Project Title

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

Project Acronym/Logo

Work Package 6

Professional Study: Italy

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Table of Abbreviations

GM	General Manager
GP	General Practitioner
HRM	Human Resource Manager
MHP	Mental Health Professional
OHP	Occupational Health Practitioner

Section 1: Overview and Commentary on the Professional Study

1.1 Overview of the Professional Study

The professional study is one of three interrelated studies within the Stress Impact Project- a pan European research study of long term absence from work due to stress related problems. The professional study has been designed to:

- Explore health care and employment professional's opinions and attitudes towards 'stress', long term sickness absence and work resumption,
- Identify their current policies for dealing with stress related long term absence,
- Explore and identify the interventions they use to support people back into the workplace, and
- Explore their experiences of dealing with long term stress related absence.

The findings of this research will highlight commonalities and discrepancies between and within professional health care and employment groups concerning long term stress related sickness absence and work resumption both in Ireland and across participating countries (Austria, Finland, Italy, the Netherlands and the UK). They will also be used to determine whether professional thinking on these issues is comparable to the experiences of those individuals who are, or have been, absent due to a stress related complaint. Ultimately these results and those of the other interrelated studies within the Stress Impact Project will be used to provide the basis for a theory of long term sickness absence and provide input in the future development of policies and guidelines of best practices for those professional groups.

1.2 Commentary on the Professional Study

The data capture process for this work package was very effective as the feedback from professionals was very high. However, at the beginning of the interviews there was a defensive attitude among professionals, especially the GMs and HRMs. Most of them said that they did not have a specific definition for stress or a statement on stress recognition. In the case studies they claimed that they have only come across non-stress related cases. However, this was not the case among the medical professionals such as the GPs, MHPs, and OHPs.

The categories of professionals interviewed do not include RTW Specialists or Health and Safety Representatives because their role is played by the OHP in Italy.

As a general comment, there was no specific policy on stress and/or absence within the companies that participated in the study. There was also a lack of return to work policies.

To summarise, there is a lack of awareness of stress and absence among Italian professionals, although they have shown a large interest in the Stress Impact project and have asked to be actively involved in events organised by the project. They are looking forward to seeing the final results of the project in order to have a better knowledge of stress and absence issues in Italy and across Europe.

We recruited the employment professionals (General Managers and Human Resource Managers) by personal contacts of the interviewers and TECHNOPOLIS researchers and management network, while the health care professionals (Mental Health Professionals, General Practitioners and Occupational Physicians) were contacted by the interviewers thanks to the personal contacts and University contacts with the Occupational Health Departments.

The methodology used was face to face interviews, which was the best way to to get the required information and feedback for the questionnaires. In some cases, for HRMs and MHPs, telephone interviews were conducted.

Section 2: Description by types/categories of professionals

2.1 Issues and Trends

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

General Managers

The incidence of stress over the past 5 years has increased for most of the GMs interviewed. Only one GM stated that stress has decreased because in the past five years his company has undertaken an innovation process which diversify the type of working tasks and reduces the stress related to routine work.

Human Resource Managers

For most of the HRMs the incidence of stress remained the same, for others it has increase and just one HRM said that it had decreased.

General Practitioners

The frequency of stress related complaints over the past five years has increased.

Occupational Health Practitioners

The incidence of stress over the past 5 years has increased according to the OHPs interviewed.

Mental Health Practitioners

Stress has increased for most of the MHPs and stayed the same for some of them.

2.1.2 Reasons for Increase or Decrease in Stress

General Managers

The reasons for the increase over the past 5 years according to GMs is related to the reduction in working personnel, a faster pace of work, work overload and increased pressure on employees. Other reasons are related to the reorganisation process of companies and the affluent society.

Human Resource Managers

In the cases where stress has decreased in the last five years, this is related to the improvement in environmental conditions (i.e. the amelioration of ergonomic work place and the application of the safety regulation in work environment in Italy [L. 626]).

General Practitioners

Life styles, social factors, environmental factors, occupational factors (too much work or too little work), economic factors, and family reasons are the main reasons for the increase in stress over the past 5 years.

Occupational Health Practitioners

The reason why stress related complaints have increased according to the OHPs is due to a better awareness of stress and absence amongst employees. Some OHPs underline the high workload on employees as the main reason for this increase.

Mental Health Professionals

For some MHPs, the increase is due to the high number of stimuli that the client experiences today, the frantic life and work pace (too many duties with the family, work, social life, etc), and interrelationship problems. The term stress is overused and it represents the cost of today progress. For other MHPs, the frequency stayed the same because in the past five years the environmental conditions remained stationary and the technological changes did not dramatically modified the life style for any of their patients.

2.1.3 Models of stress

General Managers

The GMs do not have a specific definition of stress, and pointed out that not having a positive attitude to work in the company is associated with several manifestations of stress. The high pressure of the working environment as well as of the social environment generates a mental situation of discomfort. Uneasy relationships with work colleagues is a characteristic of an employee with a stress related condition together with an excess of responsibilities to which the employee does not have the ability to cope with.

Human Resource Managers

Stress is not specifically defined by HRMs. Most of the HRMs believe that stress causes are connected to: (a) professional dissatisfaction due to lack of recognition for the achieved results, (b) insufficient acknowledgement of worker potentialities, (c) inadequate use of working time to realize an assigned task, (d) exogenous problems, (e) the increase of job assignments in short time and (f) the repetitiveness of the same activity in the assigned job. Moreover, stress is characterized by psychophysical conditions of uneasiness and suffering, which occur in the job environment and outside, and the main consequence is a negative attitude to work.

General Practitioners

The definition given by GPs of stress is when one overcomes the alarm threshold, and suffers environmental-social discomfort.

Occupational Health Practitioners

Usually stress is defined by OHPs as a condition of alteration of the psychophysical equilibrium which often ends in a psychophysical burnout. The diagnostic tool used for a stress diagnosis is the colloquium. During the colloquium with the client, the OHP analyses the patient's clinical history and their psychophysical symptoms. In the case of a stress related diagnosis the OHP aims to investigate through a deeper colloquium or health care specialist consultancy support, the patients social and clinical history.

Mental Health Professionals

Stress is the response of the organism at bio-psychic level to environmental stimuli (stressors) which are vigorous and reiterated, a continuous sensation of tension (or, chronic tension), physical and mental tiredness, maladjustment, performance deficiency, incapacity to bring to the end the current activities in a consistent and complete way. Anxious-depressive symptoms are the common diagnosis among the client group, together with a paranoid spectrum (from disease of paranoid personality to disease delirious paranoid), cephalea, and a bipolar illness.

2.1.4 Problems and Reservations in Identifying Stress

General Managers

Family problems in stress related employees, and a mental absence from work in several cases with a lack of self-assurance have been identified as causes. In general, the characteristics of the employees which identify stress are some feelings of inadequacy of the employee even to accomplish some simple tasks. The most evident manifestation is a difficulty in a relationship with the colleague who they perceive generate anxiety and quarrels at the first opportunity. The main consequence is a negative attitude to work.

Human Resource Managers

In general, a peculiarity of the stressed employee is the feeling of inadequacy with respect to a given working task. The most common signals to identify a state of stress are: (a) lack of disposition to dialogue and to collaborate, (b) shutting themselves off from everyone, (c) irritation in the execution of work, (d) absenteeism, (e) overestimation of themselves or persecution mania attitude and, (f) an attitude of unavailability due to presumed lack of time.

General Practitioners

For some GPs there are no problems, for others the approach is to evaluate the stress related person on the whole, using a holistic approach.

Occupational Health Practitioners

Very often there is a problem in making the stress related diagnosis for the variation of the clinical pictures and a difficulty in objectifying the stress situations.

2.1.5 Knowledge requirements of professionals

General Managers

GMs know when the employee works in harmony with the others or when he/she is under stress related conditions. However, they cannot detect if an employee is under treatment or not. This knowledge is usually gathered from the trade union representatives inside the company. Most of GMs feel that they do not have sufficient knowledge/awareness of stress to deal with most situations that arise on behalf of their staff.

Human Resource Managers

Almost all HRMs interviewed believe to have a discreet knowledge or skills on the stress subject but they are need further information in social and relational area (i.e. management of the dynamics of communication, etc).

General Practitioners

GPs source their information on stress from scientific publications, ECM (Educazione Continua in Medicina) and compulsory courses of continuing education in medicine organised by the Italian Health Ministry.

Occupational Health Practitioners

The OHPs refer to scientific newsletters and in depth seminars to source information on stress.

Mental Health Professionals

MHPs have sufficient knowledge of stress. Their information sources are publications in the scientific literature, the internet, psychiatry newsletters, books, internal professional courses and, external seminars and conferences mainly SOPSI(Società Italiana di Psichiatria). For some MHPs, they felt that they do not have

sufficient knowledge at the institutional level. Their knowledge relates only to the personal level because the stress is currently considered as a minor factor to be studied. An area of stress identified as critical for knowledge requirements is the stress of students and young people in general, because the institutions do not have the necessary instruments to cope with the stress problems such as in the enterprises where the employee is more safeguarded.

2.1.6 Causal Factors in Stress

General Managers

Some causal factors of stress which were unprompted included financial problems, the type of work (mental vs. manual work), relationship problems, feeling absent in the work place and too much pressure from the management or project leaders on employees. The sense of insecurity at work and relational problems in the family have also been identified as causal factors. As regards prompted responses, GMs felt that relationships with partners, job, sleep, finance and health are often causes of stress. They felt that issues with children, friends and health were not very often causes of stress.

Human Resource Managers

Factors reported by employees as cause of stress have been: lack of esteem, evaluation, and appreciation in the workplace, disagreements with colleagues, lack of leadership, family problems, inadequate quality of working life (i.e. inadequate work time shifts, etc), a feeling of contributing poorly in work and feeling inadequate in a role, scared of conflict with users, an absence in career progressions and inside mobility, inability to manage own work tasks, and difficulties in relationship with users and colleagues. As regards prompted responses, HRMs felt that finance, health, family, life conditions, relationship with partner, job and loneliness are often causes of stress. They felt that death/mourning and children were not very often causes of stress.

General Practitioners

GPs felt that finance and relationship problems were causes of stress. As regards prompted responses, GPs felt that finances, job and lack of sleep are often causes of stress. They felt that friends and living conditions are never a causal factor of stress.

Occupational Health Practitioners

OHPs stated that conflicts in the workplace, both with colleagues and with superintendents and managers, high work load, and finally, family problems were causal factors of stress. OHPs felt that finance, health, job, relationship with partner and death/mourning were common causes of stress. Sometimes children were causes of stress for patients. Friends, lack of sleep and loneliness were never causes of stress.

Mental Health Professionals

MHPs stated that family problems, financial issues and job issues caused stress. A spread causal factor in the patients is the simultaneity of roles (such as worker and mother, family stress, children problems, old parents, changes in the workplace). Other kinds of causal factors referred to by clients include both physical symptoms (palpitations, restlessness, insomnia, stomach ache) and psychological symptoms (sense of anxiety, fears, insomnia). OHPs felt that health, relatives, job, loneliness, and sleep are the more often causal factors. Finances, living conditions, relationship with partner and children are sometimes a causal factor of stress. Friends are never a causal factor of stress.

2.1.7 Frequently mentioned interventions

General Managers

GMs felt that their organisations would be willing to changing work organisation, change employment conditions, change work environment, undertake individual interventions and redeploy an employee to prevent them going out absent in the first incidence.

Human Resource Managers

HRMs felt that their organisations would be willing to changing work organisation, change employment conditions, change work environment, undertake individual interventions and redeploy an employee to prevent them going out absent in the first incidence.

General Practitioners

Pharmacological therapy based on tranquillisers together with talks with the patient.

Occupational Health Practitioners

Usually, if the client presents with a stress related complaint, the OHP investigates through a colloquium their conditions, including the workplace conditions. The interventions most frequently mentioned and that they believe are the most effective are interventions of psychological and psychiatric type together with medical interventions and associated health treatments such as massage.

Mental Health Professionals

A combined intervention of pharmacological, psychological and of support by the nursing staff. Psychotherapy cycle and/or psycho-medicine. In any case a pharmacological treatment should always be followed by a psychological treatment such as weekly meetings to elaborate the patient problems and provide strategies to overcome them.

2.1.8 Relevance and Effectiveness of Interventions

General Practitioners

Mental health services, psychiatric interventions are the most frequently used treatments, with high effectiveness. Non-health interventions and other medical interventions are sometimes undertaken, while alternative interventions are rarely or never used.

Occupational Health Practitioners

OHPs felt that the most effective intervention is psychological therapy with the use of anti-depressant and tranquillizers.

Mental Health Professionals

Mental health services, psychiatric interventions are the most frequently used treatment. Other medical interventions and non-health interventions are sometimes used with effectiveness. Psychotherapy and pharmacological therapy are used in the workplace and is the most effective intervention, while family therapy is the most ineffective.

2.1.9 Return to Work Objective

General Managers

Some interventions are in terms of assistance and incentives to employees, improvement of the work organisation with a different division of the work load, the construction of a positive context in which to work with less pressure and open dialogue with the colleagues, to shift the stress related employee onto some activities with loose deadlines and time, organisation of friendly meetings outside the working hours, medical checks at home, discussion with the employees to understand their problems, interventions aimed to identify a real stress related situation or a false sickness situation. For some GMs there was no necessity to set up procedures for returning to work as most of their employees returned to work with no interventions. This is the case of young Small-Medium Enterprises or Small-Medium Enterprises under reorganisation.

Human Resource Managers

The most frequent interventions mentioned by HRMs with regard to return to work are incentives for example with a bonus to increase their presence rate, medical checks at home and interventions aimed to identify a real stress related situation or a false sickness situation. There was also paying attention to employee needs concerning working conditions (i.e. improvement of ergonomic conditions, etc), organization of social occasions oriented to develop the “sense of community”

(organization of a friendly meetings or social initiatives outside the working time), stimulation of open dialogue between organization and worker. Some HRMs ignore the use of interventions/procedures for returning to work or believe there is no need to use it.

General Practitioners

There was a clash in opinion about investigated whether or not the patient has returned to work or not, some investigate others do not. There were discordant attitudes from GPs over whether or not to get involved in assisting a long term absent employee to return to work.

Occupational Health Practitioners

All OHPs investigate, when a patient is affected by stress, whether or not they are absent from work. Most of the OHPs interviewed are involved in assisting the employee to return to work.

Mental Health Professionals

All MHPs usually investigate whether or not the client is absent from work and get involved in assisting them to return to work. To facilitate a gradual return to work some MHPs suggest the following steps: first face the acute pathology and try to go towards a progressive reduction of the medicine load, then let the patient recover their ability to concentrate and be involved in the working activity (if he/she shows a willingness to perform the work activity), establish contacts with the general practitioner and colleagues at work and maintain them until they return to work. Finally, try to follow the patient during their return to work with the family nucleus and the working organisation in parallel.

2.1.10 Factors for successful return to work

General Managers

The most important factor in successful return to work for GMs is the friendly working environment which can reassure the employee and let him/her feel part of a community again. It is useful to favour the insertion of the employee in working ad hoc groups and his/her acceptance from their colleagues. Another factor is the

renewed interest of the company in the employee who returns to work. It is important to create a confidence environment around them. The harmony of the working group is increased as the colleagues favour the return to work and have shown a more collaborative approach.

Human Resource Managers

First of all, most of the HRMs ignore how to manage a successful return to work and this results in a repressive approach towards the absenteeism phenomenon. Despite this, during some interviews, the importance of a friendly work environment based on trust, acceptance and acknowledgement of the role from the colleagues and staff management was considered. Moreover, it had also been considered useful to encourage the development of a sense of community and to underline the precarious health state of absenteeism worker with several/different devices such as: favouring the insertion of the employee in working groups, eventually, if desired, change their role and supporting them in this phase with different facilities, i.e. flexible time shifts and improved ergonomic environmental work context. Finally, it seems to be important to assure the "continuum of contact" within the organizational context by promoting informal work networks (i.e. stimulating friendly proximity and acceptance from their colleagues community, etc) and formal communication channels (i.e. use of a firm newsletter/bulletin, e-mail and computer conference), aimed to inform the absenteeism workers about news concerning work's life organization.

General Practitioners

An effective medical-sanitary intervention and a pharmacological therapy, a solution to the economic factors and external environmental factors to better cope with the re-insertion to the workplace.

Occupational Health Practitioners

The factors understood as important for the return to work are both a renewed psycho-physical equilibrium acquainted thanks to a temporary removal from the conflict situations in the workplace and an economic necessity.

Mental Health Professionals

The most important factors are the understanding of the burnout problem, finding a solution to the symptoms and changing the working conditions which could have been the bursting factors; an increased reliance in themselves and in the other persons; pharmacological therapy integrated with the psychotherapy; any social support (by relatives, partner, doctors and social educators) to avoid loneliness. If the working environment is without mobbing and comfortable then the return to work is facilitated. In any case, it is important not to suspect any simulation by the patient, that is, sometimes the depressed person is seen as a person wishing not to work. Another factor is to overcome the stress caused by the long term absence from work.

2.1.11 Referrals

General Managers

The first referrals are to the families to reconstruct self-esteem and a positive environment, then human resource managers and occupational practitioners and psychologists.

Human Resource Managers

The most frequently mentioned referrals are the Human Resource Manager and the doctor.

General Practitioners

The specialists to whom GPs would refer their patients to are basically medical specialist or a psychiatrist and sometimes physiotherapist and psychologist and community welfare officer/social worker.

Occupational Health Practitioners

The specialists to whom OHPs would refer their patient to are psychiatrists, psychologists, a medical specialist and then a physiotherapist.

Mental Health Professionals

Their clients are referred from GPs mainly, then medical specialists, psychologists, psychiatrists, community welfare officer/social worker, self referrals and finally they mentioned Public Structures (such as SIM- Mental Health Public Institution in Italy).

2.1.12 Steps to Return to Work

General Managers

The first step is to determine the nature of the stress, even though the investigating procedures do not help to return to work; GMs usually prefer to temporarily substitute the employee affected by stress to cope with deadlines and orders and to try to recover the time lost. There are procedures for recurrent situations of absence for unknown causes which involves the OHP. For the other cases, the stress is treated as a normal sickness requiring the medical certificate from a GP for work.

Human Resource Managers

Most of the organizations discriminate between workers with a real stress related situation and workers with a false sickness situation. In the first case, the HRM primarily uses the medical check at home and, in the case of a prolonged or frequent absence, they will set up an interview aimed at uncovering the origins of worker's problems. In some cases, the HRM will look for information on the causes of the absenteeism through informal channels. Usually the interview is used to dissuade workers from continuing to be absent. The next step, if the absence occurs, is to restraint working conditions by increasing control and penalties. In the second case, the absence is seen as a normal sickness which requires only a medical certificate. For some HRMs, it is important to understand the endogenous and exogenous causes of the absenteeism to implement possible actions or individual assistances. For others, it is important to create a non oppressive climate but a friendly environment to evaluate and motivate the worker in.

General Practitioners

GPs felt that they had a central role in relation to return to work, but they have little time to dedicate to the patient in this process. Pharmacological therapy with the

support of a psychologist are the steps stated by GPs a patient should take to return to work.

Occupational Health Practitioners

Steps to return to work include contacting the Human Resource Manager and then set up a colloquium with the employee.

Mental Health Professionals

The main steps are first a diagnostic framework to evaluate the illness. In the positive case, the patient follows a pharmacological therapy, then it is possible to establish a program of psychological support in the long term. MHPs stimulate a behaviour at home which can help the patient to recover some abilities required for them to return to work, such as encouraging the patient to read specific papers, to see films and other things that have been reduced during their absence from work.

2.1.13 Family Interventions

General Practitioners

GP involved family members of the patient in the return to work process in an active way, making them acquainted with the stress conditions of the patient. Direct involvement of the patient partner is foreseen.

Occupational Health Practitioners

They do not involve family members.

Mental Health Professionals

A central role is also played with the patient family by instigating family counselling, involving the family in the process of understanding the nature of the patients' problem and sustaining the family in the recovering process by increasing the support the family offers to the patient. The family should try to encourage the directions of the doctors and to support the patient in this process. The family is invited to participate in the SIM service and collaborate with the doctors by identifying the conflict situations within the family and by deciding which type of interventions

should be performing inside the family to solve at least part of the stress caused by the family itself.

2.1.14 Employers and Return to Work

General Managers

For most of the GMs who were interviewed there is no policy in the company on stress and absence. For some of them there is a policy, where the incentives represent a good stimulus for the employee to return to work.

Human Resource Managers

Most of HRMs do not have a policy on absence. Some of them analyse the phenomenon only from a quantitative point of view (i.e. the use of statistical data), others use bonuses to improve low absence rates. Others prefer to speak more about positive actions to increase personal motivation to work (i.e. promotion of social solidarity initiatives, etc,) and of the community feeling (i.e. creation of services for workers, organization of socio-cultural events for workers inside and outside working hours, etc,).

General Practitioners

Employers contact GPs because the reasons given by the patient/employee are not always reliable. They have been asked to give the medical reasons for the long term absence period. Other GPs have no contact with employers but only with the employee.

Occupational Health Practitioners

OHP believe that they should be involved in the return to work because beside the task of making a clinical picture they know the dynamics of the workplace.

Mental Health Professionals

MHPs have contact with employers to establish with the employer a form of reciprocal collaboration on work stress and to keep a watch on the working environment to foster a good working relationship, with more flexible working time, and a less rigid work organisation. This is because, when the patient returns to work

and find some difficulties in reintegrating it is necessary to gradually let them inside the workplace and eventually evaluate a possible reallocation. The perception of some MHPs is that the employer usually tries to contact them to gather information on the reasons why the employee is absent from work and what they are doing, mainly not to help the employee, who is often seen as the causes of some trouble in the enterprise, but to investigate, with the help of a fiscal doctor, their status to decide when to substitute the employee at work.

2.1.15 Social Protection Agencies

General Practitioners

They never have been contacted by the Department of Social Security.

2.2 Illustrations from Cases

Occupational Health Practitioner

Overcoming burnout with medical therapy and the support of the OHP

This is a case of a female employee who worked as a sanitary operator and is 40 years of age. She had depression which involved a drop in her physical abilities, and increased her emotional liability. After pharmaceutical cures and psychotherapy she returned to work. She succeeded in returning to work thank to the strong support from the Occupational Physician (Law 626 in Italy) who kept her informed during the absence period and reintegration process. She was transferred into a different workplace where she changed her attitude to work and regained the motivation to work. Now she has stopped medical therapy and follows up with the psychiatrist on a periodically basis to maintain her status.

General Practitioner

Mobbing in the workplace is often the main cause

This is a case of a bank employee who is 50 years of age with anxious-depressive syndrome, sleep problems and with strong work stress related to his duties at work

because of mobbing attitude of the bank towards him. He has been supported both on a personal level and through an examination of the mobbing in his workplace.

Decided to leave work and get support from the Social Security Body

This is a case of an assistant teacher for handicapped children was affected by psychosis for 20/25 years. She would go out on long term absences on a regular basis. She agreed with her director to leave the work (as her long term absences caused many problem at school and when she was at work she faced many difficulties when teaching). Her inability to work has been declared and INPS social security body provides her with a pension. The chronic patient is getting better now after leaving the workplace and is under a maintenance therapy.

General Manager

The rigid attitude of a State employer did not help in return to work

This is the case of a male, 45 years of age with a phobic illness and panic attacks, especially when driving to work very early in the morning. All that the employer (a state agency) needs to do is allow him to start work later but this cannot be done for administrative problems.

Colleagues can play a central role in return to work

This is the case of a female researcher who graduated in Mathematics and was working as a software developer in the area of geographical information systems development. At the age of about 35, she left the company for 6 months (approx.), because of reporting problems/symptoms of depression. The most likely cause is a mix of familial problems and compelling work conditions. Her return to work was successful, and the key factors for the successful return were mainly the sustained help from her colleagues and her insertion into less compelling activities.

Isolation is the main cause of not returning to work

In this case, the non-returnee graduated in Computer Science, and was working as a researcher in modeling and simulation for industrial applications. At the age of 38, he went out absent for 3 months (approx.) and reporting symptoms of persecution. The most likely cause was an excessive self consideration and psychological fragility in a

competitive work environment. The key factors for not returning to work were isolation, scarce dialogue with his colleagues and the organization.

Human Resource Manager

A long absence from the work system compromised return to work

This is a case of a police agent, 50 years of age with generalised anxious illness. He is under medical treatment but did not come back to work because his reinsertion into the workplace is difficult after his long term absence.

Modifying dynamics in the workplace can favour return to work

This case is that of a doctor, 40 years of age in a hospital who had several psychosomatic pathologies and suffered abuse from his colleagues. After a long-term absence, he realised the problem was his relationship with his colleagues and managed to negotiate a change in his role in the hospital with less sanitary tasks and more administrative activities. This meant that he was no longer working with those colleagues.

Mental Health Professional

Changing role facilitates the return to work

This is the case of a worker in a state organization, that never accepted his role and this brought him into a state of depression with resulted in him going out absent for one year. This case has had a positive conclusion which resulted in the redeployment of the worker in a new role in the same organizational context.

Physical illnesses do not prevent reintegration

This is the case of a worker with cancer. After receiving medical care he returned to his workplace strongly determined to reintegrate into the working environment. This result has been successful thanks to the following factors: Amelioration of the environmental ergonomics (aesthetical amelioration of his office), Strong and warm reception within the workplace also through the spontaneous help of his colleagues, and the support of the HRM in granting him job permissions and working flexibility.

Section 3: Description by Themes

We have identified similar viewpoints between two large categories of professionals, namely the employment professionals (HRM, GM, OHP) and health care professionals (GP and MHP). We report hereinafter in Section 3 issues with respect to these two broad categories.

3.1 The Level of Awareness about Stress and Absence

The level of awareness about stress and absence among employment professionals is very low even if the frequency of stress related complaints over the past five years has increased. It is characterized by productivity and economical needs of the organizations. This is the reason that influences their approaches to stress and absence, and are based on the quantitative analyses and show a repressive attitude.

Stress is frequently referred to health care professionals by their clients when describing their conditions. The level of awareness among medical professionals is high. They report that family, lifestyle (a frantic lifestyle) and the simultaneity of roles in family, work and social life are the main issues were they need to increase their awareness of in the near future.

3.2 General Description of the Beliefs held about Stress

Most of the employment professionals describe stress as a psycho-physical condition, of uneasiness and suffered in and out of the job environment. It is also related to professional dissatisfaction due to lack of recognition for their results achieved.

The health care professionals describe stress differentially as provided in detail in Section 2, but with a common belief that stress is in general identified with the anxious-depressive syndrome.

Both the employment and health care professionals believe that it is important with regard to stress and absence:

- To play a starting and sustaining role in the organisation of prevention and re-integration activities in the working environment;
- To assist the management of enterprises to integrate the activities in favour of the health in the organisational policy and praxis;
- To intensify the cooperation with both the two types of professional categories (employment and health care professionals) to contribute to the rehabilitation of the LTAs.

3.3 The Issues raised in relation to Stress and Absence

In the successful return to work cases the most important factors expressed by employment professionals was to create a friendly working environment based on acceptance and human recognition and/or to change the work environment if necessary. The factors that could have prevented the individual in the successful case going absent in the first incidence are related to repressive interventions, agreement with trade union, to promote mission organization feeling, to give rapid answers with respect to symptoms and to stimulate dialogue with employees.

Concerning the health care professionals, the percentage of MHP clients whose primary diagnoses are stress related conditions are about 30% in most cases and 80% in a few of them. In the successful return to work cases, the most important factors in aiding the individual to return to work was to address the symptoms and the changing of the working environment. In the other case, the most important factors in preventing the individual from returning to work was the impossibility to modify the type of work and persistent symptoms. The factors that could have prevented the individual in the successful case going absent in the first incidence are related to the economic benefits in their condition as an ill person, both social and working benefits. In the other case, the factors that could have prevented the individual going absent in the first incidence are resolving the anxious-depressive illness and a correct institutional analysis of the interpersonal dynamics and relationships needed.

3.4 The Main Interventions Described

Concerning the employment professionals, the main findings are as follows:

(a) Periods of leave are very short ranging from two weeks to six months. Usually, what happens is that the patient asks for a short period of leave and then returns to work for a few days, then they ask for a further period of leave and this is considered as a new sickness leave without continuity with the first.

(b) No medication is suggested but only referrals to GPs or MHPs. The most frequently mentioned intervention consists of investigating the conditions of the employee through a colloquium to better grasp the working conditions and their effects on the health and well-being of the employee. This has on several occasions led to changes in the work organisation and environment and an individual intervention to reintegrate the employee.

(c) No counselling and psychological interventions are used inside the organizations. The psychological interventions is foreseen when the employee decides to start a treatment with the health care professional.

(d) If it is strictly necessary or where it is possible, an intervention of the employment professional addresses both a change to the work organization and the work environment including redeployment.

(e) Generally, the employment professionals promote an ergonomic improvement and adaptation of working environment and only some of them stimulate the acceptance climate by a friendly community of colleagues and do not underline the precarious health state of absenteeism worker.

Some other interventions of employment professionals are in terms of incentives to employees and improvement of the working organisation with different work load and responsibilities. To improve the working environment some employment professionals organise of social events to develop a sense of “community” among the employees and establish an open dialogue between the organisation and the employee.

As far as the health care professionals are concerned, we identified the following:

(a) Periods of leave are very short ranging from two weeks to twelve months. Usually what happens is that, as with the employment professionals, the patient asks for a short period of leave and then returns to work for a few days, then they ask for a further period of leave and this is considered as a new sickness leave without continuity with the first. This also happens because the social security procedures and internal companies procedure foster this way of doing things.

(b) Concerning interventions, the most pursued intervention is pharmacological therapy with the support of psychotherapy to elaborate the client problems and plan with them the strategies to overcome these problems. A frequently used effective intervention/treatment for stress related conditions is prevention in the working environment, while a frequently used ineffective intervention/treatment for stress related conditions is auto-medication or to change continuously the specialists, i.e. to wander among the doctors. Some medical professionals do not know what to answer to this question.

(c) Family counselling sessions have been suggested in the return to work process. Health care professionals are involved in the return to work and generally think that medical professionals should be involved and that it is necessary to keep a watch on the working environment to foster a humanisation of the working relationships.

(d) A mutual collaboration between the medical professional and the employer on the working stress had been underlined. Progressive reduction of the pharmacological load, contacts with the General Practitioners and with the work colleagues are envisaged. It is important to follow the client during the reinsertion process together with the family nucleus and in parallel with the working organisation (follow-up) and evaluate the possibility of deploying the clients into a different working position.

(e) The presence of a psychologist in the workplace will help to pursue a different mentality on stress fostering a more empathetic relationship with the work, and making easy the reinsertion at work.

3.5 Stress and Return to Work: Effective Interventions and Activities

The most important factor for the interviewed professionals is the presence of a psychologist in the workplace, the awareness of the occupational physician (law 626 in Italy), and finally, the presence of an anti-mobbing figure within the enterprise.

A correct and constant institutional analysis of the dynamics and interpersonal relationships is foreseen to improve the relationships within the institutions by improving the psychological conditions in the workplace; this is currently done in some banks, pharmaceutical houses, and in rehabilitation bodies.

Another factor is resolving family problems and being able to concentrate and perform the work. Other factors consist of being able to resolve chronic tiredness, depression and solve the interrelationship problems with colleagues.

The suggestion for more effective interventions and activities in relation to stress and return to work are as follows, for the employment professionals:

- exploring in depth exogenous and endogenous causes,
- individual and personal intervention,
- to create a friendly organizational environment, and
- to promote motivation and recognition.

The general feeling is that it is time to install preventive and protective measures for a high quality of life in the working environment, making the working time more flexible and the working organisation less rigid.

3.6 Opinions about the ‘causes’ of Stress

The most frequent causes of stress, including work and family factors, are in general as follows: exogenous problems (family problems, etc), an absence of organizational development, the presence of individualism attitude and lack of cooperative behaviour and inadequate gratifications. For state organizations, after the decentralization

process of the functions from central government to local state administrations, it has been detected that there has been an increase in workloads and responsibilities with the same number of staff.

Causal factors for employment professionals have mainly been identified in relationship problems, and the general attitude of the employee towards the job which showed a lack of esteem, disagreements with colleagues and superintendents, insecure behaviour in performing the working tasks or of giving a poor contribution at work, and the feeling of playing an inadequate role. Family problems have also been recognised by the employment professionals as causes of stress and their influence in the working environment have been underlined.

Further causes of stress expressed by employment professionals are inadequate use of working time to realize the assigned task, insufficient acknowledgement of worker potentialities, increasing job assignments with less time, presence of individualism attitude and lack of cooperative behaviour. The common causes of stress are often finances, health, job, and relationship with partner.

Concerning the health care professionals, the common causes of stress are often family, finances, and life conditions. A spread causal factor is the simultaneity of the roles played by the client, for example being mother and worker, taking care of old parents and children, caring for the work and family. Causal factors have both psychical and psychological symptoms.

Section 4: Discussion

This is from the researchers perspective/impressions gained during the interviews.

4.1 Current approaches to stress and absence in Italy

The health care professionals adopt a soft approach to stress and absence with their clients, being more oriented to plan a gradual return to work of the employees. They first address their pathology on a pharmaceutical basis with the support of psychiatry and then they establish contact with the working environment by establishing links with their colleagues and maintaining them until they return to work. Family and working organisation should be addressed in parallel in their view.

Generally, employment professionals do not have sufficient culture and means to approach stress and absence. The common element of their approach is based on quantitative evaluation of the phenomenon (collection and processing of statistical date, etc) and of repressive behaviours to prevent and to approach long absence after return to work. Moreover, for some of them there is no need to have a policy of return to work.

An integrated strategy in stress and absence matters, work environment, health and accident prevention, aging and economic expense touch all the interests of the main professional players, who in turn are individually competent for the definition and the implementation of the strategy for enlarging the prevention activities directed to the person and the working environment.

4.2 Understanding of Stress and Work

We have observed during and after the interviews with the employment professionals a change in their awareness and the way the should approach stress and absence. Moreover, it appears that they were satisfied to learn about stress and different kinds of interventions to prevent absence and to use procedures for returning to work. Finally, we have noted that they are aware that they need further information and they

need to develop specific skills around social and relational area (i.e. management of the dynamics of communication, etc).

Most of the health care professionals were very competent in their work on stress and absence, only some showed some draw backs in their professional institutional training on stress: their knowledge on stress is related only to their personal training because stress is considered a minor factor to study as part of their college courses.

4.3 Researchers' Comments

Most of the employment professionals expressed cynicism and negative judgements about the absent workers who have falsified sickness and they seem to have a critical attitude toward them based on more control of their work processes rather then collaboration to help in return to work.

On the contrary, health care professionals expressed cynicism about the organisation and family environment of the client rather than on their stress related claims for absenteeism which were fully justified from their point of view.

Section 5: Conclusions and Recommendations

5.1 Conclusions in relation to Italy

5.1.1 Salience of stress and absence as a problem in Italy

The salience of stress and absence is a lack of equilibrium between the stress related person and the environment, that is health problems can arise due to a discordance between the working function requirements and the capability of the employee to perform it. This is an important finding to set up suitable return to work strategies. In Italy, all the social parts, government, employers, employees, insurance company and social and security bodies are addressing the problem of stress and absence, and have showed an interest to reduce the absenteeism with return to work strategies. The Italian government have a vested interest to maintain the absenteeism at a low level and to limit the sanitary and social security costs associated with it. This is because the absenteeism has negative effects on the national economy for the lack of productivity due to a reduced working force and an increase in the sanitary and social security costs.

5.1.2 *The adequacy of system responses in Italy*

The Italian government encourages employees to work in good health until the pension age in a way that they can contribute to the gross national product. It pays attention to the public expense and to the reduction of the national debt in the public sector. The increased international competition, the spread of unemployment and the globalisation of the production processes have forced enterprises to reduce their work costs to remain competitive. The attitude of the Italian government in this context is to move the financial costs of the absenteeism onto the employers and employees, to reduce the balance of the public sector and stimulate the employers and employees to limit the absenteeism. The employers try to reduce absenteeism by enforcing procedures and controls on the absent worker. The adequacy of the system response

in Italy is low, because the preventive activities are not very common in the Italian enterprises that prefer to apply normative and disciplinary measures.

Furthermore the inadequacy of the enterprise system in Italy is proved by the attitude that the activities to reduce absenteeism are not to be integrated into the normal activities of the enterprise. The Occupational Practitioner and the Human Resource Manager often do not work together to integrate absenteeism policies into the management of the enterprise and to integrate the activities for well-being in the enterprise praxis and philosophy. The issue of absenteeism should be in the first place pertaining to the general management, which in turn can be assisted by the human resource manager and the occupational practitioner. The middle management does not have the necessary competence to address the level of absenteeism in their division. The current effort is towards the integration of the measures concerning the absenteeism in the quality system is to incorporate it in the organisational policies and practices.

Actually, there are no relevant provisions, which address long term absentees, mental health and reintegration. The actual system tends to seal in the “mental health system” the phenomenon of reintegration, which is then seen as an experimental service not altogether eked out in the “welfare system”.

The new legislation is taking into account several factors including psychological and social factors for the well-being at work and points out the need of preventive measures and co-operation for the employee rehabilitation. The current legislation supports the idea of maintaining a good working capacity throughout the working life, but do not support the absentees return to work in the best possible way. At the moment, different functions relating to absenteeism are the responsibility of different sectors and organisations and nobody controls the situation as a whole. However, future legislation will oblige the municipalities to have a rehabilitation work-group where rehabilitation matters will be organised.

5.1.3 Understanding and knowledge of stress and absence in Italy

The level of awareness is high among all the Stakeholders, namely the Government, Trade Unions and Employers, Social Security Bodies, and Not for profit Organisations, and concrete actions have been undertaken by them in forms of programs, projects, guides, laws, etc, which also prove the different viewpoints of the different parties on the debate. Nevertheless, there have been collective bargaining agreements among the parties that testify advances in social and psychological issues concerning the work.

5.1.4 Confidence in current approaches to return to work and stress in Italy

There is a variance in confidence in the current approaches to return to work and stress in Italy: they are influenced by individual factors, enterprise and the working environment related factors and social factors. For example, at the individual level biological and psychological factors such as the physical constitution and the mental capability to react affect on the working ability of the employee. The illness which does not relate to the working environment is one of the factors that reduces the capability of the employee and leads to a detachment between the work load and the capability of the employee. The costs of the absenteeism and the return to work procedures are shared among the government, employers, employees, insurance companies and the society in general. Often the employee suffers a loss of salary due to the absenteeism, and has to face different expenses for sanitary instruments and care and undergo a loss of welfare in form of pains, and suffering. Furthermore, the frequent and long term absence can lead to a loss of work or in a degradation of the colleagues and superintendent relationships.

5.2 Recommendations

Initial and continuing professional development

Most of the preventive measures are limited to direct measures on the stress related person in the field of accidents at work and professional illness, such as training and information, use of protective material and stress management and are not connected to the causes related to the working environment, which are the origin of illness and injuries. Initial and continuing professional development is foreseen as an important preventive measure by the interviewed professionals.

Knowledge management and information sharing

The interviewed professionals, both employment professionals and health care professionals, need information on the possibilities to reduce the absenteeism (methodologies, instruments and practical experiences) through prevention activities and the reintegration of the long term absentees. There are a lot of experiences in the field of initiatives in the working environment aiming at reducing absenteeism. The enterprises can learn a lot from the experiences of the other enterprises in the same country or in Europe. However there is a lack of well-documented examples of successful initiatives in the field of absenteeism. A further problem is that the best examples are often described only in the national language and are not accessible for example to a European public. Due to this situation, several professionals are not aware of the qualified factors and the obstacles that they have to face when they will start an activity to reduce the absenteeism and promote the return to work.
The professionals should have a knowledge base to start prevention and re-integration activities in the working environment. These activities should:

- Use a systematic and exhaustive formulation,
- Be based on the necessity of the work force,
- Aim to the participation of the long term absent, and
- Be applicable to all the categories of workers inside the company.

Awareness raising

The level of awareness is high among all the Stakeholders, namely the Government, Trade Unions and Employers, Social Security Bodies, and Not for Profit Organisations, and concrete actions have been undertaken by them in forms of programs, projects, guides, laws, etc which also prove the different viewpoints of the different parties on the debate. Nevertheless, there have been collective bargaining agreements among the parties that testify advances in social and psychological issues concerning the work. The level of awareness among the professionals is also high

Policy development and regulation

Concerning the treatment of stress related illness by legislation; no legislation exists because “stress” is unknown. Trade unions are now in discussions about “work organization” and “stress” but from the point of view of “mobbing”. In the last decade, a set of legislative measures has been launched to allow the most important bodies designed by law such as INPS and INAIL, to launch initiatives and projects for the return to work of state employees who have taken a period of absence from work due to industrial injury or long term sickness or for the rehabilitation of long term absent workers in general. As far as the services and the related functions of the bodies mentioned above are concerned, there have been assigned tasks to them finalised to support the return to work, besides the functions to assure the day allowance to public and private employees who are long/medium term absent for sickness or injury. Intervention strategies in different project areas related to regional, national and community programmes and actions concern the promotion of the opportunity to steady reinsert disadvantaged persons and categories.

Capacity building

There are four types of interventions for capacity building:

- Procedural interventions, aiming to raise the obstacles to the absenteeism, which consist of monitoring actions and absenteeism control;
- Preventive actions related to the working environment, aiming to reduce the gap between the workload and the capacity, by means of a reduction of the work load. This can be done by eliminating the causes related to the working environment of the problems in the accident prevention sector, health and well-being;
- Preventive actions related to the employee, aiming to let the employee play the working role in secure and healthy way. These actions foster a better equilibrium between the work load and capacity, increasing the employee capacity;
- Reintegration actions, aiming at reducing the obstacles to reintegration and accelerate the return to work of the illness employees.

In Italy prominence has been given to the procedural measures to reduce the absenteeism. These measures can be found in the changes made in the Italian legislation concerning the illness indemnity and the policies related to the absenteeism. Prevention measures instead are on a very modest scale. They tend to improve the working environment on the accident prevention and health promotion aspect, rather then the health improvement and well-being of the employees. They are limited to the activities related to the employee and not to the causes of the bad health of the working environment.

Recommendations for more effective system responses

The recommended successful factors to reduce the absenteeism and for a more effective system responses are as follows:

- To address the absenteeism with a systematic approach;
- To set a well-coordinated project group for the coordination of the return to work activities;
- To give precise tasks and responsibilities to the person that takes part in the activities;
- To ask the active support of the middle and top management and the active role of the workers by acknowledging the workers themselves as experts;
- A good information and communication exchange with personnel;
- The combined participation of the human resource manager, the occupational physician, and the general manager;
- The management of the absenteeism as a normal company phenomenon.

Next steps and actions towards a more effective response to stress and absence

The employment professionals should play a role in starting or sustaining organisational preventive and reintegration activities in the working environment. Human Resource Managers and Occupational Physicians should assist General Managers to integrate the activities for the worker well-being in the politics and praxis of the organisation. They should boost the cooperation with the health care professionals, especially General Practitioners, to contribute to the rehabilitation of the long term absentees.

The professionals, in general, should intervene in the development of new models and methodologies (especially for SMEs), in the evaluation of the existing prevention programmes, in the development of monitoring systems and in the research related to aspects such as costs and advantages of the specific interventions in the working environment. It is necessary, for a more effective response to stress and absence by professionals, to promote and exchange experiences among professionals, to spread

information on the best practices, to stimulate the production of training modules for the management of prevention and absenteeism projects, to promote the presentation of comparable statistical data on stress and absence.

Annex 1: Summary of Respondent Profiles by Category

General Practitioners

Gender	*Years of Experience*	*Location of Practice*	*Client Base*
Male	30	Outside Bari	Medical Card
Male	10	Outside Bari	Medical Card
Male	28	Bari	Medical Card and Private Clients
Male	43	Outside Bari	Medical Card
Male	8	Outside Bari	Medical Card and Private Clients
Male	23	Outside Brindisi	Medical Card and Private Clients
Male	15	Bari	Medical Card

Occupational Health Practitioners

Gender	*Years of Experience*	*Location of Practice*	*Sector*
Female	3	Bari	Public and Private
Female	2	Bari	Oublic
Male	15	Brindisi	Public and Private
Male	4	Bari	Public and Private
Male	16	Brindisi	Private
Male	3	Bari	Public and Private

Mental Health Professionals

Gender	*Location*	*Sector*	*Number of Staff*
Female	Outside Bari	Public and Private	10
Male	Outside Bari	Public	30
Male	Bari	Public	40
Male	Bari	Public and Private	20
Female	Outside Bari	Public	20
Female	Outside Bari	Public	30
Male	Outside Bari	Public	50
Male	Outside Bari	Public	40
Male	Bari	Private	15
Male	Outside Bari	Private	240
Male	Bari	Private	11

Managers

Gender	*Years of Experience*	*Location*	*Sector*
Male	20	Bari	Private
Male	10	Outside Bari	Private
Male	5	Outside Bari	Private
Male	15	Bari	Public
Male	20	Bari	Public and Private
Male	15	Bari	Private
Male	14	Outside Bari	Private
Female	10	Bari	Private
Male	20	Bari	Private

Human Resource Managers

Gender	*Years of Experience*	*Location*	*Sector*
Male	15	Bari	Private
Male	6	Outside Bari	Private
Male	15	Bari	Private
Male	15	Bari	Private
Female	18	Outside Bari	Public
Male	30	Bari	Public
Male	6	Outside Bari	Private

Annex 2: Roles and Responsibilities of Professionals

General Practitioner:

A General Practitioner is a medical graduate who gives personal, primary and continuing care to individuals, families and a practice population, irrespective of age, gender and illness.

Occupational Health Physician:

An Occupational Health Physician is a physician who specialises in workplace safety, injuries and treatment, as well as job function issues.

Mental Health Professional:

Psychiatrist: Is a physician who specialises in the study, prevention and treatment of mental disorders.

Clinical Psychologist: Is an individual who works in the area of personality assessment and prevention and treatment of emotional and mental disorders. They would usually work with individuals, groups, or families who have personal, social, emotional, or behavioural problems.

Manager

This is a person who manages the staff on a day-to-day basis.

Human Resource Manager

Is the link between the employer and the employee. They have a wide range of responsibilities which include hiring, benefits, salaries, training etc.