SPECIAL ARTICLE

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Process of recognition of occupational mental diseases: the Chilean experience

Proceso de reconocimiento de una enfermedad mental de origen laboral: la experiencia chilena

Leonardo Aguirre Aranibar[1]

ABSTRACT | The changes in the work and employment conditions worldwide, and in Chile in particular, led to the development of new risks at work. Psychosocial risks at work, and their impacts on the health of workers following exposure, have continuously increased in recent years. Prevention against such risks and adequate identification of mental health disorders are some of the main problems for the Chilean occupational safety and health authorities. For this reason, specific guidelines for the process of recognition of mental health diseases at the workplace were formulated. The current regulations include improvements of administrative aspects, professional training and duration of the full process. Nevertheless, there are still deficiencies in legal aspects and in the quality of the process that need to be overcome to improve decisions regarding the recognition of this kind of diseases.

Keywords | classification; mental health; occupational diseases.

RESUMEN | El cambio en las condiciones de trabajo y de empleo a nivel mundial, y en especial en Chile, ha propiciado la generación de nuevos riesgos en el trabajo. Los factores de riesgos psicosociales y las consecuencias en la salud mental de los trabajadores, debido a la exposición a estos, han ido en constante crecimiento en los últimos años. La preocupación por la prevención de estos y la adecuada identificación de las patologías de salud mental, son una de las principales problemáticas de las autoridades de salud y seguridad en nuestro país. Es por ello que en los últimos 5 años se elaboraron instrucciones específicas para el correcto proceso de reconocimiento de patologías de salud mental en el lugar del trabajo. La normativa actual incorpora mejoras en el proceso administrativo, en la formación de los profesionales y los tiempos que toma este proceso. Sin embargo, existen aún deficiencias que solucionar tanto en aspectos legales como en la calidad del proceso de reconocimiento que permita mejorar la precisión de las decisiones respecto al reconocimiento de las patologías mentales de origen laboral.

Palabras clave | clasificación; salud mental; doenças profissionais.

Study conducted at Mutual de Seguridad CChCh – Santiago, Chile.

[1]Department of Knowledge Management, Mutual de Seguridad CChC – Santiago, Chile.

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Many changes occurred relative to work and its organization in the past decades worldwide. The new forces that operate in the world of work, such as technological transformation and increased global competition following trade and financial liberalization, created a new scenario for workers which promotes the emergence of previously unknown occupational risks[1]. Among the latter, occupational stress and work-related mental disorders are some of the most relevant and prevalent.

In Chile, the prevalence of mental disorders for the overall population is about 22% (in the past 12 months), and about 36% of the population suffered some psychiatric disorder in life[2]. These data are similar to the ones reported in other studies conducted with Latin American and Hispanic populations[3].

The situation of mental health at work is similar. For instance, the prevalence of mental disorders was 53% among a population of housemaids[4]. This finding is consistent with the ones of other studies which indicate that work-related mental disorders exhibit a patent gender trend, i.e., they are more frequent among females compared to males[4]. Along the same lines, a study of Organization for Economic Cooperation and Development (OECD) member countries found that the prevalence of mild and severe mental disorders among workers was 15% and 5%, respectively[5].

Further differences emerge when one includes variable socioeconomic level into analysis. Some hints point out that the working population exhibits higher risk for mental health problems, as measured by the General Health Questionnaire (GHQ), more particularly workers who perform more operative tasks compared to highly qualified professionals and/or managers[6].

There are not systematic data on stress at the workplace for Chile. Some studies sought to estimate the prevalence of stress among the Chilean working population. The results indicated that about 18% of the population had suffered stress, while this proportion doubles for working women[7]. Similarly, a study performed by the Chilean Security Association found that work-related mental health problems increased by 84% in the past 12 years, corresponding to 25% of the diseases this association recognizes as being related to work[8].

General prevention of mental disorders has been a considerable subject of analysis[9-12]. However, few proposals for intervention targeting the workplace were formulated in Chile, and most of them are centered on individual factors (of workers) as the focus of intervention[13]. As a result, interventions based on the management of work-related diseases or stress symptoms are the most prevalent ones.

One the preventive proposals for management of mental disorders and exposure to psychosocial risks in Chile is the intervention model formulated by the Union Institute of Labor, Environment and Health (Instituto Sindical de Trabajo, Ambiente y Salud — ISTAS), which is based on the Copenhagen Psychosocial Questionnaire (COPSOQ)[14]. This model centers on organizational aspects of work that are a source of psychosocial risk. Consistently, it targets the dimensions the literature indicates as the most significant causes of mental health problems at work[15,16].

As a result, psychosocial risk emerges as a relevant focus of intervention for prevention of mental health problems at work. It is superfluous to stress the considerable evidence gathered along more than 30 years for the relationship of psychosocial risk not only with mental health at work, but also with work-related musculoskeletal disorders, cardiovascular health and general wellbeing[17-21].

However, preventive actions for mental health protection fail most of time, with consequent emergence of occupational diseases. Facing this scenario, elucidation of how the process of recognition and qualification of this kind of diseases is relevant. This process is explained next.

Legal framework and procedure for notification of mental diseases. Law no. 16,744 created and regulated insurance against risk of occupational accidents and diseases. This law, passed in 1968, defines as occupational diseases those "directly caused by the exercise of the profession or the work a person performs resulting in disability or death"[22]. This definition includes two significant elements: the causality of disease and its consequences (disability or death). In regard to the former, there is a significant difference relative to other countries: the Chilean law requires establishing a causal relationship between work activities (exposure to occupational risk) and disease. Therefore, the Chilean legislation does not make room for mental diseases aggravated by or related to work, because a causal relationship cannot be established. Then, the consequence of disease must be disability or death. In the case of mental diseases, disability manifests transiently as length of sick leaves.

Consideration of the context within which the aforementioned law was passed is relevant. In 1968, Chile was undergoing considerable industrial development, the manufacturing industry was the main source of jobs, and the main occupation was the one of factory worker. Yet, consistently with the situation described above, the work conditions changed in Chile, whereby services and professional and individual work replaced blue-collar work[23].

These facts might explain the definition for mental disorders caused by work given in the law. The list of occupational diseases includes "disabling occupational neuroses that might exhibit different clinical presentation, such as: adjustment disorder, anxiety disorder, reactive depression, somatization disorder and [complaints] due to chronic pain"[24].

The local authorities formulated several guidelines to specify the notion of "disabling neurosis". For instance, a circular by the Social Security Superintendence (Superintendencia de Seguridad Social — SUSESO) lists the following as possible work-related mental disorders: adjustment disorder, reactions to stress, post-traumatic stress disorder, mixed anxiety and depression disorder, anxiety disorders, depressive episode and somatization disorder[25].

The Chilean law allows for conditions not included in the list to be considered as related to work. However, the process for notification, and consequent recognition of these disorders, is more complex for workers, because the burden of the proof of the occupational nature of disease falls upon them.

Although the process is clearer for the diseases included in the list, it is not free from complications. Whenever workers suspect they are suffering a work-related mental (or any other) disease, they should contact any of the insurance mutual companies to which they affiliated. These are not-for-profit organizations that administer insurance against risks of occupational accidents and o diseases as established in the Law no. 16,744. There are four such companies in Chile, being three private and one public. All employers should be affiliated to some insurance mutual company and pay the insurance premium corresponding to each and every employee. This is to say, in Chile insurance is paid by the employers[22].

Among other activities, insurance mutual companies are responsible for providing consultancy on prevention of occupational risk, health care, rehabilitation and work reintegration. When occupational diseases are notified, they are charged of conducting the medical investigation required to establish their direct causal relationship to work.

Once a worker notifies such an occurrence to the corresponding insurance mutual company, an internal process of analysis, investigation and decision-making that involves several medical and technical activities is triggered.

Process for analysis of notifications of mental diseases. This process, known as "process of qualification", follows several rules formulated by SUSESO. The description here is based on SUSESO circulars no. 3,241 and 3.298.

The process of qualification comprises several steps:

1. medical interview;
2. clinical psychology interview;
3. workplace assessment;
4. documental analysis.

Medical interviews are performed by physicians specialized in occupational medicine and/or equivalent fields and who have specific training in mental health. The main goal of interviews is to establish a clear diagnosis of the worker's disease independently whether it is included or not in the list of mental diseases. In addition, it also serves to collect data on workers and their general state of health, to wit: age, gender, number and age of children, who they live with, occupation — including a short description of the kind of work they do, length of work for the current employer, length of work in the current position and previous employment history, among others.

Other relevant aspects are the workers' complaints against their job, and the possible relationship between the latter and psychosocial risks at work and current symptoms, including a clear description, onset and progression.

The clinical psychology interview is the most widely employed technique for data collection, but also the most difficult and complex. To be sure, it is applied in settings other than the one of psychology[26]. As a function of their complexity, this kind of interviews is conducted by clinical psychologists with experience and training in mental health at work. The information procured includes: reason for consultation and risk to which the worker was potentially exposed, past medical history, symptoms present at the time of the interview, medical and/or psychological treatments received and mental examination, among others. For this purpose, projective or psychometric tests might be applied to investigate

the presence of other relevant mental disorders and the worker's mental status.

A crucial issue clinical psychologists should establish in the interviews is the risk agents to which workers were exposed. A risk agent is defined as exposure to a given psychosocial risk factor listed in SUSESO's circular, to wit: dysfunctional task or workstation, dysfunctional leadership or underestimation and dysfunctional organizational characteristics. Identification of risk agents is relevant for the third step of the process of qualification of mental diseases.

Workplace assessment seeks to investigate whether risk agents identified in in the clinical psychology interviews are present in the work environment. It is performed by a different psychologist than the one who conducted the interview. It involves a series of semi-structured interviews with a sufficient number of informants appointed by both employer and employee. Practice shows that at least two informants, called "witnesses", from each party are needed.

Semi-structured interviews with each individual "witness" should approach aspects related with the work dynamics (potentially high-risk job demands) and context (conditions under which work is done). In the particular case of Mutual de Seguridad CChC, a test specifically developed to establish the presence or not of psychosocial risk factors, EPT Test 3.0, is applied to all the witnesses to establish more accurately the actual exposure of workers to the psychosocial factors they named in the previous interviews. This test provides a compared profile of psychosocial risk, which represents a significant tool for the qualification of work-related mental disorders.

Finally, the aim of documental analysis is to gather information on the general work and employment conditions of workers. These data should be entered by employers in an ad hoc form delivered by the insurance mutual company, and include: aspects of the employment contract, working hours, rest periods, employment relationship, payment, vacation and extra hours, among others.

The qualification committee. The regulations in force establish the creation of qualification committees for the two main causes of notification of occupational diseases: musculoskeletal and mental disorders. In the latter case, the committee should be composed of three members at least, two of whom should be physicians — an occupational physician and a psychiatrist. Based on all the collected data on employee and employer, the committee is charged of the decision to admit or not a mental disorder as being caused by work. Workers are entitled to appeal decisions to a second instance within the same insurance mutual company, to wit, the central appeals committee, and in the case of an unfavorable decision, to SUSESO.

Advantages and disadvantages of this process. I begin by the advantages. Before 2015, there was not a clearly defined process for recognition of work-related mental disorders. SUSESO guidelines ordered and made the process uniform among all insurance mutual companies, which used variable processes and criteria before.

The creation of the qualification committee, whose members should have training in mental health, also contributes to improve the quality of the decisions made vis-à-vis the recognition of work-related mental disorders. The professional and training requirements for members improve the level of the process and ensure a correct decision is made.

In addition, the new rules shortened the duration of the process. Currently, it lasts about 30 days from initial notification to committee decision. With this, the efficiency of the insurance mutual system substantially improved, and the duration of sick leaves for mental disorders is significantly shortened.

However, there also some disadvantages. SUSESO guidelines improved only the administrative side of the process. There are not still clear criteria for recognition of work-related mental disorders or criteria helping to distinguish between work-related and common mental disorders. No matter their expertise, committees still make decision based on expert, rather than on objective and independent criteria.

Then, the law demands that any occupational disease should be "directly" caused by word. This led to see causality in a univocal manner, while as is known, diseases in general, and mental disorders in particular, have multiple causes[27,28]. The result is a biased view of causality, whereby qualification "occupational" is only attributed when a disease has a single cause clearly related to work.

For instance, several authors made mention of the nosologic difficulty to identify an "occupational neurosis" as defined in the law, and called the attention to the absence of this condition in the main international systems for classification of diseases[23].

Finally, the process of recognition of work-related health disorders has no clear relationship to the program

of surveillance of psychosocial risks. In theory, facing a recognized case of work-related health disorder, the risk to which the affected worker was exposed and caused the disease should be clearly identified. This would allow for preventive management at the workplace to prevent other workers from suffering the same problem. Unfortunately, there is no clear process to put these two sets of regulations (recognition of disease and surveillance program) into relationship, especially when one considers that the former seeks to detect risk factors (agents) not included in the latter. As a result, integrated preventive management at the workplace becomes very difficult.

These are some of the factors that limit the process of recognition of work-related mental disorders, hinder the institution of appropriate treatment and return to work. They also explain the low rate of recognition of these conditions, about 0.07 per 100 workers[29], as well as the difficulties to perform interventions at the workplace aiming at effective prevention of mental disorders to thus improve the quality of life of Chilean workers.

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Correspondence address: Leonardo Aguirre Aranibar – Gerencia de Gestión del Conocimiento, Mutual de Seguridad CChC – Teatinos, 258, tercero piso – Santiago, Chile – E-mail: laguirre@mutual.cl