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Study report

February 2013
Ref. Eurogip - 81/E

What recognition of work-related mental disorders?

A study on 10 European countries

european forum
of the insurance against accidents at work and occupational diseases

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understanding occupational risks in Europe

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Report Eurogip-81/E
2013 - 53 p. - 21 x 29,7 cm
N° ISBN 979-10-91290-22-7
Paris: EUROGIP
www.eurogip.fr

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Participation in the reproduction charges: €30 inclusive of tax

Content

Foreword

In September 1998, the European Forum of Insurances Against Accidents at Work and Occupational Diseases[1] set up an internal working group, coordinated by EUROGIP[2], consisting of legal experts and doctors from the insurance organisations of several European countries. Although the original assignment of this group was to collect and compare the national statistics relating to occupational diseases, it subsequently carried out work on more specific subjects. Accordingly, the following reports have been published to date:

- *Occupational diseases in Europe - Comparative study of 13 countries: Procedures and conditions of declaration, recognition and compensation (September 2000)*
- *Occupational diseases in 15 European countries – Figures for 1990-2000 – Legal and practical news 1999-2002 (December 2002)*
- *Overview of occupational cancers in Europe (December 2002)*
- *Survey on under-reporting of occupational diseases in Europe (December 2002)*
- *Lumbago and allergic asthma: Two case studies at the European level (December 2002)*
- *Work-related mental disorders: What recognition in Europe? (February 2004)*
- *Asbestos-related occupational diseases in Europe – Recognition, statistics, specific systems (March 2006)*
- *Occupational diseases in Europe – 1990-2006 statistical data and legal news (January 2009)*

The present report, which covers 10 countries, is an update of the 2004 report on work-related mental disorders in Europe.

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1 The European Forum of Insurances Against Accidents at Work and Occupational Diseases, founded in June 1992, has set itself the objective of promoting the concept of a specific insurance against occupational injuries. In July 2012, nineteen countries - and twenty-three organisations - are represented in it. To find out more, go to: www.europeanforum.org.

2 EUROGIP is a public interest grouping of the French Social Security system, set up in 1991 to work on the subject of occupational risks in Europe. Read more: www.eurogip.fr

Introduction

The subject of work-related mental disorders is regularly examined from the prevention viewpoint. At the European level, the Senior Labour Inspectors' Committee (SLIC)[3] has chosen to focus its 2012 information and inspection campaign on psychosocial risks. The European Commission also recently referred to psychosocial risks at work as one of the priorities of the future new Community Strategy for Health and Safety at Work. At government level, psychosocial risks at work have been increasingly recognised by the authorities in recent years; many national occupational risk prevention organisations are developing research on psychosocial risks, and numerous concrete initiatives are being taken in enterprises and public services concerning specific aspects of the question (harassment, psychological violence, chronic stress, etc.).

While it is now commonly accepted that the work environment can have an impact not only on the physical health but also the mental health of workers, there is no general consensus on the question of recognition of work-related mental disorders as occupational diseases or work accidents in Europe.

Under some conditions, a mental disorder can already be recognised as an accident at work or as a sequel of an accident at work: in Europe, occupational injury and disease insurance organisations cover the mental and psychological sequels of an accident. However, a growing number of workers now report that they are suffering from disorders such as depression, concentration and sleep disorders and job burn-out which are suspected to be caused not by single traumatic events but by work organisation and working conditions, management methods, violence, or changes and restructuring taking place in the company, etc.

Faced with this growing phenomenon, the governments, parliaments, political and social stakeholders as well as the insurance organisations have for some years now been reflecting on the advisability of recognising and paying compensation for such pathologies as occupational diseases.

There are several questions regarding this issue.
Firstly, the multifactorial nature of mental disorders poses the thorny question of the causal relation between work and the disease: unlike so-called conventional occupational diseases, for which it is relatively easy to demonstrate their work-related origin when noxious chemical, physical or biological agents are involved, a worker's mental health can be affected not only by working conditions but also by extra-occupational stresses. In other words, how can it be known whether work is the "decisive" or "essential" cause of the mental disorder of an individual who is possibly already fragilised in his (her) family and social environment?
Secondly, for those European countries that accept that there could be a direct causal relation between work and certain mental disorders, the difficulty lies in defining the concept of psychosocial risk and characterising the causal relation, in order to define a framework for recognition and compensation procedures.

This study carried out on 10 European countries aims to present an overview of the possibilities for recognition of mental disorders both as occupational diseases and as accidents at work (chapter 1), before focusing on recognition and compensation procedures in the countries in question (chapter 2). This is followed by quantification of the phenomenon (chapter 3) and a detailed presentation of available statistics in the various countries (chapter 4). Finally, we review current thinking regarding the recognition of mental disorders as occupational diseases (chapter 5).

[3] The SLIC was set up in 1982 to assist the European Commission in supervising the application of European legislation at the national level. The Committee's main objective is to prepare common principles for labour inspection in the area of health and safety at work. To find out more concerning the SLIC campaign (in English), go to: http://www.av.se/SLIC2012/

It should be mentioned that this study is devoted solely to the "insurance" aspect of work-related mental disorders, i.e. their recognition and compensation of the victims by the occupational risk insurance organisations, in particular as occupational diseases. Any benefits offered by these organisations for the individual or collective prevention of psychosocial risks are not considered in this report, even though in some countries they may be the essential (or even sole) prerogative of the insurers in this specific field.

As regards the scope of the study, it is confined to mental disorders related to psychosocial risks (hence excluding mental disorders related to chemical risk, i.e. caused by toxic substances, notably solvents).

The terms "mental illnesses", "(work-related) mental diseases" and "mental disorders" are used indistinctly to refer to these pathologies, with a concern for complying insofar as possible with the term most commonly used in the country in question.

1. Possibilities for recognition of work-related mental disorders

In most European countries there is a specific national insurance system for accidents at work and occupational diseases. The system is specific in the sense that it is almost always financed exclusively by employers' contributions and managed by organisations separate from the health/disability insurance organisation, and the benefits paid to the victim are more generous.
There is therefore a definite advantage in having a disease or an injury recognised as work-related. But this recognition and the resulting compensation are subject to a number of rules which vary depending on the country. There are very contrasting attitudes in Europe regarding the special nature of mental disorders among pathologies as a whole.

It should be noted that the **Netherlands** are a special case since in this country there does not exist a specific insurance for occupational risks, there is no procedure for claims for recognition for the purpose of compensation (with the exception of mesothelioma). Because of this, other sources are needed to get quantitative information on occupational diseases. In order to collect statistics, a national notification system for occupational diseases is established in which occupational physicians are obliged to report (anonymously) to the Netherlands Center of Occupational Diseases (see Chapter 3: Statistics of recognition, Point 3.1 and Chapter 4: Classification of cases of mental disorders recognised as occupational diseases).

1.1 Recognition as an occupational disease

With the exception of **Spain** (see 1.2) and **Sweden** (see below), all the countries covered by the study and having a specific occupational disease insurance system have a mixed system for recognition of occupational diseases. This means that they have both a national list of occupational diseases (entailing a more or less strong presumption of occupational origin for the diseases recorded there depending on the country) and also a complementary system[4] of recognition for the diseases not registered on the list.

Recognition under the occupational disease list system

Only **Denmark** has registered a mental disorder on its list of occupational diseases. The disease, registered in 2005, is post-traumatic stress disorder.
This disorder must result from exposure to "traumatising situations or events of an exceptionally threatening or catastrophic nature for a short or long period of time".
The conditions relating to exposure contained in the Guide to Occupational Diseases[5] largely correspond to the former recognition practice of the Occupational Disease Committee under the complementary system, but registration on the list allows faster and smoother management of claims.

[4] Also called "complementary clause" in German-speaking countries and "general clause" in Finland, or off-list system

[5] Guide to Occupational Diseases – Guide n° 9738 of 3rd December 2010, 7th edition – National Board of Industrial Injuries
http://www.ask.dk/English/~/~/media/0839B0BDCDFA4C20AD5942AEBB0A25FB.ashx pages 197 to 205

(excerpt)

20. Post-traumatic stress disorder (F.1)

20.1. Item on the list

The disease is included on the list of occupational diseases (Group F, item 1):

Disease

F.1. Post-traumatic stress disorder

Exposure

Traumatic events or situations of short or longer duration that are of an exceptionally ominous or catastrophic nature

20.2. Diagnosis requirements

The disease must meet the below diagnosis criteria according to the WHO international classification of diseases, ICD-10: F43.1.

***A:** Exposure to stressful events or situations (of short or longer duration) of an exceptionally threatening or catastrophic nature*

***B:** 1. Repeated reliving of the trauma in intrusive memories ("flashbacks") or nightmares, or 2. Severe discomfort at exposure to circumstances reminiscent of the trauma*

***C:** Avoidance of all activities reminiscent of the trauma*

***D:** 1. Partial or total loss of memory (amnesia) regarding the traumatic experiences or*
2. Persistent symptoms of autonomic hyper arousal with hyper vigilance, including at least two of the following –
a. Insomnia
b. Irritability or bursts of anger
c. Concentration problems
d. Hyper vigilance
e. An enhanced startle reaction

***E:** The disorder is present within 6 months from the traumatic experiences*

In principle, the diagnosis of post-traumatic stress disorder cannot be made if the injured person does not fully meet the diagnostic requirements to the disease, including the requirement for exposure to exceptionally threatening or catastrophic events within 6 months before the onset of the disease.

The assessment of the diagnosis must, as a basis for recognition, take into account an assessment made by a specialist of psychiatry.

In some cases the medical specialist makes the diagnosis of post-traumatic stress disorder, even though the disease does not meet the diagnostic requirements with regard to quite extraordinary traumas and/or the symptom picture. There may for example be a symptom picture that is equivalent to the pathological picture for post-traumatic stress disorder, without any exceptionally stressful exposure having occurred.

It is the National Board of Industrial Injuries that assesses whether the diagnosis requirements are met, including the requirements for extraordinarily stressful mental exposures.

Other diagnoses such as stress disorder (including acute or unspecified stress disorder), adjustment reaction, depression and stress condition/syndrome are not covered by the item on the list, except where the National Board of Industrial Injuries finds that the pathological picture corresponds with – and meets the requirements to – the disease post-traumatic stress disorder. A number of the other conditions/diseases may, however, in case of extraordinary mental stress, be recognised without the list after submission to the Occupational Diseases Committee.

20.3. Exposure requirements

The disease is deemed to be caused mainly by external stress and may perhaps have permanent mental consequences. The diagnosis itself includes an assessment of the nature of the exposure. In principle it is not possible to make this diagnosis unless there has been exposure to extraordinarily severe stress of an exceptionally threatening or catastrophic nature.

20.4. Examples of pre-existing and competitive diseases/factors

In some cases there may be pre-existing or competitive mental illness which is without any correlation with the particularly stressful exposures in the workplace, but relevant for the overall pathological picture. Similarly, other circumstances than circumstances related to work may be

significant for a person's mental condition. Examples of pre-existing or competitive diseases may be depression, anxiety, psychoses or similar disorders.

20.5. Managing claims without applying the list

Only the disease post-traumatic stress disorder is covered by this item on the list. There must furthermore have been exposures meeting the recognition requirements.

Other diseases or exposures not on the list may in special cases be recognised after submission of the claim to the Occupational Diseases Committee.

The following mental diseases may, after a concrete assessment, be deemed to have been caused by external stresses and may be recognised after submission to the Committee:

- *Stress disorder (including acute stress disorder, other stress disorders and unspecified forms of stress disorder F43)*
- *Depression (including depressive single episode F32). Most depressions are passing, and usually it is not possible to distinguish these from the more persistent types of depression, other than by following the course of the disorder. There is no requirement for the disease to be permanent*
- *Generalised anxiety disorder (other anxiety disorders F41)*
- *Phobias (including phobic anxiety disorders F40)*
- *Obsessive compulsory disorder (obsessive actions)*
- *Somatoform conditions F45 (complaints of bodily symptoms without the presence of any physical cause)*
- *Certain psychoses. Enduring psychoses are not, however, deemed generally to have external stress factors as dominant causes.*
- *Enduring personality change after catastrophic experience (F62) (when the disease is not covered by the diagnosis of post-traumatic stress disorder). Whether these mental diseases will be deemed to have been caused by a work-related exposure will depend on a concrete assessment including symptom onset, the course of the disease and the nature and extent of mental exposures.*

Mental illness with the diagnosis of adaptation reaction will not normally qualify for recognition as an occupational disease. This diagnosis covers very moderate, unspecified and passing mental complaints which are not usually regarded as actual occupational diseases within the meaning of the Act and may besides develop after even very moderate exposures.

20.6. Examples of decisions based on the list *(see Appendix 1 of this study)*

20.7. Delimitation between accident and occupational disease

There are cases where, over a period of time, there are a number of accidents, for example in the form of violence, threats of violence or similar incidents, which may be recognised separately as accidents. For recognition of mental diseases as a consequence of accidents we refer to the guide to accidents. If, in addition to incidents that are treated like accidents, there are stressful incidents that are not recognised, it will be possible to assess the whole course of events and recognise the disease as an occupational disease – if the criteria for recognition of a post-traumatic stress disorder are met besides. When determining the compensation payment, however, we may make a deduction if compensation has previously been granted as a consequence of recognised accidents.

As this excerpt of the Danish Guide to Occupational Diseases specifies it, the post-traumatic stress disorder can also be recognised in Denmark (as in all European countries) as an accident at work. The classification as an occupational disease (under the list system) or as an accident at work will depend on the length of the period of exposure to the risk.
Recognition practices in Denmark since 2005 (see Appendix 1) show that there can in some cases be some blurring between case management of post-traumatic stress as accidents at work and as occupational diseases. It is therefore not impossible that some cases recognised as occupational diseases in Denmark would be recognised as accidents at work in other countries.

Recognition under the complementary system

In **Belgium**, **Denmark** (for mental disorders other than post-traumatic stress disorder), **Italy** and **France**, it is under the complementary system that mental disorders can be recognised as occupational diseases.

In fact, in these four countries there exists a complementary system which has already in practice allowed the recognition of such cases. However, the situation is very different in **Denmark**, where cases were recognised as of the 1980s, and **Belgium**, where only two cases have been recognised in the last fifteen years.

Like for all claims for recognition of a disease not registered on the national list of occupational diseases, the regulations of these countries require a demonstration of the existence of a direct and essential link between the disease and the occupational activity. Chapter 2 describes how the recognition procedure takes place in each of these countries.

Sweden has only a single recognition system, the proof system; it therefore has no list of occupational diseases and every claim is handled on a case-by-case basis. For a case to be recognised, there must be more serious grounds for presumption of the work-related nature of the disease than for the contrary. In practice, many cases of mental illness have been recognised each year in the past several decades.

Spain is a country somewhat apart, to the extent that diseases not registered on the list of occupational diseases can be recognised as accidents at work, provided that their exclusive cause is performance of the work. This sort of complementary system also concerns pre-existing diseases or conditions which have been aggravated by work.
Under Spanish legislation, diseases that are not registered on the list of occupational diseases can be recognised as accidents at work (their investigation as an accident at work functions truly like a complementary system), under the concept "non-traumatic diseases caused or aggravated by work".
Since 2010, these cases can be separated from accidents at work strictly speaking as a result of the establishment of a dedicated registration system called PANOTRATSS. Mental disorders are classified among the categories of diseases which can be recognised as an accident at work under non-traumatic pathologies.
The recognition of mental disorders as accidents at work has been practised since the 2000s. Note, however, that the case must usually be first recognised before a court before the insurance organisation will cover it.

Absence of recognition as an occupational disease

Three countries covered by the study do not currently allow the recognition of mental disorders as occupational diseases.

In the case of **Finland**, the obstacle is purely legal: the legislation defines an occupational disease as a disease essentially caused by physical, chemical or biological agents at work. The Finnish list of occupational diseases is merely a catalogue of examples of diseases that could be considered work-related under a mixed recognition system in which the occupational disease is defined in a general clause which does not include psychological or psychosocial factors.
Between September 2001 and June 2003, a dedicated working group set up by the Ministry of Social Affairs and Health worked on the advisability of incorporating the psychological factor in the definition of occupational diseases, in order to permit their recognition and compensation. But this group, formed of representatives of the social partners, the Ministry, the occupational injury and disease insurance organisation and medical experts, unanimously concluded against this due to the lack of knowledge and scientific and medical evidence regarding a causal link between psychological stress factors at work and mental disorders. At present, only the trade union organisations would like psychosocial factors to be included in the definition of occupational diseases.

In **Germany** and **Switzerland**, the obstacle is rather a de facto impossibility. In both these countries there exists a complementary recognition system which is theoretically open to all diseases. In practice, however, insufficient knowledge and medical and scientific evidence has so far prevented any positive decision regarding a claim for recognition of a case of mental disorder as an occupational disease.

In **Switzerland**, according to Article 9 paragraph 2 of the federal law on accident insurance under the off-list system, other diseases which have been proved to be caused exclusively or very preponderantly by performing work are deemed to be occupational diseases.

This condition is met when the causal role of the work in the disease reaches a proportion of at least 75%, which must be proved in accordance with the preponderant probability criterion. Moreover, in accordance with established legal precedents, the coverage of an occupational disease implies that the condition be typical of the occupation in question, i.e. that the incidence rate for a given occupational group is four times greater than that recorded in the population in general.

In **Germany** too, the insurance organisation emphasises the insufficient knowledge of mental disorders possibly caused by work and the lack of a definition of exposure criteria, so that it is not possible to determine a causal link between the two. Moreover, just as in Switzerland, the condition of an occupation/group of workers more exposed than the general population is lacking for mental disorders to be able to be recognised under the complementary system.

1.2 Recognition as an accident at work (or as a sequel of an accident at work)

Everywhere in Europe, numerous mental disorders are covered as accidents at work. This has no impact on the level of compensation for the victim, and proof is easier to establish than for off-list occupational diseases. But the diseases in question are limited, because the concept of accident implies a criterion of suddenness.

General case

In all the countries covered by the study, a mental disorder can be recognised as an accident at work. Apparently they all have the same position on the subject: it is necessary that an unexpected, traumatising event of short duration be the cause of the mental disorder. These are usually acts of violence (armed robbery, assault in the workplace, etc.) or traumatisms caused by involvement in a traffic accident or in the accident of a colleague. The mental disorder most commonly encountered in these circumstances is post-traumatic stress disorder.

While the essential requirements for the recognition of mental disorders as accidents at work are found in all the countries, they are not expressed in the same way.

In **Belgium**, what is required is a sudden event (mental harm) within the framework of and due to performance of the work contract either in the workplace or on the way to or from work. The risk exposure must have lasted less than 24 hours.

In **Denmark**, the mental disorder must appear following a sudden event or an event that has taken place over a period of at most five days (beyond five days, or in the case of repetitive accidents, the disorder will be investigated as an occupational disease under the list system – see 1.1).

In **Italy**, what is required is a material event that has taken place over at most one work cycle (about 8 hours).

In **Finland**, a post-traumatic stress disorder occurring following an exceptionally threatening or catastrophic stressful event or situation can be recognised as an accident at work, provided that the diagnostic criteria of ICD-10[6] are met. The criteria for compensation of post-

[6] The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), is a medical classification list by the World Health Organization (WHO), for the coding of diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

traumatic stress will be set out formally in the next law reforming the occupational injury and disease insurance system which is due to be published in 2014.

Sweden recognises mental disorders (usually cases of post-traumatic stress) as accidents at work when they are the consequence of an unexpected event that has caused a traumatism in the victim. It can be a matter of violence at work, threats of violence or any other experience that has caused a shock (quite frequent among social workers, nurses or personnel in stores and banks).

In **France**, the accidental event generating a mental disorder must be a sudden event, i.e. dated and precise (time-day-place), which can be defined as "abnormal".
The feature of accidental events customarily causing mental disorders is either a radical change from the normal course of things, or the suddenness of the event, or its unforeseeable or exceptional nature.
On the other hand, situations corresponding to normal working conditions, such as, for example, a mere work order, an evaluation interview taking place in normal and "reasonable" conditions, the employer's dissatisfaction with the quality of the work, a change of position, a disciplinary interview or a dismissal in conditions in conformity with the labour legislation, will not be considered as accidental events.

In **Switzerland**, according to the Federal Court, purely mental harm (a "psychological traumatism") is an accident when it is the result of exposure to a dramatic event of great violence occurring in the immediate presence of the insured, of a nature that would arouse sudden terror in, and disturb the mental balance, of anyone, whether persons who, due to certain morbid predispositions, are less resistant to a nervous shock or insured persons of a composition deemed to be normal.
Note that, in this country, there is no potential benefit for the victim from his accident being classified as work-related since, in addition to occupational diseases, the accident insurance system covers both non-work-related accidents and work-related accidents.

In **Germany**, the first requirement is that the mental disorder must have been objectively diagnosed and classified within the framework of an internationally recognised diagnostic and classification system (ICD-10[7], DSM IV[8]) and it must have been objectively established that it entails damage to health. After the establishment of a reliable diagnosis, the functional impairments must also be determined and the form, intensity or severity of the health damage sustained concretely must be proved in each individual case.
Moreover, proof must be provided – with a sufficient probability – that the mental disorder diagnosed was caused mainly by a specific accident (traumatism) or that said traumatism was one of the causes of this mental disorder. It may be difficult, in a given individual case, to evaluate this relationship of cause and effect. In all cases, this must be done based on the current state of scientific knowledge concerning the causes of specific mental disorders, and the person in question and their state of health must be taken into account individually.
Firstly, it must be checked whether this type of accident can – in practice and on a general level – cause the mental disorder in question (medical and scientific causal relation).
Secondly, it must be proved with a sufficient probability that the traumatism caused by the accident was the cause or one of the causes of the disorder of the person in question, given all the known facts related to the accident and all circumstances outside of the workplace which could possibly have contributed to the disorder.
Established precedents recognise in particular as causal criteria the objective degree of severity of the accident (type and magnitude of the incident), the subjective experience of the situation (chronological sequence of events and behaviour following the incident), and the evaluation of the personality structure compared with relevant characteristics of the pathology in question. In this context, established pre-existing conditions, constitutions favouring the disease (occasional cause) and secondary motivations (desire to leave working life or obtain a financial compensation) are also important.

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[7] See footnote 6 p.10

[8] The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association provides a common language and standard criteria for the classification of mental disorders.

Based on the legal definition of an accident[9], the accident allowing recognition of a mental disorder as an accident at work must be a "singular" incident which must not exceed a single work shift. That is why a mental disorder caused by harassment (mobbing, conflictual communications in the workplace which last for an extended lapse of time) cannot be recognised as an accident at work.
Moreover, the legal experts of the occupational injury and disease insurance system are currently giving thought to the legal classification of successive accidents and the question of the recognition of a psychological traumatism as a consequence of several shocks repeated over a long period of time. The problem is to be able to allow compensation for these cases even though identification of the precise episode which caused the psychological traumatism is impossible.

As regards **Spain**, this country offers two means for recognition of mental disorders as accidents at work, depending on their nature: recognition as an accident at work strictly speaking for cases of traumatisms caused by a sudden event (possibility comparable to all the other European countries), and recognition as a "non-traumatic disease caused by work" which is a special category of accidents at work, in the case of mental disorders such as emotional disorders, phobic and neurotic disorders, behavioural disorders with physical or organic deficiencies and personality disorders (see 1.1).

It is worth emphasising that in those countries that can recognise mental disorders both as an accident at work and an occupational disease (i.e. **Belgium**, **Denmark**, **France**, **Italy** and **Sweden**), the boundary between the two classifications seems to pose no particular problem: the difference between the investigation methods is the possibility of identifying a causal event in time and its sudden, unique, nature, of short duration; only the concept of "short duration" can vary from one country to another.

Specific case of suicide and attempted suicide

Cases of suicides in the workplace or claimed as being caused by work appeared in the 1990s and have recently become frequent in a few rare countries. It is legitimate to ask how these events are treated by the occupational injury and disease insurance system, i.e. whether the suicide can be classified as an accident, whether a presumption of occupational origin possibly applies when it occurs in the workplace and when working, and how the causal link between work performance and the suicide is assessed.

While in most countries a suicide can be covered by the occupational risk insurance system, the legal approaches and arguments in support of a possible recognition vary greatly from one country to another. It also often occurs that recognition is due to a legal ruling and is imposed on the insurance organisation which had initially rejected the claim.

In **Belgium** and **France**, suicide is approached like a conventional accident. Its work-related origin can be recognised if it is linked to performance of the work contract. Moreover, the presumption of work-related origin applies if it takes place during working hours and in the workplace.

In **France**, when the employee has committed suicide during working hours and in the workplace, there is a legal presumption that this suicide is of work-related origin, as is the case for any injury occurring during working hours and in the workplace. To refuse coverage, the insurance organisation must prove that the working conditions played strictly no role in the occurrence of the death, or in other words that the death by suicide is due to a cause completely unrelated to the work.
When the suicide occurs outside working hours or the workplace, it is generally the legal beneficiaries who claim recognition of the work-related nature of the death. It is they who must provide proof of the link between the death and work.
Whether or not there is a presumption of imputability, the insurance organisation always carries out an investigation in the presence of both parties. An enquiry is carried out, whereby

[9] Incidents limited in time which are external to man and act on him (his body and mind), thus affecting his health (section 8 paragraph 1 p. 2, SGB VII)

a sworn official meets the legal beneficiaries, the colleagues of the victim, relatives, the industrial doctor and the employer and/or his representatives (HR Director, etc.). The medical consultant has at his disposal the medical file containing the history of the social security benefits having required a medical opinion (chronic condition, sick leave, accident at work or occupational disease, etc.). The manager of the insurance organisation and the medical consultant meet to prepare the decision for recognition of the work-related nature of the death or not.

When there is a presumption of imputability, it may happen that, based on the information collected, the insurance organisation does not recognise the work-related nature of the death by suicide. On the other hand, it may also occur that the work-related nature of the death is recognised in the case of a person who died at home outside of working hours (excluding a presumption of imputability) because the letter found is explicit and confirmed by hearings of the family and colleagues.
It is the judge who, if the decision is disputed, will assess whether or not working conditions played a role in the death. The insurance organisation must provide conclusive information to overturn the onus of proof.
When the causal event can be precisely dated and pinpointed, the suicide can be recognised as an accident at work. This is the case for nearly all the recognised cases. In the absence of a precise causal event, the suicide may be recognised in an occupational disease as the final stage of a serious depression due to customary working conditions; this case is rare. Finally, a few cases of suicide are recognised as commuting accidents (see statistics on 3.3).

In **Belgium**, a suicide can be recognised as an accident at work if there is a link with performance of the work contract or with the consequences of an accident at work. Like in France, there is a (simple) presumption of work-related origin if the suicide takes place in the workplace and during working hours. The insurance company (insurer of accidents at work) can provide proof to the contrary by demonstrating that the suicide is attributable solely to circumstances of private life, a demonstration which may prove difficult in the absence of farewell letters by the victim, treatment for depression, or major family problems. Moreover, to rule out any recognition, the insurer must demonstrate that the suicide is a conscious and deliberate act.
Finally, when legal beneficiaries manage to demonstrate that there is a causal link between the accident at work or the occupational disease affecting a victim and the mental state that led them to commit suicide, the suicide is recognised as a consequence of the occupational risk in question (even in an occupational disease) and the legal beneficiaries are compensated accordingly.

In **Spain**, a suicide can be recognised as an accident at work provided that it be demonstrated that the emotional state that led to the decision is directly related to the victim's working conditions. It can be noted that the decisions of both the insurance organisations (mutuas) and the courts were systematically negative until the 1970s. Since then, insurers recognise cases for which the causal link is obvious, but it is usually the courts that impose recognition on them (in the event of litigation, it is up to the insurers to provide proof to the contrary).

To obtain recognition, it is essential to prove that the subject in question did not act rationally and intentionally, and that there exists a relationship of cause and effect between the harm caused and the work performed.

- Absence of intention: The suicide must not be a rational act by the subject. Absence of intention will be referred to when suicide is the last stage of a process of alienation and obeys pathological or depressive processes which imply a deterioration of the subject's reason and willpower. This amounts to saying that, to be able to classify self-inflicted harm as an accident at work, it is essential that there be a prior mental disease or a state of mental deterioration which leads the subject to inflict harm on themselves (supreme law court of Castilla y León of 18-03-2009 and supreme law court of Catalonia of 26-05-2009).

- Relationship of cause and effect: In addition to the fact that the act of suicide is not intentional and is associated with a deterioration of awareness or reason, the existence of

a relationship of cause and effect between work and the harm will have to be demonstrated. The existence of a relationship of cause and effect requires a well-considered evaluation of all the factors involved on a case-by-case basis.
Examples of a relationship of cause and effect:
The suicide of a worker for whom it was demonstrated, by the medical diagnosis, that the depressive disorder was caused by excessive work-related worries and by the work rate imposed by the company was considered as an accident at work (supreme law court of the Basque Country of 31-10-2006).
The death of a worker who committed an act of suicide in a state of depression caused by a change of responsibilities within the company that was considered by the worker as a demotion and persecution was considered as an accident at work.

- Key factors to prove the causal relation:
  - The clinical diagnosis: the medical diagnosis prior to the suicide which established a link between the subject's mental disorders and his work.
    The existence of objective work-related circumstances which could be the cause of or have an influence on the mental disorders.
  - The acts of the suicide victim: any farewell note by the suicide victim has been used by courts as additional evidence in order to determine the existence of an accident at work (supreme law court of the Community of Valencia of 1-09-2008).
  - The presumption of Article 115.3 of the General Social Security Act (LGSS): "worker's injuries which have occurred during work and in the workplace are considered as accidents at work, barring evidence to the contrary". But on this point the case law is not unanimous. It is feared that the automatic application of this presumption could lead to fraud against the law by deliberately choosing the workplace as the place of suicide to improve the widow's pension or the allowance for orphans which could be received by the family. When presumption applies, the only way to rule out classification as an accident at work is to prove the complete separation between work performance and the worker's suicide.
  - The most recent court decisions seem to take into consideration as an increasingly decisive factor the explanatory note left by the suicide victim as evidence.

Some countries such as **Germany** and **Italy** consider suicide as the consequence of a causal event itself classified as an accident at work or an occupational disease. We may specify that it is not necessary for the accident at work or the occupational disease giving rise to the suicide to have been recognised beforehand.

In **Germany**, to the extent that the concept of accident implies an involuntary aspect, voluntary death (suicide) is in principle not an accident at work. However, if internal circumstances in the enterprise contributed essentially to the fact that the victim no longer had all his will or if these circumstances essentially led to the decision to commit suicide, the suicide may be considered as an indirect sequel of an accident at work or an occupational disease. Such cases are rare, but they do exist.
Concretely, this may concern suicides by victims suffering from conditions such as a nervous breakdown due to the permanent sequels of an accident or severe persistent pains, but also victims of purely psychological disorders, such as the feeling of responsibility for the accidental death of a colleague or post-traumatic disorders. But in all cases there must be an event triggering the suicide which is related to the company. This condition poses a problem for cases of suicide following a serious dispute with senior management or mobbing (see box).
It should be specified that in **Germany** there is no presumption of work-related origin for accidents occurring in the workplace and during working hours, except for accidents suffered by seamen on their ship or in a port.

In the event of a suicide due to mobbing, can the legal beneficiaries claim benefits?

In 2008, the Bavarian higher court for social disputes ruled that suicide could be recognised as an accident at work and specified the circumstances in which the accident insurance organisation was required to pay benefits for suicide. It had to judge the case of an insured who committed suicide and who, in the letter he left, indicated that his job had been an essential motive for his decision. His widow had presented a claim to the insurer for survivor's benefits, declaring that her husband's act had been caused "by mobbing at work". The insurer had rejected the award of benefits. The widow then brought legal action.
The Social Security Code characterises the accident at work by the existence of an external event which causes a health injury and which is not voluntary. In principle, a suicide is not an accident at work because it is a self-inflicted injury. But it may, in exceptional cases, be the consequence of an event related to the company and thus justify the obligation for the insurance institution to award benefits for an accident at work. In the case examined, the court considered not the suicide but the company's influence on the insured as the event which caused the accident. According to established precedents, this influence constitutes an accident at work when it is limited in time to at most one working day. Mobbing should therefore not be considered as an accident at work because it generally occurs over a longer period. On the other hand, if the influence of the company is exerted during the same single working day (e.g. a personal interview, police enquiry, assault), this may be considered an accident. In this precise case, the court took into account the psychological stress of a personal interview which had caused the insured a psychological shock and led to a depression. It is the psychic injury caused by this interview that was considered as an accident at work, and not the suicide which, for the court, was an unintentional consequence of the accident. Suicide should therefore be compensated as the consequence of an accident at work when the insured sustains a violent psychological shock in the context of his work causing an exceptional mental state which leads to suicide.
haufe.de, online – 06.11.2008 Bei Selbstmord wg. Mobbing – Hinterbliebenenrente von der Berufsgenossenschaft? Bayerische LSG, Urteil v 29.04.2008, L 18 U 272/04

In **Italy** too, the recognition of suicide is possible if the act is the consequence of an accident at work (acute risk) or an occupational disease (chronic risk). A pathological state caused by work is required, even if the insured had not previously reported any event.

In **Sweden**, **Switzerland** and **Denmark**, the legal possibility of recognition of the work-related nature of a suicide exists, but cases are extremely rare, even non-existent.

In **Sweden**, suicide can be recognised as an occupational disease if it is the consequence of exposure to stress or exceptionally hard working conditions. However, recognition as an accident at work is not ruled out. To date, only a few suicide cases have been recognised as occupational diseases.

In **Switzerland**, there are tight laws governing the potential for coverage of the suicide by the accident insurance organisation. We should mention here a specific feature of the Swiss system, namely that the accident insurance organisation covers accidents at work and occupational diseases, but also non-work-related accidents.
Article 37 para. 1 of the Federal Law on Accident Insurance stipulates that if the insured intentionally caused the health damage or death, no insurance benefit is allocated, except compensation for funeral expenses. Hence suicide (or attempted suicide) is in principle not recognised as accidental.
However, Article 48 of the official order on accident insurance defines two exceptions to this principle:

- If the insured was, through no fault of his own, completely incapable of acting reasonably, or
- If the suicide, the attempted suicide or self-mutilation is the obvious consequence of an accident covered by the insurance organisation.

The rare suicide cases covered generally come under insurance for non-work-related accidents. For the work-related nature of a suicide to be recognised, it would in practice be necessary for the act of suicide to be clearly due to working conditions exclusively (personal reasons would be completely ruled out and the suicide would take place in the workplace), or

else the obvious consequence of the sequels of a work-related accident or an occupational disease.

In **Denmark**, recognition of suicide as the consequence of an accident at work or an occupational disease is legally not ruled out, but no cases can be identified for want of claims for recognition.

Finland is the only country covered by the study to strictly rule out any recognition of suicide as an accident at work, because killing oneself is a deliberate act which therefore does not come within the definition of an accident (an unexpected external event causing injury). Recognition as an occupational disease is likewise ruled out.

2. Procedure for recognition as an occupational disease, and compensation

For those countries in which recognition of mental disorders as an occupational disease is possible and in which cases have already been recognised (**Belgium**, **Denmark**, **Italy**, **France**, **Sweden**, and **Spain** for non-traumatic pathologies caused by work), the following explanations specify any regulatory constraints and practices relating to the recognition procedure and then compensation.

2.1 Conditions of recognition

In those countries where mental disorders can be recognised as occupational diseases, they are recognised under a complementary recognition system (**Belgium**, **Denmark** – except for post-traumatic stress which is listed -, **France**, **Italy** and **Spain**) or a proof system (**Sweden**).

In Europe, these systems have in common the fact that they require the demonstration of a direct, decisive, essential and very probable link (the terms used vary depending on the country) between the off-list disease and work performance.

These systems have few or no specific features in terms of prerequisites for recognition (e.g. relating to the diagnosis or the risk covered), because by definition their purpose is to "offer a chance" to off-list diseases, i.e. those for which there is no consensus, to undergo work for the definition and demarcation of possibilities for coverage.

Whatever the country in question, given the specific nature of mental illnesses, special attention is paid to examination of possible extra-occupational causes of the pathology, whether they be personal predispositions of the victim or events in the private sphere which could have had an impact on the occurrence of the disease. The existence of such extra-occupational factors does not rule out recognition of the work-related nature of the mental disease, but it is essential that they should not be considered sufficient to cause the disease.

Specifically regarding mental disorders, some countries have first chosen to define more or less precisely the framework of the recognition procedure, by defining the diseases concerned and/or the risks covered and giving instructions or tools for investigation. Other countries have a more empirical approach.

Italy is the country that has most precisely defined the practice of recognition of and compensation for mental disorders. The latter will be recognised as occupational diseases if they have been caused by specific and particular conditions attributable to dysfunctions arising from work organisation.

In 2001, the Board of Directors of the occupational injury and disease insurance organisation INAIL confirmed a recognition practice initiated in the late 1990s under the complementary system, and entrusted to a Scientific Committee the role of defining methods for etiological diagnosis of disorders of a psychological and psychosomatic nature caused by stress sustained in the workplace, including mobbing.

In 2003, this committee delivered its conclusions regarding the guidelines to be adopted for recognition.

Occupational risk thus defined covers risk situations created by inconsistencies in the organisation process ("*costrittività organizzativa").* The situations most frequently encountered (partly derived from legislative and judicial sources and from the preliminary results for cases reported to INAIL) are:

- Marginalisation of work activity, duties voided of their content, failure to allocate work instruments, and unjustified and repetitive transfers;
- Prolonged assignment to duties implying qualifications below the job profile of the person concerned;
- Prolonged assignment to over-heavy or excessive duties, including in relation to a possible mental or physical disability;
- Systematic or structural prevention of access to information;
- Structural or systematic inappropriateness of the information inherent in normal work activity;
- Repeated exclusion of the employee from training, reskilling or occupational upgrading initiatives;
- Exaggerated or excessive exercise of various forms of control.

The category of "*organisation-related harassment*" includes the notorious "strategic mobbing" for occupational purposes, namely all actions organised in the workplace to alienate or marginalise an employee.
On the other hand, the risk covered excludes organisation factors related to the normal process of the work relationship (dismissal, reassignment, etc.), and situations caused by psychological and relational dynamics common to the occupational environment and the circle of social and family life.
Finally, the purely subjective attitudes adopted by people in their workplace are not taken into account, unless said attitudes, repeated, result in and materialise in inconsistencies that can be documented and demonstrated in the organisation process.

The nosographic framework of the pathologies covered by the insurance system corresponds to the two types of stress-correlated syndromes according to the classification of mental and behavioural disorders of ICD-10 and according to DSM-IV, namely the inadaptation syndrome (manifestation of emotional and behavioural symptoms of clinical significance, in response to one or more stress factors, identifiable and non-extreme) and post-traumatic stress syndrome (delayed or prolonged response following an event that caused intense stress or a situation of an exceptionally threatening or catastrophic nature liable to cause diffuse malaise in almost anyone).

In **Sweden**, mental disorders can be recognised as occupational diseases on condition that they are directly linked to the work. There are several exceptions set out in a law that came into effect on 1 July 2002, the main purpose of which was to simplify the rules relating to the onus of proof. The psychosocial risks not covered are, notably, disorders caused by a plant shutdown or staff cuts, personal disputes or disputes concerning a work contract, a change in a worker's tasks, lack of promotion, or a feeling of being under-esteemed.
Moreover, in Sweden the recognition of this type of disorder is subject to a legal constraint that applies to all occupational diseases and accidents at work: since, by nature, occupational injury and disease insurance benefits are paid only in cases of permanent consequences for the victim, the latter must, due to his or her mental disorder, have suffered a loss of income and/or retained lasting psychological sequels.

In **France**, the complementary system of recognition of occupational diseases allows the recognition of any pathology, irrespective of the nature of the diagnosis or risk, provided that it has been caused essentially and directly by work and that it has resulted in a permanent disability of a certain severity, because a "predictable" rate of at least 25% must be estimated by the insurance organisation's medical consultant. This regulatory condition applies to mental disorders in the same way as to any off-list disease (however, see a relaxation of the rule in 2.3).

In **Spain**, the PANOTRATSS system, for the identification of off-list pathologies recognised (under accidents at work) as non-traumatic pathologies caused or aggravated by work, distinguishes between and accordingly defines the four types of mental disorders that can be recognised by the insurance organisations: emotional disorders, phobic and neurotic disorders, and behavioural disorders with physical or organic deficiencies and personality disorders.

In **Denmark**, any mental disorder can be recognised as an occupational disease, either under the list system in the case of a post-traumatic stress disorder, or under the complementary system in all other cases. In this second possible case, this usually concerns non-specific stress disorders or depressions.

Since **Belgium** only very marginally permits recognition of mental disorders as occupational diseases, it is not possible to define recognition conditions or practices.

2.2 Investigation of the claim for recognition

In none of the complementary systems for recognition of occupational diseases are there special requirements for the investigation of cases of mental disorders. On the other hand, some countries have tried to produce performance aids for the insurance organisations.

Onus of proof, investigation and decision making

Except in **Sweden** where there is only a proof system, everywhere mental disorders are investigated under the complementary system (except certain post-traumatic disorders in **Denmark**).

Everywhere, the investigation of an off-list disease is entrusted to an entity/person within or related to the insurance organisation. In **Denmark** and **Belgium**, this is a single structure at the national level (it can be assumed that this ensures a certain consistency of decisions on the national level), while in the other countries the entities/persons in charge of investigation and/or the decision of recognition have a territorial competence.

In **France**, it is the medical consultant of the Social Security organisation who confirms the diagnosis and gives a decision concerning a predictable permanent disability rate exceeding 25% (an essential requirement to obtain recognition under the complementary system – see also 2.3).
When the predictable permanent disability rate exceeds 25%, the medical consultant sends a report to the regional committee for recognition of occupational diseases ("CRRMP"). Meanwhile, the Social Security fund carries out an administrative enquiry in the presence of both parties, the victim and the employer. The enquiry report is sent to the committee together with the opinion of the industrial doctor.
This committee, consisting of a medical consultant of the Social Security system, a labour inspector doctor and a hospital practitioner specially qualified in the area of occupational diseases, must establish the existence of a direct, essential link between the disease and work. This doctors' body does not necessarily have competencies in the area of mental disorders, but the investigation dossier very often includes the opinion of a psychiatrist; if this is not the case, the committee can ask for one. The regulatory investigation period is six months at most. However, in the case of off-list conditions such as mental disorders, the regional committee may have to continue its investigation beyond six months. The average time observed between the claim for recognition and the decision on coverage is 10 months. The opinion of this committee is binding on the fund.

Apart from post-traumatic stress disorder, which can be recognised in **Denmark** under the list system, claims for the recognition of other types of mental disorders are investigated by the Occupational Diseases Committee. One of the roles of this committee, consisting of employees' and employers' representatives and medical experts, is to give a ruling on cases of diseases not registered on the list, by assessing the existence of a causal link between the

disease and work, based on the investigation conducted by the insurance organisation, the Danish National Board of Industrial Injuries. The claim is investigated when the victim's state of health is stable. In Denmark also, the onus of proof in this case is on the victim, but the reality is less clear-cut, because the insurance organisation's case manager assists it, for example by questioning the employer, collecting the necessary medical information and obtaining relevant scientific articles.

In **Italy**, the onus of proof of the work-related origin of the disease is theoretically on the victim for off-list diseases, whether regarding the existence of the risk or else the disease. However, the insurance organisation INAIL takes part in gathering evidence; it is in fact an occupational medicine specialist and expert in legal medicine from INAIL who investigates the claim, in cooperation with the worker and possibly their industrial doctor, when the victim's state of health has stabilised. The INAIL's doctor calls on specialist doctors (psychiatrists), even from outside the institute.

In **Belgium**, a doctor from the Occupational Diseases Fund insurance organisation (*FMP: Fonds des Maladies Professionnelles*) assesses whether there exists a direct and decisive causal link between the disease and work; if necessary, he can call on the expertise of a specialist (e.g. a psychiatrist). The "open system" Commission, formed of doctors from outside the FMP and FMP civil servants, gives a ruling on the recognition decision based on the investigation dossier.
The investigation time between the date of the claim and the decision is approximately one year.

In **Sweden**, the national social insurance agency *Försäkringskassan* investigates the claim. The case is recognised if there are more serious grounds for presumption of the work-related nature of the disease than for the contrary. The facts must be documented by information coming from several sources, in particular testimony from the victim's seniors, his colleagues, the trade unions and personnel administrative representatives. This investigation lasts about four months.
The investigation of the claim for recognition takes place when the victim has suffered a loss of income due to the mental disorder for at least one year.
Another organisation, *AFA Försäkring*[10], acts in the field of recognition and compensation of the victims of occupational risks in Sweden. While it has no prerogatives to cover a disease that has not first been recognised as work-related by *Försäkringskassan*, it can, on the other hand, recognise and cover an accident whose work-related nature has not been recognised by the national insurance agency. In this way, numerous mental disorders are recognised by this complementary insurance system (see statistics in 3.2). The onus of proof lies with the victim, but *AFA Försäkring* is obliged to investigate each claim (mostly by telephone, in accordance with predefined protocols).

In **Spain**, it is the doctor of the insurance organisation[11] who determines whether the pathology is caused exclusively by work or is aggravated by it.
However, an increasing number of legal rulings have been given in favour of the recognition of mental disorders as accidents at work, and these rulings are binding on the insurance organisations.

[10] A contractual complementary insurance system funded by the employers and covering nearly all employees, which pays compensation for other damage such as the loss of income not covered by the national insurance system (due to the existence of a ceiling), but also immaterial damage (pain and suffering and moral prejudice) as well as bodily harm and loss of amenities of life.

[11] The very great majority of companies take out insurance against accidents at work, commuting accidents and occupational diseases with one of the employers' mutual insurance companies *(Mutuas de accidentes de trabajo)* accredited by the Ministry of Labour and Immigration and having the status of private non-profit organisations which work jointly with the public-service Social Security system. Companies can also choose to be insured directly by the national Social Security institute INSS (*Instituto Nacional de la Seguridad Social*).

Tools

Three countries indicate that they have (or had in the past) instructions designed to help the competent entity regarding the recognition of mental disorders as occupational diseases. In the other countries, tools not specific to the insurance area are used.

In **France**, a working group of the Occupational Diseases Commission of the Steering Committee on Working Conditions (*Conseil d'orientation sur les conditions de travail* – COCT) conducted work on compensation for mental disorders in 2012 (see chapter 5). This work led to the dissemination to medical consultants by the insurance organization CNAMTS of a performance aid to assess better – and uniformly throughout France – the predictable permanent disability rate exceeding 25% in cases of mental disorders (*lettre-réseau*[12] of 4 January 2013[13]).

This working group also recommended to update the Guide for regional committees for recognition of occupational diseases (see excerpt from the Guide below), a decision aid tool, the second part of which sheds light on mental damage related to psychosocial risks. The work to update the Guide is in progress.

Excerpt from the Guide for regional committees for recognition of occupational diseases (2009 version)

"7.8 Conditions of psychological origin

The committees can be questioned to establish a direct, essential link between conditions of psychological origin and the work customarily performed under off-list diseases.
Conditions related to a one-off event that could be termed accidental, in the form of a post-traumatic neurosis or post-traumatic stress (codes F 43.0 and F 43.1 of the WHO's International Classification of Diseases, 10th revision), are generally covered as accidents at work, although boundary situations can exist between accident and disease.
Conditions of psychological origin can be related to customary working conditions.
These may be:
- Generalised anxious or depressive disorders (F 32.0, F 32.1, F 32.2, F 41.1);
- Neurotic disorders related to stress factors and somatoform disorders (F 45.1, F 45.3, F 45.4);
- Physical and mental burn-out (Z 73.0).
These clinical tables can be combined.
In order to give a decision, the committees must have sufficient information on the disease and the nuisance(s).

7.8.1. Characterisation of diseases
Regarding the disease, the committees may use as a basis specialised medical decisions which provide information concerning any psychiatric antecedents and which will clarify the diagnosis of the disease suffered by the claimant. The symptomatology of the anxio-depressive syndrome related to harmful working conditions is now well described. In these difficult cases, the committees must be able to have detailed medical observations providing information regarding the start of the symptoms and the successive phases of the disease, its duration, its evolution, the treatment provided and the sequels. The chronological description of the disease must be able to be compared with the chronological description of the nuisance(s). The coverage of pre-existing characterised psychoses should be ruled out.
It is essential that the members of the committee should be able to know the precise positive diagnosis of the disease and the differential diagnoses ruled out in order to be able to establish an etiological diagnosis.

[12] The *lettres-réseau* are documents which are not public and which are disseminated internally by the insurer CNAMTS. They are decision aid tools aimed at harmonizing practices; they have the force of good practice recommendations.
[13] Guide pour les Comités régionaux de reconnaissance des maladies professionnelles (Guide for regional committees for recognition of occupational diseases), 2009 version: http://www.inrs.fr/accueil/produits/mediatheque/doc/publications.html?refINRS=TM%2013

7.8.2. Nuisances
A disease which could be work-related must be directly and essentially related to customary working conditions. The role of the committee is therefore to determine whether the customary working conditions are harmful for the patient's mental health.
The dossier must contain documents allowing the committee to make a decision: medical consultant's report, opinion of the industrial doctor, opinion of the employer, established facts and information collected by officers of the Social Security organisations in charge of the enquiries, with their conclusions. The committee must also take into account any other available data such as, in particular, the data provided by the parties and the enquiries and observations of the staff representative bodies.
It is essential that the committees be able to identify the various possible causes of suffering. Assessing the pathogenic nature of working conditions is a tricky task, and it must be based on arguments that are as non-subjective as possible.
These may be:
- *Work organisation methods: organisation of the enterprise and its changes; specified and actual work of the employee and its changes (job position, material resources, procedures, independence in the work, etc.);*
- *Interpersonal relations with the other members of the enterprise, whether they be senior managers or fellow workers, with possibly pathological personalities behaving violently or making statements reflecting a conflict of values, a conflict of objectives, etc.;*
- *Working conditions that are gruelling by nature.*

The harmful nature of the work for mental health may possibly have been classified beforehand as harassment by courts (industrial relations tribunal, criminal court). Such classifications are possibly a factor to be taken into account, but they must not be either the sole positive or negative argument to be considered by the committees, nor should they be systematically awaited in order for them to deliver their opinion.
The existence of legal proceedings, often in industrial relations tribunals concerning disputes of various kinds (e.g. grounds for dismissal, or compensation), is one item of information among others for the committees regarding working conditions. "

In **Denmark**, the Occupational Diseases Committee, competent for the recognition of off-list diseases, uses for the cases of mental disorders that are submitted to it a reference document published in 2007 on the relationship between work-related psychosocial factors and the development of mental disorders[14]. This document is a compilation of about one hundred scientific studies concerning the various aspects of the issue.

It is worth mentioning that, in **Italy**, as of 2003 INAIL had distributed to its territorial organisations a circular stipulating the procedures for handling claims for recognition of mental disorders. This circular, which established procedures for the verification of risk conditions and for establishment of the diagnosis, was attacked before administrative courts by numerous employers' organisations and was declared void by the Italian administrative courts[15]. It was criticised for giving instructions regarding the definition and diagnosis of mobbing, and for considering mental disorders caused by organisational constraints as real occupational diseases which would enjoy a presumption of occupational origin.

Nevertheless, the 2003 report by the Scientific Committee appointed following the resolutions of the INAIL Board of Directors of July 2001 (see 2.1) gives guidelines which are still relevant regarding the methods and criteria used for the diagnosis of work-related mental disorders, in particular in Chapter 5.

[14] *The relationship between work-related stressors and the development of mental disorders other than post-traumatic stress disorder - A reference document on behalf of the Danish Work Environment Research Fund;* Bo Netterstrøm, Nicole Conrad. Clinic of Occupational Medicine, Hillerød Hospital, Denmark, September 2007.
http://www.ask.dk/~/media/4A37CFA4013E41C4B89F56C2F812D5F0.aspx

[15] The INAIL circular No. 71/2003 was declared void by the Regional Administrative Tribunal of Latium (ruling No. 5454 of 4 July 2005), cancellation confirmed by the Council of State (decision No. 1576 of 17 March 2009).

Excerpt from the report of the ad hoc Scientific Committee (2003)

" Like all off-list occupational diseases, the mental or psychosomatic disorders reported by the insured must undergo an in-depth enquiry and be analysed in light of not only the statements by the subject, but also those of the employer and information collected directly from the company managers and fellow workers. These enquiries, covering the occupational case history, should make it possible to detect risk factors related to organisational constraints.
At the same time, all the available medical data should be collected. In the field of psychiatry even more than in other medical specialties, reconstitution of the subject's prior condition is especially important, not to mention extra-occupational causal factors. This is because the pathologies in question are multifactorial (family/personal, environmental/social factors) and, of these factors, occupational risk may seem to be only an accessory factor without any direct relationship with the causes of the pathology.
Such an analysis of the subject's prior condition will make it possible to reach conclusions concerning:

- *The presence of pre-existing disorders which could explain the entire clinical presentation of the pathology (and hence rule out an occupational cause);*
- *The presence of pre-existing disorders (predispositions) having a partial causality;*
- *The absence of pre-existing disorders.*

In the latter two hypotheses, analysis of the reported risk will be decisive if it makes it possible to demonstrate, with certainty or at least a high level of probability, that exposure to the occupational risk is the predominant (or even sole) cause of the pathology.

To support this analysis, it is worth mentioning that there exist in the literature "scales" worked out on the basis of the replies obtained through questioning various groups of subjects (see Homes and Rahe, 1967; Dohrenwend et al., 1974, 1988; Fisher, 1996) which classify the events in life that can be sources of stress; at the top of the list, for example, is the death of the spouse or a child, and then, in decreasing order: divorce, separation from the spouse, imprisonment, the death of a close relative, accidents or diseases, marriage, the loss of a job or a professional failure, demotion, promotion, retirement, the death of a close friend, a change of job and other changes in social life. Even though events related to work activity are not at the top of this list, they can have a significant influence and should therefore be allowed for and assessed in the context of the other events in life, even the positive events, which each individual may have to face.
To ascertain the reported pathology, only sworn specialists are competent: they perform a full clinical examination in order to analyse the personality of the subject before the pathology, and the evolution of the clinical presentation. "

2.3 Assessment of and compensation for permanent mental damage

The type of benefits paid by the insurance organisation to the victim of a mental disorder recognised as work-related is the same as for any occupational disease. The nature and scope of these benefits depend on the compensation system specific to each country[16].

Of the five countries that can recognise mental disorders as occupational diseases, three have in their national scale for assessment of permanent disability headings dedicated to mental disorders, which will enable them to deduce a level of compensation.

Although they are not dealt with in this chapter devoted exclusively to the recognition of mental disorders as occupational diseases, the other countries which recognise only certain mental disorders as accidents at work likewise have either specific headings for post-traumatic stress in their national scale, or medico-legal tools to assess this type of traumatic situation in order to calculate the level of compensation for the victim.

[16] *To find out more, go to:* Accidents at work and occupational diseases: flat rate or full reparation? European survey on the conditions of compensation for the victims, June 2005, Eurogip–21/E *and* Compensation of permanent impairment resulting from occupational injuries in Europe, comparative analysis in ten European countries of the case studies submitted to the members of the European Forum of Insurances Against Accidents at work and Occupational Diseases, December 2010, Eurogip–59/E

In Denmark

Faced with an occupational disease that has caused permanent damage, the occupational injury and disease insurance organisation provides separate compensation for the loss of earning capacity sustained by the victim (pecuniary damage) and the permanent disability caused by the disease (physiological and psychological damage).
The former damage, assessed concretely, depends on the result of a comparison between the wage that the victim received before the occurrence of the occupational disease and his new wage or the wage that he can still expect, but factors such as age and capability for occupational conversion are also taken into account.
The latter damage is assessed by means of a medical scale. This tool assigns to each defined pathology an indicative rate of permanent disability. This rate can be used to calculate the amount of the benefits for permanent disability, paid in the form of a lump sum, which is identical for all victims irrespective of their age, gender and income. Heading J is devoted to mental disorders. The rate granted for a mental disorder varies from 5% to 35% depending on the condition, which corresponds to a lump sum of between DKK 39,525 (or €5,317*) and DKK 276,675 (or €37,216*).
* Exchange rate prevailing as at 20 June 2012

Extract of the Danish permanent injury rating list (item J dedicated to the mental illnesses)

J MENTAL ILLNESSES FOLLOWING VIOLENCE OR SHOCK
Exposure to inconsiderable violence, threats or shock due to a minor emotional trauma is not accepted as the only cause of a permanent injury of 5 per cent or more.

J.1 POST-TRAUMATIC STRESS DISORDER
When assessing the severity, the number of symptoms, the frequency/intensity of the symptoms as well as their impact on an everyday life are emphasised.

Over time the symptoms will quite often change into the diagnosis "personality change after catastrophic disaster"[17], thus some nuisances will decrease/ease off, while others might appear. As regards permanent injuries, these two conditions are therefore considered as one condition with a joint permanent injury rating, cf. the rating list. In most cases a post-traumatic stress disorder is temporary.

If a post-traumatic stress disorder has eased off entailing that the diagnosis criteria when assessing the permanent injury is no longer fulfilled, a compensation for a permanent injury equivalent to less than a mild degree of severity will be compensated, i.e. 5-8 per cent.

J.1.1. Mild post-traumatic stress disorder	*10%*
J.1.2. Moderate post-traumatic stress disorder	*15%*
J.1.3. Moderate to severe post-traumatic stress disorder	*20%*
J.1.4. Severe post-traumatic stress disorder	*25%*
J.1.5. Severe symptoms of post-traumatic stress disorder and simultaneous symptoms of other mental illness such as psychotic symptoms and/or severe symptoms of chronic depression or personality change	*35%**

J.2 UNSPECIFIED STRESS DISORDER
The symptoms of unspecified stress disorder are less specific than of post-traumatic stress disorder. The symptoms are often alertness, irritability, concentration problems, noise sensitivity, sadness, etc. When comparing with the symptoms of post-traumatic stress disorder, the symptoms of unspecified stress disorder are often less comprehensive. The degree of severity is assessed from the symptoms, the severity of the symptoms and their impact on the everyday life.

J.2.1. Mild unspecified stress disorder	*5%*
J.2.2. Severe unspecified stress disorder	*10%*

[17] Item F62 of classification ICD-10 (author's note)

J.3 CHRONIC DEPRESSION

Depression means depression according to the classification of diseases ICD-10. Most depressions are temporary, however some become chronic. In accordance with the classification of diseases, the degree of severity is assessed on the basis of nuisances, the severity of the nuisances and their impact on the everyday life.

J.3.1. Mild chronic depression	*10%*
J.3.2. Moderate chronic depression	*15%*
J.3.3. Severe chronic depression	*20%*
J.3.4. Severe chronic depression with psychotic symptoms	*25%*

J.4 POST-TRAUMATIC ANXIETY DISORDER

Post traumatic anxiety disorder is a condition with no significant nuisances other than anxiety. In many cases, the nuisances will be temporary, however in some cases the anxiety becomes permanent. The degree of severity is assessed as with other mental illnesses.

J.4.1. Mild post-traumatic anxiety disorder	*5%*
J.4.2. Severe post-traumatic anxiety disorder	*10%*

* On 1 July 2011, the rate corresponding to item J.1.5 was increased from 25% to 35%. While the scale applies to all victims of occupational diseases, it was in a context of the return from war zones of numerous Danish soldiers suffering from serious mental disorders that this measure was decided.

In France

The Social Security system calculates the amount of benefits for permanent disability for the victim of an occupational disease by means of an indicative disability scale. The permanent disability rate associated with each disease can, where appropriate, be adjusted by an occupational coefficient.
The amount of benefits paid to the victim is calculated by combining their last wage with the permanent disability rate weighted downward if it is less than 50% and upward if it is higher.
The indicative disability scale following an occupational disease is not appropriate for mental disorders. Because it is merely indicative, the medical consultants of the Social Security system have considerable leeway to assess the permanent disability rate of the victim of a mental disorder.

Excerpt from the French indicative disability scale (occupational diseases)

Chapter 4 Neurological, neurosensorial and psychiatric conditions
Sub-chapter 4.4. Mental disorders – Organic mental disorders
4.4.2. Chronic

Depressive states of variable intensity:
either with a persistent asthenia……..10% to 20%
or, conversely, major melancholic depression, pantophobic anxiety ……50% to 100%
Behavioural disorders of variable intensity ……10% to 20%

In practice, until very recently, the permanent disability rate fixed by medical consultants for cases of mental disorders was often 25%, because in **France** this rate corresponds to the minimum rate to obtaining recognition of off-list diseases. This 25% rate was in many cases overestimated, but it was binding to the extent that a causal link had been recognised by the CRRMP in charge of the case.
A ministerial letter of 13 March 2012 clarified the procedure for setting the permanent disability rate for off-list diseases: the "predictable" rate of less or more than 25% serves merely to decide on whether to send the claim for recognition to the CRRMPs, while the actual permanent disability rate will be determined only after stabilisation of the victim's medical

condition, which may occur after the recognition decision. It is this latter rate which will determine the amount of benefits paid to the victim for permanent disability.
This new practice should make it possible for medical consultants to set more realistic permanent disability rates (even less than 25%, if after medical treatment and de facto removal of the risk the victim no longer has any residual sequels), and should also make it possible to register a greater number of claims for recognition.

In Italy

Since the 2000 reform of the compensation system for occupational injuries and diseases, it is biological damage that is the basis of compensation for permanent disability.
The biological damage rate (permanent by definition) for a case of mental disorder is determined by analogy with the two items in the disability scale devoted to mental disorders, presenting a precise overview of the pathology which must be in accordance with the classifications corresponding to syndromes and disorders of a psychological nature (ICD-10 and DSM-IV).
Bearing in mind that the disorders in question are mostly temporary, allowance must be made for polymorphism in the clinical presentation and a gradual approach should be adopted depending on the seriousness of the predominant symptomatology: see the classifications indicated in ICD-10 and DSM-IV. For light/moderate forms, the percentage could be close to the range provided for under item 180, and for severe forms (major depressive and behavioural symptoms) to that under item 181.

Excerpt from the Italian disability scale of 12 July 2000 on permanent biological damage

(180) Post-traumatic disorder caused by a moderate chronic stress	*up to 6%*
(181) Post-traumatic disorder caused by a severe chronic stress	*up to 15%*

Note that, in **Italy**, a disease (off-list or not) can be recognised as occupational even if it has only temporary consequences in terms of disability (concretely, the victim will be absent from work and paid compensation for absolute temporary disability). It will then be assessed whether there are permanent sequels, in which case compensation for biological damage is provided for. The existence of, improvement in or worsening of these permanent consequences may be reassessed subsequently.

In Belgium and in Sweden

In **Sweden**, there exists no scale establishing a framework for assessment of the permanent disability of the victims of occupational diseases. This absence is perfectly logical to the extent that the national occupational risk insurance system compensates only the loss of earning capacity, when it has been reduced by at least 1/15th for more than one year. The amount of these benefits paid in the form of a pension depends on the difference between the (theoretical) income that the victim would receive in the absence of an accident or occupational disease, and the income actually received after the event (including any other welfare benefits).

There is no scale either to determine the permanent disability as a consequence of an occupational disease in **Belgium**. In practice, doctors rely on "custom" and are monitored by the labour courts and tribunals.

3. Statistics of recognition

The legal possibilities for recognition of mental disorders were described in Chapter 1. Regarding recognition as occupational diseases, these possibilities proved limited to five European countries (six counting **Spain** and its concept of "non-traumatic diseases caused by work"). Regarding recognition as accidents at work, the procedure is easier in all the countries covered by the study, although it is generally limited to a precise type of risk exposure (criterion of a sudden, traumatising event).

Leaving aside the legal possibilities, it is clear that the number of cases of mental disorders recognised as occupational diseases is very limited, and although this is less true for accidents at work, the insurance organisations' statistics are often relatively imprecise.

This chapter presents the statistics reported by the insurance organisations of the various countries, for both occupational diseases and accidents at work.

The reader should be warned that any attempt at comparison between countries requires great caution given the diversity of insurance systems, differences in the coverage of these systems (private/public sector, exclusion of agriculture, etc.), and the heterogeneity of recognition and compensation practices.

3.1 Mental disorders as occupational diseases

Only five of the ten countries covered by the study are capable of providing, via the insurance organisation, statistics on the number of cases of mental disorders reported and the number recognised as occupational diseases over the last 15 years. Four of these countries (**Denmark**, **France**, **Italy** and **Sweden**) are those which customarily allow such recognition (see Chapter 1), to which can be added **Germany**, which, although not allowing this, nevertheless has figures concerning the number of cases reported.

In those countries where cases are effectively recognised

Five countries allow recognition of mental disorders as occupational diseases (see Chapter 1). However, **Belgium** is excluded from the following tables and figures because this country has no data on claims for recognition and the possibility of recognition is very marginal there: only two cases have been recognised until now (in 2002).

Table 1

Mental disorders: claims for recognition and recognised cases as occupational diseases in 4 European Countries between 1996 and 2011

	Denmark		France		Italy		Sweden	
Year	Claims for recognition / recognised cases		Claims for recognition / recognised cases		Claims for recognition / recognised cases		Claims for recognition / recognised cases	
1996	434	**3**	1	**0**	30	**7**	313	**55**
1997	449	**9**	4	**1**	26	**4**	185	**39**
1998	359	**8**	2	**0**	26	**6**	184	**39**
1999	483	**19**	3	**2**	37	**11**	235	**77**
2000	690	**11**	5	**1**	62	**14**	387	**99**
2001	1,052	**36**	12	**4**	169	**57**	640	**146**
2002	1,167	**32**	17	**7**	167	**49**	903	**177**
2003	1,397	**71**	41	**18**	254	**49**	1,260	**238**
2004	2,010	**79**	59	**30**	522	**65**	1,639	**213**
2005	2,534	**146**	72	**26**	543	**70**	1,987	**168**
2006	2,990	**99**	73	**28**	511	**53**	1,985	**149**
2007	3,445	**148**	78	**33**	554	**51**	1,914	**209**
2008	3,521	**196**	86	**44**	476	**55**	700	**104**
2009	3,089	**223**	142	**72**	415	**42**	648	**111**
2010	3,106	**246**	136	**63**	380	**37**	710	**103**
2011	3,486	**212**	196	**94**	378	**13**	451	**70**

Methodological notes

In **Sweden**, the statistics indicated cover not the number of mental disorders reported and recognised, but the number of benefits claimed and awarded by the insurance organisation. These figures are therefore not exactly comparable to those of the other countries. The figures regarding benefits are in fact slightly overestimated relative to the number of persons concerned, since one person can get more than one benefit.

In **Sweden** and **France**, the number of claims for recognition corresponds not to the number of cases filed during the year in question, but to the number of cases that received an unfavourable decision added to the number of cases that received a favourable decision that year.

Comparison between countries

The differences in volumes from one country to another are hard to comment on, because the sample of countries concerned is limited and volumes are low.
Moreover, the insured populations are comparable only in **Denmark**, **Italy** and **Sweden** where all categories of workers are insured with the same insurance organisation (agriculture – industry & services – civil service). Indeed, in **France**, civil servants and the numerous special schemes related to public services (public transport, security forces, education, hospital staff, etc.) are excluded from the general Social Security regime represented in this study. Now, it is well known that these categories of workers, due to their work in contact with the public or to the occupations they practice, are particularly exposed to psychosocial risks (armed forces, education, hospitals, etc.). But more precise statistics (see 4.3) show that if public officials represent less than 1% of recognised cases of mental disorders in **Italy**, this percentage rises to 70% in **Denmark**.

It must be admitted that the volumes of claims for recognition, but especially of recognised cases of mental disorders, are small relative to the insured population and the total number of occupational diseases recognised in each of these four countries.

Table 2
Insured population, claims for recognition and cases recognised for all occupational diseases (orders of magnitude)

	Insured population (scope)	Insured population (number)	Total number of claims for recognition as occupational disease	Total number of recognised cases of occupational diseases
Denmark (2009)	All workers	2,830,000	18,000	4,810
France (2009)	Employees of private sector	18,110,000 (FTE)	99,275	70,000
Italy (2008)	All workers, except for civil servants stricto sensu	18,360,000	27,700	10,100
Sweden (2009)	All workers	4,400,000 (2010)	9,145	1,900

FTE: Full Time Equivalent

Nevertheless, it can be noted that there are more cases in **Denmark** and **Sweden**, whether it be claims or cases recognised.
It cannot be deduced from this that there is a greater prevalence of mental disorders in these two countries. But it may be assumed that these Nordic countries have a better-established practice of the recognition of this type of condition due to an older tradition of allowance for them. The first cases recognised in these two countries date from the 1980s, whereas it was not until the mid-1990s that cases were recognised in **France** and **Italy**. And we note that there were already numerous claims for recognition in the two North European countries as of the mid-1990s (see figure 2).

Relative to the insured population, the number of cases of mental disorders recognised is highest in **Denmark**, with 6.36 cases for 100,000 insured. This can be partly explained by the fact that over half of the cases correspond to the post-traumatic stress diagnosis registered on the Danish list of occupational diseases since 2005 (see Chapter 1 for the possibilities of recognition and Chapter 4 for the statistics of recognised cases per diagnosis).
The fact that this condition is listed facilitates the procedure for recognition of this pathology, and demonstrates the readiness of the Danish insurance organisation to cover it.
Moreover, one cannot rule out the possibility that, although post-traumatic stress disorder is recognised in Denmark, as in all the other countries, as an accident at work when the risk exposure was of short duration, some cases of post-traumatic stress have been classified here as occupational diseases when they would have been recognised as accidents at work in the other countries, which would have resulted in an overestimation of the Danish ratio.

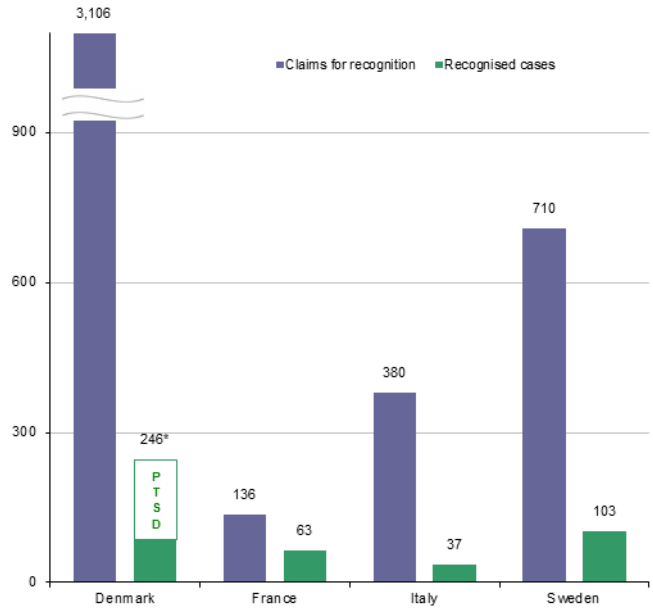
The ratio is of the same order of magnitude in **Sweden**, where the insured population is about 4.5 million for 70 benefit payments made in 2011 for mental disorders.
Italy and **France** are far behind, with an insured population of about 18 million and less than 100 work-related mental disorders recognised per year.

As regards recognition rates, that is to say the proportion of claims which actually leads to recognition, they are relatively low everywhere, and in practice less differentiated than they appear visually on figure 1:

For 2010, the rate was 7.82% for **Denmark**, 9.74% for Italy and 14.51% for **Sweden** respectively. In the case of **France**, the rate is 46.32% of cases that can be investigated under the complementary system of recognition of off-list diseases, i.e. cases that meet the prerequisites for any investigation (the victim's state of health had to be medically stabilised and the pathology had to cause a permanent disability rate of at least 25%: see Chapter 2, point 2.3 on the relaxation of these conditions since March 2012). However, it is estimated that less than 20% of claims for recognition are in fact investigated by the dedicated recognition committees out of about 500-600 claims each year, for want of validity. Due to this specific feature, the rate of recognition relative to all claims stated is estimated at around 12%.

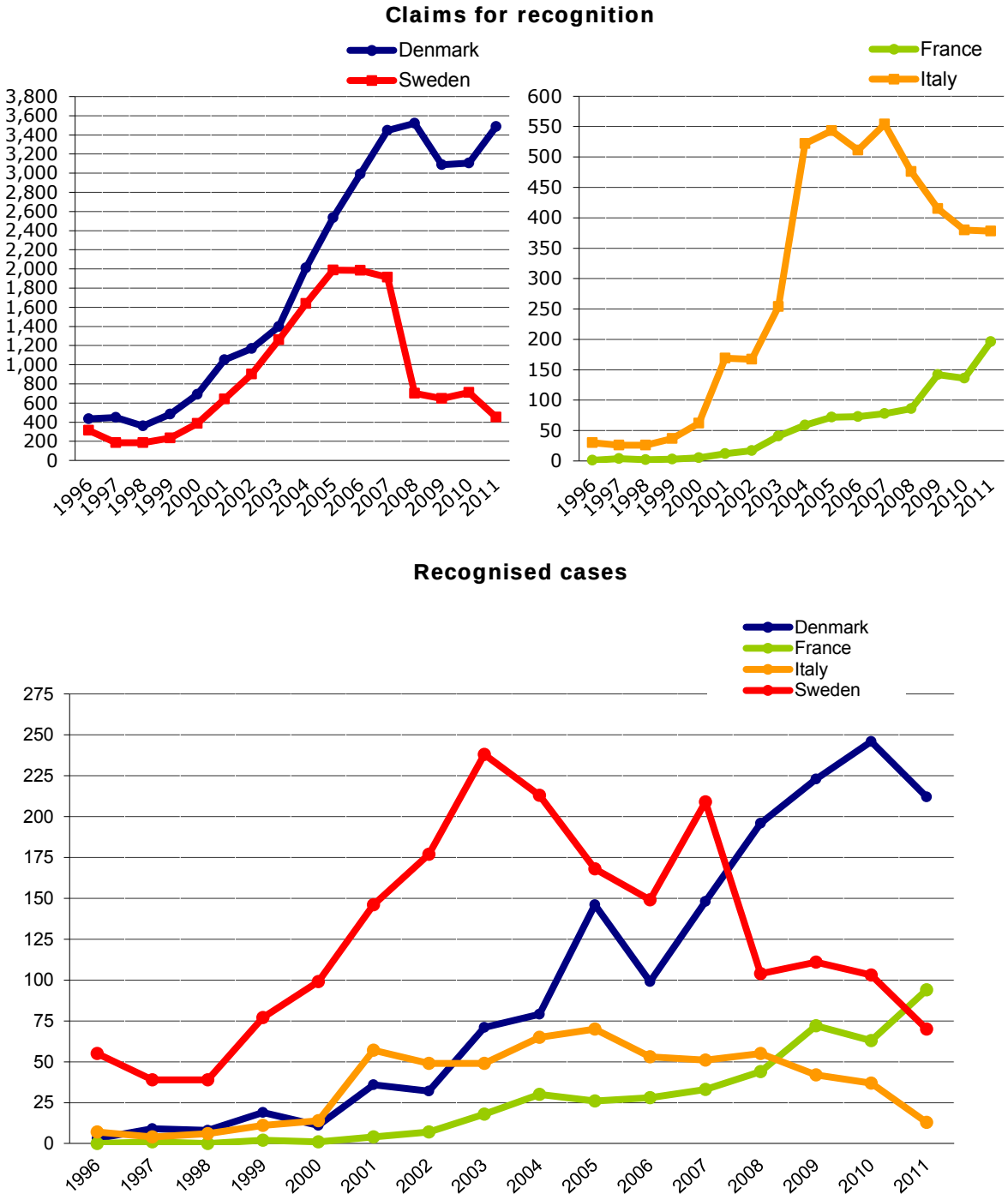
Over time, in **Denmark**, the recognition rate varies between 4% and 8% depending on the year in question. This recognition rate is the lowest for the four countries in question. This low level can be explained by the fact that, although recognised cases are more numerous than in the other countries, the number of claims for recognition there is extremely high (123 claims for recognition of mental disorders per 100,000 insured). This phenomenon is observed in **Denmark** for all occupational diseases (600 claims per 100,000 insured). It seems, indeed, that more so than elsewhere and for a long time now, **Denmark** has ensured that there is no obstacle to the reporting of diseases that could have a work-related origin.
The recognition rate is stable for these pathologies in **Italy** (the provisional statistics for 2011 distort the calculation of the rate, which in all previous years was around 10%) and in **Sweden**.

Figure 1
Mental disorders: number of claims for recognition and number of recognised cases in 2010



* 246 recognised cases, of which 149 cases of post-traumatic stress disorder (on the list)

Figure 2
Mental disorders: claims for recognition and recognised cases between 1996 and 2011



Over the past 15 years we note contrasting trends depending on the country in question.

In **Denmark** and **France**, claims for recognition and recognised cases have increased continually (the provisional data for 2011 should be left out and hindsight will be needed to understand whether the recent fall in Danish claims is significant). This upward trend is likely to continue in France as a result of the recent ministerial letter (see 2.3) which modifies the

conditions relating to medical stabilisation of the victim's state of health and the severity of the permanent disability for admissibility to the recognition system for off-list diseases. And the statistics show that recognised cases of mental disorders represent an increasing proportion of all off-list occupational diseases recognised (21% in 2011 versus 8% in 2003). This upward trend is also likely to continue in **Denmark**, because, after registering post-traumatic stress disorder on its list in 2005 to facilitate the recognition of such cases, in 2013 the Danish insurance organisation expects to receive the conclusions of a scientific study on the consequences of harassment at work in terms of mental disorders, in order to get a better idea, in these circumstances, of the potential for recognition of cases (see Chapter 5).

In **Italy**, the figures seem to have stagnated since 2004 for claims for recognition, and since 2001 for recognised cases. The incipient decline seen since 2009 should be viewed cautiously to the extent that, in Italy, the statistics are often revised upward during three years, after which they become definitive.

In **Sweden**, there has been a fall both in claims for recognition (the data in fact corresponds to the addition of benefits awarded and benefits refused over the year) and in cases recognised, that began around the mid-2000s. Formerly, burn-out and depression due to job burn-out were the most frequent mental disorders, and the issue was the subject of extensive debate in the media. When the phenomenon calmed down, the number of cases became fewer.
The acceleration of the decline observed since 2008 is possibly related to the publication, the same year, of a report designed, among other things, to help with the assessment of mental disorders of work-related origin such as depression and anxiety. It is likely that this document had an impact on the way in which certain mental disorders were recognised.

In those countries where no case is recognised

In **Switzerland**, according to information possessed by the SUVA[18], the country's leading insurer against occupational and non-occupational accidents and occupational diseases, no case of mental disorder has ever been recognised as an occupational disease.
Regarding the number of claims for recognition, there are no reliable statistics (lack of specific coding), but it can be asserted that they are more than marginal. Judicial research made it possible to identify only three claims for recognition in the past 15 years, one to the SUVA and the other two to private insurers; these cases were initially reported to the insurance organisations and refused by them, and hence the insured appealed to a cantonal insurance court (then a federal court for one of the cases):

- Cantonal ruling of 1996: the depression of a foreign professional basketball player due to difficulties of fitting in with the rest of the team does not constitute an occupational disease.
- Cantonal ruling of 2003: a state of job burn-out in a teacher does not constitute an occupational disease, because this condition is not four times more frequent in teachers than in the rest of the population.
- Federal order of 2011: the symptoms of mental disorders developed by a primary school teacher following serious criticism by parents related to his teaching abilities do not constitute an occupational disease, on the grounds that the frequency of mental disorders in the education sector is not four times greater than in the rest of the population.

In **Finland**, claims for recognition are not counted, but it is estimated that they are extremely rare, since the insured population is undoubtedly well aware that there is no legal possibility of recognition of mental disorders as occupational diseases.

The **German** statistics regard only claims for recognition, since Germany does not allow the recognition of mental disorders as occupational diseases.

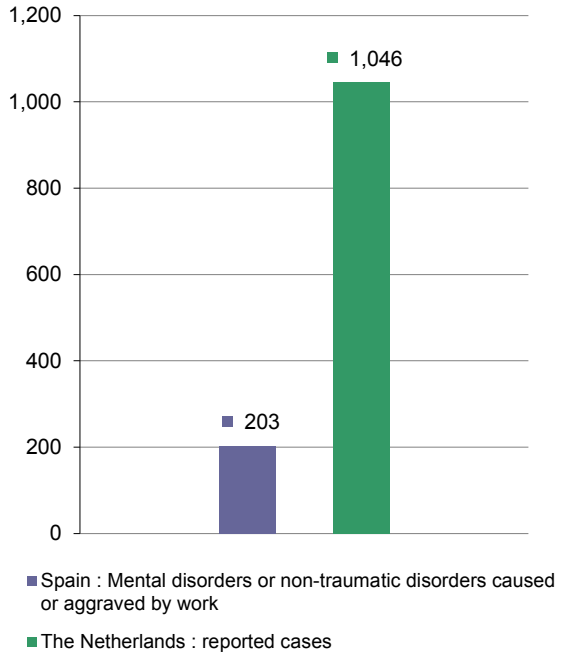
[18] Caisse nationale Suisse d'assurance en cas d'accidents (Swiss national accident insurance fund).

Table 3
Germany: claims for recognition of mental disorders as occupational diseases between 1996 and 2011

	Claims for recognition
1996	7
1997	1
1998	4
1999	3
2000	7
2001	5
2002	8
2003	5
2004	6
2005	10
2006	4
2007	27
2008	15
2009	8
2010	13
2011	18

Particular cases

Figure 3
Mental pathologies in 2010 (particular cases)



The statistics for the **Netherlands** and **Spain** are covered by a separate presentation because, although in these countries statistics on mental disorders of work-related origin are indeed available, what is covered by these figures is not precisely comparable to the concepts of claims for recognition and recognised cases commonly used in the countries mentioned earlier.

In **Spain**, the concept of a "non-traumatic disorder caused or aggravated by work" corresponds to cases of occupational diseases that are not registered on the Spanish national list of occupational diseases, but which are recognised as accidents at work (see 1.1). This concept is, in short, fairly similar to that of off-list occupational diseases commonly used in the other countries, but the corresponding cases legally remain accidents at work.
The PANOTRATSS system now makes it possible to distinguish between these cases and accidents at work strictly speaking. Out of the 11,069 non-traumatic conditions recorded in 2010 (breaking down as follows: 10,434 conditions caused by work and 635 aggravated by work), 203 were mental disorders (of which 191 caused by work and 12 aggravated by work). Before 2010, these cases of non-traumatic conditions were "drowned" in the mass of recognised accidents at work, so that it is not possible to establish a series over several years. But it appears that cases of mental disorders recognised as work-related are increasingly numerous, especially those recognised by court decisions.

3.2 Mental disorders as accidents at work

Although all the countries regularly recognise mental disorders as accidents at work (mainly post-traumatic stress disorders), it is hard for most of them to provide statistics regarding their quantity, often for want of a specific coding system.

Table 4
Number of mental disorders recognised as accidents at work in 2010

	Recognised cases (2010)
Germany (estimation)	minimum 4,900*
Belgium	606
Denmark	730
Spain	non traumatic pathologies: 203 accidents at work stricto sensu: NA
Finland (estimation)	between 100 and 180 PTSD / year
France (estimation)	between 10,000 and 12,000 / year**
Italy	NA
Sweden	Social insurance Agency (2011): 99 Complementary insurance AFA Försäkring (2009-2010): 2,010
Switzerland (2009)	24

NA: Not available

* **Germany**: It is not possible to deduce absolute or valid figures concerning mental disorders recognised as accidents at work from the statistical data of the DGUV.

Mental disorders are entered in the statistics in two places:

1) Type of damage (code 86) "Mental traumatism"
   Under the heading "Type of damage", it is possible to indicate as the diagnosis the term "mental traumatism" (code 86), as both the first and second diagnosis. However, doctors are instructed to indicate in this place the more serious diagnosis. In cases where physical injuries are also present, it may be imagined that the bodily injury will always be indicated first, especially since the physical diagnosis is performed from the start, whereas the psychological diagnosis of these cases is made only later, and even then the psychological diagnosis is often not indicated as second diagnosis.
   For 2010, the DGUV statistics concerning accidents at work show more than 4,900 cases coded under the figure 86 as first or second diagnosis. Mostly, these cases probably represent isolated cases of mental traumatisms. Moreover, these statistics show only the accidents that must mandatorily be reported, and therefore their actual number is greater than 4,900.

2) Consequence of damage: "Reactions to an incident (psycho-vegetative and psychosomatic reactions), neuroses".
   In cases where a pension is awarded, this consequence of damage can be indicated in code form. But because a single consequence of the damage is sufficient, it is not sure that, in cases where a physical consequence of the damage exists, the psychological consequence is always indicated second.
   For 2010, in the DGUV statistics concerning accidents at work, we can find among the pensions newly awarded by the industrial and commercial insurers (exclusively pensions awarded following an accident at work, not following an occupational disease) 20,611 cases of pensions in all, including 160 cases representing mental consequences of damage of the type "Reactions to an incident (psycho-vegetative and psychosomatic reactions), neuroses". This figure represents about 0.8%. In no less than 75 of the 160 cases, there were no other sequels to the damage; in such cases, the sole grounds for the pension are

mental consequences. In 105 of the 160 cases, the diagnosis indicates as the type of damage "States of mental/reactive shock", including 87 as main diagnosis.

If it were really wanted to give a figure concerning recognised cases, 4,900 cases could be taken as a starting point. However, this figure, as well as the number of pensions awarded, is rather vague. As a reference base, definite figures are known for the *Handel und Warendistribution* BG (Trade and Distribution, retail trade branch) likewise dating from 2010: this BG by itself counts about 1,350 armed robberies subject to a reporting obligation and 43 new cases of pensions caused by armed robberies (total new pension awards in 2010: 600). These figures suggest that the actual figure for recognised cases is likely to be higher, because the *Verwaltung* BG (Administration, including rail commuting systems branch), the *Gesundheitsdienst und Wohlfahrtspflege* BG (Health and welfare assistance services) and the *Verkehr und Transportwirtschaft* BG (Travel and transport) probably recorded a figure at least as high.

** In **France**, it is not possible to isolate accidents at work caused by psychosocial risks from all accidents at work recognised, for want of an indication of the factual circumstances in the statistical classification. On the other hand, an estimate is possible insofar as, when faced with a case of permanent disability, the medical consultant of the social security system is required to indicate the reason for it. By calculating the customary proportion of mental disorders among all cases of permanent disability investigated and recognised each year as accidents at work (i.e. 1%), and by extrapolating this to all accidents at work recognised each year, it can be estimated that 10,000 to 12,000 accidents at work are covered under damage of a psychological nature each year.

3.3 Suicides as accidents at work / occupational diseases or as a sequel of an accident at work /occupational disease

It appears relatively difficult to collect figures regarding the number of claims for recognition and recognised cases of suicides as accidents at work or occupational diseases.

Of all the countries in which it is possible to classify a suicide as an accident at work (cf. 1.2), **France** stands out for the quality of the statistics available on the subject, and for the larger number of suicides recognised and compensated by the occupational injury and disease insurance system than in its European neighbours.

_____

Table 5

France: number of suicides reported and recognised as an accident at work, commuting accident or occupational disease in 2010 and 2011

2010	Claims reported	Claims recognised	Claims rejected	Gender	Average age
Accident at work	68	21	47	61 men 7 women	45 years
Commuting accident	3		3	3 men	37 years
All risks	71	21	50	64 men 7 women	45 years

2011	Claims reported	Claims recognised	Claims rejected	Decision pending	Gender	Average age
Accident at work	72	22	31	19	64 men 6 women	46 years
Commuting accident	4		4		4 men	40 years
Off-list Ods	1			1	1 man	47 years
Not classified	1			1	1 man	59 years
All risks	78	22	35	21	72 men 6 women	46 years

In **Italy**, the insurance organisation INAIL recognised only a single case of suicide in 2010, in this instance as an occupational disease.

Denmark, which does not legally rule out the recognition of suicide, has so far counted no claim for recognition.

In **Switzerland**, there are no truly reliable statistics in this area given the very small number of cases of suicide covered and since in theory said cases are covered by non-occupational insurance[19]. It is reminded that suicide is excluded from the scope of the accident insurance, except in two cases defined by law (see 1.2).
The figures for 2011 and 2010 are not available, but in 2009 eleven cases of suicide were recognised as accidents. None of the six cases concerning the SUVA were accidents at work and probably none of the five cases concerning the other insurers either.

In the other countries (**Germany**, **Belgium**, **Spain** and **Sweden**), the information systems of the insurance organisations (the *Berufsgenossenschaften*, the *Fonds des Accidents du Travail*, the *mutuas* / the Ministry of Employment and Social Security and the National Insurance Agency respectively) cannot distinguish suicides in the database of accidents at work. But it can be asserted that a few cases are covered as accidents at work each year, usually after recognition by the courts.

In **Finland**, the question of the number of cases recognised is not applicable, because the recognition of a suicide as an accident at work or an occupational disease is legally not possible.

[19] In **Switzerland**, the accident insurance organisation covers both non-work-related accidents and work-related accidents and occupational diseases. There are several insurers, chief of which is the SUVA.

4. Classification of cases of mental disorders recognised as occupational diseases

Those countries that authorise the recognition of mental disorders as occupational diseases and that recognise a significant number of cases (**Denmark**, **France**, **Italy**, **Sweden**, and **Spain** if non-traumatic diseases are counted) are mostly able to provide relatively precise statistics regarding cases recognised by the insurance organisations. Data regarding cases of mental disorders recorded by the Centre for Occupational Diseases in **the Netherlands** have also been included in this chapter, even though these cases do not correspond to cases recognised and compensated as occupational diseases, for want of a specific insurance system in the Netherlands.

The information provided makes it possible to establish a classification of cases recognised according to the country, based on the most frequently recognised mental disorders, the type of psychosocial risks to which workers are most exposed, the sectors of activity or the occupations most affected, and statistics concerning the gender and age of the victims. However, due to the great heterogeneity of the statistical classifications, it is hard to establish a real comparison between countries. The data are therefore presented country by country, for the most recent year for which statistics are available (generally 2010 or 2011).

4.1 Disorders most frequently recognised/diagnoses

Table 6
Denmark: breakdown by syndrome of the recognised cases of mental disorders as occupational diseases in 2011

Syndrome	Recognised cases
PTSD (OD on the national list)	130
Unspecified stress disorders	43
Depression	20
Other mental illnesses	19
TOTAL	**212**

Table 7
France: breakdown by syndrome of claims for recognition and cases of mental disorders recognised as off-list occupational diseases in 2011

Syndrome	ICD-10	Claims for recognition	Recognised cases
Depressive spells	F32	137	62
Combined anxious and depressive disorder	F41-2	26	15
Adaptation disorders	F43-2	24	14
Generalised anxiety	F41-1	2	2
Persistent mood [emotional] disorders	F34	1	1
Combined conduct disorders and emotional disorders	F92	1	0
Specific personality disorders	F60	1	0
Recurring depressive disorder, unspecified	F33-9	1	0
Agoraphobia	F40-0	1	0
Bipolar emotional disorder	F31	1	0
Conduct disorders with depression	F92-0	1	0
TOTAL		**196**	**94**

In **Italy**, the only two diagnoses possible correspond to those of the biological damage scale: post-traumatic disorder caused by a moderate chronic stress and post-traumatic disorder caused by a severe chronic stress.

In **Sweden**, the insurance organisation is currently working to improve the quality of statistics relating to occupational diseases. While it is not at present possible to provide precise details, syndrome by syndrome, on claims for recognition and recognised cases of mental disorders, the most frequent diagnoses are as follows:

Table 8
Sweden: most frequent diagnoses of mental pathologies which give rise to claims for benefits, in descending order of importance (as occupational diseases)

	Syndrome	ICD 10
1	Reactions to severe stress, and adjustment disorders	F43
2	Depressive episodes	F32
3	Other anxiety disorders	F41
4	Recurrent depressive disorder	F33

Among the cases of benefits granted, the most frequent diagnoses are the "reactions to a severe stress factor and the adjustment disorders" followed by "depressive episodes".

Table 9
Spain: breakdown by syndrome of cases of mental disorders recognised as non-traumatic diseases caused or aggravated by work (legally accidents at work) in 2010 and 2011

Syndrome	2010	2011
Diseases caused by work:	**191**	**144**
Affective disorders	*10*	*11*
Other mental disorders	*155*	*16*
Phobic and neurotic disorders	*26*	*117*
Diseases or troubles aggravated by work:	**12**	**20**
Affective disorders	*1*	*1*
Other mental disorders	*11*	*1*
Phobic and neurotic disorders	*0*	*18*

4.2 The most frequent risk factors

In **Denmark**, as regards PTSD, the characteristics of the strain are included in the diagnosis criteria (see point 20.3 of the excerpt of the Danish Guide to occupational diseases in 1.1). As regards other mental illnesses, typical strains are violence, threats of violence, stressful events as well as bullying and harassment.

Table 10
France: breakdown by causal agent of claims for recognition and cases of mental disorders recognised as off-list occupational diseases in 2011

Causal agent	Nr. of claims	Recognised cases
Unknown causal agent	2	1
Physical burden of handling work	1	0
Mental workload	43	21
Psychosocial factors	142	70
Work rate	1	1
Mental traumatisms	4	1
Unlisted other known causal agent	3	0
TOTAL	**196**	**94**

In **Italy**, INAIL has no classification by risk of its statistics relating to mental illnesses. However, practice has made it possible to identify the following most pathogenic situations:

- Marginalisation of the work activity;
- Jobs voided of their content;
- Failure to provide work instruments;
- Unjustified, repetitive transfers;
- Prolonged assignment to duties implying qualifications below the job profile of the person concerned;
- Prolonged assignment to over-heavy or excessive duties, including in relation to a possible mental or physical disability;
- Systematic or structural prevention of access to information;
- Structural or systematic inappropriateness of the information inherent in normal work activity;
- Repeated exclusion of the employee from training, reskilling or occupational upgrading initiatives;
- Exaggerated or excessive exercise of various forms of control.

No data in **Sweden** nor in **Spain**.

Table 11

The Netherlands: breakdown by causal agent of the three most commonly reported work-related psychological disorders in 2010

Causal factors in work	Adjustment disorders, burnout		Depression		Post-traumatic stress disorder	
	N	%	N	%	N	%
Amount of work required Little satisfaction / Boring, monotonous work / Highly demanding work / Large or uneven amount of work / Uneven amount and requirement / Excessive amount of work required	200	22	14	18	2	3
Work relations Problems involving relations with fellow employees / Problems involving relations with superiors / Ambiguous role / Incomprehensible management principles	189	21	24	30	5	7
Pace of work Continuous physical work / Uneven distribution of work / Pace of work controlled by a machine	135	15	8	10		
Quality of work required Coordination work / Precision work / Complexity of the task / Attention and concentration / Responsibility / Discipline/ethic / Emotional involvement / Contradictory or incompatible requirements /Ambiguous requirements	114	13	10	13		
Traumatic experiences (fear of, anxiety) Threat of violence / Sexual harassment / Repeated shock / Micro traumas/ Traumatic experiences resulting from shock, violence or accident	13	2	3	4	65	87
Arrangement of working hours Shift work / On-call service / Overtime	69	8	4	5		
Other psychosocial exposure factors	59	7	7	9	1	1
Personal influence on one's work No personal influence on one's work / Little personal influence on the planning or the execution of the work	62	7	4	5		
Risks Risk of accident (to oneself or to another person) / Risk of damage to tools and machinery or to the product / Risk of injury / Risk of losing one's job	38	4	5	6	2	3
Social contacts Few social contacts arising from one's work / Few informal social contacts / Working alone / Working with noise / Little or no possibility of contacting the family, etc. during working hours	5	1				
Types of pay Piecework / Piecework pay	3					
Other or unknown causal factors	5	1				
TOTAL	**892**	**100**	**79**	**100**	**75**	**100**

4.3 Sectors of activity or occupations most concerned

In **Denmark**, the National Board of Industrial Injuries has no classification of its data on recognised cases of mental illnesses by sector of activity or by occupation. However, it can be

asserted that about 70% of recognised cases concern public-sector employees (see examples of recognised case in Appendix 1).

Table 12
France: claims for recognition and recognised cases of mental disorders by occupation in 2011

Occupation	Nr. of claims	Recognised cases
Other intermediate occupations	34	17
Company managers	28	12
Office workers	16	11
Direct personal services and protection and security services personnel	13	5
Other specialist intellectual and scientific occupations	11	7
Unskilled service and sales employees	9	2
Machinery operators and assembly workers	8	1
Reception employees, checkout operators, counter clerks and similar	8	7
Physics, mathematics and technical science specialists	8	7
Models, salespersons and demonstrators	8	1
Drivers of vehicles and heavy lifting and handling machinery	7	3
Life science and health specialists	6	3
Intermediate occupations in physical and technical sciences	6	3
Labourers in the mining, building and public works, manufacturing and transport industries	5	4
Intermediate occupations in life sciences and health	4	1
Leaders and managers	4	3
Other craftsmen and workers in artisanal type trades	4	2
Craftsmen and workers in the excavation and building sectors	4	1
Craftsmen and workers in the metallurgy, mechanical engineering and similar sectors	4	1
Farmers and skilled workers in commercial agriculture and fishing	2	1
Operators of fixed and similar facilities and equipment	2	1
Education specialists	2	0
Intermediate education occupations	1	0
Members of the executive and legislative bodies and senior managers in general government	1	1
Craftsmen and workers in the precision mechanics, arts and crafts, printing and similar sectors	1	0
TOTAL	**196**	**94**

Table 13

Italy: claims for recognition and recognised cases of mental disorders by regime and by sector of activity in 2010 and over the period 1996-2010

	2010		1996-2010	
Sector of activity	Claims for recognition/ recognised cases		Claims for recognition/ recognised cases	
Agriculture	**1**	**0**	**50**	**23**
Industry and services	**364**	**37**	**3,927**	**522**
Industry	88	17	981	194
Agriculture	*2*	*0*	*21*	*4*
Fishing	*0*	*0*	*1*	*0*
Mining and quarrying	*0*	*0*	*12*	*1*
Manufacturing	*63*	*8*	*801*	*146*
Electricity, gas and water	*9*	*4*	*54*	*12*
Construction	*14*	*5*	*92*	*31*
Services	209	18	1,941	293
Retail and wholesale trade	*46*	*4*	*338*	*48*
Accommodation and food service activities	*11*	*1*	*104*	*9*
Transport and communication	*33*	*4*	*362*	*58*
Financial activities	*15*	*3*	*131*	*20*
Real estate activities and business services	*39*	*2*	*345*	*46*
Public administration	*18*	*2*	*255*	*42*
Education	*7*	*0*	*24*	*4*
Human health and social work activities	*30*	*2*	*214*	*32*
Other public services	*10*	*0*	*163*	*34*
Domestic staff	*0*	*0*	*5*	*0*
Undefined	67	2	1,005	35
Civil servants	**15**	**0**	**195**	**25**
TOTAL	**380**	**37**	**4,172**	**570**

No data in **Sweden** nor in **Spain**.

Figure 4

The Netherlands: psychological disorders reported per economic sector in 2010 (in %)

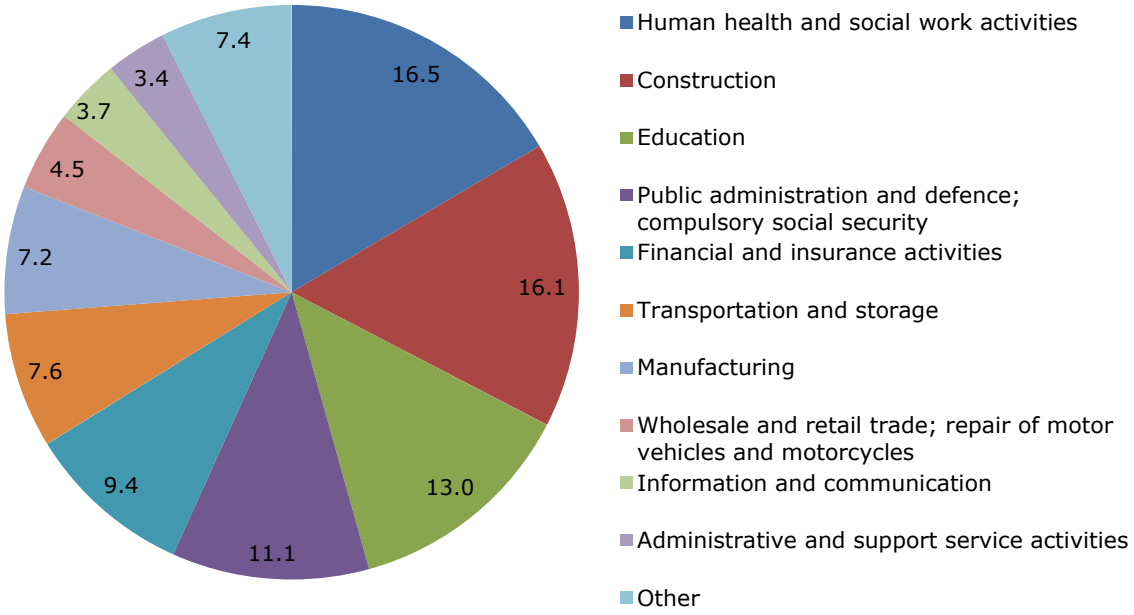


Table 14

The Netherlands: top 5 of occupational classes with a lot of notifications of work-related psychological disorders

	2007		2008		2009		2010	
Top 5 of occupational classes	N	%	N	%	N	%	N	%
Office clerks	114	9.6	135	11.5	152	10.5	127	11.3
Teaching professionals	91	7.6	84	7.2	137	9.5	120	10.6
Service workers and shop and market sales workers	110	9.2	108	9.2	97	6.7	86	7.6
Other associate professionals	181	15.2	188	16.1	173	12.0	82	7.3
Personal and protective services workers	60	5.0	62	5.3	58	4.0	76	6.7

4.4 Gender and age factors

Table 15
Denmark: claims for recognition and recognised cases of mental disorders by gender over the period 1996-2011

Gender	Nr. of claims	Recognised cases
Men	6,981	781
Women	20,064	719

In Denmark, the National Board of Industrial Injuries has no age-based classification of its data on recognised cases of mental illnesses. However, it can be asserted that two-thirds of claims for recognition are made by workers aged between 37 and 56.

France has no data of this type at the national level.

Figure 5
Italy: psychological disorders per age group in 2010 and over the 1996-2010 period, all systems taken into account (number of cases)

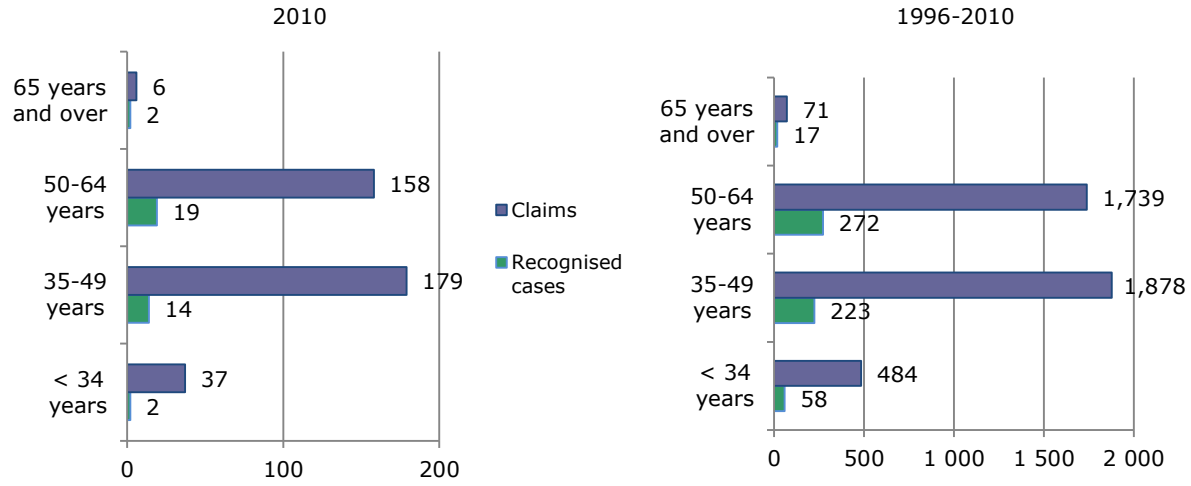


Table 16
Sweden: number of claims and benefits awarded for mental diseases by gender in 2011

Gender	Nr. of claims	Benefits awarded
Men	152	29
Women	299	41
TOTAL	**451**	**70**

Table 17
Spain: mental disorders recognised as non-traumatic pathologies caused or aggravated by work by gender in 2011

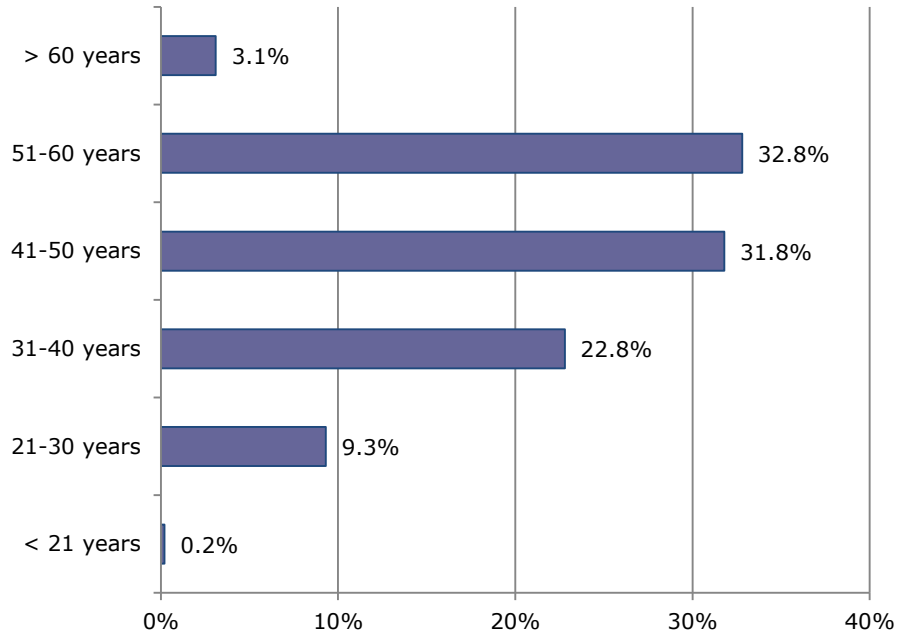
Gender	Pathologies caused by work	Pathologies aggravated by work	Total non-traumatic pathologies
Men	63	12	**75**
Women	81	8	**89**
TOTAL	**144**	**20**	**164**

The PANOTRATSS data show that the 30-40 age group is the most concerned.

Table 18
The Netherlands: mental disorders reported to the Center for Occupational Diseases by gender in 2010 (distribution in %)

Gender	Percentage
Men	51
Women	49

Figure 6
The Netherlands: psychological disorders per age group in 2010 (distribution in %)



5. Discussions in progress

It appears that at present very few countries are reflecting on the coverage of mental disorders by the occupational risk insurance organisation. The countries involved in this type of approach are countries that already allow recognition as occupational diseases.

However, the subject of work-related mental illnesses is increasingly researched from the viewpoint of psychosocial risk prevention (excluded from the framework of this study).

In **Denmark**, the National Board of Industrial Injuries (insurance organisation) expects to receive by the end of 2013 the conclusions of a report by the Danish Working Environment Fund on mental disorders caused by harassment. The aim of this work is to try to determine whether harassment can give rise to an increased risk of occurrence of mental illnesses (depression, anxiety, somatisation), whether harassment can cause a stress hormone imbalance, and to what extent harassment affects ability to work and has an impact on prolonged sick leaves. The conclusions of the report will serve as a foundation for thinking about possibly registering mental disorders caused by harassment on the Danish list of occupational diseases.

In **France**, a working group reflected in 2012 on compensation for mental disorders of occupational origin. This group stems from the Occupational Diseases Commission of the Steering Committee on Working Conditions ("*Conseil d'Orientation sur les Conditions de Travail" - COCT*). This Commission is responsible for creating and revising the occupational disease tables. It is formed of the social partners, qualified leading figures, and representatives of the state, the case management organisations and the agencies.

The objectives of the working group were the following (excerpt of the mandate):

Based on an initial analysis of potential legal changes to improve the recognition of mental disorders, the members of the Occupational Diseases Commission agreed, during the session of 20 January 2010, to adopt a pragmatic approach consisting, first, of facilitating the investigation of claims by the regional committees for recognition of occupational diseases ("CRRMPs") within the existing legal framework and, subsequently, considering other potential improvements in the coverage of mental disorders.

For this purpose, the working group is responsible for:
1- Producing a descriptive and nosological classification of disorders of mental origin that could be investigated by the CRRMPs, specifying in particular, for these disorders, the diagnoses of the occupational and extra-occupational causes, the stabilisation criteria to be used to set a permanent disability rate, and the level of severity above which it is possible to set a permanent disability rate at least equal to 25%[20]*;*
2- Drawing up recommendations to help the CRRMPs assess the links between these disorders and the work activity;
3- Investigating other ways of improving the coverage of work-related mental disorders.

The conclusions of this work are recorded in a report which should shortly be widely disseminated.

[20] As a reminder, in **France** this 25% permanent disability threshold is a prerequisite for an off-list disease to be investigated by the regional committees for recognition of occupational diseases ("CRRMPs") as part of a recognition procedure.

Finally, in **Finland**, the advisability of including the psychosocial factor in the definition of occupational diseases as a potential causal agent was discussed again in 2007-2008 in the working group responsible for reforming the legislation on accidents at work and occupational diseases. No consensus was reached by the working group, and the scientific experts of the FIOH found no reasons to justify going back on the conclusions to reject this proposal adopted previously by the 2001-2003 working group.

Appendix

Denmark: Examples of decisions of recognition or rejection of post-traumatic stress disorder cases (the examples are extracted from a document written by the *National Board of Industrial Injuries*).

Posting (military stationing and relief work)

Example 1: Recognition after stationing to the peace-keeping forces (Kuwait / Croatia)

An officer who was stationed to Kuwait and later to Croatia in the peace-keeping forces saw how an Iraqi soldier was executed by being shot through the mouth. He was furthermore exposed to a number of violent incidents, direct war action, and assaults on civilians. He developed a post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. As part of the service in the peace-keeping forces, the officer had been exposed to a number of stressful situations. The medical examinations established a mental disease in the form of post-traumatic stress disorder, and there was good correlation between the work-related exposures of an exceptionally threatening and stressful nature and the disease.

Example 2: Recognition after work for the Danish Refugee Council (Dansk Flygtningehjalp) in Kosovo

A male employee of the Danish Refugee Council worked for nearly 6 months as a warehouse manager in Kosovo, where he was exposed to violence and murder threats. According to the medical specialist's report the diagnosis was post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. The warehouse manager was exposed to threats of violence and murder and had reason to take the threats seriously. There is furthermore good correlation between the work-related exposures and the disease.

The prison service and the police

Example 3: Recognition after work as a police officer

A police officer was called out, in connection with his work, to several fatal road accidents, an accident where a small child was drowned, murder incidents and a fatal shooting incident, where the injured person himself was in serious danger. It appeared from the medical specialist's certificate that the diagnosis was post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. The police officer, as part of his work in the police force, was called out to a number of incidents involving violent deaths as well as a fatal shooting incident. In two of the situations his life was at risk. He subsequently developed symptoms of post-traumatic stress disorder.

Example 4: Claim turned down – work as a prison officer

A 50-year-old prison officer had worked for 20 years for the Copenhagen Prisons (*Kobenhavns Fangsler*). In this employment he was exposed to daily conflicts with the inmates, was threatened with broken glass and knives, and was kicked in the face in connection with an arrest. Well over 4 years after leaving the job he had symptoms of a mental disease with nightmares and emotional complaints. The medical specialist established symptoms of a moderate traumatic stress condition.
The claim does not qualify for recognition on the basis of the list, and there are no grounds for submission of the claim to the Committee. The prison officer had psychologically very stressful experiences from his work, but only developed mental symptoms 4 years after

cessation of work. Therefore there is no good time correlation between the exposure and the development of the disease.

Healthcare work

Example 5: Recognition after work as a home help

A home help had for some years worked with a female patient who was paralysed on one side. The patient's spouse behaved very aggressively and threateningly in the home help's presence, hit and kicked at objects and knocked a fist into the wall, right above the head of the home help. The medical specialist's certificate stated the diagnosis of post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. In her work, the home help experienced instances of a very threatening and aggressive behaviour on the part of a client's husband. Against the background of the description of the incidents it must seem likely that she had reason to feel sincerely and personally threatened. Furthermore she had developed symptoms of post-traumatic stress disorder in relevant time correlation with the exposure.

Example 6: Recognition after exposure to complaints of neglect in the press (nurse)

A nurse worked as head of a group in a nursing home where she was in charge of care quality, staffing and work plans. There were co-operation problems in the staff group, and when trying to handle the conflict the injured person was accused of poor management. The Medical Officer came on a surprise visit as a consequence of the conflicts and compiled a very critical report on the care conditions and the care quality in the department. The report was handed over to the press, and the case became the object of great media attention. The nurse was not mentioned by name in the press, but did feel personally and directly exposed and accused of neglect. Several times the press turned up and laid siege on her home, and she witnessed i.a. how a bus with pensioners stopped at her home to see where she lived. In connection with these incidents she developed symptoms consistent with post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. In connection with co-operation conflicts the nurse experienced being accused in the press of poor professional quality in the department of a nursing home for which she was responsible. The case became the object of great media attention, and even though she was not directly mentioned by name, she felt exposed and accused of being personally responsible. She experienced several times that journalists laid siege on her home, and also other people came to her home as a consequence of the media coverage. She developed symptoms consistent with post-traumatic stress disorder as a consequence of the very personally stressful and offensive media coverage of the case, where she was made responsible for a substantial part of criticised care conditions and criticised for neglect.

Education

Example 7: Recognition after complaints and exposure to violence from autistic child (teacher)

A teacher had for many years worked in a school for autistic children and was reported for strangulation attempts after having held a child tight. The charges were later dropped. Later the injured person again received complaints from parents after having helped a colleague in a conflict situation. The medical specialist's report stated there was a personality change.
The claim qualifies for recognition on the basis of the list. In connection with the incident with the child and the accusation of strangulation, as well as the continued complaints, the teacher had developed symptoms that were consistent with post-traumatic stress disorder. The charges of violence against the child were later dropped. In connection with the extraordinarily stressful course of events he developed post-traumatic stress disorder.

Serious sexual accusations or offences

Example 8: Recognition after paedophilia charges (qualified pedagogue)

A male pedagogue employed in afternoon after-school care developed mental symptoms in connection with charges and court proceedings regarding outraging of modesty, the alleged victim being a child in the after-school facility. He was later acquitted of the charges. The symptoms described in connection with the disease, such as insomnia, restlessness, concentration problems and evasive behaviour, were consistent with the diagnosis criteria for post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. As a consequence of his work the pedagogue was exposed to an exceptionally mentally stressful course of events in the form of serious accusations of sexually offending children, which later led to charges and court proceedings with subsequent acquittal. He developed symptoms of post-traumatic stress disorder, and there was good correlation between the course of the disease and the exceptionally severe, mental exposure in the form of charges of paedophilia and subsequent acquittal.

Example 9: Recognition after exposure to sexual harassment (chef)

A young woman was employed as an untrained cook. After 6 months' employment her boss started making increasingly offensive sexual advances, including physical touches. Later he unjustly accused her of making mistakes and harassed her on the phone. The injured person developed a post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. The female cook was exposed to exceptionally offensive and cross-border mental exposures in the form of extensive sexual harassment with physical advances and subsequent telephone harassment by her boss. There is good correlation between the documented course of events, in the form of offensive and very cross-border sexual harassment with physical touches, and the pathological picture.

Other exceptional exposures

Example 10: Recognition after exposure to threats and violent deaths in the workplace (Danish Rail Service)

A clerk selling tickets in a train station experienced suicides, other deaths and threats while working in the station. Therefore she developed a post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. The incidents in the form of threats and violent deaths in the workplace are much in excess of what she might be prepared for in a job as a clerk. The incidents are of an exceptionally stressful nature, and there is furthermore good correlation between the onset of the disease and the incidents.

Example 11: Recognition after exposure to several robberies (bank employee)

A bank clerk had worked in different banks for many years. Down through the years she had witnessed several armed robberies against the bank. In two robberies in 1998 she was in close contact with the robber and was threatened with a gun. After the two robberies in question she developed symptoms of a mental disease in the form of flashbacks, vigilance, lack of energy and concentration problems. A specialist of psychiatry made the diagnosis of post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. The bank clerk witnessed a number of armed bank robberies and was threatened herself a couple of times. Following the threats against herself she developed symptoms of a post-traumatic stress disorder, and there is good correlation between the pathological picture and the exposure to the exceptionally threatening situations.

Exposure to complaints, co-operation problems, etc.

Example 12: Claim turned down – exposure to co-operation problems (employed in the Air Force)

A warning operator employed in the Air Force experienced a poor work environment and co-operation problems. Besides she had problems in connection with the introduction of new technology. She developed symptoms that were consistent with the diagnosis of post-traumatic stress disorder.
The claim does not qualify for recognition on the basis of the list as there was not any extraordinary exposure that might in itself be sufficient to cause a post-traumatic stress disorder. At the same time it must be deemed to be futile to submit the claim to the Occupational Diseases Committee.

Examples of delimitation between accident and occupational disease

Example 13: Recognition after work as a train driver

A train driver employed with the Danish Rail Service for well over 30 years had through the years been exposed to several stressful incidents. He had run down a suicidal person and had run down other persons several times. These cases had been recognised as accidents. Apart from that, he had been threatened with a knife. After nearly having run down a group of persons who were drunk he went on sick leave. He had developed a post-traumatic stress disorder.
The claim qualifies for recognition on the basis of the list. The train driver was exposed to several severe incidents that were mentally stressful, and he developed post-traumatic stress disorder with anxiety symptoms, flashbacks (nightmares) and avoidance behaviour. In this case the particular incidents were not handled as separate accidents, and no previous compensation had been paid for them. The different incidents can therefore be seen as one occupational disease following exposure to several exceptionally stressful incidents over a number of years, and the compensation is determined in connection with the one and same claim.

Example 14: Claim turned down – occupational disease after work with the mentally handicapped (social worker)

A social worker had since 1963 worked with mentally disabled clients, primarily mentally disabled men. He had obtained recognition as accidents of three violent incidents. In 1992 a mental trauma was recognised as an accident at work, and he was granted compensation for permanent injury. He had not since been exposed to experiences in the workplace that were very mentally stressful.
The claim does not qualify for recognition as an occupational disease. The social worker has not since the incident in 1992, which had already been recognised as an accident, been exposed to violent incidents to an extent that might lead to a permanent mental disorder. There is no description of any mental consequences in excess of what has already been compensated as a consequence of the recognised accidents.

Example 15: Claim turned down – occupational disease after work as a psychiatric healthcare assistant

A healthcare assistant had been employed in a psychiatric nursing home since 1978 on regular night duty. In later years he had been alone on night duty. Two incidents had been reported and recognised as accidents at work. In March 1992 he was kicked by a threatening and scolding patient. The incident was recognised as an accident without any compensation being granted. After this incident he had violent anxiety attacks and became weepy and afraid of the dark. He resumed work in June 1992. In 1994 there were violent incidents where his colleagues were involved, and he felt unwell again and started drinking.

The claim does not qualify for recognition as an occupational disease on the basis of the list. The event in 1992 was recognised as an accident, and in 1991 he developed symptoms of post-traumatic stress disorder, which was complicated by excessive alcohol consumption. The condition was passing, but he had a relapse in 1994 in connection with violence/threat incidents in relation to colleagues. There is no documentation of any relevant mental trauma in connection with the relapse, and the relevant previous incidents were recognised as accidents. It should be assessed, however, whether the relapse might be attributable to the recognised accident in 1992, and if this previous case therefore should be reassessed.

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All have in common European aspects of the insurance or the prevention of accidents at work and occupational diseases.

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