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Recognition and compensation of work-related mental disorders in Europe

(Belgium, Denmark, France, Germany, Italy, Spain, Sweden)

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CONTENTS

Introduction

Several European surveys (in particular the ESENER[1] and Labour Force Survey[2]) note an increase in the number of workers affected by psychological suffering related to their work during the last decade. Psychosocial risks have accordingly become a prevention priority in most European countries.

While it is now admitted that working conditions can have an impact on workers' mental health, the question of recognition of the work-related nature of mental illnesses is far from creating unanimous agreement in Europe.

The potential benefit of such recognition is, for the victim, compensation by the injuries insurance organization that is generally more favourable than that of the health and disability insurance schemes.

Occupational injuries insurance is initially designed to cover, on the one hand, physical injuries caused by an accidental event, and on the other hand pathologies caused by exposure to chemical, mechanical or biological factors. That is why the recognition of mental disorders comes up against two types of obstacle.

First of all, legal obstacles. Specifically, the national definitions and judicial interpretations of what corresponds to an accident at work, but also the regulatory procedures for recognition of occupational diseases, do not universally allow compensation of mental illnesses as such.

Where such recognition is possible, there is the question of objectively establishing the causal link between exposure and the disease, almost never presumed in law. This is because a worker's mental health can be affected both by poor working conditions and by extra-occupational factors.

It occurs that, on certain conditions, a mental illness following a precise, sudden and unforeseeable event can theoretically be recognized as an accident at work in many European countries.

However, a growing number of workers now report that they are suffering from non-traumatic disorders such as depression, concentration and sleep disorders and job burn-out caused by work organization and working conditions, or the violence or method of management faced by them in their workplace.

These situations, corresponding in this case to prolonged exposure to a psychosocial risk, raise the question of recognition of mental disorders as occupational diseases, a question regarding which only a few countries - Denmark, Spain, France, Italy and Sweden - adopted a favourable position already about twenty years ago.

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1 https://osha.europa.eu/fr/publications/managing-psychosocial-risks-european-micro-and-small-enterprises-qualitative-evidence-third-european-survey-enterprises-new-and-emerging-risks-esener-2019

2 https://ec.europa.eu/eurostat/documents/7870049/13554106/KS-FT-21-007-EN-N.pdf/38ff3174-d590-dbbf-9f9b-50d70b7907a9?t=1634031059061

This document therefore considers:

- mental disorders related to psychosocial risks (hence excluding mental disorders related to chemical risk, i.e. caused by toxic substances, notably solvents);
- chiefly the countries which recognize mental disorders as occupational diseases, as well as Germany and Belgium for which information is available concerning recognition as accidents at work;
- the process of recognition of the work-related nature of these pathologies;
- the statistical data published by occupational injuries insurance organizations, of good quality for occupational diseases, but often consisting of estimates for accidents at work.

Executive summary
Recognition & compensation of work-related mental disorders as occupational injuries

The recognition of mental disorders as occupational injuries is a relatively recent issue compared with the traditional risks covered by occupational injuries insurers. It poses several legal problems related to national definitions of the accident at work (judicial conditions of extraneous cause and unintentional nature of the accident in many countries) and to the regulatory framework of the recognition of occupational diseases (no system of recognition of unlisted diseases).

At present, it appears that a majority of countries have been able to go beyond these obstacles to allow recognition of mental illnesses as an accident at work when they are caused by a one-off violent event, i.e. a sudden, short event on a given date.

However, the occupational injuries insurers' statistics can only seldom assess the number of cases recognized in this capacity, due to European nomenclatures which generally do not make it possible to distinguish between psychological injuries and physical injuries caused by the "violence" factor.

That said, exposure to psychosocial risks over an extended period of time - the consequence of which is more like an occupational disease - is also a reality in the work environment. It can take various forms, also depending on the sector of activity concerned: bullying or hostile behaviour by colleagues, users or immediate superiors, but also the assignment of excessive workloads or, on the contrary, meaningless work. The causal link between this type of exposure and the occurrence of psychological disorders is less easy to establish than in the case of a one-off violent event.

Five countries - Denmark, Spain, France, Italy and Sweden - have nevertheless chosen to also recognize this particular type of pathologies as occupational diseases. They have therefore opened their insurance coverage to cases of repeated exposure to psychosocial risks over time, of smaller intensity than a single traumatizing episode[3]. This form of recognition makes it possible to cover a broader range of situations, including those resulting from dysfunctions in the work organization. These countries are therefore more protective and aware of certain mental health problems arising from work (job burn-out, harassment).

For this purpose, the occupational injuries insurance systems of these five countries had to adapt. Lacking a genuine system of recognition of off-list diseases, Spain has resorted to a mixed concept of "non-traumatic work accidents-diseases". Denmark has recorded two mental illnesses on its list of occupational diseases, backed up by scientific research. France has lowered the minimum permanent disability rate to be able to enter mental illnesses

[3] The boundary between recognition as an accident at work or an occupational disease may be porous. Admittedly, an accident at work is presumed to take place in a short lapse of time, which may range from a maximum duration of one work cycle to five days' exposure in Denmark. But in some cases, where there are a series of exposures, only the last episode is taken into account for classification as an accident at work.

in its off-list recognition system, and decided that this rate could only be "foreseeable".

Within this group of countries, however, practices are not uniform, being often constrained by the regulatory framework of each country regarding occupational diseases.

Concerning the investigation of claims for recognition as ODs, most cases are treated according to the procedures of the off-list system. This means that an onus of proof weighs on the worker (although, de facto, in cooperation with the insurer's investigating officer) and there is a strong requirement regarding the quality of the causal link between occupational exposure and the occurrence of the disease.

Only Denmark investigates certain cases within the framework of the list of occupational diseases (post-traumatic stress and returned servicemen's depression), but the low level of presumption entailed in the terms of the Danish list does not prevent a strict interpretation of the causal link between the disease and the exposure (illustrated by a recognition rate of less than 10% for these two listed pathologies).

While it can be noted, where data are available, that the syndromes recognized are roughly the same everywhere (namely depressions, post-traumatic stress disorders, anxiety disorders), the scope of the exposures may vary from one country to another.

Italy, for example, has chosen to limit the exposure factors to be taken into account to merely the inconsistencies in the corporate organization process, thereby ruling out situations in which mere interpersonal relations, even violent from a psychological viewpoint, are to blame.

Regarding the severity of the diseases recognized, it depends on the system of recognition, which generally lays down a related condition: in Denmark and Sweden, the investigation of claims for recognition as an occupational disease implies a permanent disability or a loss of income, like in France where a foreseeable permanent disability rate of at least 25% is required for an investigation under the off-list system. Spain and Italy can recognize a mental illness as an OD even when the worker is only suffering a temporary disability.

As regards job positions, the available statistics show that the workers most likely to be afflicted by a work-related mental illness are those in contact with the public. Accordingly, civil servants and healthcare workers appear as those most exposed to psychosocial risks.

Regarding recognition volumes, there are major differences from one country to another (see summary table on page 32).

A recognized case is first a case which has been the subject of a claim for recognition. Now, claims for recognition of mental illnesses as ODs, relative to the insured population, show substantial differences between Denmark (ratio of 162 claims per 100,000 insured), and France (ratio of 16) and Italy (ratio of 2). The reporting data for Spain and Sweden are not available.

The number of cases recognized as ODs, relative to the insured population, ranges between 11 per 100,000 insured in Denmark, 8 in France, and less than 1 in Spain and Italy. However, the French statistics only cover private-sector workers. It is possible that by adding the unavailable figures for the public sector (in particular healthcare workers, teachers, policemen and prison personnel), France would be at the head of the ranking.

Although Denmark tops (in relative terms) the list of countries recording the most claims for recognition and recognized cases, it should be noted that its rate of recognition is lower (7%) than in Italy (10%) and in France (52%). It is tempting to interpret these rates of recognition as an illustration of the degree of openness of

the system fo recognition of work-related mental diseases.

The country which recognizes the most mental illnesses as an accident at work is France (ratio of 50 per 100,000 insured, 100 if one considers similar cases), followed by Denmark (ratio of 33). Spain posts a ratio of 3.

Finally, one observes almost everywhere a relative stability over time in the number of claims for recognition and recognized cases. In France, however, the easing, in 2012, of the conditions for inclusion in the off-list recognition system led to a continuous uptrend in both claims for recognition and recognized cases.

Recognition as an accident at work

At present, the classification of a work-related event that caused harm to physical health as an accident at work is a mechanism that is clearly defined and widely applied. This same process is more complex for harm to mental health.

Nevertheless, in many European countries, psychological disorders are compensated as a work accident risk. Apparently, all the countries have an identical position on the subject: an unexpected, traumatising event of short duration must 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 (during commuting or travel) or else in an accident suffered by a colleague. The mental disorder most commonly identified in these circumstances is post-traumatic stress disorder.

However, the phenomenon is hard to quantify, because often the statistical publications dedicated to accidents at work are unable to single out mental disorders. But a presentation of the figures according to the cause of deviation, in this case violence, makes a quantified estimate sometimes possible.

Germany

In its annual statistical report on accidents at work, the DGUV[4] presents a specific section on accidents caused by acts of violence, assaults, threats and surprises.

In 2021, there were 13,369 such accidents with more than three days off work, mainly for bruises, sprains or superficial injuries. Only 16% of them correspond to states of mental shock (i.e. about 2,140 – scope: employees and entrepreneurs), giving rise to 124 new benefit payments.

Belgium

A psychological shock can be recognized as an accident at work. Established legal precedents require that the sudden event causing the shock be identified sufficiently precisely in time and space, that it be of a sudden nature and that it takes place in a short lapse of time.

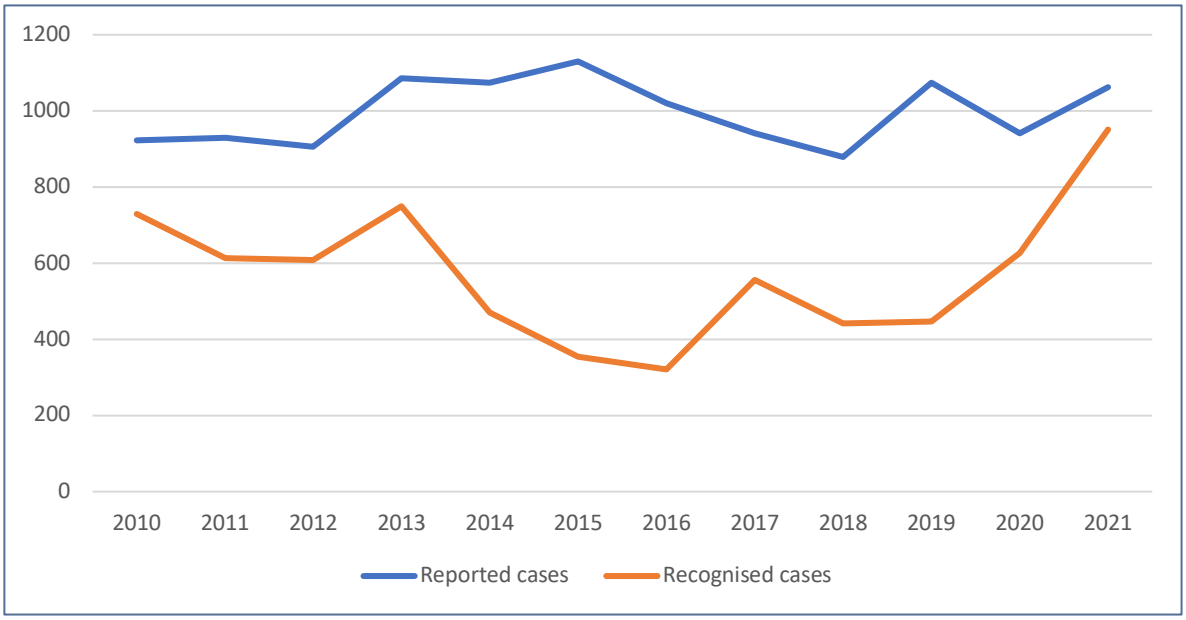
For 2021, the statistics of Fedris, the Federal Agency for occupational injuries, report 1,095 cases of "shocks" recognized as accidents at work for the private sector, including 433 temporary disabilities, 178 permanent disabilities and 1 fatal case.

Denmark

The post-traumatic stress syndrome can be recognized as an accident at work if the exposure lasted at most five days. This exposure often consists in practice of an act or acts of violence or threats, but it could also concern physical injuries which caused psychological damage. After more than five days' exposure, recognition as an occupational disease is possible (listed, see below).

[4] DGUV: Deutsche Gesetzliche Unfallversicherung - German national insurance organization for accidents at work and occupational diseases - Statistical report 2021: https://publikationen.dguv.de/widgets/pdf/download/article/4590 (chapter 10)

Denmark: Cases of psychological shocks and violence reported and recognized as accidents at work (2010-2021)



Source: Arbejdsskadestatistik reports, 2016 and 2021 (AES)

A guide[5] to the investigation of these cases shows, through examples, the diversity of the exposures taken into consideration: physical and verbal violence of a student to a teacher, of a patient to their doctor, threatening an employee with a sharp weapon, persecution and false accusations by colleagues (but not a mere disagreement on the work), sexual assault by an immediate superior, fire fighter particularly threatened by a risk of explosion, accident on a machine with danger of death, psychological distress after a paralysis caused by an accident at work.

The number of claims for recognition as an accident at work is around 1,000 cases per year (cf. graph above).

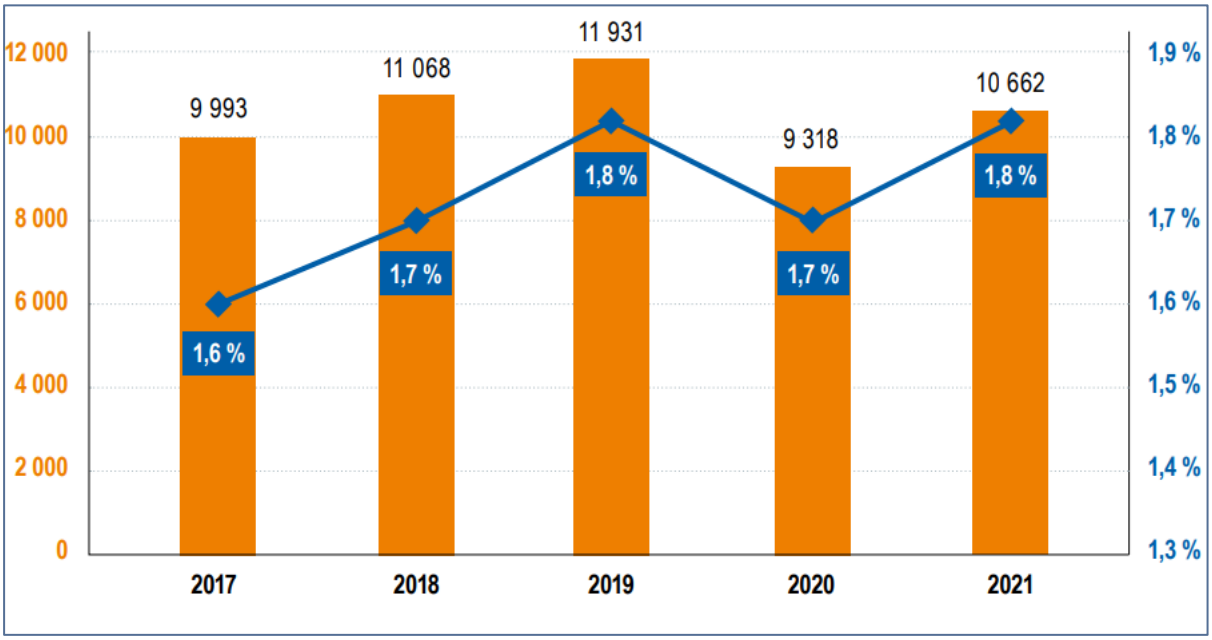
Spain

Under accidents at work strictly speaking (see below for work-related diseases legally assimilated to accidents at work, since mental illnesses are not present on the Spanish list of occupational diseases), the 2021 statistical report dedicated to accidents at work published by the Ministry of Labour[6] counts 560 cases of psychological harm due to assaults or threats. All of these cases are classified as "mild".

5 https://www.aes.dk/dokument/praksisbeskrivelse-om-anerkendelse-af-psykiske-arbejdsulykker-vedroerende-skader-sket-foer (in Danish), version updated in December 2022

6 https://www.mites.gob.es/estadisticas/eat/eat21/ATR_2021_Completa.pdf page 89

France: number of work-related mental disorders and weight of those disorders in accidents at work (2017-2021)



Source: 2021 annual report of the Health/Occupational Risks Insurance system, page 189

France

Several social security schemes ("*régimes*") coexist. Only the scheme applicable to private-sector employees (the "general regime") possesses and publishes reliable statistics.

Thus, according to the Health/Occupational Injuries Insurance system, more than 10,000 mental disorders (described as such on the initial medical certificate drawn up by a doctor and necessary for the claim for recognition as an accident at work) are recognized annually as accidents at work.

These mental disorders recognized as accidents at work are concentrated in three sectors of activity (2021 statistics):

- the medico-social sector (medico-social and social accommodation, welfare work without accommodation and activities for human health), which accounts for more than 25% of psychological accidents at work whereas it employs 11% of workers;
- transport (especially passenger transport), which accounts for 15% of cases for 3% of workers;
- retail stores: 10% of cases, 8.6% of workers.

Bear in mind that these data come from the general social security scheme, which covers private-sector workers; the civil service (including teachers in the public sector, for example) and regional and hospital civil services are not covered by these figures.

To these ten thousand or so cases recognized as accidents at work each year should be added 10,000 others whose circumstances described in the initial medical certificate or in the work accident report drawn up by the employer resemble those of the psychological complaints compensated as accidents at work, without strictly ending up as a mental disorder.
The sectors of activity concerned by these quasi-psychological accidents at work are the same as those in which psychological accidents at work strictly speaking are concentrated.

We know, moreover, that the rate of recognition for this type of accident at work is around 70%.

Italy

The statistics of the occupational injuries insurer, INAIL, do not make it possible to assess the number of recognized accidents at work corresponding to cases of post-traumatic stress or related to psychosocial risks. But the literature suggests that such recognition is rare in this country.

Sweden

This country recognizes mental disorders both as accidents at work and as occupational diseases, but the statistics of the Social Security Agency (Forsakringskassan) do not make it possible to distinguish between the former and the latter according to the type of injury.

For the figures relating to mental disorders recognized among occupational injuries as a whole (accidents at work and occupational diseases), see below.

The case of suicide recognized as an accident at work

In several countries, the courts and insurers have gradually accepted the possibility of recognizing cases of suicide as accidents at work.

The scope of this recognition depends on the national definition of an accident at work and the legal reasoning developed by the established legal precedents of each country, the main stumbling block being the voluntary nature of the act of suicide.

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. But the cases recognized are exceptional.

Concretely, these may be 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 by victims of purely mental disorders, resulting for example from a feeling of responsibility for the accidental death of a colleague or from post-traumatic disorders. In any case there must be an event related to the company which triggers the suicide.

In **Belgium**, a suicide can be considered as an accident at work if there is a link with performance of the work contract. The suicide must also result from intense occupational stress preventing the worker from having all their mental faculties. The existence of an irresistible force which could rule out an intentional and conscious act thus makes it possible not to classify the accident as a voluntary act.

The statistics do not make it possible to distinguish suicides among accidents at work, but it can be asserted that a few cases have been recognized in Belgium. Usually these are legal decisions which have been been forced on insurers.

In **Spain**, suicide can be recognized as an accident at work on two conditions:

- The worker must not have acted rationally and intentionally. Suicide must therefore be the last stage of a process of alienation and obey pathological or depressive processes which imply a deterioration of the subject's reason and willpower. Concretely, it is essential that there be a prior mental disorder or a state of mental impairment which leads the subject to inflict harm on themselves.
- There must also exist a relationship of cause and effect between the victim's working conditions and the emotional state which determined the decision to commit suicide.

As regards the legal presumption associated with any accident occurring during working hours and in the workplace, it apparently does not apply to suicide (non-unanimous established legal precedents).

Lastly, we note that it is often the courts that impose on insurers the recognition of cases of suicide.

In **France**, suicide is considered as a conventional accident at work: if it takes place during working hours and in the workplace, the suicide benefits from a presumption of work-related origin; it is recognized unless the employer can demonstrate a cause completely unrelated to work. When the suicide occurs outside working hours or the workplace, the legal beneficiaries must provide evidence of the link between the death and working conditions (letter, testimony, etc.).

It is as an accident at work that the suicide can be recognized if a causal event (related to work) can be precisely dated and located. This is the case for nearly all the recognised cases (10 to 30 per year for the general regime covering salaried workers). In the absence of a precise causal event, rare cases are recognized as an occupational disease, as being the final stage of a serious depression due to working conditions. Recognition as a commuting accident is also technically possible.

In **Italy**, suicide can be recognized as an accident at work if it appears as the consequence of a causal event itself classified or classifiable as an accident at work or an occupational disease. Rare legal decisions have illustrated this position during the last decade. In each case these were suicides caused by a work-related stress syndrome (work overload, harassment).

Other countries such as **Sweden** and **Denmark** do not rule out the possibility of recognition of suicide as an accident at work or occupational disease, but such cases are extremely rare, or even inexistent.

Finland is to our knowledge the only country which strictly rules out any recognition of suicide as an accident at work. The fact of putting an end to one's days is a deliberate act, which accordingly does not come within the definition of an accident (an unexpected exogenous event causing an injury). Recognition as an occupational disease is also ruled out.

Recognition as an occupational disease

While the accident at work implies an injury as the consequence of a sudden, single dated event, the occupational disease is a condition resulting from more or less prolonged exposure to a risk, recognized (by presumption or demonstration of the causal link) as originating in the customary work activity.

This postulate of long exposure could seem more suited to the occurrence of a mental illness. And yet, few European countries allow recognition of these conditions as an occupational disease.

Apart from the Danish exception, mental disorders (caused by psychosocial factors) appear on no list of occupational diseases.

Theoretically, however, recognition is still possible because in most countries there exists an off-list system of occupational diseases. Only the off-list systems of certain countries (Germany, Austria, Switzerland in particular) are more or less "closed": those countries accept only certain pathology/causal agent combinations that have previously been confirmed scientifically. Mental disorders caused by psychosocial factors are not currently among them, for want of sufficient medical and scientific knowledge and evidence regarding the causal link with the work activity.

In 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. Since psychological or psychosocial factors are not included in this definition, any recognition is for the time being impossible.

In Belgium, the nature of the off-list system does not exclude such recognition; a few marginal cases can be mentioned, moreover, but they are too scarce and old to include this country in the scope of those which routinely cover mental disorders as occupational diseases.

A. The recognition framework

Mental illnesses can be recognized as occupational diseases in five countries.

They are recognized under an off-list recognition system (Denmark, Spain, France, Italy), but also under the list system in Denmark for two of them, and under a unique proof system in Sweden.
In Europe, the shared feature of these systems is the fact that they require the demonstration of a direct, decisive, essential and very probable link (the terms used vary from one country to another) between the pathology and the work activity. The situation is less clear-cut for the two syndromes listed in Denmark which, due to their presence on the list of occupational diseases, enjoy a certain presumption but undergo investigation (no automatic recognition).

Almost all these countries have first chosen, for these specific pathologies, to more or less restrict the recognition procedure, by defining the illnesses concerned and/or the risks covered and giving instructions or tools for investigation.

Denmark

Two mental illnesses on the list of occupational diseases

Denmark has included two mental illnesses on its list of occupational diseases: post-traumatic stress disorder (PTSD) after more or less chronic exposure, and depression after taking part in acts of war, in 2005 and 2016 respectively.

To be recognized under the list system, cases of **post-traumatic stress disorder (PTSD) after more or less long exposure** must comply with the following diagnostic and exposure conditions.

The diagnostic must be produced by an expert psychiatrist and the symptoms of the disease[7] must have appeared in the six months following the last exposure.

Delayed PTSD is also covered, i.e. cases where the worker shows only certain symptoms during the initial months and where the full diagnostic can only be produced one or two years after the end of exposure.

In the following cases, PTSD can be recognized under the off-list system:

- if there is no symptom at all during the first six months and the condition appears several years after exposure;
- since 2021: where a few symptoms appear within six months but complete clinical symptoms of the condition within 3 to 10 years;
- since 2020: if symptoms are documented at the latest four years after the end of the exposure and a complete diagnostic is made up to 15 years following the exposure.

As regards the exposure, the traumatizing events or situations must be of an exceptionally threatening or catastrophic nature, such as violent threats.

Typically, those affected are peacekeeping forces, support or humanitarian personnel exposed to exceptionally violent situations in war zones, as well as workers in the medico-social sector (especially those in contact with the mentally handicapped) or civil servants (prison officers, police officers, teachers), here again exposed to recurrent violent acts. In the private sector, station ticket office employees, public transport drivers and bank employees are likely to be concerned.

The second mental illness included on the list of occupational diseases is **depression after taking part in acts of war.** It must correspond to diagnostic criteria established by ICD-10[8], but neither the degree of severity (mild-moderate-severe), nor its temporary or chronic nature has an impact on its recognition as an occupational disease.

The time condition requires that the depression appear within a maximum period of three months after the end of exposure.

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7 According to the WHO International Classification of Diseases (ICD 10), for F43.1: Typical symptoms include re-experiencing the traumatic event or events in the present (intrusive memories, flashbacks, or nightmares); avoidance of activities or situations reminiscent of the event(s); partial or complete avoidance of thoughts and memories of the event(s), or persistent hypersensitivity or hypervigilance symptoms including at least two of the following symptoms: insomnia, irritability, or problems of concentration.

8 For the depressive episode (F32), the symptoms are as follows: depressed mood, decreased energy and reduced activity, loss of interest or pleasure in activities that are normally pleasurable, diminished ability to concentrate, commonly associated with increased fatiguability, sleep disturbance, decreased appetite, and loss of confidence and self-esteem.

As regards the exposure, it must concern participation in acts of war having involved traumatizing events and/or more or less chronic situations of an exceptionally threatening or catastrophic nature. The most common examples of exposure are bombardments and movement in mined areas.

Mental illnesses recognized off-list

In Denmark there exists a system of recognition of diseases that are not listed or for which some conditions of the list are not met. The difference between the list system and the off-list system lies mainly in the decision maker.

Whereas a case manager, assisted, if necessary, by a specialist doctor and in accordance with the content of an investigation guide[9]), recognizes or rejects cases coming under the list, it is the Occupational Diseases Committee[10] which recommends the acceptance or rejection of cases that are off-list or for which a condition of the list is lacking.

In both systems, the investigation is conducted by the case manager by various means (enquiries with the victim, the employer, the trade union organizations in the firm, medical information coming from the health system), and it is also the case manager who decides to submit a case to the Occupational Diseases Committee.

This "filter" is applied according to the practice of this Committee, i.e. disease/exposure combinations which are accepted there and regularly updated, but also (good) chances that the case has of being recognized.

Other cases that can be submitted to the complementary system are cases corresponding to:

- a disease/exposure that has never been the subject of a decision on the causal link;
- a particular centre of interest of the Occupational Diseases Committee;
- cases submitted by the National Social Appeals Board (Ankestyrelsen).

This Committee is especially competent to decide on off-list cases because its other role is to regularly recommend to the employment minister diseases which fulfil the conditions for inclusion on the list of occupational diseases or the updating of recognition criteria included on this list.

It can also propose diseases/exposures to be recognized as occupational diseases even if they do not appear on the list of occupational diseases. It is also this Committee that regularly orders scientific research necessary for such updates.

In practice, the Occupational Diseases Committee investigates cases for which the victim's health condition has stabilized (within a time limit of about two years). It assesses whether the occupational exposure is the main, or even unique cause, of occurrence of the disease. This is the second difference with the list recognition system, less demanding regarding the quality of the causal link.

Mental illnesses account for around 80% of the cases investigated by this Committee each year.

The following mental illnesses or disease/exposure combinations are currently eligible:

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9 Version 17 applicable from 1 January 2022, available in Danish on https://www.retsinformation.dk/eli/retsinfo/2021/10046; see chapter 8 for mental illnesses.

10 The Occupational Diseases Committee, chaired by the Director of the Arbejdsmarkedets erhvervssikring insurance organization (AES), is formed of employee and employer representatives, the National Health Council (Sundhedsstyrel) and the Danish Working Environment Authority (Arbejdstilsynet), as well as occupational health experts and medical experts.

- Cases of post-traumatic stress disorder not fulfilling the time condition of the list (see above), i.e. when the diagnostic has been given several years after the exposure; also, cases for which the time and exposure conditions are met, but the PTSD symptoms seem insufficient and correspond rather to another mental illness such as a non-specific stress reaction, a depression (not linked to a war environment), generalized anxiety, etc.
- Cases of depression due to participation in war which do not correspond to the diagnostic criteria (e.g. when the symptoms correspond rather to an adaptation response) or exposure criteria (faced with recurrent violence or threats rather than "traumatizing events and/or more or less chronic situations of an exceptionally threatening or catastrophic nature").
- Mental illnesses unrelated to the list, i.e. mainly reactions to a severe stress factor (F43.9) and depressions (F32, excluding participation in war). Also eligible are cases of anxiety disorders (F41), phobias (F40), obsessive-compulsive disorders, somatoform disorders (F45), and enduring personality changes (F62). The most common occupational exposures are harassment (moral or sexual), violence/threats and stress (including work overload).

Compensation of work-related mental diseases

Faced with an occupational disease that has caused permanent damage, the occupational injuries insurance organization 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 loss of earning capacity, assessed pragmatically, is based on a comparison between the victim's salary before the occurrence of the occupational disease and their new salary or the salary that they can still expect. But factors such as age and capacity for reconversion are also taken into account. Compensation for pecuniary damage is provided by granting a pension which ceases to be paid when the victim retires.

Physiological and psychological damage is assessed using 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, irrespective of the victim's income and gender.

Section J of the scale devoted to mental illnesses comprises four items: post-traumatic stress reaction, non-specific stress reaction, chronic depression and post-traumatic anxiety. The rates associated with these mental disorders vary, depending on the condition and its severity, from 5% to 35%, which corresponds to a lump sum of between [11] DKK 48,950 (or €6,580) and DKK 342,650 (or €46,061).

Spain

Spanish legislation provides that pathologies that are not included on the list of occupational diseases can be recognized as equivalent to accidents at work, under the concept of "non-traumatic conditions caused or aggravated by work".

Mental disorders correspond to one of the 16 categories of diseases that can be recognized in this way.

Recognition is possible on condition that work performance is the exclusive cause of the non-traumatic condition. Pre-existing diseases or conditions which have been aggravated by work

[11] For the scale applicable in 2023 and the exchange rate prevailing in May 2023

are also concerned by this sort of complementary system.

France

The mental illnesses caused by psychosocial factors not appearing on the French list of occupational diseases[12] can be recognized under the complementary system of recognition in cases of prolonged exposure.

This complementary system dedicated to non-listed pathologies, established in 1993, has evolved to allow better compensation of these diseases: in 2002, the minimum rate of permanent disability for recognition off-list, initially set at 66.66%, was lowered to 25%.

Moreover, after 2012, this threshold was interpreted as corresponding to a "foreseeable" and no longer a fixed rate after medical stabilization of the victim's state of health. This then made it possible to register a greater number of claims for recognition.

Finally, since 2016, the regional committees for recognition of occupational diseases ("CRRMPs"[13]), competent for non-listed diseases, can call on a university professor - a hospital practitioner specialised in psychiatry - when cases of mental illness are submitted to them.

In practice, the cases for which the medical consultant of the Social Security organization confirms the diagnostic and gives a decision concerning a foreseeable permanent disability rate of at least 25% are forwarded to the geographically competent CRRMP (there are sixteen of these committees, and a national committee for Covid-19).

The CRRMP determines whether the condition was caused essentially and directly by work, on the basis of an administrative enquiry in the presence of both parties carried out first with the victim and the employer by the Social Security fund.

To assess this causal link, it has a decision aid tool: the Guide for CRRMP committees[14]. In the case of mental illnesses, this document states that the quality of the various parts of the dossier, in particular the reports of the investigating officials and industrial doctors, is essential. The items required are accordingly the report of the occupational injuries insurance organization's medical consultant, the opinion of the industrial doctor, the opinion of the employer, company data sheets, alerts in writing, the information collected by the investigating officer and his conclusions, together with the data provided by the parties and the enquiries and observations of the staff representative bodies.

The psychosocial risk factors most often mentioned are reiterated there: aggressive behaviours with verbal violence, humiliations, bullying, and unjustified sanctions by senior management, fellow workers or the persons whom the worker mixes with, and obvious discrepancy between the objectives assigned and the means made available.

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12 Initial thinking had been undertaken in the 1980s on the creation of a new item in the ODs list relating to the post-traumatic stress syndrome developed following an armed hold-up in banks, but the negotiations in the Higher Council for the Prevention of Occupational Risks (now specialist committee No. 4 of the Steering Committee on Working Conditions) had not materialized. Again, in 2006, work was performed on the creation of a table relating to psychological disorders, but no social compromise was reached.

13 The CRRMP is formed 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

14 https://www.inrs.fr/media.html?refINRS=TM%2073 pages 36 and 37 for psychological disorders (in French)

The Guide also gives instructions on taking into account the victim's prior condition and on mental disorders that could be work-related and that are logically found in the statistics by family of syndromes (see statistics below): depression, generalized anxiety and post-traumatic stress conditions; adaptation disorders being generally of mild severity, they are not very likely to be submitted to the CRRMP. The average time observed between the claim for recognition and the decision on coverage is 10 months. The opinion of the CRRMP is binding on the occupational injuries insurance fund.

For a permanent disability rate of 10%, compensation is paid in the form of a fixed lump sum (amounting to €4,439 in 2022). If the permanent disability rate is higher than 10%, compensation is paid in the form of a life annuity, the amount of which corresponds to the annual salary multiplied by the permanent disability rate previously reduced by half for the part of the rate not exceeding 50% and increased by half for the part exceeding 50%.

France: Indicative scale for setting the permanent disability rate in cases of occupational disease (excerpt)

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%

Compensation of work-related mental diseases

The "foreseeable" rate of permanent disability lower or higher than 25% serves merely to decide on the possible forwarding of the claim for recognition to the CRRMPs.
The actual rate is determined only after stabilization of the victim's medical condition, which may occur after the decision on recognition. It may be lower than 25% if, after medical treatment and elimination of the risk, the victim has only residual sequels. It is this latter rate which determines the amount of benefits paid to the victim for permanent disability.

Italy

Italy is no doubt the country that has defined most strictly the guidelines for the recognition of mental disorders as occupational diseases.

In 2001, the Board of Directors of INAIL, the national occupational injuries insurance organization, confirmed a recognition practice which began at the end of the 1990s under the complementary system, and entrusted to a scientific committee the role of defining methods for etiological diagnosis of disorders of a psychological nature caused by stress sustained in the workplace, including harassment.

Since then, mental disorders are recognized as occupational diseases if they have been caused by specific and particular conditions attributable to dysfunctions arising from work organization.

Since these conditions are not included on the Italian list of occupational diseases, they can be recognized off-list. The onus of proof of the work-related origin of the condition is therefore theoretically borne by the victim. However, INAIL takes part in gathering evidence. It is indeed an occupational medicine specialist and expert in forensic medicine from the Institute who investigates the claim, in cooperation with the worker and possibly their industrial doctor, when the victim's state of health has stabilized. The INAIL doctor calls on specialist doctors (psychiatrists), even from outside INAIL.

Guidelines on the methods and criteria used for the diagnosis of work-related mental illnesses define the nosographic framework of the pathologies covered and the exposure factors to be taken into consideration[15].

The two stress-related syndromes that can be recognized are:

- inadaptation syndrome (appearance of emotional and behavioural symptoms having a clinical significance, in response to one or more stress factors that are identifiable and not of an extreme nature);
- post-traumatic stress syndrome (delayed or extended response following an event that caused intense stress or a very threatening or disastrous situation likely to cause widespread malaise in almost everyone).

The risk situations covered are exclusively those created by inconsistencies in the organization process ("costrittività organizzativa").

Concrete examples of situations most frequently encountered (partly derived from legislative and judicial sources and from the preliminary results for cases reported to INAIL) are:

- marginalization of work activity, duties voided of their content, failure to allocate work instruments, and unjustified and repetitive transfers;
- prolonged assignment to duties involving reduced skills by comparison with 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.

A condition also covered is "strategic mobbing" or harassment for occupational purposes, namely all actions organized in the workplace to alienate or marginalize an employee.

On the other hand, organization 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 are excluded.

Lastly, the inconsistencies in the choice of work organization must be enduring and objective, verifiable and documented. The purely subjective behaviours adopted by people in their workplace are not taken into account, unless said behaviours, being repeated, are reflected and materialized in inconsistencies that can be documented and demonstrated in the organization process.

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[15] Taken from group 7 of list II of diseases which must be reported and whose work-related origin is of limited probability - Decree of the Ministry of Labour and Social Policies of 1 April 2010 https://www.gazzettaufficiale.it/eli/gu/2010/04/01/76/so/66/sg/pdf

Compensation of work-related mental diseases

Note that, unlike Denmark, France and Sweden, in Italy there is no need for the victim to sustain permanent damage (of a medical, financial or mixed nature, depending on the country) to obtain recognition of their mental disorder as an OD.

If there is a permanent disability (of a medical nature in Italy), the disability rate can be determined, for the mild/moderate forms, within a range of 1% to 6% (no compensation below 6%), and up to 16% for the severe forms (major depressive and behavioural symptoms).

As an illustration, a man aged 51 with a disability rate of 6% receives a lump sum of €5,527; a man aged 47 with a rate of 14% receives a lump sum of €24,476.

Sweden

Mental illnesses have been recognized as occupational diseases by the Swedish Social Insurance Agency (Försäkringskassan) for many years now.

Since occupational injuries insurance benefits are paid by the Swedish insurance organization only in cases of permanent consequences for the victim, the victim must have suffered a loss of income.

Regarding the recognition of this type of condition, there exists a regulatory limit (section 4 of the Social Security Code[16]): psychological or psychosomatic damage can be recognized as work-related only if it was caused by conditions which form an integral part of working life such as the shutdown of a firm, lack of work recognition, dissatisfaction with regard to one's responsibilities, or disagreement with fellow workers.

The investigation of claims is based on a proof system, like for any occupational disease (there exists only a list of infectious occupational diseases in Sweden). 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, colleagues, the trade unions and personnel administration representatives. This investigation lasts about four months.

The complementary welfare insurance organization, AFA Försäkring[17], acts in the area of support to victims of occupational risks in Sweden. While it has no prerogatives to compensate a disease that has not first been recognised as work-related by Försäkringskassan, it does have such prerogatives for accidents whose work-related nature has not been recognised by the Swedish Social Insurance Agency. It is through this channel that AFA Försäkring recognizes numerous mental disorders.

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 fact, the work-related mental diseases eligible are often due to stress caused by a heavy workload, and some cases correspond to situations of intimidation and harassment.

Compensation of work-related mental diseases

In Sweden, there exists no scale establishing a framework for assessing the permanent disability

16 Based on a law that came into force on 1 July 2002

17 Conventional insurance financed by employers and covering nearly all workers, which pays complementary compensation to victims of occupational injuries and diseases.

of victims of occupational diseases. This absence of a scale 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 (i.e. 6.66%) for more than a 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).

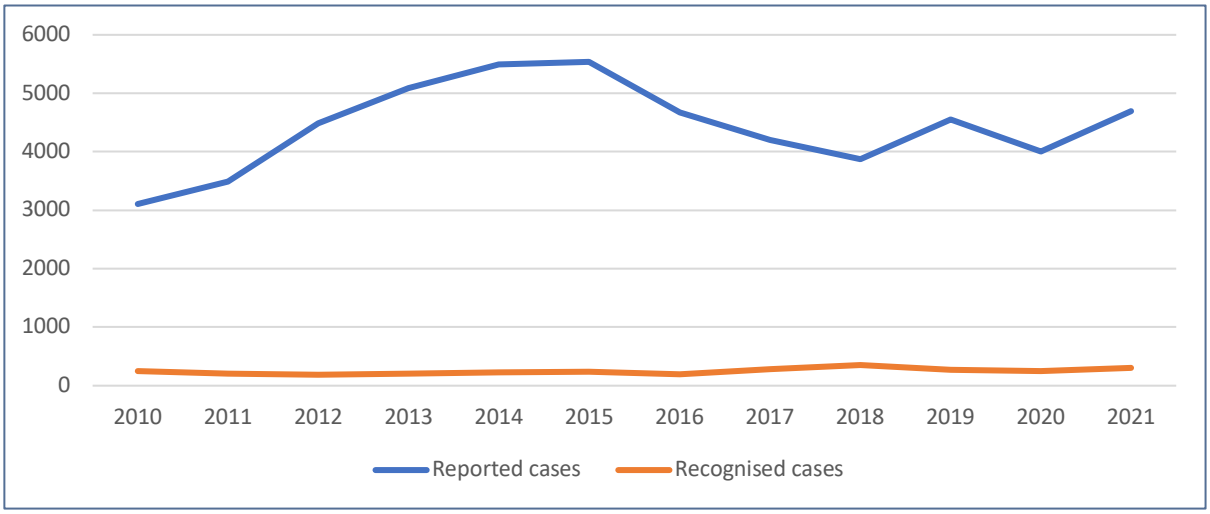
The complementary insurance organization AFA, for its part, pays compensation for damage such as the loss of income not covered by the national insurance system (due to the existence of a ceiling), but also immaterial damage (pain and suffering and moral prejudice) as well as bodily harm and loss of amenities of life.

B. Statistics relating to recognition as an occupational disease

With regard to mental disorders, access to the occupational disease statistics is easier than for accidents at work. These disorders being illnesses and not injuries, the statistical lists of occupational diseases facilitate their classification.

Denmark

Denmark: cases of mental illnesses reported and recognized as occupational diseases between 2010 and 2021



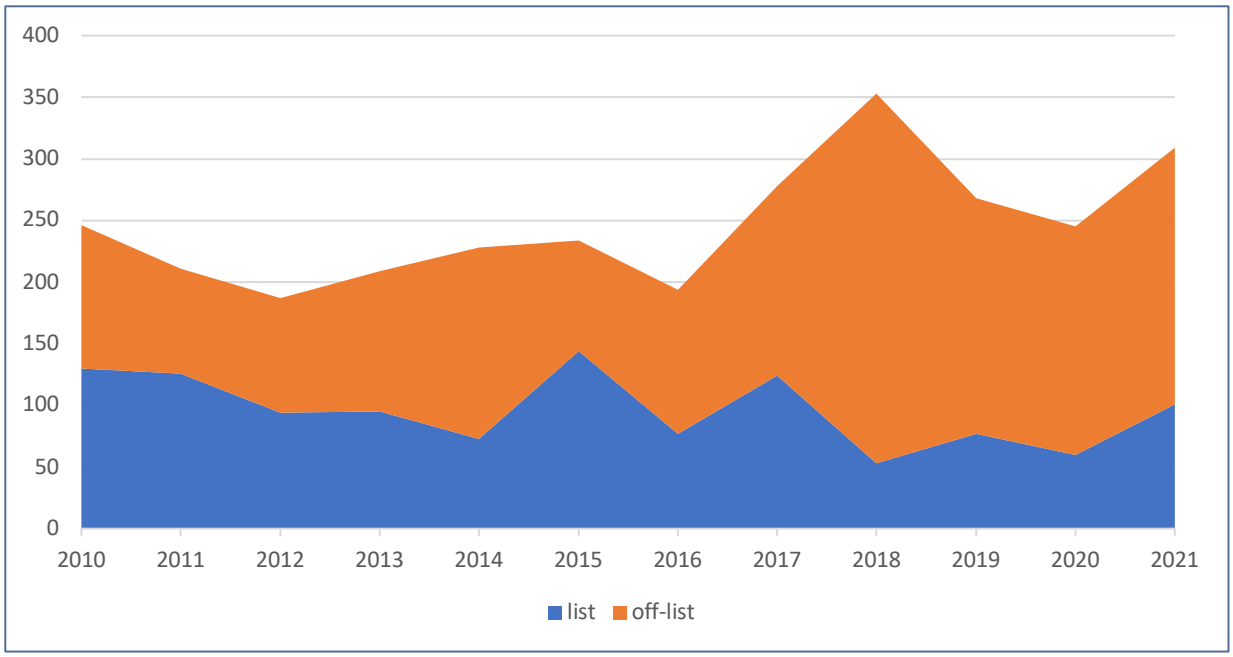
The average rate of recognition of mental illnesses as occupational diseases is around 7%.

However, it is interesting to note that this rate is high (between 80% and 95% in the past five years) when the condition is investigated under the off-list system, and on the contrary low (around 2%) when the cases correspond to one of the two listed diseases: post-traumatic stress disorder (PTSD) after more or less chronic exposure, and depression after taking part in acts of war.

This difference is perhaps due to the fact that off-list cases are more or less filtered beforehand by the investigating officers of the insurance organization before being examined by the Occupational Diseases Committee for its opinion. It may be imagined that only cases for which the dossier is sound are sent to this body.

On the other hand, the claims corresponding to the two listed diseases, which are very numerous (about 95% of the total), are of variable quality and investigation of the link between the disease and the work activity eliminates most of the cases.

Denmark: cases of mental illnesses recognized as occupational diseases according to the list and off-list systems between 2010 and 2021



Note that, in recent years, cases recognized off-list are more numerous than those recognized under the list system.

Classification of cases

In the list system, 101 cases were recognized in 2021, but their breakdown between post-traumatic stress disorder after chronic exposure on the one hand and war veteran's depression on the other hand is not known.

The 208 cases of mental illness recognized off-list in 2021 break down as follows:

- 2 stress and depression
- 31 returned servicemen
- 23 cases of harassment/mobbing
- 152 other (violence and threats).

In the examples of recognized cases taken from the Guide to investigation of ODs, it appears that the recognition of mental illnesses mostly concerns personnel devoted to healthcare (nurses, educators, healthcare assistants, etc.) or employed in a public service (teacher, prison personnel, armed forces).

Spain

Since 2010, "non-traumatic conditions caused or aggravated by work", legally assimilated to accidents at work, can be isolated from accidents at work strictly speaking due to the establishment of a dedicated registration system called PANOTRATSS.

In terms of economic sectors, the 72 cases recognized break down among transport & storage (14), healthcare activities & social services (13), business (10), administrative activities (7), general government, defence & social security (6), hotel industry (5), manufacturing industry (4), water, sewerage & waste management (2), construction (2), artistic activities (2), information & communication (2), financial activities (2), agriculture (1), scientific and technical activities (1) and education (1).

Spain: mental disorders recognized under non-traumatic diseases (2021)

Categories and syndromes	Number of cases recognized
Mental disorders caused by work	61
of which affective disorders	1
of which phobic and neurotic disorders	14
of which other mental disorders	46
Mental disorders aggravated by work	11
of which affective disorders	1
of which phobic and neurotic disorders	0
of which other mental disorders	10
Total mental disorders	**72**

France

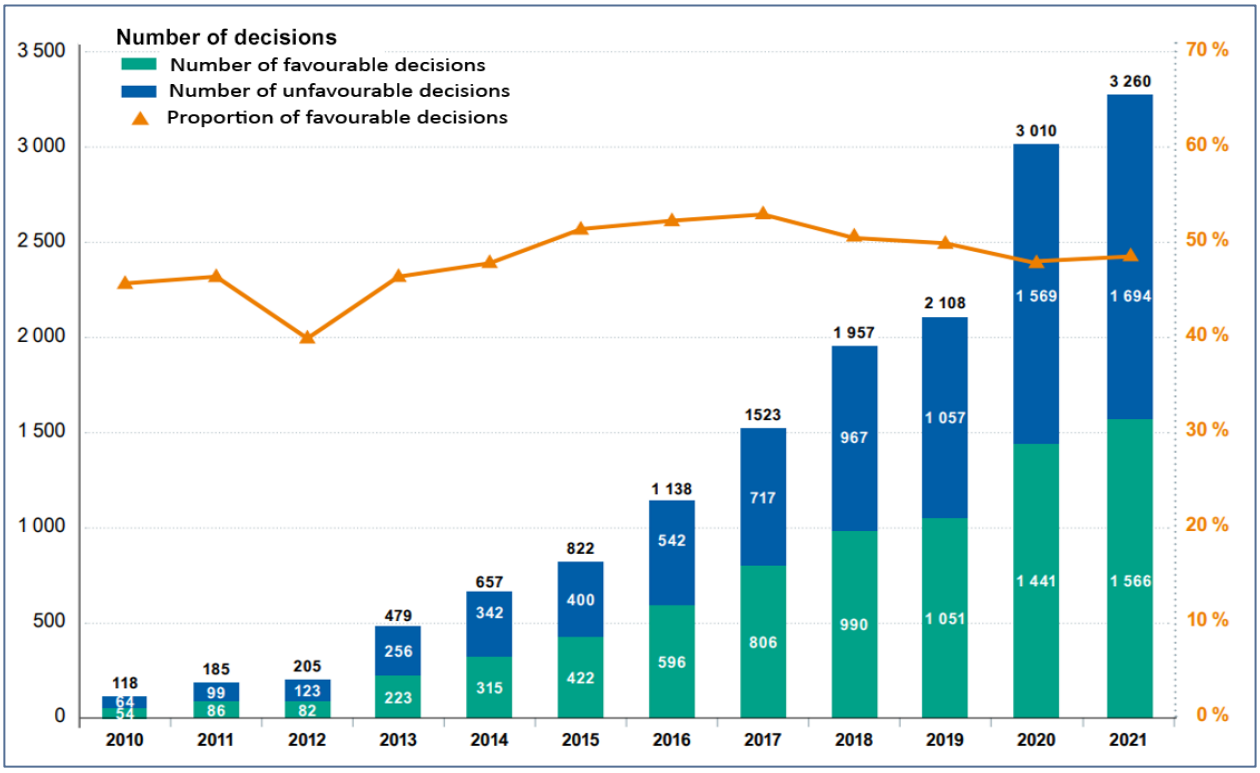
Only the general regime, i.e. that insuring workers in the private sector, publishes exhaustive, reliable statistics on the incidence rate of occupational diseases.

The number of claims for recognition and cases recognized has increased constantly since 1996, the year in which a complementary recognition system was established allowing, in particular, the coverage of mental illnesses.

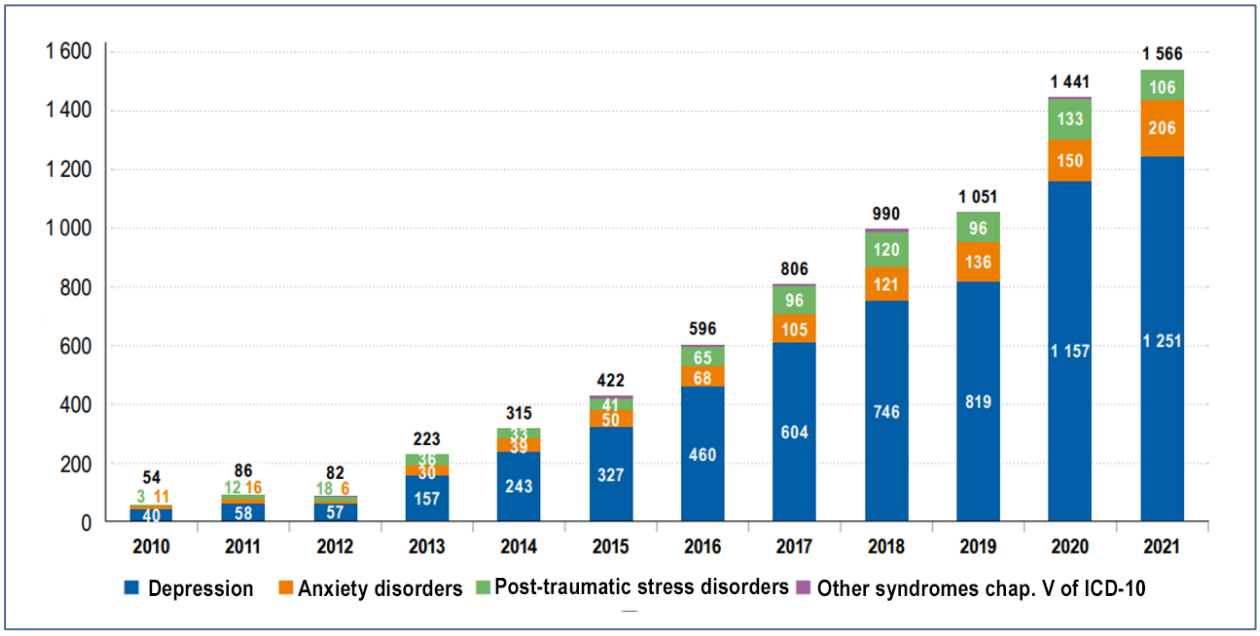
The number of recognitions accordingly increased from about one hundred cases in 2010 to more than 1,500 in 2021. The recognition rate for this type of disease remained stable, at around 50%.

As regards recognized syndromes, there is always a predominance of depressions (80%), followed far behind by anxiety disorders (13%) and post-traumatic stress syndromes after prolonged exposure (7%). The other syndromes of Chapter V of ICD-10 are rare.

France: Number of favourable (green) and unfavourable (blue) decisions of CRRMPs relating to psychological disorders from 2010 to 2021 (Chapter V of ICD-10)



France: Number of favourable decisions of CRRMPs relating to psychological disorders from 2010 to 2021 according to the category of syndrome (Chapter V of ICD-10)



Sources of the two diagrams: 2021 Annual Report of the Health/Occupational Risks Insurance System - Statistics and financial data

A publication of the Health/Occupational injuries Insurance organisation in 2018[18] indicates that the victims are mostly women (around 60%), aged 40 on average.

For work-related mental diseases, the average sick leave is about 400 days (versus 112 days for mental disorders recognized as accidents at work).

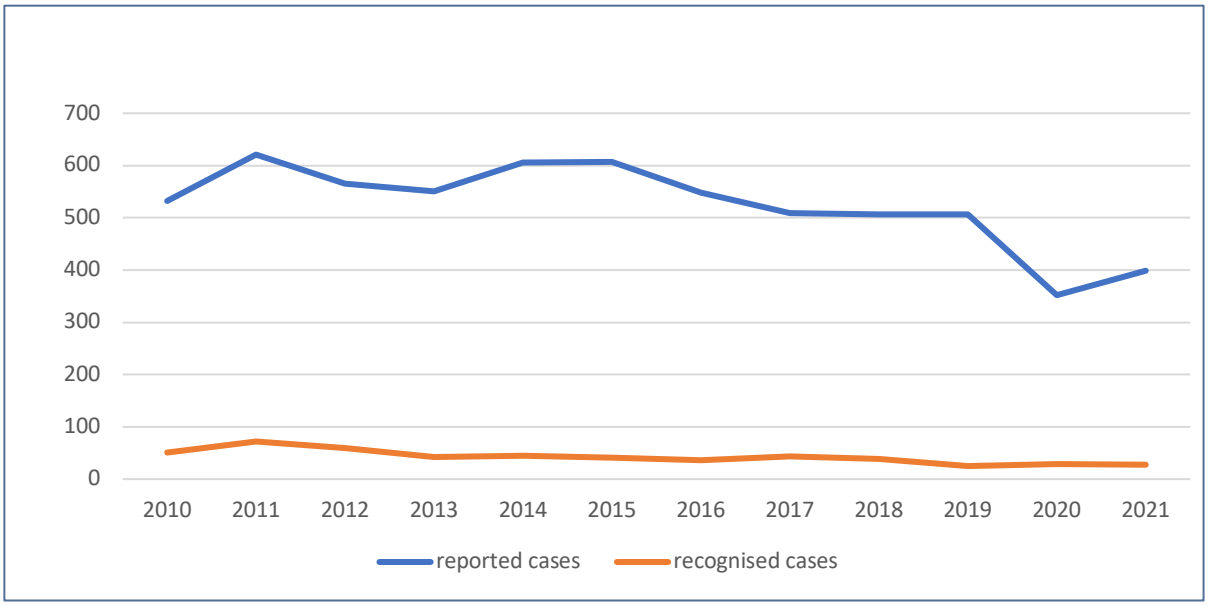
For mental disorders recognized both as accidents at work and as occupational diseases, information is available concerning the sectors of activity most affected, which have in common relations with the public: the medico-social sector, passenger transport and retail stores.

As a reminder, civil servants and public officials are not covered by the general social security regime; certain categories which are inherently constantly faced with the public are therefore not shown here (notably hospital personnel, teaching personnel, the police, and prison personnel). The incidence rate on the national level is therefore probably far higher.

Italy

The statistics of the INAIL insurance organization cover all schemes, namely industry and services, farmers and civil servants (except military personnel, police officers and fire fighters).

Italy: Mental illnesses reported and recognized as ODs between 2010 and 2021



[18] Santé travail : enjeux & actions (January 2018) available on https://assurance-maladie.ameli.fr/sites/default/files/2018-01_affections-psychiques_enjeux-et-actions_assurance-maladie.pdf

We note a decrease in the number of claims for recognition since 2016 and a very stable number (around 40) of cases recognized each year.

The recognition rate for these conditions is between 5% and 11%, depending on the year.

There are no published data on the syndromes, jobs and sectors concerned by the recognition of mental illnesses as occupational diseases.

However, a presentation by INAIL to the Italian Senate in 2011[19] makes it possible to determine, on the sample of 500 cases recognized between 2001 and 2011:

- The type of compensation granted: 27% of the victims had received compensation for temporary disability or no compensation as all, 64% compensation as a lump sum (for a permanent disability rate ranging between 6% and 15%), and 9% a permanent disability pension (which implies a permanent disability rate of at least 16%).
- The gender and age of the victims: 60% were men and the age group most affected was the 46-55 age group (46% of cases).
- Sectors most affected: services (42% of cases), followed by public administration (29%) and industry.
- Status of those most affected: 59% white-collar workers, 21% blue-collar workers and 20% managers.

Sweden

The figures from the Swedish Social Insurance Agency[20] show, for 2021, 659 requests for the allocation of a pension concerning mental or behavioural disorders (classified F00-F99 in ICD-10) and 297 favourable decisions, i.e. a recognition rate of 45%.

These are cases that were recognized either as accidents at work or as occupational diseases.

40% of rejections were motivated by the absence of a link between the disease and the work activity; the remaining 60% concern ineligible cases (e.g. no loss of earning capacity giving entitlement to a pension).

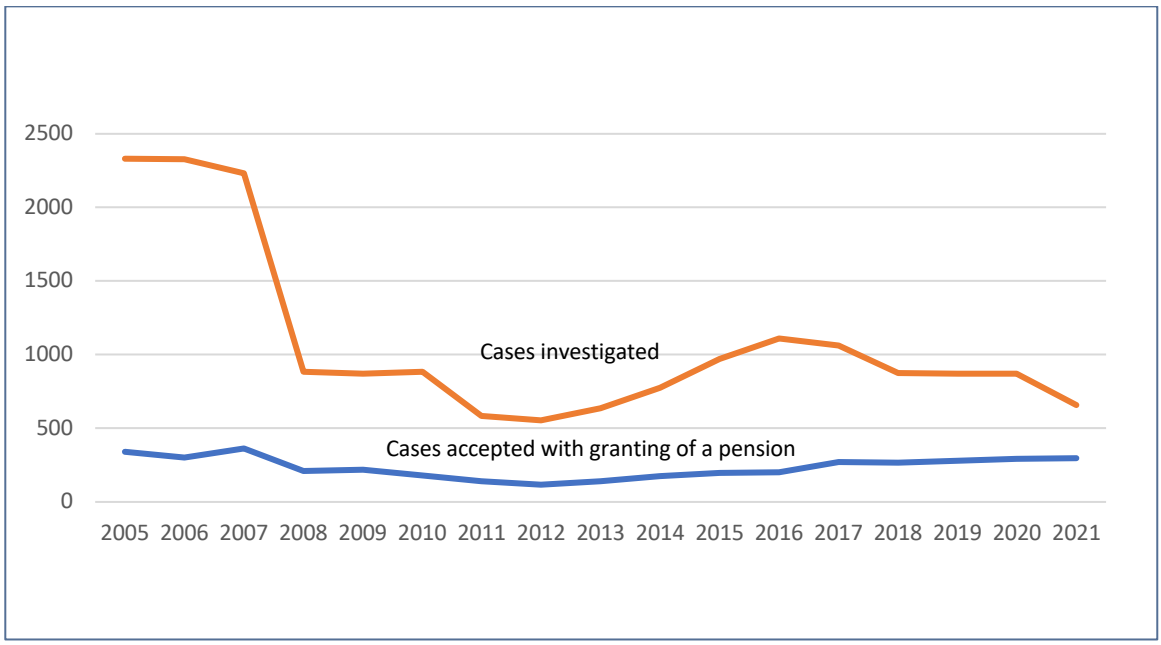
The complementary insurance organization AFA Försäkring, in a document on work-related mental diseases recognized over the period 2007-2019[21], gives, for its part, the figure of 595 cases recognized over a period of 12 years (see diagram on following page).

19 https://www.gruppoalis.it/stress-lavoro-correlato-i-dati-inail/

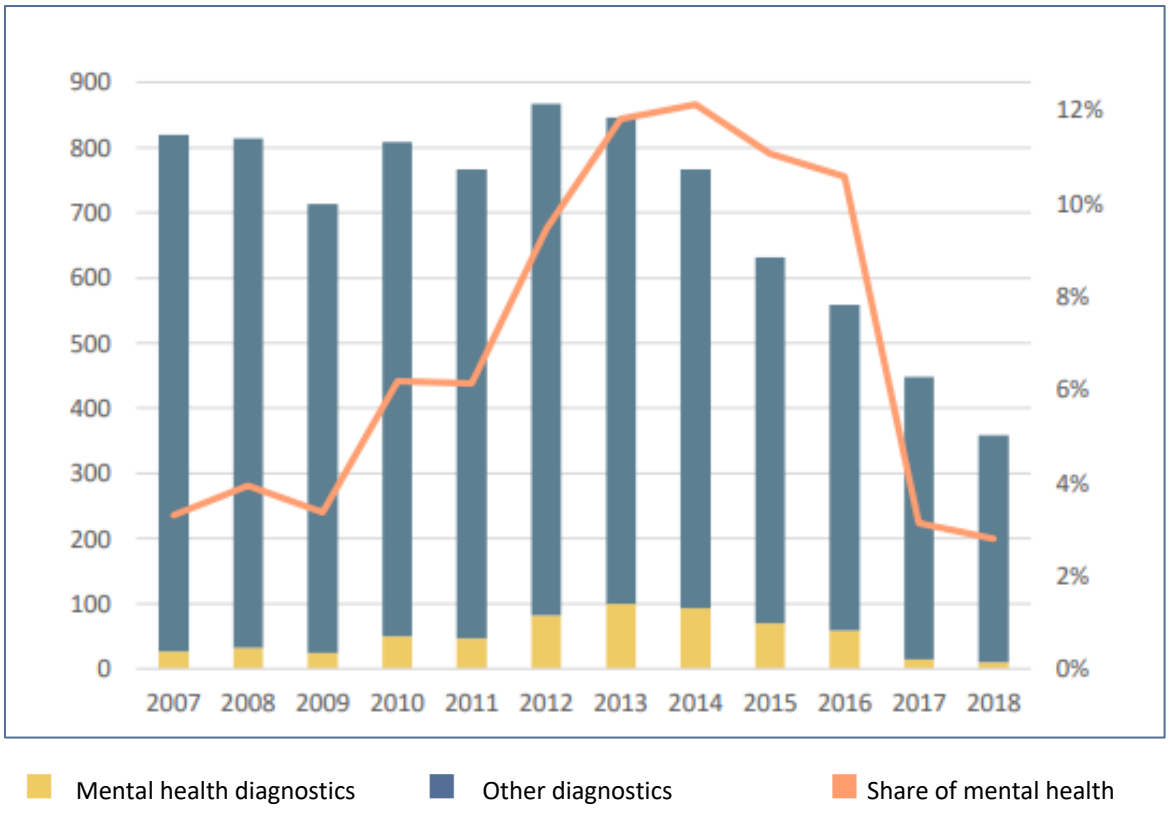
20 https://www.forsakringskassan.se/statistik-och-analys/sjuk/statistik-om-arbets--och-yrkesskadelivrantor (in Swedish)

21 https://www.afaforsakring.se/globalassets/nyhetsrum/seminarier/2021/att-arbeta-med-psykisk-ohalsa--chefens-roll/f6389_arbetssjukdomar-med-psykiska-orsaker.pdf

Sweden: Claims for benefits investigated by the Swedish Social Insurance Agency and mental illness cases accepted between 2005 and 2021



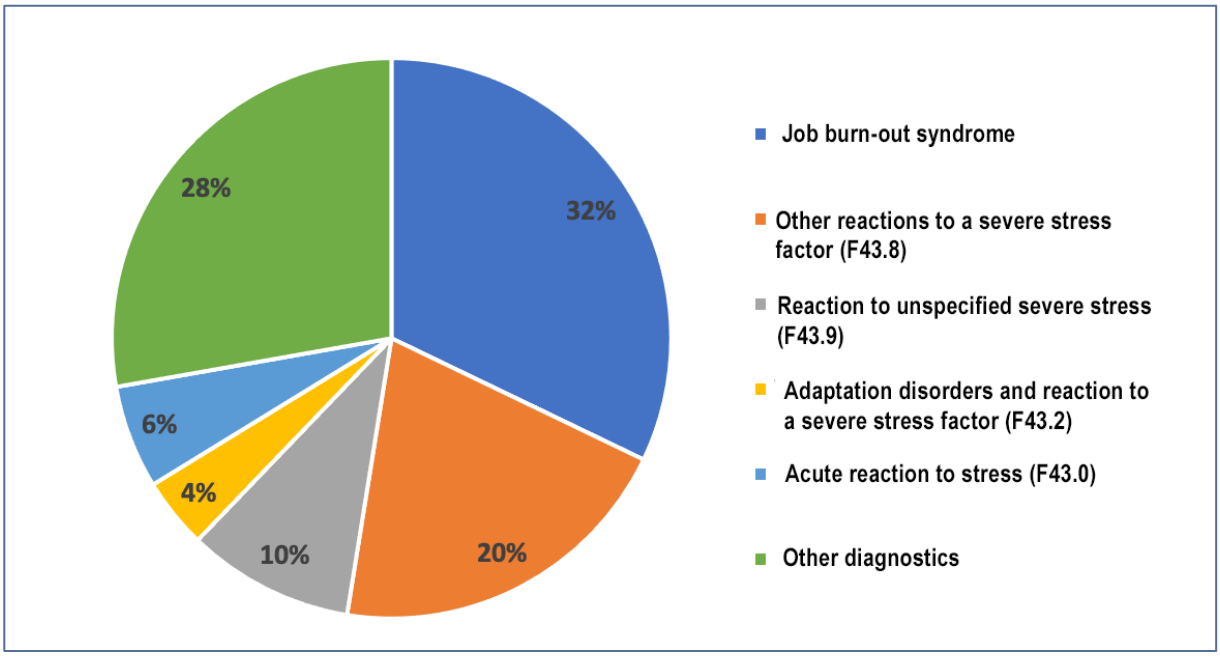
Sweden: Mental disorders as a proportion of all occupational diseases compensated by AFA Försäkring between 2007 and 2018



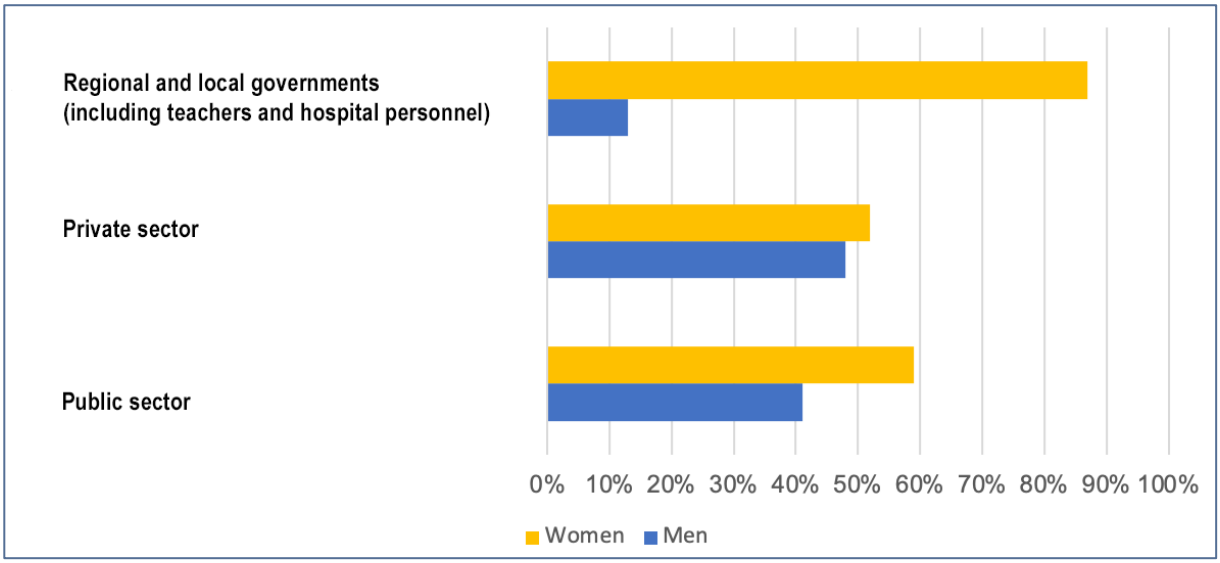
Over the period 2007-2019, some data exist regarding the classification of the 595 cases covered by complementary insurance:

- 68% (403) concerned women;
- as regards the diagnostic (ICD-10), the job burn-out syndrome tops the list, as shown by the following diagram.

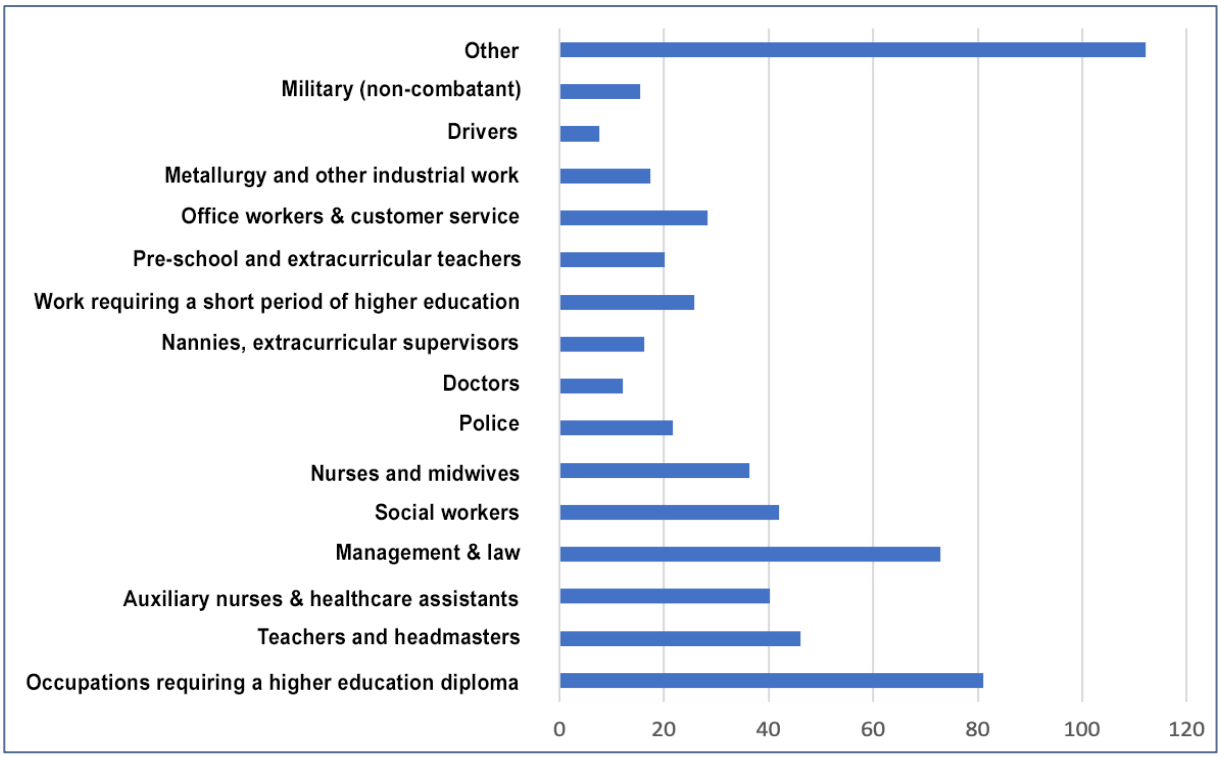
Sweden: Breakdown of the 595 cases of mental illnesses compensated by AFA Försäkring over the period 2007-2019 by ICD-10 diagnostic



Sweden: Mental illnesses compensated by AFA Försäkring by sector and gender (2007-2019)



Sweden: Occupations of the 595 mental illness cases compensated by AFA Försäkring (2007-2019)



Work-related mental disorders: Summary of cases reported and recognized as accidents at work and occupational diseases (2021)

	Insured population*	OD reports (or total cases investigated)	Cases recognized	
			as occupational diseases	as accidents at work
Denmark	2,900,000	4,691 (of which 223 off-list)	309 (of which 208 off-list)	951
	Ratio per 100,000 insured	*162*	*11*	*33*
Spain	19,200,000 (including public officials, except civil servants strictly speaking and self-employed agricultural workers who have not subscribed voluntarily to insurance for accidents at work)	Not given	72	560
	Ratio per 100,000 insured	*-*	*0.38*	*3*
Italy	21,200,000 All schemes (private sector, agriculture, public sector)	399	27 (± 40, after consolidating the statistics)	Not given
	Ratio per 100,000 insured	*2*	*0.19*	*-*
Sweden	5,330,000	659 claims for benefits	297 benefits granted	
	Ratio per 100,000 insured	*12*	*6*	
France	19,983,000 ⚠ General scheme only (private-sector workers)	3,260	1,694	10,000 + 10,000 work-accident equivalents
	Ratio per 100,000 insured	*16*	*8*	*50 + 50*

* Unless otherwise specified, the insured population corresponds to the working population

Recognition and compensation of work-related mental disorders in Europe

(Germany, Belgium, Denmark, Spain, France, Italy, Sweden)

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