the frame of indirect employment effects, the finding indicates that the studied public policy intervention has no capability to reduce the social-class-based health inequalities.

When the participant group was studied as a whole, our conclusions are partly in line with earlier studies of Strandh (2001), Breidahl and Clement (2010) and Reine et al. (2011). That is to say, we did not find health effects. On the other hand, the studies of Vastamäki et al. (2009) and Creed et al. (2001) have obtained more optimistic results. The differences probably reflect differences in the settings and samples of the studies.

However, when our analyses were carried out separately by socioeconomic categories among the participants, significant variation in the development of mental health was shown. For the white-collar participants, the training was largely accompanied by improvements, whereas for the blue-collar participants, the change, if any, tended to be negative.

Table 4. Participants' mental well-being in the beginning (T1) and in the end (T2) of the vocational training courses in two sub-groups defined by the social class of the subject occupation (white-collar occupation, $n = 34$; blue-collar occupation, $n = 178$).

	T1	T2	Change from T1 to T2 (1)	Time*sub-group interaction	
				Model 1 (2)	Model 2 (3)
Stress symptom score				$p = 0.162$	$p = 0.027$
white-collar occupation	28.2	26.1	$p = 0.008$		
blue-collar occupation	27.3	27.0	$p = 0.438$		
Difference by social class	$p = 0.635$				
Psychological distress				$p = 0.015$	$p = 0.019$
white-collar occupation	25.3	22.5	$p = 0.007$		
blue-collar occupation	22.2	23.1	$p = 0.141$		
Difference by social class	$p = 0.06$				
Sense of coherence				$p = 0.396$	$p = 0.490$
white-collar occupation	64.1	67.4	$p = 0.027$		
blue-collar occupation	65.2	65.7	$p = 0.516$		
Difference by social class	$p = 0.837$				

Notes: (1) Analysis of variance for repeated measures. (2) Analysis of variance for repeated measures, adjusted for gender, age and pre-course unemployment. (3) Analysis of variance for repeated measures, adjusted as (2) and change in marital status and employability at T2.

Table 5. Mental well-being of the students with former tertiary education in the beginning (T1) and in the end (T2) of the vocational training courses by social class of the subject occupation of the course (white-collar course, $n = 22$; blue-collar course, $n = 33$).

	T1	T2	Change from T1 to T2 (1)
Stress symptom score			
white-collar occupation	28.5	27.1	$p = 0.115$
blue-collar occupation	26.5	26.0	$p = 0.486$
Psychological distress			
white-collar occupation	25.9	23.1	$p = 0.044$
blue-collar occupation	22.4	21.5	$p = 0.164$
Sense of coherence			
white-collar occupation	63.0	65.6	$p = 0.138$
blue-collar occupation	67.4	69.7	$p = 0.076$

Note: (1) Analysis of variance for repeated measures.

We stratified the participants by the level of former education and by the subject occupation of the course. In both cases, trends in mental health were parallel. The findings provide stronger support for our hypothesis about greater improvements of well-being among members of upper social classes. They are also in line with earlier research

(Auer et al., 2005; Nordlund, 2011) indicating that participants with the best resources benefit more from the measures. The persistence of strata differences during unemployment and also during ALMP measures is in fact in line with statements stressing the multidimensional nature of the strata differences and health inequalities (Goldthorpe, 2010): the salariat has a lower risk of unemployment, although job loss is perhaps more stressful for them. However, they have higher capability to benefit from ALMP, most obviously due to their greater experience of utilizing education and better employment prospects in general.

The figures showing substantial improvement in mental health among white-collar participants can be considered either as a desired outcome or as evidence of socioeconomic inequality. The outcome is desired if we take as a starting point the fact that on entry into the courses the higher-class participants had relatively poor mental health. This may have been a reflection of preceding unemployment or an effect of the conditions during the early stage of the course; at any rate, we may conclude that they in particular were in need of 'therapy', and that the therapy was successful. On the other hand, we may start from the point that among lower-class participants the 'therapeutic effects' tend to be the opposite, even if the analyses are adjusted for employability at the end of the courses. This at the very least indicates that the proposed salutary health and well-being effects of the ALMP measures are not self-evident, and, at worst, that the measures are not able to slow down the deterioration of mental health that is associated with unemployment and may even accelerate it among those in low socioeconomic positions. Thus, bona fide intentions of the policy measures may carry a risk of less-desired effects for a considerable part of the unemployed population.

In summary, the beneficial interpretation is supported when considering the cross-sectional figures at the beginning and end of the measures, whereas the analyses of variance for repeated measures give support to the deterioration interpretation. Although the latter analysis does not take into account baseline differences in the variables, this statistical strategy is more likely to provide unbiased causal effect estimates than baseline-adjusted estimates (Glymour et al., 2005).

Better employability in higher socioeconomic positions seems to explain the difference only weakly; that is to say, adding the variable in the analyses did not change the *p*-values substantially. This supports the conclusion that a vocational course as such may improve mental well-being. A possible explanation is that more educated participants are more experienced and better prepared for the training and education that the courses represent. Further, this view is supported by the finding that for more educated participants, not even attendance at a blue-collar course – a sort of downward social mobility – was a risk factor for decreased well-being.

Although the general pattern of the results was similar for the three indicators of mental well-being, the findings deserve attention vis-à-vis the differences in the nature of the outcomes. Stress symptoms were interpreted as an indicator of mental health, but the list of symptoms may also reflect somatic health. From this point of view ALMP seems to have some effects on the physiology but they are less prominent than the effects on mental health. The General Health Questioner (GHQ) has a long tradition in research on employment status and mental health (Banks et al., 1980). The GHQ score reflects actual

mental well-being and is quite sensitive to changes of life conditions; therefore the changes observed in this outcome are most probably due to the course in question. As to the sense of coherence, theory states that it is stabilized in early adulthood in the form of a personality trait that is resistant to stressful life events. Although empirical research has to some degree questioned the stability of the sense of coherence (Volanen et al., 2007), it is evident that it reflects an individual's relatively permanent global orientation and feeling that the environment is comprehensible, manageable and meaningful. The changes in sense of coherence during training courses may thus mean that the effects on the mental state are relatively profound.

Overall, the outcome of this study reflects aspects of mental health that are relatively changeable and subject to a multitude of life events and conditions. The variables in the multivariate models control the age, gender and change in marital status as well as the length of earlier unemployment spells and perceived employability. Nevertheless, an inherent limitation of this kind of research setting is that the data cannot be entirely comprehensive with respect to all potentially relevant determinants. The attrition rate is crucial regarding the reliability of a survey-based follow-up study. In our study the attrition was at a reasonable level, taking into account that it consisted of both non-response and dropout during the course – for example, due to getting a job. In summary, the loss did not bias the sample severely. The Finnish context of course raises questions and a need for international replication studies. Larger samples are also needed to study whether the class difference depends on, for instance, gender or age. With the present sample the second order analyses according to them did not reveal statistically significant interactions.

This follow-up study was designed with no control group. The limitation was hardly of crucial importance, as our main question was not about changes in the well-being of ALMP participants compared with non-participants, but about differences in the changes between the sub-groups of ALMP participants. Still, without a control group it is not possible to prove with absolute certainty that the observed differences between groups are not the result of stratified processes that would have occurred over time without the ALMP intervention. To demonstrate this would have required a randomized controlled experiment, but there are both practical and ethical reasons why such trials are not possible in the case of policy interventions.

Turning to Jahoda's deprivation theory as a context of our study, participation in the training perhaps compensates for the latent functions of work more adequately among the more educated. Although the results do not enable ranking of the five functions in this respect, our suggestion is that the socioeconomic difference may appear predominantly in the areas of social contacts, collective purpose and social identity. In the frame provided by Fryer (1986) the ALMP course emancipates the agencies more extensively among the more highly educated.

The current trend in ALMP seems to be an increasing variation in the measures. Hence, a focus on the quality of the measures and tailoring the courses according to the socioeconomic position of the participants hardly evokes critique in principle. It is clear that the 'same size fits all' logic is no more valid when the socioeconomic background of the unemployed is becoming more diverse and the changes in the labour market more unpredictable. However, as suggested by our findings, the policy measures may maintain or even produce health differences between the socioeconomic groups. In the case of a public service

intervention, the risk of such effects deserves particular attention if we are to be in line with the Health in All Policies principle. In fact, in the context of the Finnish health service system, the demands to grant special care to the unemployed are increasing (Sinervo, 2009). In this sense, our results might also have a positive perspective: vocational training courses targeted to blue-collar occupations could, if redesigned, provide an opportunity to reach one group that might benefit from such 'positive discrimination in health care'. The realization of this option would require profound re-orientations in the goals and means of the active labour market measures. A less ambitious and perhaps realistic goal would be enhanced awareness of the complex links between the measures and well-being.

The observations of this study ultimately have to be incorporated into the complex understanding of socioeconomic inequality. Although the universalistic services of the Nordic model may be superior in contributing to improved population-level welfare (Dragano et al., 2011), it seems that they are not so good at maintaining equality in the distribution of the improvements (Mackenbach, 2012; Tarkiainen et al., 2011). The persistence of the socioeconomic health gradient may partly be due to health services: those who benefit most tend to come from higher socioeconomic positions (Virtanen et al., 2006). Our study suggests that rather than levelling these health inequalities, the ALMP services boost them.

The study was conducted during favourable macroeconomic conditions. Regarding the current economic turmoil, it is obvious that the time of interventions to activate the unemployed is not past. As to future research, we stress three themes: (i) when researching the outcomes of ALMP interventions, attention should be given, in addition to re-employment and incomes, to the experiences and the motives of the participants; (ii) as layoffs hit all employee groups, potential participants in ALMP measures are becoming more heterogeneous – in particular, there is reason to study the effects of tailored programmes that are linked to major downsizings or closures; and (iii) it would also be important to conduct studies with corresponding aims nationally and in societies with different welfare policy models.

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Antti Saloniemi works as a Professor of Sociology in the University of Tampere (School of Social Sciences and Humanities, Pori). His present research activities include job insecurity, fixed-term employment, unemployment, health and safety at work and student employment.

Katri Romppainen, MA (Psychology), is a researcher and PhD student at the School of Health Sciences, University of Tampere. Her research centres around unemployment and inequality.

Mattias Strandh is Professor of Sociology at Umeå University and adjunct Professor at the School of Psychology, Social Work and Social Policy at the University of South Australia. His research interests include longitudinal evaluations of labour market events for mental health, labour market outcomes as well as the micro-level impact of policy and policy configuration in relation to gender, family and the labour market. He is currently working on a project investigating the long-term impact of unemployment experiences over the life course.

Pekka Virtanen, MD, PhD, is currently working as a Senior Research Fellow at the Institute for Advanced Social Research at the University of Tampere. He is affiliated at the School of Health Sciences at the University of Tampere as Principal Lecturer of Health Sociology. His main research interest is in disturbances in the labour market attachment due to atypical employment and unemployment and their relations to health, to sickness absence and to the use of health services.

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