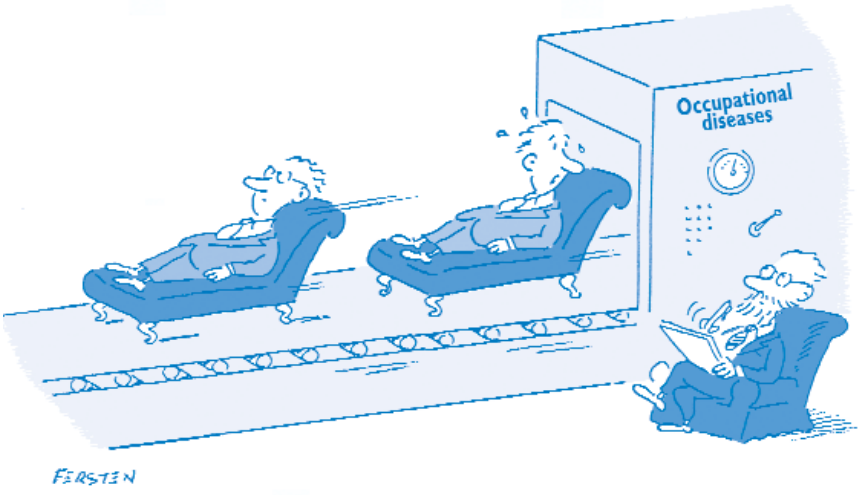
EUROPEAN FORUM of the insurance against accidents at work and occupational diseases

EUROGIP

Work-related mental disorders: what recognition in Europe?



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Foreword

The European Forum of Insurances against Accidents at Work and Occupational Diseases[1] set up, in September 1998, a working group on occupational diseases in Europe and confided its leading to Eurogip.

The work performed by this working group led to the publication of the following reports:

- *Occupational diseases in Europe - comparative study of 13 countries: reporting, recognition and compensation procedures and conditions* (Sept. 2000)
- *Occupational diseases in 15 European countries – Figures for 1990-2000, legal and practical news 1999-2002* (Dec. 2002)
- *Overview of occupational cancers in Europe* (Dec. 2002)
- *Survey on under-reporting of occupational diseases in Europe* (Dec. 2002)
- *Lumbago and allergic asthma: two case studies at the European level* (Dec. 2002)

The present study follows on from this work.

[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 risks. At the end of 2003, seventeen countries -and twenty-three organisations- are represented in it.

The following persons took part in the study

Andreas KRANIG	Hauptverband der gewerblichen Berufsgenossenschaften (HVBG)	Germany
Peter PILS	Allgemeine Unfallversicherungsanstalt (AUVA)	Austria
Patrick STRAUSS	Fonds des Maladies Professionnelles (FMP)	Belgium
Danielle de BRUCQ	Ministère des Affaires sociales, de la Santé publique et de l'Environnement	
Lars Hog JENSEN	Arbejdsskadestyrelsen	Denmark
Carmen ESCALANTE BLAZQUEZ Javier TRALLERO VILAR	Asociacion de mutuas de accidentes de trabajo (AMAT)	Spain
Kirsi POHJOLAINEN	Tapaturmavakuutuslaitosten Liitto (TVL)	Finland
Andrée GIRARD Didier LAPORTE	Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (CNAMTS)	France
Margaret DAWSON BAXTER	Department of Social, Community and Family Affairs	Ireland
Daniela GERMANI Roberto PIANIGIANI	Istituto Nazionale per l'Assicurazione contro gli Infortuni sul Lavoro (INAIL)	Italy
Claude RUME	Association d'assurance contre les accidents (AAA)	Luxembourg
Gert van der LAAN	Nederlands Centrum voor Beroepsziekten (NCvB)	The Netherlands
Fatima VENTURA	Centro Nacional Protecçao contra os Riscos Profissionais (CNPRP)	Portugal
Monica SVANHOLM	Riksförsäkringsverket (RFV)	Sweden
Rodolphe WIPF	Schweizerische Unfallversicherungsanstalt (SUVA)	Switzerland

The work carried out was coordinated by Eurogip: Marie-Chantal BLANDIN and Christine KIEFFER.

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Introduction

The subject of work-related mental illnesses is regularly examined from the prevention viewpoint. In 2000, the European Commission published a *Guideline Manual on stress at work*; the European Week for Safety and Health at Work 2002 was devoted to the prevention of psychosocial risks; the national OH&S organisations are developing research on this emerging risk, and numerous concrete initiatives are being taken in certain large firms and public services concerning specific aspects of the question (harassment, violence, 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 the job-related nature of mental illnesses in Europe.
Admittedly, certain psychosocial pathologies are already recognised as accidents at work: in Europe, mental or psychological results of an accidental event are compensated by the industrial injuries insurance organisations, on condition that the event which caused the trouble is of short duration, occurred at a definite date, in work time and in the workplace, and that the disorders appear at a time close to the event.
But these conditions being less and less checked, the insurance organisations and the authorities have been reflecting for some years now on the advisability of recognising, and hence paying compensation for, this type of pathologies as occupational diseases.

The debate raises several questions:
On the one hand, the multifactorial nature of mental illnesses poses the thorny question of the causal relation between the work and the disease: unlike so-called conventional occupational diseases for which it is relatively easy to demonstrate the work-related origin when noxious chemical, physical or biological agents are involved, a worker's mental health can be affected both by his (her) working conditions and by extra-occupational constraints. In other words, how can it be proved that the work is the “decisive” or “essential” cause of the mental illness of an individual possibly already fragilised in his (her) family and social environment?
On the other hand, for the European countries that admit the existence of a direct causal link between work and certain mental illnesses, the difficulty consists in defining the concept of psychosocial risk and that of mental illness, in order to define the context for recognition and compensation procedures. To date there is no definition of these two terms common to all the countries.

In this study, the phrase "psychosocial diseases" covers all mental, psychosomatic and psychological illnesses due to work-related stress and psychosocial risks such as harassment, violence, mobbing and all the other risks related to work organisation and working conditions; excluded from the scope of this study are mental illnesses related to chemical risks (caused by toxic substances, and especially solvents) and mental or psychological results of an accidental event generally recognised as accident at work.

1. Possibilities of recognition

The present survey, carried out on 14 European countries, revealed that nearly half of them now allow recognition of psychosocial diseases as occupational diseases. While, for some of them (Belgium, France, Italy and Portugal), this recognition is recent, it was possible from the early 1980s in Sweden and at the start of the following decade in Denmark. Elsewhere in Europe (Germany, Austria, Spain, Finland, Ireland, Luxembourg and Switzerland), recognition is currently impossible, although the subject is under discussion in several of these countries. The case of the Netherlands has to be studied distinctly.

A - Recognition possible in six countries

Psychosocial diseases can be recognised as occupational diseases in **Belgium**, **Denmark**, **France**, **Italy**, **Portugal** and **Sweden**. However, this type of disease is not currently included in any of the lists of occupational diseases in these countries and it is therefore within the framework of the complementary system (except in Sweden where no mixed system exists) that victims must make their claim for recognition, providing proof of the link between their disease and their work.

In **Sweden,** psychological or psychosomatic illnesses may be recognised as occupational diseases when they are caused by an "adverse influence at work", i.e. associated with organisational and social factors linked to the work environment.
However, it should be remembered that in Sweden, since the reform of the system of recognition and compensation for occupational injuries introduced in 1993, ad hoc insurance provides coverage for the disease only if the insured suffers from a permanent work disability and/or loss of earning capacity.
If this prerequisite is met, the victim must prove that the mental illness from which he (she) suffers results from harmful factors in the workplace. The new legislation in force since 1st July 2002, which simplifies the rules relating to the onus of proof, requires that there be more serious reasons in favour of presuming the job-related nature of the disease than the contrary.
This same Act, however, limits the recognition of this type of disease. Thus, compensation may not be paid for mental health disorders caused, for example, by a plant shutdown or staff cuts, personal disputes or disputes concerning a work contract, a change in work tasks, lack of promotion, a feeling of boredom, of being under-esteemed or not succeeding in accomplishing one's work.
One can deduce from this that bullying, harassment, persecution and humiliations suffered at work but also burnout can be recognised as factors having caused a job-related mental illness.
In practice, the reality of risks is assessed on a case by case basis: the facts must be able to be documented by collecting information from several sources, in particular by questioning the victim's superiors, his colleagues and representatives of staff administration and the trade unions. Such a collection of information requires time, sometimes up to one year.

In **Denmark**, the Occupational Disease Committee[2] can recognise mental health disorders if they have been caused, in full or in large part, by particular features of the work; the Committee's practice is to recommend recognition and compensation for cases of long-term stress related to situations of violence or threats of violence, or any other similar constraint, which is not typical of the work in question. Cases in which the employee was subjected to very serious bullying or harassment have also been accepted.

[2] Body (consisting basically of representatives of employees and employers) competent for updating of the list of occupational diseases and recognition of off-list diseases

In general, the Committee requires that an expert appraisal have demonstrated a correlation between the situation of stress and the development of the illness. The diagnosis concerns first the nature of the stress, which must be exceptionally serious, caused by factors exogenous to the person, and have permanent consequences for his (her) state of health. The link between the disease and the existence of stress in the work environment will then undergo a practical assessment with regard to the stress factors involved.
If these conditions are met, the job-related nature of the following diseases can be recognised: depression, pervasive anxiety, phobias, compulsive obsessional disorders, somatic disorders (bodily symptoms having no organic cause), and certain psychoses.

As is the case in other European countries, the boundary between occupational disease and accident at work is, in the area of psychosocial pathology, very fine. So much so that in Denmark, a case of post-traumatic stress can be recognised as an accident at work but also as an occupational disease (if the Occupational Diseases Committee considers that the traumatism is caused by a series of events that are emotionally stressing in the long term).

In **Italy**, mental and psychosomatic illnesses which are consequences of occupational stress can be recognised as an off-list illness since a deliberation by the Board of Directors of the Istituto Nazionale per l'Assicurazione contro gli infortuni sul Lavoro (INAIL)[3] in July 2001.

Compensation is paid for this type of disease on condition that the worker has been exposed for a long period of time (at least a few months) to a risk arising from dysfunctions in the work organisation.
INAIL has defined a series of causal agents, such as the unjustified loss of roles previously assigned to the worker, forced inactivity, failure to make available work instruments, repeated and unjustified changes of work station, prolonged assignment to debasing or on the contrary exorbitant tasks (allowance for the possible existence of physical or psychological handicaps), systematic, organised blocking of access to information, the repeated rejection of applications for training, new qualifications or occupational upgrading, and the excessive exercise of forms of control.
It has also decided to consider as a risk related to work organisation strategic mobbing, i.e. all the actions (behaviour and decisions) planned by the employer and designed to drive away or marginalise the worker, so as to create in him (her) a state of malaise likely to force him or her to resign.
On the other hand, the risks related to the contractual work relationship (laying off) and those resulting from relationships between persons (difficult relations between people working in the same environment) were excluded, since they are independent of the work organisation.

The diseases related to the risks covered appear in the form of inadaptation syndrome (adaptation disorder) and of post-traumatic stress syndrome, within a symptomatic context ranging from anguish to depression, from behavioural disorders to emotional disorders.

In **France,** the tables of occupational diseases mention no illness due to mental or psychological factors. Compensation for such an illness can, however, be paid under the complementary system. A claim for recognition as an occupational disease can be filed for submission to a Regional committee for recognition of occupational diseases, which consists of three doctors (regional medical consultant, regional medical labour inspector and university professor/hospital practitioner), if it is observed that the patient is affected by a work disability of at least 25% (66.66% prior April 2002). By lowering the threshold for the permanent disability rate, it should be possible in the future to recognise a greater number of diseases, knowing that it is too soon yet to measure the effect of this new legislation.

In practice, the conditions for recognition of an occupational disease under the complementary system are very strict; victims must prove that their disease is essentially and directly caused by their customary work and the investigation is performed in the presence of both parties (information

[3] Italian organisation in charge of occupational injuries insurance

collected in particular from the victim and the employer). The recognition takes place on a case by case basis, pragmatically.

Since psychosocial diseases are not covered by a table of occupational diseases, there is no legal definition of them. With regard to occupational diseases, like for accidents at work moreover, any cause which may trigger a decompensation (including for a pre-existing condition) is taken into account. Decompensation occurs after a series of facts due to habitual exposure to the risk.

The causes of such decompensation can be:

- Stress: The risk in question is the risk of a negative physiological or psychological response of the organism related to an increase in the workload, an unrealistic deadline, an inadequate number of employees, etc.
- Moral harassment: The risk in question is the risk of being subjected to repeated intriguing the purpose or effect of which is to bring about a deterioration of working conditions and hurt the dignity of the employee, adversely affect their physical or mental health, or compromise their career future. This intriguing may take the form of sanctions, discriminatory measures, bullying, taking as a scapegoat, etc.
- Sexual harassment: The risk in question is the risk of being subjected to undesired behaviour imposed forcefully by a person whose aim is to obtain favours of a sexual nature for his (her) benefit or for the benefit of a third party. This behaviour may consist of conduct with sexual or sexist connotations, obscene jokes, touching, sexual proposals, etc.

It should be emphasised that in France, in most cases, recognition of the job-related nature of such diseases takes place on the basis of the "accident at work" risk and not the "occupational disease" risk; which has no consequences for the victim at the compensation level but allows easier coverage since there is no condition relating to a minimum rate of permanent disability. For example, a nervous breakdown suffered by an employee following a demotion announced in the course of an evaluation interview was recognised as an accident at work by the case law, as was an attempted suicide by a female employee subjected to ruthless psychological pressure by her senior and who, the day before the attempt, had received a new schedule with new tasks which seemed impossible to perform in addition to her habitual work.

In **Portugal**, recognition of the job-related nature of psychosocial diseases is also possible under the complementary system. It would seem that the stress created by work organisation and the productivity requirements of the enterprise are the cause of most recognised cases.

In **Belgium**, only two cases were recognised within the framework of the off-list system in 2002. The Fonds des Maladies Professionnelles (FMP)[4] admits that these cases cannot be considered as constituting precedents. Under Belgian law, "an occupational risk exists […] when the exposure to the harmful influence is inherent in the exercise of the job"; now, the FMP does not consider itself competent to recognise that psychosocial risks (especially harassment) meet this definition.

B - Recognition currently impossible in seven countries

Several European countries have, to date, recognised no case of psychosocial pathologies as occupational disease: **Austria**, **Finland**, **Germany**, **Ireland**, **Luxembourg**, **Spain** and **Switzerland**.
For some of them, it is true that recognition is theoretically not ruled out due to the existence of a complementary system, but in practice the insurance organisations competent in the area of occupational diseases have adopted a position opposing such recognition.

[4] Belgian organisation in charge of occupational diseases insurance

In **Finland**, the working group set up in 2001 by the Ministry of Social Affairs and Health to reflect on the possible introduction of psychic factor into the Act on occupational diseases reported its conclusions in June 2003: mental disorders caused by a psychic factor at work should not be considered as occupational diseases nor be entitled to compensation as such within the framework of the legislation in force. The working group feels that, on an individual level, present scientific and medical knowledge does not make it possible to demonstrate with sufficient certainty a causal link between a psychic factor at work and a mental disorder (see appendix 1).

In **Germany**, according to the prevailing opinion, the research carried out has not, until now, been able to show sufficiently clearly that some groups of people are, due to their professional activity, more exposed than others to specific factors/influences which cause psychosocial diseases; it is, in particular, very hard to make a distinction between the work-related factor and other causes such as personal predispositions and factors related to the family or the social environment.
It is considered that, at the present time, all the conditions of the complementary system are not met for recognition of this type of disease as an occupational disease. Only a development of knowledge in this field could change this position and thus make recognition possible.

In **Switzerland**, a psychosocial work-related disease can in theory be recognised as an occupational disease in the framework of the complementary system, on condition that the occupational cause represents 75% of the origin of the disease, which no victim has been able to prove up to now. In practice, recognition of certain mental illnesses is possible only as an accident at work, in special circumstances accepted by case law, and in particular when the person insured, without being injured themselves, suffers a major nervous or mental shock. The victim can also apply to the civil court for the moral damage they have sustained.

Spain and **Ireland** are countries in which recognition of the job-related nature of a disease is based on a list; since illnesses due to mental or psychological factors do not appear on this list, and in the absence of a complementary system, the recognition of psychosocial diseases as occupational is currently impossible in these countries. Nevertheless, this kind of diseases is recognised by Spanish courts as accidents at work.

C - The case of the Netherlands

This country having no specific occupational injury insurance, it offers no compensation other than that of the health insurance system. Occupational disease reports by occupational physicians therefore do not correspond to claims for recognition, but they enable the Nederlands Centrum voor Beroepsziekten (NCvB)[5] to get an expression of the extent of health effects of harmful factors at the workplace, namely psychosocial factors.

In the Netherlands, psychosocial diseases are defined as psychiatric disorders caused predominantly by occupational factors. In fact, this expression basically covers job burnout, overwork and post-traumatic stress, which are dealt with in specific directives regarding the procedure for reporting to the NCvB (see appendix 2).

[5] Dutch institute for research and information on occupational diseases, responsible in particular for registering reports of occupational diseases

2. Extent of the phenomenon

A - Claims for recognition

The report on *Occupational diseases in 15 European countries* published in December 2002 mentions that psychosocial diseases are among the diseases which account for the largest number of claims for recognition/reports in **Denmark**, **Sweden** and **the Netherlands**. In the other countries allowing recognition, this number is smaller, but it is growing constantly.

In **Denmark**, nervous disorders ranked fifth in 2000, behind musculoskeletal disorders, hypoacusia, lumbago and skin diseases. In 2002, this type of disease accounted for 9.3% of reported diseases, versus 2.8% in 1996. The number of claims has increased regularly, rising thus from 434 in 1996 to 1,169 in 2002. All, however, are not examined by the Occupational Diseases Committee (177 cases were examined by the Committee between January 2001 and October 2003).
Three-quarters of the reports are made by women constantly over the period 1996-2002. The economic sectors most affected are government departments, defence and the social security organisations, far ahead of healthcare and educational organisations (see appendix 3).

In **Sweden**, affections related to organisational and social factors ranked as the fourth most often reported diseases in 2000. They currently account for 16% of such diseases, and are growing exponentially in a context in which claims for recognition were three times more numerous in 2001 than in 1997. Accordingly, 907 claims for recognition of mental or psychosomatic injuries as occupational diseases can be counted for 2002.

In the **Netherlands**, psychosocial disorders have since 1999 been in second position among reported diseases (after musculoskeletal disorders), thus representing in 2001, with 1,517 cases, more than a quarter of the total number of work-related diseases reported.

Italy registered 110 claims for recognition over the period 2000-2002, of which 64 have received unfavourable opinions and 34 are currently being investigated.

In **France**, the Regional recognition committees examined 5 claims in 2000, 13 in 2001 and 15 in 2002.

In **Belgium**, the Fonds des Maladies Professionnelles received, in 2000, 9 claims for recognition for psychosocial diseases, 11 in 2001, 16 in 2002 and 12 in 2003.

Note that those countries which do not admit recognition of psychosocial diseases as occupational diseases received no claim for recognition, with the exception of Germany.

B - Recognised cases

a) Figures

Country	1996	1997	1998	1999	2000	2001	2002	Total 1996/2002
Belgium	0	0	0	0	0	0	2	**2**
Denmark	3	9	8	18	11	38	32	**119**
France	0	0	0	0	2	6	6	**14**
Italy	0	0	0	0	0	0	12	**12**
Portugal	No available data		14	24	27	21	19	**105**
Sweden	55	39	39	77	99	148	177	**634**

It must be noted that, even though the phenomenon is recent (even very recent in Belgium, France and Italy), the number of cases recognised is on an upward trend. In Denmark (where 50 cases have already been recognised in the first three quarters of 2003), this growth can partly be explained by the increase in the number of claims for recognition.
One should also emphasise the difference between the number of claims for recognition and the number of cases recognised in all countries.

b) Typology of recognised risks and/or diseases

In **Italy**, ten of the twelve cases recognised in 2002 concern employees of the same enterprise who, after sustaining a major, unjustified job demotion, were transferred to a building separate from the rest of the enterprise without any work to perform. The management of this enterprise was sentenced in court in December 2001.
The 11th case recognised is that of a manager who, following restructuring of his enterprise, was first demoted in his position and then transferred for no reason, without regaining his position as manager, despite a court decision condemning the demotion and ordering that he be reassigned. In this case too, the management of the enterprise was sentenced.
The last case recognised is that of a female pharmacist who, following a change of management in the communal dispensary, and although she had until then shown great professional autonomy and was appreciated by the population, was faced with a climate of hostility designed to exclude her from management of the pharmacy.

As regards the permanent disability rate awarded to these twelve people, it is 7.5% on average (with a maximum of 13% for two of them).

Whereas, at the start of the period 1996-2002, the cases recognised In **Denmark** concerned women more than men, it can be considered that since 1998 both sexes have almost equal recognition rates: in 1998 there were three cases recognised for women and five for men, and 17 and 15 cases respectively in 2002. On the other hand, considering that three-quarters of claims for recognition are made by women, the latter are represented relatively less than men in terms of recognition.
Over half of the cases recognised belong to the sector of government departments, defence and Social Security (see appendix 3).

80% of the cases currently recognised are diagnosed as cases of post-traumatic stress (see Appendix 4). On the Danish permanent disability scale, the disability rate corresponding to mental disorders is 10%, 15%, 20% or 25% depending on whether the post-traumatic stress syndrome is low, moderate, moderate to severe, or severe. The compensation for repair of this type of physiological

damage (paid irrespective of the loss of earning capacity) therefore amounts to between €8,153 and €20,380 (January 2003).

In **France**, the cases recognised correspond to serious anxio-depressive syndromes. Out of the 14 cases recognised during the period 2000/2002, two concern management jobs, two concern sales & marketing staff, three concern executives, three concern paramedical workers and four concern other occupations.

As regards the benefits paid, in the case of occupational diseases recognised under the complementary system and hence "by definition" entailing a permanent disability rate of at least 25%, they consist of a pension of at least 12.5% of the reference wage (as defined in the Social Security Code) for cases recognised from April 2002 on; before then, the pension was at least 50% for a disability rate of at least 66.66%.

In **Sweden**, most cases concern stress and mobbing.

3. Review of thinking

After outlining the legislation and practices of the member countries with regard to recognition of psychosocial diseases as occupational diseases, and before reviewing current national thinking, the Community position on the subject should be mentioned.
Psychosocial diseases were not listed in the European list of occupational diseases steming from the recommendation of 1966 brought up to date in 1990.
Within the framework of the recent process of revision of this list, the Advisory Committee on Safety, Hygiene and Health Protection at Work (CCSHS)[6] expressed itself in December 2002 concerning the European Commission's proposal.
The CCSHS Workers Group regretted the fact that one of the main shortcomings in the Commission's proposal concerns damage to health caused by psychosocial factors (stress, harassment, burnout), and considered that mental illnesses caused by stress at work should be added to Appendix 1 of the European list.
The Employer Group, without stating its opinion explicitly concerning this type of disease, considered that "if it is of a multifactorial nature, a disease should not be included in Appendix I due to the difficulty of recognising it as an occupational disease".
The recommendation of 19 September 2003 in the end confines itself to recommending, in its article 1- 7° "the promotion of research in the field of complaints related to a professional activity, especially […] for work-related disorders of a psychosocial nature".

A - Towards more precise diagnosis

In those countries that already allow and practise recognition of psychosocial diseases, thinking is underway on definition of the framework for recognition and compensation of these diseases.

In **Italy**, following the decision of the INAIL Board of Directors in July 2001 to allow the recognition of mental and psychosomatic illnesses under the off-list system, a scientific committee was set up. It has been assigned responsibility for defining the procedures for examining claims for recognition of this type of disease, so as to uniformise the treatment of cases at the national level (see appendix 5).
In December 2003, instructions were sent to the heads of central and territorial INAIL organisations, regarding how to assess the risks involved, the worker's prior pathological condition, establishment of the diagnostic and any tests which should be carried out and specialist visits to be provided for, so as to reach a clinical and then forensic medicine diagnostic (see appendix 6).

In **France**, a study financed by the Occupational Risks Department of the Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (CNAMTS)[7] concerning moral harassment properly speaking is currently being carried out in four occupational disease consulting centres in Toulouse, Clermont-Ferrand, Lyons and Garches, in cooperation with the competent Regional Health Insurance Funds in the regions in question. The purpose of the study is to define an interview and diagnosis protocol for use by the occupational physician, thus allowing a uniform approach to be adopted in the whole country and facilitating the examination of claims for recognition. The results of this study will be presented at the end of 2004.

[6] The Advisory Committee on Safety, Hygiene and Health Protection at Work - the so-called Luxembourg Consultative Committee - is a tripartite body created in 1974 by a decision of the Council of Ministers to assist the Commission in the preparation and performance of activities in the fields mentioned; in 2003, upon a decision by the same Council, it merged with the Safety and Health Commission for the Mining and other Extractive Industries and is now called the Advisory Committee on Safety and Health at Work.

[7] French National Health Insurance Fund for Employees, in charge of sickness and occupational injuries insurance

The legislative authorities have also investigated the question of harassment and, by voting for the social modernisation act of 17 January 2002, introduced into the Labour Code articles defining and prohibiting moral harassment and into the Penal Code a new offence allowing punishment of acts of moral harassment. An Act of 3 January 2003 changed the conditions of the onus of proof by requiring that the employee establish the facts allowing presumption of the existence of the moral or sexual harassment of which he (she) considers himself (herself) a victim (formerly, the employee had to present the facts suggesting the existence of harassment).

In **the Netherlands**, the Nederlands Centrum voor Beroepsziekten in 2001 initiated a project which aims at defining a better set of criteria for registering psychological illnesses of occupational origin. The method involves, in particular, questioning about fifty physicians who have made numerous psychosocial disease reports. A report presenting the conclusions of this study will be published at the end of 2005.

B - Towards recognition?

In the other countries, thinking covers (or has covered) the possibility of allowing recognition of psychosocial diseases as occupational diseases.

As has already been pointed out in Part One, **Finland** recently abandoned the idea of including a psychic factor in its Act on occupational diseases. It was considered that present scientific and medical knowledge does not make it possible to demonstrate with sufficient certainty a causal link between a psychic factor at the workplace and mental troubles (see appendix 1).

In **Germany**, the recognition of psychosocial diseases has not yet been discussed in the scientific committee on "occupational diseases" responsible for advising the Ministry of Health and Social Affairs.

In **Spain**, the working group set up as part of the "Round Table for social dialogue" by the Ministry of Health to revise the Spanish list of occupational diseases decided in October 2003 not to include psychosocial diseases in the list, thus acting in line with the position adopted by the European Commission in the recommendation of 19 September 2003.

Switzerland poses questions concerning the potential for and consequences of recognition of diseases related to mental or psychosomatic phenomena sustained at work.
The Schweizerische Unfallversicherungsanstalt (SUVA)[8] has accordingly set up an interdisciplinary working group to reflect on the definition of this type of so-called occupational diseases, to list the conditions of recognition and to measure the financial impact of such a legislative change. The SUVA nevertheless considers that the range of benefits offered by the insurer is currently not appropriate for this type of disease.
The problem was also examined at the second National Forum for discussion on work-related health disorders, organised by SUVA in November 2003, which brought together 70 people representing the government, the trade union and employers' organisations, and physicians and health specialists. All the participants unanimously demanded concrete measures for the prevention of situations such as stress, burnout and mobbing which are the cause of "work-related health disorders". But given the scarcity of scientific data on this topic and the complex nature of these multifactorial diseases, the employers stated that they were opposed to their recognition as occupational diseases. This Forum showed clearly that any change toward recognition first required discussion between social partners, due to the probable increase in health costs that would result from such a decision.

[8] Swiss organisation of insurance against accidents (including occupational injuries)

Appendix 1: Summary of the conclusions of the Working Group on compensation of mental disorder-related occupational diseases in Finland

In September 2001 the Ministry of Social Affairs and Health set up a working group with the assignment to clarify whether or not a psychic factor related to work or work environment could constitute the basis for occupational disease compensation. In particular, the working group was to focus on the following questions:

1) whether or not there is any undisputed medical evidence showing that a particular external factor could cause to an individual a specific condition that could be classified as a mental disorder;
2) what is the state of current knowledge regarding the potential causal relationship between psychic factors and physical diseases?
3) whether or not there are any medical procedures to distinguish various causal factors from each other and to evaluate their impact on the occurrence of mental disorders;
4) whether or not there are objective methods to evaluate the respective quantitative and qualitative impacts of psychic exposure at work and outside work;
5) whether or not there are reliable methods to evaluate and analyse the role played by a person's different mental disorders for his/her overall mental or physical health;
6) what role should be given to individual personal factors contributing to the onset of mental disorders?

Moreover, the working group was charged with the task of evaluating whether or not there is sufficient justification for compensating mental disorders caused by psychic factors as occupational diseases, i.e., whether or not psychic factors should be added in section 1 of the Occupational disease Act among other factors causing occupational diseases.

The working group -comprised of members of social partners, the Ministry, the occupational injury insurance branch and medical experts- completed their work in June 2003. The working group was unanimous in finding that, at present, there is not sufficient evidence to include the psychic or psychological factors in the occupational disease legislation. The stand taken by the working group was based on the following aspects:

A mental disorder can already now be compensated through the statutory accident insurance system either as a consequence of an accident at work or as an occupational disease resulting from a chemical factor.
The accident refers to a sudden, unexpected event caused by an external factor, taking place irrespective of the insured person's will and causing him/her a physical or mental injury or disease. Therefore, mental disorders, such as stress reactions, can be compensated as a result of an accident at work.
The Occupational Disease Act includes the definition of occupational disease: it refers to a disease which is probably primarily due to physical, chemical or biological factors associated with work done during a period of employment. A disease caused by psychic or social factors is not compensated as occupational disease. Every year, individual cases of intoxication caused by organic solvents are diagnosed as occupational diseases resulting from exposure to chemical factors. The frequent mental symptoms associated with such intoxication cases are compensated in the same way as any other occupational disease symptoms.

According to the Occupational Disease Act, the occupational disease diagnostic is based on a two-step causal relationship:
The first aspect that has to be cleared is the general causal relationship between the exposure (physical, chemical or biological factor) mentioned in the Act and the patholgy, i.e., whether or not such exposure can cause the disease in the first place. This has to do with the probability criteria

included in the definition of occupational disease. Secondly, the connexion between the said exposure and the disease will be determined, through individual diagnostic methods, in the work of the employee. As regards the exposure/disease pairs mentioned in the Occupational Disease Statute (the so-called occupational disease list), the first-level causal relationship has been established when the exposure/disease pair has been recognised and included in the Statute.

In its report the Working Group points out that the impact of psychological strain and mental disorders on work have been increasing. According to research results there is a recognisable connexion, at group level, between work-related strain factors and mental symptoms. However, there is no unambiguous scientific evidence of the causal relationship between a clearly definable work-related strain factor and individually diagnosable mental disorder. When the compensability of occupational diseases is considered, the two-step causal relationship criteria of occupational disease diagnostics must be satisfied both at the general and the individual level. In fact, the report states that the group level knowledge of the connexion between exposure and disease is often sufficient for prevention purposes but such knowledge of a causal relationship at group level is not sufficient for insurance compensation purposes.

If mental disorders were compensated in accordance with the Occupational Disease Act as occupational disease caused by psychic factors, problems would arise due to the still lacking medical knowledge of causal relationship, to the undeveloped methods to measure psychological strain objectively at individual level, as well as to the descriptive nature of psychiatric diagnoses.

Since the stand taken by the working group was based precisely on the fact that current knowledge is still insufficient, the group made certain research and development proposals aiming at the investigation and clarification of the connexion between the psychological work-related strain factors and mental disorders. It is necessary to develop methods to measure mental strain at work and to engage in further research on the connexion between work-related mental strain factors and mental disorders. In the future research should also focus on the impacts of prolonged psychological strain situations.

Appendix 2: Extract from the Review of Occupational Diseases 2002 by the Nederlands Centrum voor Beroepsziekten concerning work-related psychological disorders in the Netherlands

In the Netherlands, psychological disorders are the cause of a large proportion of sick leaves and work disabilities.
The Donner Commission I[9], which reviewed the measures to be taken in this area, has published a guide aimed at preventing further disability leaves for psychological disorders.
One quarter of the occupational disease reports registered by the Nederlands Centrum voor Beroepsziekten (NCvB, Dutch centre for occupational diseases) concern psychological disorders. As a supplement to the reports -compulsory since 1999- currently made by the *Arbodiensten* (occupational health and safety services) to the NCvB, it would be advisable to have several sources of information concerning the extent and breakdown of psychological disorders of occupational origin, for example via a monitoring network or the Nederlands Kenniscentrum Arbeid en Psyche (NKAP)[10].

1 - Description of disorders

Overwork and job burnout, post-traumatic stress syndrome (PTSS) and depression of occupational origin are examples of work-related psychological disorders. The NCvB has drawn up diagnostic aid sheets for cases of overwork, job burnout and PTSS (there are not yet any for depressions of occupational origin, anxiety neuroses and alcohol/drug addiction).

Editor's note: these diagnostic aid sheets are available in full in Dutch on the site www.beroepsziekten.nl under the heading "protocol en richtlijnen". Those corresponding to depressions, neuroses and alcohol/drug addiction are currently being worked out and should be completed in 2006.

Overwork and burnout
Overwork and burnout have several symptoms in common: fatigue, inability to relax, anxiety, sleep disorders, heightened irritability, digestive disorders, headaches and vertigo. They are distinguished, however, by their duration, burnout being a problem of a chronic nature. Moreover, a person suffering from burnout becomes increasingly distant with regard to his (her) work and has the impression of being less competent. When these reactions are very pronounced, they go so far as to disturb social or occupational functioning.
The cause of these disorders is generally a set of interacting factors, in particular work, but also personality and private life. Overwork and job burnout often go together with long sick leaves and a high risk of disability leave.

Post-traumatic stress syndrome (PTSS)
The post-traumatic stress syndrome can appear as a result of traumatising events, such as an assault or a serious accident. The risk of PTSS is highest for policemen, firemen, military personnel, bank and shop staff, ambulance staff and train drivers.
People suffering from PTSS constantly relive the traumatising experience, they avoid the stimuli associated with the traumatism and are more irritable.

Depression of occupational origin and anxiety neuroses
Depression is characterised by a morbid dejection, often accompanied by various physical and psychological disorders and difficulties in social relations. A recent study showed that work-related factors can play an important role in the aetiology of depressions (Schene, 2002).

[9] or Commissie Psychische Arbeidsongeschiktheid (commission on work disability due to psychological disorders), which published its report in November 2001
[10] Dutch centre for research on psychological disorders in the work environment)

Anxiety neuroses, which may likewise be work-related, are manifested by strong emotions of anguish or panic.

Alcohol and drug addiction
The risk of alcohol and drug addiction is higher in certain jobs or sectors, e.g. for employees of hotels, restaurants and cafés.

2 - Extent of the problem

One quarter of the occupational disease reports concern psychological disorders.
The 1st table shows the various disorders reported to the NCvB. The 2nd table indicates in what sectors of activity psychological disorders are frequently reported.

Overview of reported cases of work-related mental disorders by diagnostic

Diagnosis	2000		2001		2002	
Overwork	926	62.4%	888	58.5%	695	60.0%
Burnout	331	22.3%	348	22.9%	245	21.1%
Post-traumatic stress	77	5.2%	110	7.3%	79	6.8%
Other	150	10.1%	221	11.3%	140	12.1%
Total	**1,484**		**1,517**		**1,159**	

Most of the reports concern burnout and overwork, which often result in sick leaves and hence high costs.
Occupational physicians apparently hesitate to consider psychological disorders as occupational diseases. Indeed, the records of the NCvB mention the influence of personal characteristics in cases of psychological disorders far more often than for other diseases. The role played by work in the aetiology of psychological problems is therefore often under-estimated.
The NCvB has no diagnostic aid sheets for mood disorders (depression), anxiety neuroses and alcohol/drug addiction. The records for 2001 report only 51 cases of depression and 23 cases of anxiety neuroses; there is no reported case of work-related alcohol/drug addiction. Now, other works (Laitinen-Krispijn and Bijl, 2002; Schene, 2002) have shown that these problems affect many people and are to a great extent of occupational origin.

Sectors in which there are numerous reports of work-related mental disorders (2001)

Sector	Number of reports	Working population	Number of reports for 100 000 workers
Education	212	433,000	49
Transport, storage and communications	182	435,000	41
Health and social work	316	932,000	34
Public Administration	153	487,000	31
Industry	204	1,065,000	19
Other sectors	450	3,565,000	13
TOTAL	**1,517**	**6,917,000**	**22**

The sectors in which there is a high risk of psychological disorders of occupational origin are:
1. education
2. transport, storage and communications
3. health and social work
4. the Public Administration.

These results are confirmed by the large-scale survey by Trimbos Instituut[11] (Laitinen-Krispijn and Bijl, 2002) carried out as part of the Nemesis project, which studies psychological problems in the Dutch population as a whole and takes into account repeated measurements on the same people.
This survey showed that the annual prevalence of psychological disorders in men is higher in the sectors of education (mood disorders: 6.9%), healthcare (mood disorders: 8.8%, anxiety neuroses: 9.5%) and the hotel/restaurant industry (anxiety neuroses: 10%, alcoholism: 17.5%) and in women in the sectors of industry (mood disorders: 10%, anxiety neuroses: 18.7%) and the Public Administration (anxiety neuroses: 19.2%).

The NCvB's declarations show that overwork (497 cases), a reorganisation and/or a merger of the firm (121 cases) and problems with a hierarchic senior (89 cases) are the most frequent causes of psychological disorders.
According to the study by Trimbos Instituut, employed persons who are not very satisfied with their job position, whose activities do not correspond to the skills they believe they have, who do not find their work pleasant, or whose work interferes with their private life, have a higher risk of suffering from psychological disorders. Heavy demands, little autonomy and few prospects for personal development, together with poor social support for the work and uncertainty as to the permanence of the employment also increase this risk.

Disability leave
On the whole, the number of new disability leaves in the Netherlands is high by comparison with other countries. The proportion due to psychological disorders is significant: in 2000, they account for 36% of new cases of disability leave. One should also note the relatively high number of young people and women on disability leave (Donner Commission I, 2001).

3 - Scientific and social developments

Psychological disorders and disability
As we observed above, psychological disorders are the cause of a large proportion of new disability leaves in the Netherlands. The guide prepared by the Donner Commission I emphasises the essential aspect of cooperation between the various players (the patient's referring doctor, occupational physician, psychologist and hierarchic senior). It is important to apply these recommendations as soon as possible, being identical, moreover, to the recommendations for the "medico-social monitoring of psychological disorders" issued by the Nederlandse Vereniging voor Arbeids- en Bedrijfsgeneeskunde (NVAB)[12] for occupational physicians.
To reduce the number of new disability leaves, it was considered not giving leave in cases of psychological disorders. But this proposal does not allow for the seriousness of such problems and is likely to lead to an increase in the number of civil liability proceedings. It seems preferable to opt for effective prevention and active rehabilitation.

Workload
It is not realistic to explain sick leaves and disability leaves due to psychological disorders merely by the relative ease with which the employees can receive these benefits. Several studies have shown that the appearance of psychological disorders is related to the corporate culture and the quality of social relations at work. Part-time workers, the proportion of which is higher in the Netherlands than

[11] Dutch institute of mental health and addiction
[12] Dutch association for occupational medicine and company medicine

anywhere else, are frequently subjected to greater time pressure. The permissiveness of Dutch culture, which prefers to cover up conflicts rather than face up to them, could also play a role in the appearance of psychological disorders. Dutch employees have to meet heavy demands (great flexibility, high productivity), and more and more often within the framework of part-time jobs. It may well be asked whether they have the necessary resources to meet these demands. In the area of child care, for example, the Netherlands are not the best placed in Europe.
It is therefore recommended making sure to balance the demands weighing on employees and the resources available to them to remedy the labour wastage observed today. Various collective labour agreements propose reducing overwork by various measures such as management training, treatment of identified problems by an appropriate audit and introduction of structural consultation, but their effectiveness has not yet been scientifically proved.

Scientific research
Based notably on epidemiological studies, the "*Psychische Vermoeidheid in de Arbeidssituatie"* programme (mental fatigue in work situations) has given us a deeper knowledge of the link between psychological disorders and work.
But many questions remain. The effectiveness of prevention actions and prognosis factors, for example, is still not well-known. Scientific research should therefore be continued in this area, in particular because of the major social costs resulting from psychological disorders.

Conclusions

Knowledge of psychological disorders has improved in recent years. However, the effectiveness of prevention actions and prognosis factors is still not well-known. Scientific research should therefore be continued in these areas.

It is desirable to balance the demands weighing on employees and the support they receive to cope with them in order to avoid labour wastage. Various collective labour agreements propose reducing overwork.

The recommendations concerning the approach to mental problems intended for occupational physicians and the guide by the Donner Commission I should be implemented rapidly so as to reduce the number of new disability leaves due to psychological disorders.

Appendix 3: Statistics on work-related mental disorders (claims for recognition and recognised cases) in Denmark

Claims for recognition of mental disorders by sector of activity and by gender

Sector of activity	2001		2002	
	Women	Men	Women	Men
Agriculture, hunting and fishing	5	2	6	0
Mines and quarries	0	1	1	1
Manufacturing activities	34	17	30	28
Electricity, gas, heating and water	0	1	2	1
Building and construction	4	4	1	1
Trade and repair services	33	11	36	9
Hotel and restaurant industry	7	2	5	2
Transport	22	18	26	31
Banking, finance, insurance	12	6	12	8
Real estate	28	12	27	22
Civil service, defence and Social Security	413	129	437	140
Education	38	20	50	28
Health and welfare institutions	146	33	181	23
Entertainment and culture	23	12	28	14
Other	14	2	14	5
Total	**779**	**270**	**856**	**313**

Recognised cases of mental disorders by sector of activity and by gender

Sector of activity	2001		2002	
	Women	Men	Women	Men
Manufacturing activities	0	0	0	1
Transport	1	1	0	1
Banking, finance, insurance	0	0	1	0
Civil service, defence and Social Security	9	12	13	7
Education	1	1	2	1
Health and welfare institutions	3	3	1	3
Other	2	4	0	2
Total	**16**	**21**	**17**	**15**

Appendix 4: Examples of cases of recognised mental illnesses related to abnormally high occupational stress factors in Denmark

The Occupational Diseases Committee has recognised that all the following mental disorders were due to situations of occupational stress. All these cases were recognised as occupational diseases.

In the prison environment

- Situation: employee having worked for many years as a prison officer.
  Facts: unruly behaviour of some prisoners, violent attacks on the prison by bikers, victim of threats and jeering, witness to suicide attempts.
  Diagnostic: post-traumatic stress syndrome.

- Situation: employee having worked for many years as a prison officer.
  Facts: Scenes of violence, threats, hand-grenade attacks, shooting with automatic weapons, discovery of a prisoner's suicide attempt.
  Diagnostic: post-traumatic stress syndrome.

- Situation: female teacher employed as a substitute from August to November 1993 in the high-security block of a prison.
  Facts: victim of constant humiliations and threats of violence.
  Diagnostic: reactive depression.

Exposure to occupational stress while posted abroad

- Situation: officer posted in Kuwait and then in Croatia with the peacekeeping forces.
  Facts: involved in violent situations (direct military actions or assaults against the civilian population), witnessed the execution of an Iraqi soldier who was shot in the mouth.
  Diagnostic: post-traumatic stress syndrome.

- Situation: driver in a humanitarian aid convoy in Bosnia.
  Facts: witnessed the destruction of whole towns, drove in areas affected by direct military operations, and was threatened by soldiers and armed civilians to get money.
  Diagnostic: post-traumatic stress syndrome.

- Situation: employee of the Danish Refugee Council working as manager of a warehouse in Kosovo for almost six months.
  Facts: exposed to threats of violence and murder.
  Diagnostic: post-traumatic stress syndrome.

Health and welfare occupations

- Situation: home help having worked for a few years for a woman paralysed on one side.
  Facts: very aggressive and threatening behaviour by the patient's husband, who hit and kicked at things and banged his fist against the wall just above the home help's head.
  Diagnostic: post-traumatic stress syndrome.

- Situation: social worker having replaced the matron of an institution for one year.
  Facts: conflicts with her superiors, who spoke ill of her and gossiped about her.
  Diagnostic: isolated depressive incident of a moderate nature.

- Situation: employee having worked for several years in a 24-hour institution for the mentally handicapped.
  Facts: was the victim of four violent assaults in one year, involving hitting and kicking.
  Diagnostic: post-traumatic stress syndrome.

Educational occupations

- Situation: teacher having taught in a school catering for mentally deficient children with learning problems, and acting as sole teacher to an autistic boy with recurring extroverted and aggressive behaviour.
  Facts: blows struck by the autistic boy, accusations made by the child's parents against the teacher and reported on television.
  Diagnostic: mental disorders.

- Situation: teacher having working for many years in a school for autistic children.
  Facts: accused of having tried to strangle a child whom he had gripped firmly by the neck. Charges subsequently dropped, but further complaint by parents following help provided by the teacher to a colleague in a conflict situation.
  Diagnostic: personality change, symptoms of post-traumatic stress syndrome.

Police and security guards

- Situation: police officer.
  Facts: called to the scene of several fatal road accidents, the drowning of a young child, a murder and a fatal shooting incident.
  Diagnostic: post-traumatic stress syndrome.

- Situation: security officer in a library for one year, helping employees enforce the regulations and checking that the premises were empty at closing time.
  Facts: discovery of drug addicts hidden in the toilets, threats made by mentally ill people who went to the library, etc.
  Diagnostic: phobic anxiety.

Sexual harassment

- Situation: unskilled female cook.
  Facts: six months after beginning the job, sustained increasingly aggressive sexual advances and physical touching by her boss. Later on, he unjustly accused her of making mistakes, and harassed her on the phone.
  Diagnostic: post-traumatic stress syndrome.

Appendix 5: Summary of the report by the ad hoc Scientific Committee on the Recognition of Mental and Psychosomatic Illnesses in Italy

1 - Introduction

By a resolution of 26 July 2001, the Istituto Nazionale per l'Assicurazione contro gli Infortuni sul Lavoro (INAIL) board of directors decided to permit the recognition of mental and psychosomatic illnesses caused by stress in the workplace, including mobbing. It then approved the plan aimed at defining methods for risk assessment and the causal and forensic diagnosis of said illnesses.
For this purpose, the chairman of INAIL, upon a proposal by the Managing Director, set up a Scientific Committee by appointing, alongside the INAIL managers (Central Benefits Department, General Medical Supervision and Legal Department), six experts in occupational medicine, forensic medicine, work psychology and forensic psychopathology. In October 2003, this Committee delivered its conclusions concerning the guidelines to be adopted with regard to recognition of mental and psychosomatic illnesses as occupational diseases.

2 - The risk covered

As part of an insurance-based approach, reference should be made to established legal and forensic criteria allowing very separate diagnosis of a job-related illness by comparison with a common illness. The following criteria were adopted to define the risk of incurring mental and psychosomatic illnesses in the workplace:

- occupational risk includes the conditions created by inconsistencies in the organisation process, what are called "organisational constraints" ("Costrittività organizzativa");
- if there are indeed organisational constraints, the existence or absence of specific subjective responsibilities matters little, but these responsibilities could constitute a factor of proof once their existence has been proved by the legal authorities;
- organisational constraints include "strategic mobbing" for an occupational purpose, namely all the actions organised in the workplace to alienate or marginalise an employee and making use of the acts mentioned in section 3 or other similar acts.

On the other hand, the following are excluded from the risk covered:

- organisational factors relating to contingencies of professional life (dismissal, reassignment, etc.);
- situations resulting from psychological and relational dynamics common in the occupational environment and in social life and the family circle.

3 - Work organisation and organisational constraints

Inconsistencies noted in the organisation processes may become psychological risk factors for the employee.
Given below is a list of the organisational constraint situations most frequently observed, established on the basis of legislative and case law sources, and the preliminary results of the examination of cases reported to INAIL:

- marginalisation of professional activity, jobs voided of their content, failure to provide work instruments, and unjustified, repetitive transfers;
- prolonged assignment to tasks that are disqualifying by comparison with the occupational profile of the person concerned;

- prolonged assignment to tasks that are too heavy, including with reference to a possible psychological or physical handicap;
- systematic, organised obstruction of access to information;
- systematic, structural inadequancy of the information required for normal performance of the job;
- repetitive exclusion of the employee from occupational training, requalification and upgrading initiatives;
- excessive exercise of various forms of control.

4 - Main tables of mental and psychosomatic illnesses

If one accepts that individual predispositions may influence an increased susceptibility to occupational stress factors, it is essential to define a nosographic framework and to perform both qualitative and quantitative definition of mental and psychosomatic illnesses.
According to the classification of mental and behavioural disorders in ICD-10[13] and according to DSM-IV[14], there are two types of stress-related syndromes: the inadaptation syndrome and post-traumatic stress syndrome.
The inadaptation syndrome (adaptation disorder) is the expression of emotional and behavioural symptoms having a clinical significance, in response to one or more identifiable stress factors that are not of an extreme nature.
The post-traumatic stress syndrome (post-traumatic stress disorder) is the delayed or extended response to an extremely stressing event or a situation of a very threatening or disastrous nature, which could cause widespread malaise in almost everyone.

According to the DSM-IV (multi-axis classification designed for clinical use), post-traumatic stress disorder is accompanied by the same symptoms as the adaptation disorder, except that these symptoms are more severe and can leave sequels such as obsessive thoughts and/or episodes in which the subject relives the stressful situation, and avoidance behaviour.
The post-traumatic stress disorder corresponds to a clinical table that it is harder to correlate to the occupational risks described earlier. The higher rate of occurrence of the inadaptation syndrome is confirmed by certain national studies underway.

5 - Methods and criteria used for the diagnosis of occupational diseases

Like all off-list occupational diseases, the mental or psychosomatic disorders reported by the insured must undergo an in-depth survey 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 surveys, 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 so 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 illnesses 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 illness.

[13] International Statistical Classification of Diseases and Related Health Problems
[14] Diagnostic and Statistical Manual of Mental Disorders

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 table of the illness (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 illness.

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 which could be sources of stress. At the top of the list are the death of a spouse or a child, then in decreasing order: divorce, separation from one's spouse, imprisonment, the death of a close relative, accidents or diseases, marriage, the loss of a job or a professional failure, downgrading, promotion, retirement, the death of a close friend, a change of work and other changes in social life.
Even though events related to professional activity are not to be found at the top of the 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.

For recording the reported illness, it is the sworn specialists who are competent: they perform a comprehensive clinical examination to analyse the subject's personality before the illness and the evolution of the clinical table.

6- Harm assessment criteria

Within the framework of reparation for biological harm by the occupational injuries and diseases insurance system, the permanent disability scale provides exclusively for the following two headings:
(180) - Moderate chronic post-traumatic stress disorder: up to 6%
(181) - Severe chronic post-traumatic stress disorder: up to 15%.

To assess this percentage in the case of a chronic adaptation disorder, one should proceed by analogy, drawing up a precise table of the illness in accordance with the aforementioned clinical and forensic criteria, knowing that it will have to comply with the ICD-10 and DSM-IV rankings, but be adapted according to the handicapping effects of the observed disorders.
To quantify the harm, allowance will have to be made for polymorphism in the clinical table and a gradual approach should be adopted depending on the seriousness of the predominant symptomatology (see the rankings indicated in ICD-10[15] and DSM-IV[16]), with the percentage possibly corresponding, for the light/moderate forms, to the range provided for under heading 180, and for the severe forms (major depressive and behavioural symptoms) to that under heading 181.

[15] adaptation disorder accompanied by:
- short depressive reaction
- extended depressive reaction
- mixed reaction of anxiety/depression
- predominant disorder of other emotional aspects
- predominant disorder of behaviour
- mixed disorder of the emotions and behaviour
- other specific predominant symptoms

[16] adaptation disorder with
- depressive mood
- anxiety
- anxiety and depressive mood.

Appendix 6: Excerpt from the circular disseminated in December 2003 to the managers of the central and local structures of INAIL in Italy dealing with the procedures for examining claims for recognition of psychic pathologies

1 - Verification of risk conditions

As is the case for all the other diseases that are not included in the list, the insured is obliged to produce the necessary documentation to support his (her) claim, with regard to both the risk and the illness.

INAIL, for its part, has the power and the duty to make sure of the existence of the legal foundation claimed by the insured, for which purpose it may have to take part in reconstituting the evidence of the causal link.

The experience acquired to date has demonstrated to us that the insured is not always capable of providing sufficient documentary evidence, just as the Institute cannot always acquire it itself.

It is therefore necessary to carry out INAIL inspectorate surveys to collect the testimony of fellow workers, the employer, the managers of corporate loss prevention and reduction departments, and any person having information concerning the facts, in order to collect objective proof of what is stated by the insured and supplement the evidence produced by the insured.

Additional information could be obtained by the Provincial Department of Labour or by the competent offices of the National Health Department by performing subsequent verification of the facts within a legal framework or within the labour inspectorate framework.

As for all other occupational diseases, the survey carried out with a view to acquiring objective evidence and any supplements to the statements and proof provided by the insured shall be triggered at the request of the health organisation which will also be responsible for indicating the specific aspects to be examined more closely.

On the other hand, for the diseases with which we are concerned here, and unlike other occupational diseases (for which action by the inspectorate is provided for only in case of need), the labour inspectorate survey must be carried out systematically. Exceptions to this, of course, will be those cases in which the health organisation, on completion of the initial phase of investigation, has reached the conviction that the claim should be rejected due to the absence of a disease or because it is certain that a work-related origin of the disease can be ruled out.

2 - Procedure for diagnosis of occupational diseases caused by "organisational constraints"

The diagnosis procedure to be followed to ensure uniform forensic treatment of all the cases brought to the attention of the Institute will be found below:

• Past and present occupational case history:

- indicate the sector of activity, the year of recruitment, qualifications and positions held;
- describe the job position considered as being the cause of the disease by defining the specific conditions of dysfunctions in the work organisation;
- put in place, if this has not already been done, the necessary labour inspectorate surveys during which will be collected the testimony of the employer and fellow workers and any legal proceedings, etc.

• Physiological case history: indicate living habits (eating habits, tobacco abuse, alcohol consumption, hobbies, education diplomas, etc.)

• Remote pathological case history

• Close pathological case history:

- mention the diagnostic given when establishing the first medical certificate of job-related illness;
- describe the evolution and symptoms of the mental disorder;
- enclose with the medical literature relating to the case the assessments by specialists, the preventive and routine health inspections performed in the enterprise and any previous involvement of the INPS[17].

• Comprehensive objective examination

• Neuropsychiatric examinations:

- neuropsychiatric inspection and report possibly supplemented by tests of a psycho-diagnostic nature, on condition that a neuropsychiatry specialist be available on the spot;
- consultation by a government-regulated neuropsychiatry specialist having recognised experience, or, if the latter is not available on the spot, by a public body.

• Tests of a psycho-diagnostic nature:

- given the particular features of the illness in question, the specialist is completely free, based on his (her) professional experience, to choose the tests that will supplement the objective psychological examination but can in no way replace them. These tests, in the psychiatric context, are extremely important because they are reproducible and comparable over time; they therefore prove very useful for forensic purposes. We give below the list of examinations most frequently used:

a) Personality questionnaires (MMPI and MMPI2, EWI, MPI, MCMI, etc.)
b) Scale of evaluation of psychiatric symptoms:
    - anxiety and depression, self-assessment and hetero-assessment (BDI, HAD scale, HAM-A, HAM and Zung depression rating scale, MOOD scale)
    - aggressiveness and anger (STAXI)
    - disorders due to post-traumatic stress (MSS-C)
    - amplification of somatic symptoms (MSPQ)
c) Projective tests (Rorschach, SIS, TAT, Response to pictures, etc.).

• Forensic diagnosis:

- for the nosographic description, only the following two tables should be referred to:
  . chronic inadaptation syndrome (disorder)
  . post-traumatic or chronic stress syndrome (disorder).

The diagnostic commonly associated with the risks dealt with is the chronic adaptation disorder, with its whole series of clinical symptoms (anxiety, depression, mixed reaction, behaviour change, emotional disorders and disorders of a somatic nature).

By assessing these symptoms, it will be possible to classify the illness as light, moderate or severe. The diagnostic of a post-traumatic stress symptom (or disorder) may be given in cases for which the professional activity, when it has extreme connotations, can be compared with the events mentioned in the international rankings of ICD-10 and DSM-IV. These cases are those that are defined as being cases of "extreme/exceptional threat or disaster" (we give a reminder, in this respect, that those cases in which a "critical event" occurs should of course be included among occupational injuries).

[17] Istituto Nazionale della Previdenza Sociale: national health insurance organisation

- for the purposes of differential diagnosis, one should exclude the presence of:
  - psychological syndromes and disorders having a link with a disease affecting an organ or a systemic disease, or with the consumption of medicines and with drug taking;
  - psychotic syndrome of schizophrenic type, bipolar manic-depressive emotional syndrome, serious personality disorders.

• Assessment of permanent biological harm:

The scale of disabilities relating to the assessment of biological harm within the framework of INAIL provides for the presence of two items both concerning the chronic post-traumatic stress disorder which may be moderate (heading 180) or severe (heading 181).

The assessment interval indicated [in the scale] offers a thoroughly suitable reference framework to allow, by analogy, assessment of the biological harm that could be caused by a chronic adaptation disorder.

EUROGIP is a Public interest grouping (groupement d'intérêt public) formed by the National Health Insurance Fund for Employees (CNAMTS) and the National Research and Safety Institute (INRS) in order to organize, coordinate and develop at the European level the actions of the French Social security system regarding occupational hazards.

EUROGIP

Groupement de l'Institution Prévention de la Sécurité sociale pour l'Europe

55, rue de la Fédération - 75015 Paris
Tel. (+33) (0) 1 40 56 30 40 - Fax (+33) (0) 1 40 56 36 66
eurogip@eurogip.fr - www.eurogip.fr