Work and mental health: a roadmap for health administrations in Spain

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MINISTRY OF HEALTH

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Foreword

Europe is experiencing a silent crisis in the mental health of its working population, fuelled by worsening working conditions and a steady increase in precariousness. This multifactorial phenomenon is deeply influenced by the logic of contemporary capitalism: profit maximisation, the intensification of the pace of work, the erosion of collective rights and the reduction of social protection structures. All of this is happening without clearly acknowledging the human costs that these production models impose on those who sustain them.

In a context where it is increasingly difficult to access decent housing, and where job instability defines the pace of life for many people, it is considered necessary to accept any type of employment. This pressure is compounded by the difficulty, often the impossibility, of refusing harmful working conditions without jeopardising one's livelihood. This twofold exposure -needing to work and finding it difficult to protect oneself from the effects of work-, leads to often-negative work experiences, with obvious consequences for mental health.

However, when working conditions are right, work can be a powerful source of well-being, life structure, social recognition and a sense of purpose. Work is not only a means of subsistence, but also a central dimension of human development, of the possibility to contribute to the common good and to sustain life in its multiple forms: economic, relational and symbolic. Precisely because of its importance, when work becomes a source of discomfort or harm, its effects are particularly profound. Ensuring decent, safe and fair working environments is therefore not only a legal or economic obligation, but also a public health and social justice imperative.

The COVID-19 pandemic was a collective wound, the cumulative impact of which we are only beginning to understand. Add to this a cultural context that extols individualistic, competitive values and gives productive work a central place in people's identity and social value, and you have a perfect storm for the rise of work-related mental health problems.

In recent years, the government has promoted reforms that have contributed to improving working conditions. These include the labour reform aimed at reducing temporary employment and the proposals aimed at reducing working hours. These much-needed measures must continue to be expanded from a comprehensive perspective, one that incorporates mental health as a strategic pillar for protecting workers.

Currently, our country lacks a standardised system to systematically recognise the occupational origin of mental disorders. Nevertheless, scientific evidence is abundant, and the available clinical tools, such as psychopathological screening, individual formulation or the use of validated instruments, allow the link between exposure to psychosocial risks and psychological harm to be established with sufficient strength. This difficulty in establishing causality is not unique to mental health: it is also present in many other health conditions that are recognised as work-related illnesses, such as musculoskeletal disorders. Therefore, diagnostic complexity can no longer be an argument for denying recognition.

The absence of such recognition also generates an unequal gender impact. Women are over-represented in more precarious sectors with less social protection,

and bear the majority of the burden of reproductive and care work that is systematically invisible, unpaid and undervalued. Ignoring the effects of work on mental health reinforces these structural inequalities and leaves women particularly exposed to and unprotected from harm.

The relationship between work and mental health poses a double challenge. On the one hand, people with severe mental disorders have enormous difficulties in accessing employment: more than 80% do not enter the labour market, and those who do are in poorly paid and unsuitable jobs. On the other hand, work itself, in contexts of precariousness and insecurity, has become a factor generating suffering, identified both as a trigger of underlying psychopathology and as a direct generator of symptoms.

From a regulatory point of view, the recognition of incapacity for work is anchored in a list of occupational diseases that does not currently include any mental disorders. This omission contravenes recommendations such as Recommendation 194 of the International Labour Organisation, which already in 2002 urged states to incorporate mental disorders into their national lists. To date, few countries have done so, and Spain has not been one of them.

The consequences of this omission are both individual and collective: less financial compensation, lack of recognition of the cause, and lack of assumption of responsibility by the companies or institutions that caused the damage. In political terms, the benefits of work pressure are privatised, while the economic, social and health costs are socialised.

From clinical practice, we can clearly see how this phenomenon crosses into primary care and mental health services. People affected by harmful working conditions overcrowd consultations and waiting lists. If we do not incorporate a structural perspective of the social determinants of suffering, we run the risk that health care -instead of repairing the damage- will reproduce it, individualising the cause and medicalising what has a collective origin. Consultations should be spaces where, together with the people being cared for, shared, social, and fair narratives can be built.

The scale of the problem is undeniable. According to the PRESME report, in 2022 alone, approximately 170,000 cases of depression in Spain could have been prevented if precarious working conditions did not exist. This figure illustrates not only the health magnitude of the phenomenon, but also its economic, human and social cost.

Fortunately, we are witnessing a change of approach. Increasingly, national and international research, strategies, documents and resolutions recognise the close relationship between mental health and conditions of work and employment. This report is part of that process. It brings together the knowledge and commitment of a multidisciplinary group of experts and proposes a solid roadmap to advance institutional recognition, clinical detection, organisational prevention and epidemiological surveillance of work-related psychological harm.

As the Mental Health Commissioner at the Spanish Ministry of Health, I consider it essential that the healthcare system have effective clinical, regulatory, and organisational mechanisms to detect, report and monitor mental disorders related to work. This task is a key component in protecting public health and in building a system that places collective well-being above profit-at-any-cost logics.

I am deeply grateful for the rigorous, committed, and generous work of the team at the Mental Health Commissioner's Office, the Occupational Health Area of the Directorate-General for Public Health and Equity, other units of the Ministry

of Health, and all the people who have contributed to making this report possible. But above all, I want to thank Jesús, María, Juana, Óscar, Soledad and so many other people who have passed through my office. You, who asked me to, if I ever could, do something so that the harm caused by work would not be repeated in other lives.

This work is for you and because of you.

Belén González Callado

Mental Health Commissioner at the Ministry of Health

Executive Summary

In this document, we propose a roadmap for healthcare administrations in Spain to strengthen the role of the healthcare system in preventing, identifying and addressing work-related mental health problems. The mental health of the working population cannot be separated from the conditions in which labour activity takes place, and this report aims to help close a historical gap in the institutional understanding of work-related suffering.

The text is structured into four parts: a theoretical framework, a review of the scientific evidence on psychosocial risks, specific clinical guidelines, and a proposal for an epidemiological surveillance system.

Part One. Theoretical framework

We start from the recognition of work as a key social determinant of mental health. When carried out in dignified, stable and meaningful conditions, work can be a protective factor. However, when it develops in contexts of precariousness, insecurity, overload, violence or lack of recognition, it becomes a persistent source of psychological distress.

We propose a structural and eco-social conceptual model that articulates five levels of analysis: global political and economic factors, social position, employment conditions, working conditions and individual biopsychosocial characteristics. This model not only allows us to understand how inequalities in mental health are produced, but also guides public and health intervention strategies from an equity perspective.

Part Two. Psychosocial risks at work and mental health

In this section, we present the main analytical models of occupational psychosocial risks and their relationship with mental health, drawing on the best available scientific evidence. We explain how certain working conditions are linked to the onset of mental health symptoms or syndromes, both in subclinical forms and in clinically defined cases.

We detail how prolonged exposure to excessive emotional demands, high quantitative demands, lack of autonomy, job insecurity, harassment, lack of recognition or organisational injustice is associated with anxiety and depression disorders, adjustment and sleep disorders and psychotropic drug use.

The relationship between these risks and mental health has been systematically documented over the past decades. However, problems arising from these exposures continue to be underreported in the healthcare system and in occupational health records. This underreporting has structural causes: administrative difficulties in recognition, the absence of stable coordination mechanisms between systems, lack of specific training among clinical teams, and the stigma surrounding mental disorders.

It is important to remember that the International Labour Organization called for the inclusion of mental disorders in the list of occupational diseases more than

twenty years ago, yet this recommendation has not been broadly implemented in the regulations of most countries. This document aims to help demonstrate the urgency of advancing in that direction.

Part Three. Clinical approach

From the healthcare system, the clinical approach to work-related mental health problems requires tools and criteria adapted to their social and structural origins. Often, clinical manifestations of occupational origin are treated exclusively symptomatically, which can lead to insufficient care, iatrogenesis, or even chronicity of distress.

We propose three intervention axes:

1. Clinical assessment with an occupational perspective

We recommend systematically including questions about the patient's working conditions: type of contract, working hours, shift work, emotional load, hierarchical relationships, experiences of violence or harassment, and work-life balance. This information is key for an accurate assessment of the origin and maintenance of distress.

2. Assessment of suspected occupational origin

When a person's symptoms coincide with already described occupational risk conditions and a temporal or contextual relationship with the work environment is established, a clinical suspicion should be raised that work is contributing to the mental health problem. This assessment guides case management and helps make decisions that are better aligned with the causes of suffering.

3. Coding and communication

The suspicion should be recorded in the medical history using the Z-Codes of the International Classification of Diseases (hereinafter, ICD), which allow the social and occupational factors contributing to the disorder to be reflected. This practice not only improves the quality of individual care, but also generates aggregated data for better epidemiological surveillance.

Identifying work as a possible trigger or aggravating factor of psychological distress constitutes an essential step in clinical care. When there is well-founded suspicion that a mental health problem may be related to adverse working conditions, the care process should follow three key steps:

1. **Detection and diagnosis of the mental health disorder** through clinical interview, psychopathological examination, and standard diagnostic tools.
2. **Assessment of suspected occupational origin**, integratingthe patient's account, the chronology of symptoms, and exposure to psychosocial risks in the work environment.
3. **Communication of the suspicion** to the prevention services or to the competent occupational health authorities, always with the informed consent of the person concerned.

This process should be documented in the medical history using **ICD Z Codes**, which allow associated social and occupational factors to be recorded. This practice not

only improves care quality, but also contributes to generating useful data for epidemiological surveillance and the development of preventive policies.

Formally recognising the suspicion of occupational origin allows the individual to make sense of their experience, access their rights, and activate social, institutional, or legal support resources. In this sense, clinical practice not only alleviates symptoms but can also contribute to protecting mental health in the workplace.

Part Four. Epidemiological surveillance

We propose the implementation of a surveillance system for mental disorders of possible occupational origin, coordinated with public health, occupational health and primary care services. This surveillance should not only quantify the disease burden, but also guide preventive and remedial measures in the workplace.

The system should regulate its objectives, the events under surveillance, the information to be collected, the mechanism, form, and frequency of data collection, the communication circuit, and the specific coordination mechanisms when coordination is required between multiple administrations, agencies, and entities; as well as any other aspects deemed necessary.

This system cannot be understood as an exclusively technical tool. It is, above all, a mechanism for institutional recognition of an invisible structural problem. Our aim with this document is to help make that gap visible and offer realistic proposals to begin addressing it.

1. Rationale and explanatory models of the relationship between mental health and work

1.1. Work and health: Work as a social determinant of health

Concept of work and mental health

The concept of *work* has evolved throughout history and has been defined in various ways depending on the context. According to the International Labour Organization (ILO) definition, work is the "set of human activities, paid or unpaid, that produce goods or services in an economy, or that meet the needs of a community or provide the means of subsistence necessary for individuals" (International Labour Organization, 2025). Work plays a central role in sustaining life and shaping subjectivity by influencing cognitive, emotional, and moral capacities, in addition to being a structuring axis of personal and collective identity.

The concept of *health* proposed by the World Health Organization (WHO) in 1948 defines it as "a state of complete physical, mental, and social well-being and not merely the absence of disease." However, the adjective *complete* has been strongly criticised, as it can lead to a conception of health from which a large portion of the population would be excluded most of the time. An alternative proposal would be to define health as the "ability to adapt and to self-manage" (Huber et al., 2011); or, in a similar vein, as the WHO itself posits in contemporary definitions of mental health: "A state of mental well-being that enables individuals to cope with the stresses of life, realise their abilities, learn and work effectively, and contribute to the improvement of their community" (World Health Organization [WHO], 2022).

In this context, work is established as a key social determinant that profoundly influences the physical, psychological and social well-being of individuals and communities. Adverse working conditions erode personal identity and the sense of life purpose and are associated with a higher risk of developing numerous mental health problems, as well as increased disability (Ervasti et al., 2021).

The relationship between work and mental health has therefore been recognised as a strategic priority in health and mental health policies by the European Union (EU) (European Commission [EC], 2023; European Parliament, 2022; EC 2008), the International Labour Organization (ILO) (World Health Organization & International Labour Organization, 2022), the World Health Organization (WHO) (WHO, 2021), as well as the member states of these organisations, including Spain. It is noteworthy that the theme chosen by the WHO to commemorate World Mental Health Day in 2024 reflected this concern: *Mental health at work* (WHO, 2024).

Below, a conceptual framework is presented, based on the best available evidence, which describes how working conditions and dynamics influence individual and population mental health. This framework provides a structured basis to guide health interventions and public policies aimed at the prevention and promotion of mental health at work

Work and subjectivity

Work is an essential human activity involving the performance of physical and mental tasks intended to maintain certain living conditions. Beyond organising the collective production of goods and services, work structures our time, enables social relationships, contributes to identity formation, and, in many cases, helps us achieve personal fulfilment.

The concept of work is not limited to performing productive tasks in salaried employment; it can take many forms: inside or outside the home (reproductive or productive work), voluntary, mandatory, or forced (community, paid, forced, or slave labour), with or without a contract (formal or informal work), with or without remuneration, regulated or not by labour and social security laws, and under safe or hazardous conditions.

Work produces and transforms individuals, poses physical and psychological demands, and constantly requires responses from the person. Any work activity involves not only fulfilling prescribed tasks but also adaptation, interpreting situations, problem-solving, and mobilising physical and intellectual capacities. Work deeply engages personality, exposing it to both failure and frustration, as well as success and development.

Current evidence links harmful working and employment conditions with deterioration in mental health, making this relationship a public health problem and a challenge for public policy. However, most approaches remain focused on individual interventions that decontextualize distress and overlook its structural causes. This same logic dominates social perception, prioritising symptom reduction and adaptation to work demands over recognising work as a key determinant of mental health.

1.1.1. Work as a Fundamental and Undervalued Social Determinant of Health

Mental health, like health in general, is distributed unevenly across the population. These inequalities are not only systematic—disadvantaging the most socially and economically marginalised groups—but also unjust and avoidable, as they stem from social determinants shaped by the decisions and priorities of politically influential actors and groups (Navarro et al., 2006; Whitehead, 1992; Benach & Muntaner, 2005). As the WHO Commission on Social Determinants of Health notes: "Social injustice is killing people on a large scale," and "reducing health inequities, between and within countries, is an ethical imperative" (Commission on Social Determinants of Health [CSDH], 2008).

The biopsychosocial model of mental health emphasises the interrelation of biological, psychological, and social factors, highlighting the importance of psychosocial determinants (Engel, 1977; Havelka, Lucanin & Lucanin, 2009; Prince et al., 2007). Unlike other reductionist approaches, the biopsychosocial model is crucial for understanding how socioeconomic inequalities translate into mental health ine-

qualities. Thus, the position we occupy in the social hierarchy conditions the degree of control we can exercise over our lives, our opportunities for social participation, and, by extension, our health (Marmot, 2004; 2016; Sapolsky, 2005). For example, the risk of developing mental health problems with potential psychiatric diagnoses can be up to ten times higher between the extremes of the socioeconomic gradient (Marmot, 2016; Muntaner et al., 2013). From the biopsychosocial model, interventions focused on preventing mental health problems are prioritised by acting on the social determinants that shape the population's living conditions, beyond the clinical sphere or those already diagnosed (McGinnis, Williams-Russo & Knickman, 2002; Woolf, 2007).

Different employment and working conditions involve an unequal distribution of resources and opportunities to cope with life's demands, which is closely associated with differences in perceived lack of control or psychological stress, a well-established risk factor for both physical and mental health (Benach et al., 2014; Torjesen, 2014). The biopsychosocial model further expands the analysis of social determinants of health to include ecological determinants, recognising the impact of social factors such as consumption (Starr et al., 2023) or economic policies (Hope & Limberg, 2022) on the degradation of planetary boundaries, which are fundamental both for the health of the planet and for our survival as a species (Richardson et al., 2023; Bordera, Turiel & Valladares, 2024; Muntaner & Benach, 2023).

In 2023, *The Lancet* published a series of articles on "Work and Health" (The Lancet Series on Work and Health, 2023), one of which focuses specifically on mental health. It concludes that work is a key social determinant of health, whose impact has historically been undervalued, especially in high-income countries. According to the authors, improving working conditions could have a substantial impact on population well-being and help reduce health inequalities (Frank et al., 2023). The article also includes a conceptual framework that facilitates understanding of the complex relationships between work and health. Below is a brief summary of its different levels of analysis:

- **First level: socio-economic and political conditions.** This includes structural factors such as the economic situation, labour policies, labour market governance, technological innovation, and climate change. These factors determine how the labour market is organised and the availability of jobs. For example, technology has significantly transformed the world of work through the rise of remote work and automation, while climate change has created new risks, especially in outdoor jobs or those related to emergency situations.
- **Second level: social position.** This refers to individual characteristics that influence access to employment opportunities, such as socio-economic status, gender, sexual orientation, age, ethnicity, and migration status. The interaction between these characteristics and employment conditions generates structural labour inequalities. Some social groups are overrepresented in more precarious, less stable, and less protected jobs.
- **Third level: employment conditions.** This includes the various types of labour relationships in the market, from permanent full-time contracts to more precarious or less protected forms such as temporary contracts, self-employment, gig work or independent work. These conditions directly

affect job security, access to rights and benefits, and economic stability, influencing health differently depending on the specific type of employment.

- **Fourth level: working conditions.** This level addresses any characteristic of the work itself that may significantly influence the generation of risks to worker safety and health. Examples include the general features of the workplace, facilities, equipment, products, and other tools; physical, chemical, and biological agents present in the work environment; and the procedures for using these agents. Working conditions also encompass all other characteristics of the work, including its organisation and structure, that influence the magnitude of risks to which workers are exposed. All these conditions can have significant adverse effects on the physical and mental health of those experiencing them.
- **Fifth level: personal and individual characteristics.** Each worker possesses individual characteristics developed throughout their life course that can either mitigate or exacerbate the impact of working conditions on health. These individual differences influence coping capacity and the degree of vulnerability to prolonged exposure to chronic stress (Acoba, 2024).

Another significant contribution of the article by Frank et al. (2023) is the identification of the main emerging challenges in the relationship between work and health, which can be summarised as:

- The long-term impact of introducing technology into the workplace and the effects of remote work.
- The influence of various axes of inequality, such as gender, ethnicity, and social class, on the relationship between work and health.
- The increasing presence of migrant workers and the structural dependence of high-income countries on these migratory flows.
- The worsening of precariousness in its multiple dimensions.
- The extension of working hours, irregular schedules, and erosion of rest time.
- The impact of climate change on working conditions, especially in occupations exposed to the environment or emergencies.

1.1.2. The Integral Precarity Model and Its Relationship with Work

As stated in the article cited above (Frank et al. 2023), precariousness is a key dimension in understanding the impact of work on mental health. To this end, a multidimensional model called integral precariousness is used, which combines not only aspects of labour precariousness, related to the conditions and characteristics of work, but also employment precariousness, linked to contractual instability and vulnerability. This approach incorporates other forms of social precariousness that extend to broader domains, such as family and community living conditions. From this perspective, exposure to psychosocial risks at the individual or micro level is redefined by simultaneously considering broader power relations, and access to resources and opportunities present at the structural or macro level (Muntaner & O'Campo,

1993; Martikainen, Bartley & Lahelma, 2002; Benach et al., 2010; Rönnblad et al., 2019; Kreshpaj et al., 2020; Méndez Rivero, 2022; Méndez Rivero et al., 2021; Méndez-Rivero et al., 2022).

This definition of precarious work incorporates social mechanisms related to power, such as exploitation (Muntaner et al., 2015; Muntaner et al., 2006; Prins et al., 2021; Muntaner et al., 2011; Prins et al., 2015), domination and subordination relationships (Muntaner et al., 1998; Muntaner et al., 2003), and discrimination based on different axes of social stratification, such as gender, ethnicity, or social class (International Labour Conference, 2003; Pascoe & Richman, 2009; Clausen, Rugulies & Li, 2022). Forms of violence are also included, such as workplace and/or sexual harassment, as well as repeated threats or behaviours aimed at humiliating, offending, or victimizing individuals. This approach broadens the perspective beyond the classical psychosocial risk model—which it also includes—such as night or rotating shifts, excessive working hours, insufficient breaks, unpredictable schedules (Muntaner et al., 2006; Prins et al., 2021; Muntaner et al., 2011; Prins et al., 2015; Muntaner et al., 1998; Muntaner et al., 2003; International Labour Conference, 2003; Pascoe & Richman, 2009; Clausen, Rugulies & Li, 2022; International Labour Organization, 2019; Artazcoz et al., 2016; Åkerstedt, 2003; Kecklund & Axelsson, 2016; Karpman, Hahn & Gangopadhyaya, 2019), or high emotional demands (Kogovsek, 2014).

The phenomenon of work precarisation has three fundamental characteristics: it is historical, relational, and multilevel.

First, precarious work must be understood from a historical perspective. Although its current form is closely related to the consolidation of the contemporary economic system and reforms carried out over the last five decades, its roots go much further back. Precariouness has characterised various forms of labour subordination over time: from medieval peasant labour and early modern workshops, to manual labour in the industrial working class, and more recently, employment in the service sector and the digital economy.

It is striking that, throughout history, labour precarity has been "rediscovered" repeatedly. In the 1970s, for example, there was talk of the discovery of the informal economy. Later, during the 1980s and 1990s, the increasing participation of women in the labour market was presented as novel, even though women have historically worked in multiple ways, both visible and invisible. More recently, precarious work has again become central to public debate with the emergence of the concept of the precariat: an emerging social class characterised by the accumulation of multiple insecurities and a lack of community support networks (Standing, 2011).

Deregulation policies, especially the deregulation of labour law, have strengthened employer power, weakened worker protections, and deepened social and health inequalities (Chamayou, 2022). In countries where trade unions are stronger, workers have greater collective bargaining power, lower wage inequality, and higher job quality, which in turn translates into greater health equity and quality of life (Wilkinson & Pickett, 2019). Precariouness takes different forms depending on the historical evolution and social characteristics of each country (Padrosa, Bolíbar, Julià & Benach, 2021).

The second characteristic of precarious work is its relational nature, as it requires considering power relations, both at the macro and micro levels, existing between the different social groups that make up a society. Work reveals the interdependence that defines human beings: as a social relationship, paid work is permeated by dynamics of power, domination, and control, which can take more or less visible, symbolic, or vio-

lent forms. Our economic system tends to turn this interdependence into competition and fragmentation. However, conversely, work can be a source of cooperation, autonomy, recognition and a sense of belonging (Wright, 1976; Pahl, 1988).

Finally, precariousness is a multilevel phenomenon, as we will see, whose effects depend on the interaction of multiple economic, legislative, political, labour, and social factors operating simultaneously at local, national and global levels.

Evidence also indicates that, in general, employed individuals have higher levels of health and well-being than inactive individuals, particularly the unemployed. Unemployment, in fact, is a risk factor for multiple mental health problems (Yur'yev, Värnik, Värnik, Sisask & Leppik, 2012; Das-Munshi & Thornicroft, 2018).

To analyse precarious employment from a multidimensional perspective, the internationally validated Employment Precariousness Scale (EPRES) has been developed (Padrosa, Bolíbar, Julià & Benach, 2021). This questionnaire evaluates six key dimensions of precariousness, including temporariness, insufficient wages, and lack of collective bargaining power (disempowerment). Beyond its impact on health, precarious employment has been shown to be unequally distributed: it disproportionately affects women, young people, migrants, and socially disadvantaged groups (Padrosa, Vanroelen, Muntaner & Benach, 2022).

Pathways and Mechanisms Linking Work, Precariousness and Mental Health

The framework described allows for understanding the complex relationships between different forms of precarious work and employment affecting workers in very diverse occupations. The prevalence of these situations is not random: it is unevenly distributed based on factors such as social class, gender, age, migration status, ethnicity or place of residence. Additionally, unpaid reproductive work (domestic and caregiving work) constitutes a form of precarity that is often invisible, despite being essential for sustaining the economy and social cohesion.

Precarisation affects both employment trajectories and other areas of life, introducing instability, insecurity and vulnerability into daily life. As noted previously, precariousness can manifest both in employment and working conditions, and extend to other spheres of everyday life through processes of social exclusion, material instability and structural vulnerability. From this framework, three main pathways through which precariousness impacts mental health can be identified:

- **First pathway: employees' career trajectories.** The transformation of the traditional employment model—defined as permanent, stable, full-time, with labour rights and social protection—toward progressively precarious forms has resulted in professional trajectories marked by instability, insecurity and loss of rights and protection. This evolution blurs the boundaries between employment situations that are formally distinct but functionally precarious.
- **Second pathway: exposure to adverse working conditions.** Precarious employment is associated with greater exposure to psychosocial stressors arising from work design and organisation (work overload, low control or autonomy, high demands, low social support, etc.), situations of exploitation, domination or discrimination, and other risk factors (physical, chemical, biological and ergonomic). These exposures are exacerbated by lower institutional protection (lack of compensation, representation or collective bargaining) and by greater uncertainty, fear and helplessness regarding dismissal (Karasek & Theorell,

1990; Siegrist & Theorell, 2006; Krieger, 2000; Muntaner et al., 2011; Muntaner & Lynch, 1999; Muntaner, Benach, Hadden, Gimeno & Benavides, 2006; Prins et al., 2021).

- **Third pathway: precariousness in everyday life conditions**. Vulnerability generated in the workplace extends to the home through processes of material deprivation and impoverishment, affecting both workers and their family environment, particularly children (Rubery & Piasna, 2017). Examples of this social precariousness include housing harassment, evictions, and energy poverty, all of which with significant consequences for mental health (Caroz-Armayones, Benach, Delclós & Julià, 2022; Belvis, Bolíbar, Benach & Julià, 2022).

1.1.3. Productive and Reproductive Work and Its Impact on Health

In this document, the concept of work encompasses both traditionally paid activities performed in the labour market—regulated by legal frameworks—and reproductive activities, i.e. unpaid domestic and caregiving work performed outside the commercial sphere.

Both forms of work—productive and reproductive—have a significant impact on population mental health, especially when combined, as often occurs with women due to the persistent inequality in the distribution of caregiving work. However, the effect of reproductive work on mental health has historically been invisible and much less studied than paid work.

Therefore, any rigorous analysis of the relationship between work and mental health must integrate both spheres, recognising the structural weight of domestic and caregiving work in shaping mental health.

Regarding reproductive work (domestic and caregiving), these activities have a significant impact on mental health, partly due to their interaction with paid work. From a gender perspective, despite the gradual increase in men's participation in these tasks, women continue to bear the majority of the burden, with the consequent impact on their health and well-being.

This unequal distribution of reproductive work plays a key role in the gender inequalities that intersect with precarious work. One of the main factors explaining the higher concentration of women in precarious jobs is the disproportionate time they dedicate to unpaid domestic and caregiving work, largely invisible and socially unrecognised. This burden affects their position in the labour market and increases their vulnerability to discrimination (Buckingham et al., 2020; Krimshaw, 2015).

Women are often socialised to take care of others and, in the face of family needs, tend to reduce or leave their participation in the labour market to care for both children and dependent family members. Frequently, to balance paid work with family responsibilities, they choose part-time or local jobs, even if precarious, prioritising family care over job quality (Verniers & Vala, 2018). Although about half of part-time workers do so because they could not find full-time employment, family obligations—especially caring for children or dependents—are five times more common among women. In contrast, men more often cite educational reasons, twice as frequently as women (Moya-Martínez, Escribano-Sotos & Pardo-García, 2012).

In terms of health impact, women exclusively dedicated to domestic and car-

egiving work generally show poorer health indicators than those with paid employment. This difference is partly explained by the lack of rewards associated with employment, such as economic autonomy, social recognition, professional identity or interpersonal relationships outside the family sphere.

One dimension of reproductive work that remains underexplored is the *mental load*: a set of intangible activities related to anticipating, planning, organising, and monitoring household needs and social relationships. The limited available evidence suggests that managing these responsibilities alone negatively affects life and marital satisfaction, and consequently, mental health (Reich-Stiebert, Froehlich & Voltmer, 2023).

Regarding the combination of paid and unpaid work, studies show that when domestic work is shared equitably, work outside the home has a positive effect on women's mental health compared to those without paid work. However, this beneficial effect disappears when the distribution of domestic work remains unequal (Bacigalupe & Martín, 2007).

A reflection of the still early stage of healthcare detection of mental health problems related to reproductive work is the absence of specific diagnostic codes that allow its link to mental health to be identified. Currently, there are no Z codes that explicitly capture this relationship, constituting a double injustice for those who perform this work as their main occupation (Stein, Palk & Kendler, 2021).

1.2. Suffering, Mental Health Problems and Work-Related Mental Disorders: Right to Health Protection and Mental Healthcare Systems

1.2.1. Suffering, Mental Health Problems and Mental Disorders

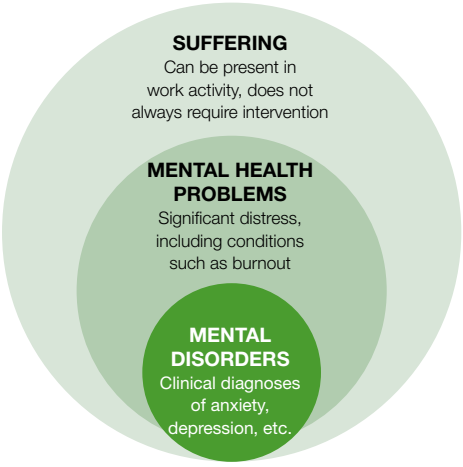
Engaging in work involves effort, which entails doses of suffering that can vary significantly depending on employment and working conditions. Under certain conditions, related to the level or type of demands and responsibilities, the context in which the activity takes place and/or the work relationships/conditions, work can cause suffering and increase the risk of developing mental health problems. Despite these demands, it is essential to recognise that not all suffering associated with these dynamics can or should be considered diagnosable as a mental disorder.

Mental disorders are descriptors referring to clinical phenomena such as depressive disorders, anxiety disorders, and psychotic disorders, which are included and coded in diagnostic manuals such as the WHO's ICD (Stein, Palk & Kendler, 2021; World Health Organization, 2019).

The emergence of specific psychological symptoms always responds to a complex combination of factors whose impact on individuals is variable and necessarily goes beyond the categories used. In this regard, it is necessary to define the concept of mental health problems in a way that transcends the concept of mental disorder and includes a broader range of situations related to mental health, covering the continuum from suffering to pathology. This includes subclinical situations as well as conditions not recognized as pathologies in diagnostic manuals but still coded therein—for example, occupational burnout (Rugulies et al., 2023). Therefore, a contextualised analysis

tailored to each particular situation is necessary to differentiate between suffering generated by normal work demands (which should not require intervention by the healthcare system) and that which may lead to mental health problems and mental disorders when prolonged risk factors and adverse employment and working conditions accumulate.

Figure 1. Model of the continuum of work-related psychological distress



Source: Created by the author.

1.2.2. The Mental health in all policies approach for the improvement of working conditions

In a context where working conditions significantly influence mental health, any effective intervention must start by strengthening public policies that affect the structural determinants of employment, including macroeconomic policies, employment and working conditions, social protection, and the prevention of risks arising from work activities.

Protecting the mental health of the working population requires a cross-cutting approach that integrates mental health into all policies (Mental Health in All Policies), prioritising the creation of decent, safe and healthy working conditions. In Spain, the right to health and to adequate working conditions is enshrined in Articles 40.2 and 43 of the Spanish Constitution and developed through Ley 31/1995 de Prevención de Riesgos Laborales (Law 31/1995 on Occupational Risk Prevention), which establishes the obligation to protect physical and mental health at work and ensure occupational safety and health.

However, much progress is still needed to create an environment that actively protects mental health in the workplace, as advocated by initiatives such as the United Nations Sustainable Development Goals (United Nations, 2025), the International Labour Organization's Decent Work Agenda (ILO, 2025), and WHO/ILO men-

tal health guidelines at work (WHO & ILO, 2022). The European Union's mental health initiative (EC, 2023) is also noteworthy—a comprehensive strategy focused on prevention, accessibility and recovery. This political initiative aims to address factors affecting mental health, such as social, economic and environmental crises, and proposes measures in collaboration with member states to improve mental health support through training, prevention initiatives and accessible care.

Work-related stress and difficulties reflect structural problems in the work environment that should be addressed through labour conditions, not exclusively by the healthcare system. It is essential to recognise that addressing work-related problems requires policies promoting well-being, safety and health at work, preventing the healthcare system from over-relying on diagnoses and/or pharmacological prescriptions when the optimal intervention is improving employment and workplace conditions.

1.2.3. The healthcare system in addressing and preventing work-related mental health problems and disorders

The healthcare system acts through diagnosis and psychopharmacological and/or psychotherapeutic treatment of mental disorders at the individual level. However, its impact on preventing risk factors (adverse working conditions that determine the occurrence of mental health problems) is, at best, limited. For example, the use of Z- and Q-codes (International Classification of Diseases 10 and 11, respectively) (WHO, 2019) is infrequent, yet their use would allow problems arising from adverse working conditions to be recognised in clinical practice and studied/intervened upon from a public health perspective.

Furthermore, integration between public health services, occupational health, primary care, and hospital care allows not only the management of symptoms but also collaboration in primary, secondary and tertiary prevention of work-related mental health problems. In the context of mental health and work, effective intervention should promote community mental health, consider social determinants of health, and encourage seamless coordination with other stakeholders. In this way, the healthcare system can contribute to mobilising social resources and providing comprehensive coverage that protects the patient when adverse social and working conditions affect them.

Principles and challenges in healthcare interventions

In healthcare contexts, all interventions—diagnostic, pharmacological, psychotherapeutic, or community-based—follow basic guiding principles: interventions must provide clear, evidence-based benefits; benefits must outweigh risks, respecting patient autonomy and ensuring informed consent; and resource allocation must follow justice criteria (Law 14/1986, 1986; Law 41/2002, 2002; Beauchamp & Childress, 2019).

Benefits of health system interventions

The health system could play a crucial role for people with employment-related pathologies, especially if there is coordination with other institutional systems and social partners. Inequality and poverty have normalised many abusive practices and unhealthy working conditions, so that people exposed to adverse working conditions

are subjected to stressors that may be accompanied by additional harmful factors. For many of these individuals, the healthcare system can serve as a first step for recognition and treatment of problems, which often present as symptoms without a clear origin.

Health asset prescriptions and non-intervention

It is important for the healthcare system to recognise when not to intervene This does not mean abandoning the patient, but rather acknowledging that some situations require understanding and activation of support resources rather than medical treatment.

A key strategy in this approach is health asset prescription or social prescription (Ministry of Health, 2021; WHO, 2022), i.e., actions or resources that strengthen individuals' and communities' capacities to cope with their situation and improve quality of life. This may include referrals to social services, trade unions, local associations, among others. This approach emphasises that not all experiences of suffering should be medicalised, and that the most valuable role of healthcare may be guiding and mobilising resources to empower individuals and communities, avoiding unnecessary interventions that could cause more harm than benefit.

This approach is grounded in the principle of non-maleficence (*primum non nocere*), meaning the avoidance of interventions that may cause more harm than good. A real risk in addressing work-related mental health problems is *iatrogenesis*, i.e., harm caused by the healthcare intervention itself. This can occur when the system only treats symptoms such as anxiety, insomnia or low mood without addressing the work-related conditions generating them, resulting in a reductionist and insufficient intervention.

Symptomatic treatments—often psychopharmacological—may provide temporary relief but risk masking the root cause of distress, perpetuating exposure to a harmful work environment. Additionally, individual medicalisation of social suffering can implicitly convey that the problem lies in a supposed lack of personal capacity, reinforcing the idea that distress is a private, individual matter. This diminishes the possibility of collective action on social and work-related determinants of suffering and shifts responsibility onto the sick individual. For example, a worker develops insomnia and muscle tension from excessive shifts and only receives anxiolytic medication. Once symptoms improve, they continue to accept long hours without question, internalising that the problem is a personal inability to "manage stress," rather than recognising overwork as the source of their distress.

Inverse Care Law

As in other health areas, mental health management in healthcare services could be subject to the Inverse Care Law, which states: "*The availability of good medical care tends to vary inversely with the needs of the population served. This law is most pronounced where medical care is exposed to market forces and less so where exposure is lower*" (Hart, 1971). Studies have examined primary care professionals' attitudes toward patients with depression according to the socio-economic status of their patient panels: professionals in affluent areas viewed depression as a treatable disease and a rewarding task, whereas those in deprived areas saw it as an environmental problem and therefore difficult to address (Chew-Graham et al., 2002). Some professionals re-

ported greater reluctance to recognise and act on such cases due to structural factors perceived as less manageable within the consultation.

In the workplace, the Inverse Care Law manifests when workers in more precarious jobs have more difficulty accessing quality psychosocial interventions. Similarly to primary care, workers in vulnerable settings may receive less clinical and preventive support despite higher stress levels and risk of mental disorders. This reinforces inequality: better-organised, well-resourced care (both healthcare and employer-provided) concentrates in higher socio-economic workplaces, while high-risk work environments face fewer resources. This pattern penalises those most in need and perpetuates the subjectivation of distress: by not recognising it as a structural problem, work-related stress is seen as an individual responsibility, hindering collective action to improve working conditions.

1.2.4. Work, health and disability

People with disabilities are particularly vulnerable to labour market inequalities and are under-represented in the labour market. This results in exclusion from paid work, increased precariousness, or disproportionate access to jobs with insufficient wages and lower social recognition.

The report "Employment of People with Disabilities", published by the Spanish National Statistics Institute (INE) and corresponding to the year 2022 (Instituto Nacional de Estadística, 2023), highlights the difficulties in accessing the labour market. The activity rate of people with disabilities stands at 35.3%, that is, 42.7 points lower than that of the population without disabilities; the overall employment rate among people with disabilities is 27.8%. Within this group, the same gender gap observed in the general population is reproduced, with women with disabilities having less active participation in the labour market than men: 34% versus 36.3%.

The report also notes that people with psychosocial disabilities occupy the second-lowest position in terms of employment rate within the disability spectrum. The employment rate of people diagnosed with mental health conditions increased by 1.2 points compared to the previous year (2021), rising from 17.7% to 18.9%.

Other characteristics of the jobs most often accessed by people with disabilities include part-time work and a wage gap compared to other workers. In Spain, according to the Observatorio sobre Discapacidad y Mercado de Trabajo (Disability and Labour Market Observatory) of Fundación ONCE (Fundación ONCE, 2024), people with disabilities have higher rates of part-time employment (17.8%) than people without disabilities (13.8%). And, according to INE data, the gross annual salary of employees with disabilities is 16.1% lower than that of employees without disabilities (United Nations, 2006).

Disability has historically been understood as a condition or trait of the individual derived from the existence of certain impairments or anomalies of an individual nature. As a result, society has deployed measures and actions aimed at cure, rehabilitation, and normalisation. In this way, existing limitations on participation in social life (in the labour market, in this case) were understood as a necessary consequence of the aforementioned impairments or anomalies. This interpretation, and its consequences, accepted and justified what the current rights-based approach regards as discrimination and violations.

The Convention on the Rights of Persons with Disabilities (Romero, 2023) (adopted in 2006 and ratified by Spain in 2008) is a binding legal instrument that breaks with the idea that persons with disabilities merely need protection, treatment, and care, recognising them instead as rights-holders. The text states that "attitudinal and environmental barriers hinder their full and effective participation in society on an equal basis with others." This pursuit of equality also includes "the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that are open, inclusive and accessible to persons with disabilities." The States Parties to the Convention are obliged to safeguard and promote the exercise of the right to work, and this must be done not through charitable or welfare-based approaches, but by demanding openness, inclusion, and non-discrimination in the labour market. To address the high unemployment rate and low activity rate, it is necessary to "implement anti-discrimination policies, including tools such as mandatory compliance with accessibility requirements, reasonable accommodations, affirmative action measures, and the quality of sheltered employment" (Romero, 2023).

The rights-based approach plays an especially relevant role in the relationship between the labour market and psychosocial disability. The strong stigmatisation that has characterised mental health problems in our society has led both to systemic discrimination and to the internalisation of stigma itself. Welfare-based approaches have overlooked crucial issues such as non-segregation and the need for work to have a meaningful dimension beyond simply employing people who face difficulties accessing the labour market. People with psychosocial disabilities also need dignified and meaningful jobs; indeed, these are a crucial part of recovery processes and, therefore, key to preventing chronicity (WHO & ILO, 2022).

1.3. Executive summary and conceptual framework

Throughout this chapter, the key concepts of work, health, mental health, and mental health problems have been defined, highlighting work as a key social determinant of health with salutogenic potential when carried out under favourable conditions. The most relevant evidence has also been synthesised on how the interaction of adverse factors can negatively affect the mental health of the working population, thus establishing a solid conceptual basis for the design of policies and institutional strategies aimed at promoting healthy work environments.

The conceptual model presented (Figure 2) integrates the main actors, policies, social determinants, and structural causes underlying the relationship between work and mental health. It is a structural knowledge framework that, drawing on the best available scientific evidence and theoretically plausible factors—although in some cases still under-studied—helps to simplify the complexity of these relationships. Its goal is to identify the main pathways of influence and explanatory mechanisms that affect mental health and the inequalities in its distribution. These are not deterministic relationships but dynamic, interrelated, and contingent processes (Havet, Bayart & Bonnel, 201; Benach & Muntaner, 2010; Muntaner et al., 2010).

The model is organised into different levels of analysis that allow for an understanding of how ecological, social and psychobiological factors interact:

1. **Ecological, socio-economic and political conditions** include structural factors such as labour policies, macroeconomic governance, technological development and climate change, which shape the organisation and sustainability of the labour market.

2. **Social position:** includes axes of inequality such as social class, gender, age, ethnicity and migration status, which modulate access to employment opportunities and determine differential levels of exposure to precariousness.

3. **Employment conditions:** refer to the type of employment relationship (permanent, temporary, informal, self-employed, etc.), which are directly linked to economic stability, legal security, and access to labour rights.

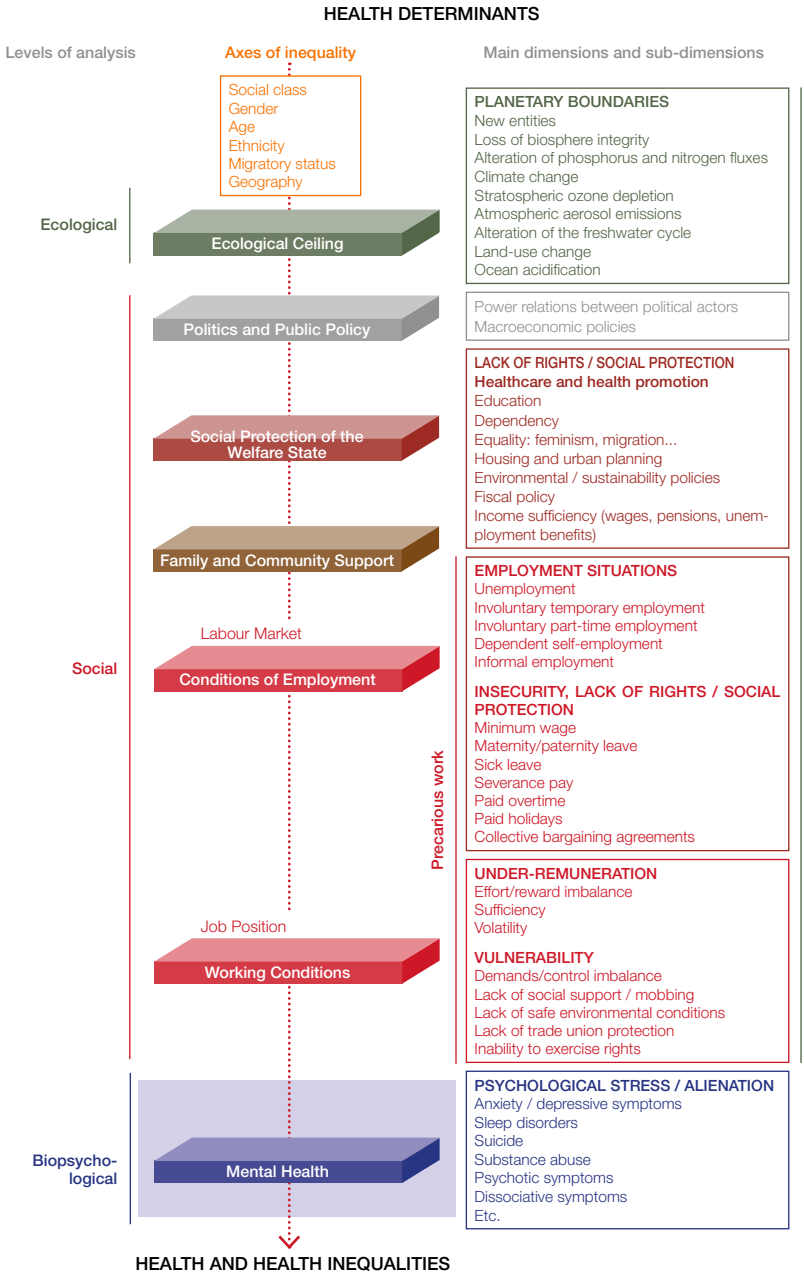
4. **Working conditions:** encompass specific factors of the work environment (physical, chemical, biological, and psychosocial) that directly affect mental health, such as work hours, workplace climate or exposure to risks.

5. **Biopsychological characteristics:** refer to individual vulnerability or resilience in the face of adverse work-related conditions, mediated by biographical, social and contextual factors.

In addition, this framework identifies three main pathways linking precariousness to mental health inequalities: employment trajectory, depending on the stability and type of contract; lack of labour protection, linked to the absence of rights and security; and social precariousness, related to economic insecurity, fragility of the family environment and exclusion from resources.

This structural and eco-social approach underscores the need to intervene in employment and working conditions and public policies, going beyond approaches focused solely on the individual or clinical responses. Finally, the model incorporates the ecological dimension, recognising that mental health also depends on respecting planetary boundaries, which are essential to ensuring healthy, sustainable, and dignified lives for both present and future generations.

Figure 2. **Theoretical conceptual model of the relationship between work and mental health**



Source: created by the author based on Benach et al., (2023)

Main concepts

- **Work.** A set of human activities, paid or unpaid, that produce goods or services in an economy, satisfy community needs or provide livelihood means for individuals. It is a key social determinant of health that structures time, identity and subjectivity.
- **Health.** According to WHO (1948), a "state of complete physical, mental and social well-being and not merely the absence of disease." Operationally, health can also be understood as the "ability to adapt and take care of oneself."
- **Mental health.** A state of well-being that allows individuals to cope with life stress, develop capacities, learn, work effectively and contribute to the community; beyond the mere absence of disorder, it is a resource for adaptation and self-care.
- **Comprehensive precariousness** A multidimensional model including three interrelated spheres: 1) job precariousness: conditions of the workplace (intensity, demands, risks, etc.); 2) precarious employment: contractual instability and legal insecurity; and 3) social precariousness: economic, family and community difficulties that limit autonomy and social rights.
- **Mental disorder.** A clinical entity coded in the International Classification of Diseases (e.g., anxiety, depressive, psychotic disorders) that meets formal diagnostic criteria.
- **Mental health problems.** A broader concept that includes the continuum between suffering and pathology: encompassing subclinical situations and conditions not coded as disease in diagnostic manuals.
- **Suffering.** A psychological and physical response, generally adaptive, to adverse work-related demands. It is not equivalent to illness but can act as a warning signal against harmful conditions.
- **Productive work.** Paid activity regulated by the labour market and its laws, oriented toward producing goods, services and social recognition.
- **Reproductive work.** Unpaid activities aimed at sustaining daily life, such as caregiving, domestic tasks or household management. Beyond sustaining life, this work imposes an additional psychosocial burden that limits autonomy, available time, and the equitable participation of women in public and labour spheres.
- **Iatrogenesis.** Harm resulting from the healthcare intervention itself. In occupational mental health, it can occur when only symptoms are treated without addressing the structural conditions that cause them, reinforcing tolerance to harmful conditions.
- **Inverse care law.** A principle stating that the availability of healthcare tends to be lower where needs are greater. In occupational mental health, it manifests as people in more precarious work environments having more difficulty accessing clinical and preventive resources.

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2. Psychosocial risks at work: models, evidence and strategies for intervention

2.1. Psychosocial occupational risks and mental health

The European Agency for Safety and Health at Work defines psychosocial risks at work as occupational risks arising from inadequacies in the design, organisation and management of work (EU-OSHA, 2024). At present, the evidence on health problems attributable to work-related psychosocial risks is very extensive and of high scientific quality, as it is based on longitudinal research and large databases that reliably rule out chance (Kivimäki M. et al. 2019). Examples include systematic literature reviews and meta-analyses associating psychosocial occupational risks with prevalent health problems such as anxiety and depression (Harvey SB, et al. 2017), myocardial infarction or stroke (Taouk Y. et al. 2020). In this regard, these risks are also considered one of the most relevant causes of sick leave (Duchaine CS. et al., 2020), and a link has been established between exposure to psychosocial occupational risks and the consumption of psychotropic drugs and analgesics (Milner A. et al., 2019).

2.1.1. Explanatory models

In the field of occupational epidemiology, since Selye's work in the late 1930s, various explanatory models have been developed to understand the relationship between psychosocial occupational risks and health (Kompier, 2002; Rugulies, 2019). Of these, the demand-control-social support model (Johnson & Hall, 1988; Karasek, 1979) and the effort-reward imbalance model (Siegrist, 1996) have been the most widely used to demonstrate their harmful effects, concentrating the strongest scientific evidence internationally (Gilbert-Ouimet, Trudel, Brisson, Milot & Vézina, 2014; Niedhammer, Bertrais & Witt, 2021). This explains their use in this section, which is framed within the social determinants of health, specifically in the occupational domain (CSDH, 2008; Donkin et al., 2014).

The *Demand-Control-Social Support* (DCS) model (INSST: NTP 603) originated and developed in a social and scientific context in Europe and the U.S., characterized by radical critique of Taylorism's core features (separation between design and execution, task fragmentation, and standardisation of execution work). These features were seen as sources of alienation, loss of both individual and collective bargaining power, and deteriorated health due to psychosocial and ergonomic risks. This model aligns with social movements advocating for improved working conditions, the humanisation of work, and industrial democratisation (Johnson, 2008). The *effort-reward imbalance* (ERI) model was formulated in a neoliberal context, marked by

flexibilisation and precarisation of working conditions, and was less rooted in social claims. Its focus is on threats to job continuity and compensation (Kompier, 2002).

Though distinct, these conceptually related models allow differentiation of four major groups of psychosocial occupational risk factors:

- Work demands *(demand* in the DCS or *effort* in the ERI): in both models, this refers to quantitative aspects, particularly workload relative to available time and work pace. The most studied health risk is excess—*high quantitative demands and high work pace.*
- Job control (specific component of the DCS model): includes two sub-dimensions, on the one hand, the scope of influence that the worker has on decisions in everyday work life *(decision authority*), and on the other hand, the possibilities of applying skills and knowledge and acquiring new ones in the performance of work *(skill discretion*); the health risk is by default the low influence and the low possibilities of development in the performance of work.
- Social support (specific component of the DCS-*social support* model): refers to both the structural aspect or the possibility of social relationships at work, and the functional aspect of relationships at work, i.e. receiving or not receiving the necessary help, both from colleagues and superiors, to perform the job properly. The risk to health is the absence or scarcity, or lack thereof, in other words, isolation and *low instrumental support*, both from superiors and peers, the latter, the functional aspect, being the most studied.
- Work-related rewards (specific component of the *ERI-reward* model): includes pay (fair), esteem (recognition), stability of employment and working conditions and career (status control). Again, the risk arises from absence or insufficiency (*low compensation*).

Scientifically, these risks have been studied both separately (as assessed in companies and institutions) and jointly. In fact, more recently, the *demand-resource* model has been added to the research (Bakker and Demeroutti, 2007; INSST: NTP 1166), which brings together in these two concepts the dimensions mentioned in the two previous constructs. Job demands are physical, psychological, social and/or organisational aspects requiring physical and/or mental effort from the worker. Work resources, on the other hand, are the physical, psychological, social and/or organisational aspects that favour the achievement of work objectives and promote personal growth and development.

However, these models do not cover the full spectrum of psychosocial occupational risks known today. From a gender perspective, significant gaps remain, particularly regarding emotional demands and work-family conflict.

Emotional demands are those required in order not to become involved in the emotional situation arising from the interpersonal relationships involved in the work, especially in those occupations in which services are provided to people and which may involve the transfer of feelings and emotions, e.g. in circumstances of suffering and trauma. Dealing with such situations requires expressing emotions that are sometimes not genuinely felt. The health risk is the situation of excess (Vanroelen, Levecque, Moors, Gadeyne & Louckx, 2009; Zapf, Seifert, Schmutte, Mertini & Holz, 2001).

Work-family conflict, the conceptualisation of which as a psychosocial occu-

pational hazard is fairly new, deals with the possible consequences of employment in care work in households. On the one hand, it takes into account the increase in overall work demands and total working hours (double workload). On the other hand, it considers the need to organize and manage demands from both domains, which may be simultaneous (double presence). Both double workload and synchronous demands have been shown to create conflicts of time and energy for salaried workers—primarily women, given the unequal gender distribution of domestic and family tasks—affecting their health and well-being (Lunau, Bambra, Eikemo, Van Der Wel & Dragano, 2014; Cooklin et al., 2016; Mortensen et al., 2018; INSST: NTP 1185 and 1186).

Other psychosocial work risks not addressed by these two models concern lack of justice, distinguishing distributive, procedural and relational aspects that may affect workers' health (Virtanen et al., 2018).

2.1.2. Summary of the evidence on mental health harms from psychosocial work risks

Mental health disorders have multiple origins and are multifactorial, meaning intervention is possible in several domains to prevent them. One such domain is the design, organisation, and management of work, along with employment regulation. Work is not neutral for health: it can serve as a protective and enriching factor for mental health, providing opportunities for professional and personal development and for economic independence in our market-driven world (Dejours, 2009). Nevertheless, certain working conditions negatively affect workers' mental health. Specifically, those known as psychosocial occupational risks, which the WHO already in 2008 identified as social determinants of workers' mental health (CSDH, 2008; Donkin et al., 2014).

Based on the two most recent meta-reviews and meta-analyses in the scientific literature (Niedhammer et al., 2021; Rugulies et al., 2023)—which can be considered summaries of the past 20 years of research on the link between psychosocial occupational risks and anxiety-depressive disorders—and selecting only results from the highest-quality studies, the following conclusions can be drawn:

- being exposed to working conditions characterised by *high stress*, i.e. *high quantitative demands* (having more workload than can be performed during the working day, which means either working at high speed, at a high pace, or working longer hours) and low opportunities for influence (low autonomy in performing the work) and low possibilities to apply skills and knowledge and to acquire new ones in performing the tasks (both aspects conceptualised as *under control*) increases the likelihood of suffering from depression by 77%;
- if exposed to *high insecurity* (worries about job loss and changes in working conditions), the chances of suffering from depressive disorders increase by 61% and up to 77% of suffering from anxiety disorders and up to 30% of using psychotropic drugs;
- If you are exposed to *high quantitative demands and low compensation*, the chances of depression could increase by up to 66%;
- if exposed to *violence or threats*, the chances of suffering from depression increase by 42% and the chances of suffering from sleep disorders by 49%;

- if you are exposed to *work-family conflict*, the chances of using psychotropic drugs increase by 26%;
- *high quantitative demands* increase the likelihood of depression by 23% and the likelihood of psychotropic use by 16%;
- *high emotional demands* increase the likelihood of depression by 21%;
- *low control* over work (low influence and low possibilities to apply new knowledge and learn) increases the likelihood of depression by 25%;
- *low peer support* increases the likelihood of depression by 37% and *low support from superiors* increases the likelihood of depression by 33%;
- long working hours (≥55h/week) increase the likelihood of depression by 14%.

2.1.3. Exposure inequalities

Numerous studies using the *demand-control-social support and effort-reward* models have considered the social characteristics of the working population, showing significant inequalities in exposure to psychosocial work and health risks based on occupational class or gender (Landsbergis, Grzywacz & LaMontagne, 2014), in line with a segmented labour market resulting from the unequal implementation of corporate labour management practices (Rubery, 2007). Thus, wage earners in performing positions (semi-skilled and unskilled in industrial, agricultural or service activities) are more exposed to psychosocial occupational risks related to low levels of *control*, *support* and *compensation* than those in technical and professional positions. The most pronounced occupational inequalities in exposure are those related to low *control*, which contribute most to health inequalities (Schütte, Chastang, Parent-Thirion, Vermeylen & Niedhammer, 2015).

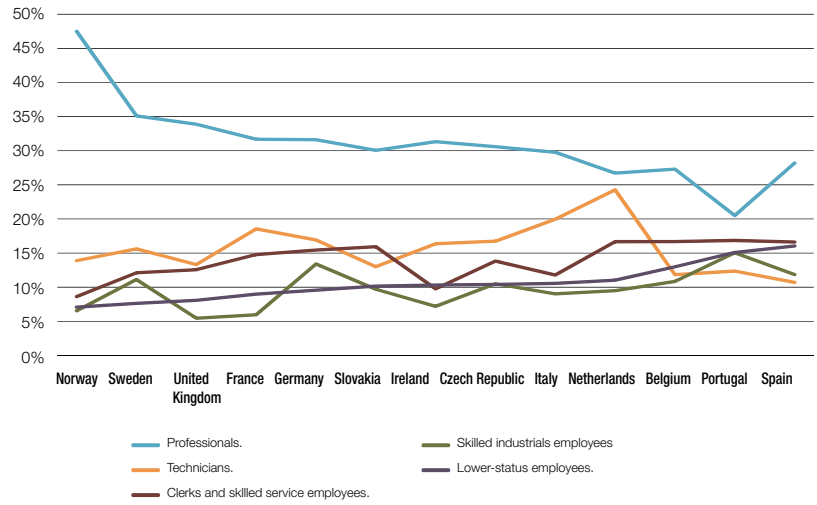
Recent studies on the evolution of psychosocial risks at work in the EU, the US and Spain have found that inequalities by occupational group persist over time. Taking into account data from the European Working Conditions Survey (EWCS) from 1995 to 2015, salaried workers in performing jobs (semi-skilled and unskilled in industrial, agricultural or service activities) were not only more prevalently exposed to *high stress* (high demands and low control) and *effort-reward imbalance*, but also experienced a more pronounced increase in high stress than salaried workers in professional and technical jobs during that period. The persistence of low control in performance jobs over the twenty years studied was characterised by a decrease in the possibilities of applying skills and knowledge and acquiring new ones during work performance and an invariably low influence on decisions about how to perform the work (Rigó et al., 2021).

In Spain, exposure to psychosocial work risks is also characterised by persistent low control—with one of the highest prevalence rates in the EU and the most unequal by occupational group—alongside high job insecurity and low social support (Eurofound, 2019). All of these are characteristics of precarious work. According to one of the most recent prevalence studies published (Utzet, Llorens, Moriña & Moncada, 2021), before the pandemic, in 2016 in Spain, exposure to low control covered 63% of workers in executive positions, high job *insecurity* 53.6% and low *support* 49% compared to 28%, 36.7% and 31% respectively among workers in professional and technical positions, showing significant exposure inequalities. No significant differences were observed between men and women in these dimensions of psychosocial risks.

In terms of gender inequalities, women would be more exposed to job insecurity and low control and men to low *social support* and *effort-reward* imbalance, according to the most recent systematic literature review (Campos-Serna et al., 2013). Yet, based on its findings, the research on inequalities in exposure between men and women is inconsistent; even today, almost a decade later, it remains so. Subsequent studies show greater exposure of women to *effort-reward* imbalance (Johannessen & Sterud, 2017) or *high demands* (Sterud, 2014) or only find differences in managerial positions (Nyberg, Leineweber & Magnusson Hanson, 2015). One possible explanation may be that gender inequalities are usually studied by cross-referencing data by sex and are overlooked among the important occupational class inequalities. Gender inequalities are more visible when data are shown by occupation and a higher prevalence is observed among occupations that are an extension of reproductive work and others that are largely feminised (kitchen assistants, fast food preparers, geriatric care workers, workers in food and commodity shops, cleaners...), evidencing class and gender inequalities and the vertical and horizontal segregation of men and women in the labour market (Llorens-Serrano C., Navarro A., Salas-Nicás S. & Moncada S., 2021). It should be added that if *emotional demands* or *work-family conflict* are studied, instead of focusing on the dimensions of the DCS and ERI models, the picture is different, with inequalities between men and women being more visible. Similarly, although age may highlight important inequalities in exposure, the scientific evidence regarding mental health disorders is inconclusive (Van Veen et al., 2023). However, it should be noted that, as in other areas, inequalities and discrimination are under-studied in the field of psychosocial risk prevention in the workplace, both in terms of class, gender, age or migrant/racial status in particular, and with more gaps if we refer to an intersectional approach (Valero, Martin, Bacigalupe & Utzet, 2021).

All this evidence points to the idea that the design, management and organisation of work, and by extension production patterns, are a risk factor for mental health disorders in workers. Spain is one of the EU countries with the highest incidence of mental disorders and, in view of the evidence analysed, this may have something to do with the production model. Despite the recent reforms implemented by the Ministry of Labour and Social Economy of the Government of Spain, aimed at stabilisation and quality employment, Spain is characterized by the creation of low-skilled jobs (Figure 3) with precarious working conditions, in a context of "low-road" competition. In this productive model, part of the business sector achieves profitability by increasing workload, intensification, and precarisation of work (low wages, long hours, low skills, and low added value of products or services), as opposed to a model centred on improving efficiency through innovation and development to increase labour productivity. In principle, from a business point of view, both routes are equally profitable, but one is more harmful to the health of workers than the other.

Figure 3. Distribution of employees by socio-occupational groups in different European countries



Source: Created by the authors based on data from the European Working Conditions and Quality of Life Survey, EWCS 2021.

2.2. How to intervene in workplaces

From this type of evidence, it can be reliably established that among the social causes of mental health disorders is exposure to psychosocial risks at work, defined at the European level as risks arising from inadequacies in the design, organisation and management of work (EU-OSHA, 2024). In other words, these are risks that are avoidable or modifiable, by changing the organisational deficiencies that cause them or that can mitigate them, in compliance with a law that, in Spain, is almost 30 years old (Art. 4.7d and 15 of Ley 31/1995 de prevención de riesgos laborales (Law 31/1995 on occupational risk prevention), 1995).

In accordance with current labour legislation, companies and institutions should avoid psychosocial risks at work, assess those that cannot be avoided and prevent them at source, thus avoiding damage to health derived from work.

The objective of the preventive management of psychosocial working conditions is the elimination of the risk arising from these working conditions or, where elimination is not possible, their reduction to tolerable limits, through the assessment, intervention and control of psychosocial risk factors.

Psychosocial occupational risk assessment includes the identification of psychosocial risk factors present in the workplace and the estimation of the magnitude and extent of exposure. With this information, the level of risk to which workers are exposed will be determined and preventive and/or protective measures will be established, where appropriate, with priority criteria and subject to planning, as set out in the regulations on the prevention of occupational risks.

The assessment of psychosocial risks requires the planning of fieldwork and the choice of participatory methodologies and tools, both quantitative, such as the use of questionnaires (for example, the most widely used in our country are the FPSICO Psychosocial Risk Assessment method or the COPSOQ-ISTAS21 psychosocial risk assessment and prevention method, PSQCAT), and qualitative, such as interviews or focus groups.

The consultation and active participation of the working population and their representatives in this process and the consideration of contextual variables allow for a better adaptation of preventive measures to the specific needs of each organisation, company or institution.

Psychosocial intervention consists of defining, planning, implementing and monitoring specific preventive actions aimed at eliminating, reducing and/or controlling exposure to psychosocial risks at work. These measures should focus on working conditions as a priority. As in the assessment, the consultation and active participation of the working population and their representatives in this phase of preventive management is essential.

It should not be forgotten that, after the intervention, it is necessary to control and monitor the preventive measures implemented. The monitoring of the preventive action plan involves checking both the form (implementation of the planned plan) and the content (effectiveness of the measures on the basis of a new evaluation). This requires regular monitoring through indicators, which can be quantitative and qualitative. For more information on psychosocial management, it is recommended to read the document "Directrices Básicas para la gestión de riesgos psicosociales" (Basic guidelines for the management of psychosocial risks) (INSST, 2022).

This approach is promoted by the ILO and WHO in their joint guidance document on mental health at work, which states that the first step in addressing mental health at work is to prevent psychosocial risks at work: to assess the risks and reduce them at source, through organisational interventions that directly modify the employment and working conditions that are known to make workers ill (WHO & ILO, 2022).

This position is also maintained in the WHO global report on mental health 2022, in which workplace action is considered one of the three priorities for intervention to improve mental health, targeting changes in working conditions through organisational interventions that reduce psychosocial risks at work (WHO, 2022).

Moreover, this approach would facilitate the return to work after a period of sick leave due to mental disorder and prevent relapses, once the worker is cured, as he/she would return to a work environment where the employment and working conditions that could make him/her ill have changed. Thus, the main issue for the workplace is to ensure healthy working conditions. The employer's obligation to protect the safety and health of workers by acting on risks at source, changing deficiencies in work management to prevent or reduce psychosocial occupational risks and thus reduce the likelihood of mental disorders in the workplace.

Also the prolific and robust research on psychosocial work and health risks points to interventions at the organisational level, changing corporate work management practices, as actions aimed at minimising occupational health problems in the workplace and with it, public health problems and associated inequalities. Most research agrees in recommending organisational interventions (Schnall, Dobson & Landsbergis, 2016; Theorell et al., 2015).

This is also required by law in all European countries, including Spain, where the legal framework (Framework Directive 89/391/EEC; Law 31/1995 on occupational risk prevention) prioritises preventive actions at source, changing the organisation of work, in

order to reduce occupational risks, including psychosocial risks, as a step towards reducing pathologies associated with working conditions. This legal framework also requires adapting work to the individual through organisational changes, specifically in job design, choice of equipment, and working and production methods, in order to avoid, in particular, monotonous and repetitive work. It is likely that if this legal framework were developed today, this requirement for prevention at source and adaptation of work to the individual would include many more aspects of labour management practices.

The law also empowers the collective representation of workers by recognising their right to information, prior consultation and proposal on any issue that may affect the safety and health of workers, including, but not limited to, technology, work organisation or production (Art. 33, 34, 36, 14 LPRL). And in the event of a company's rejection of the proposals of the workers' representatives, the employer is obliged to give reasons for this ("reasoned refusal"). The participation of workers is not only a legal requirement, but also a methodological and operational requirement, since prevention is a socio-technical process. Scientific-technical and experiential knowledge are complementary and necessary in the process of preventive intervention. Furthermore, the active involvement of workers and their representatives, as well as the management of the company, is necessary if effective prevention is to be achieved, as they have the ultimate power to make decisions and take action within the company. Likewise, the persons negotiating collective agreements, which regulate working conditions in the various sectors and companies, under Articles 3 and 4 and Title III of the Estatuto de los Trabajadores (Workers' Statute – ET), can address and agree on all matters deemed appropriate in this respect.

To sum up, from the point of view of occupational health in the company environment, psychosocial risks are inadequate working conditions and immediate causes of possible health disorders, but the origin of these risks is to be found in work management practices. In the field of occupational risk prevention, psychosocial risks are identified as exposure to harmful working conditions that must be detected, located and quantified through risk assessment in the company. These exposures are rooted in organisational work management practices, on which it is possible, and necessary, to intervene to reduce the burden of psychosocial risk factors. Finally, the disorders and diseases resulting from these conditions represent the impact that preventive action aims to avoid (Moncada & Llorens, 2014).

Research to date suggests that various aspects of work management practices, such as the amount, arrangement and modification of working time, work methods, job design, employment relationship, number of staff or wage structure, are modifiable job characteristics that are at the origin of psychosocial work exposures and at the core of their reduction (Montano, Hoven & Siegrist, 2014; Roquelaure, 2018; Schnall et al., 2016). The employer's obligation to achieve the reduction of occupational risks through the implementation of appropriate measures to address identified psychosocial occupational risks could include:

- improving technology and processes for the production of goods and services and increasing the workforce to reduce demands;
- ensure that the organisation of working time is compatible with reproductive work;
- encourage the use of participatory and cooperative working methods to avoid lack of influence and increase functional support among colleagues and from superiors;
- the establishment of fair recruitment, assignment, training and promotion procedures in order to improve the quality of leadership;

- the design of enriched tasks to make it possible to apply skills and knowledge and to learn new ones; promoting stability in employment and working conditions and predictability in changes, which need to be reasoned and reasonable, to avoid job insecurity;
- and an adequate living wage in accordance with applicable legislation, social dialogue and collective agreements.

All these measures would contribute to the protection of mental health.

However, there are gaps in academic research on the relationship between corporate labour management practices and psychosocial risks, and there is a vast field to investigate the specific characteristics of healthy corporate labour management practices (La Montagne, Keegel, Louie, Ostry & Landsbergis, 2007; MacDonald, Härenstam, Warren & Punnett, 2008; Rugulies, 2019). In the same vein, the WHO recently warned of the need to strengthen research on organisational interventions against psychosocial work hazards to reduce mental health problems (WHO, 2022).

This approach to the necessary changes in labour management practices to reduce exposure to psychosocial risks at work, from the point of view of prevention at source of occupational risks, is in line with the approaches to working conditions of segmentation theory, contrasted from the sociology of work or labour economics. From this perspective, business labour management practices are understood as a set of firm-level actions that aim to recruit, promote, reward, use, develop and retain or dismiss workers (e.g. work process design, working hours, recruitment, wages). Corporate labour management practices are the result of management strategies used to achieve workforce flexibility, availability, productivity and profitability. From this theoretical perspective, business practices in labour management are influenced by the economic, institutional and social context (macro-level characteristics, which determine the correlation of forces between capital and labour, the distribution of power) and, in turn, are key factors in shaping the scenarios of these contexts. Moreover, corporate labour management practices vary according to occupation, gender, age or ethnicity, using, reproducing and reinforcing social inequalities.

From this theoretical perspective, corporate labour management practices determine employment and working conditions and thus psychosocial occupational risks and mental health (Llorens et al, 2010).

The management of psychosocial occupational risks in the Spanish business world is very disparate, starting from the fact that the prevention of these risks is the least implemented preventive speciality in companies, institutions and organisations, despite the legal obligation to do so. In this sense, the management of psychosocial occupational risks varies depending on who carries it out: external prevention services (EPS), own prevention services (OPS) or joint prevention services (JPS). Medium and large companies with OPS, health and safety committees (HSC) and prevention delegates (PD) have better integrated occupational risk prevention in general, and this has a positive impact on the management of psychosocial occupational risks.

Generally speaking, there is a profound lack of knowledge about psychosocial occupational risks in the workplace. There are several reasons that may justify this situation and one of them may be the fact that they do not have a specific regulatory development as occurs with risks of another nature and this leads to psychosocial management not being a priority within preventive management, being relegated to the background, as risks of this nature are considered, due to lack of knowledge, to be of lesser seriousness. It is also important to emphasise that psychosocial labour man-

agement is directly related to organisational conditions which can be understood, without regard to the law, as the exclusive power of the employer, and technical advice in this contested area can be hampered. In this sense, there is an added difficulty in the control of compliance with the legislation regulating this matter, insofar as the Health and Safety Sub-inspection scale of the ITSS lacks competence in this area.

2.3. How to act in the health sector

One of the fundamental problems in occupational mental health care lies in the non-inclusion of mental disorders in the occupational diseases of the Social Security system. As they are not included in this table, their recognition as occupational is only acquired by declaring them as occupational *accidents* or as *non-traumatic pathologies caused by work*, which leads to the enormous under-recognition of these ailments as occupational contingencies.

In the preamble to Royal Decree 1299/2006 of 10 November, which approves the schedule of occupational diseases within the Social Security system and establishes criteria for their notification and registration, we can read that: "*The available information indicates that the shortcomings in the protection of workers affected by these occupational contingencies arise largely not only from the outdated nature of the list of occupational diseases but, more importantly, from deficiencies in their notification, caused by a procedure that has proven inefficient, lacking sufficient involvement of the medical professional responsible for classifying the contingency or of any other professional who may issue a suspected diagnosis*." This certainty led to the inclusion in Article 5 of this Royal Decree of the notification of a suspected occupational disease by the doctors of the National Health System (NHS) and the occupational risk prevention services.

The health system plays a crucial role for people with work-related diseases, especially if there is coordination with the other systems involved and with the social partners, in order to bring hidden occupational diseases to light and to avoid under-reporting of such diseases.

Identifying the relationship between mental disorders and psychosocial occupational risks by primary care and mental health specialists in the health system and prevention services should serve to improve the reporting and recognition of occupational diseases, as well as to strengthen epidemiological surveillance of work-related health damage and occupational risk prevention that cause such damage.

The following section provides tools that aim to make it easier for practitioners to identify exposure to psychosocial risks at work.

2.3.1. Tools for identifying exposure to psychosocial occupational risks in the health system

A comprehensive view of the conceptualisation of psychosocial occupational risks developed so far is the one proposed by the COPSOQ-ISTAS21 method of assessment and prevention of psychosocial risks, PSQCAT (Burr et al., 2019; Kristensen et al., 2010; Moncada i Lluís, Llorens Serrano, Salas Nicás, Moriña Soler & Navarro Giné, 2021).

It is an international instrument that among its tools proposes a questionnaire adapted and validated in the Spanish context with health data, the scales of which could be used in primary care to identify the exposure of employees to psychosocial risks at work.

It originates in an international questionnaire that incorporates scientific knowledge and method, referenced in hundreds of publications in indexed journals. Its conceptual framework is similar to the one presented here, based on scientific evidence of the relationship with health. General health and mental health scales (SF36), among others, were used for its validation internationally and in Spain. Examples of their **questions that could be used for the presumptive diagnosis of a work-related illness** in connection with psychosocial occupational risks for employees would be:

Quantitative requirements		
Definition	**Questions in the questionnaire**	**Origin**
These are the demands arising from the amount of work in relation to the time available. The most obvious unhealthy situation is excess. They are high when we have more work than we can do in the time allotted.	21c) Are you late in delivering your work? 21e) Is the distribution of tasks irregular and causing a backlog of work? 21g) Do you have enough time to do your work? 21o) Do you find it impossible to finish your tasks during your working day?	The risk is associated with understaffing, poor planning, misallocation of tasks or incorrect time measurement, but can also be related to the wage structure (e.g. when the variable part of a low wage is high and forces to take on more of the burden) or inadequate tools, materials or work processes. High quantitative demands can lead to longer working hours or a high pace of work.

Pace of work		
Definition	**Questions in the questionnaire**	**Origin**
This is the requirement relating to the intensity of the work. The most studied health problem is excess.	21a) Do you have to work very fast? 22i) Is the pace of work high throughout the day?	The risk is associated with understaffing, poor planning, misallocation of tasks or incorrect time measurement, but can also be related to the wage structure (e.g. when the variable part of a low wage is high and forces to take on more burden) or inadequate tools, materials or work processes.

Emotional demands		
Definition	**Questions in the questionnaire**	**Origin**
These are the demands of not getting involved in the emotional situation or managing the transfer of feelings, arising from interpersonal relationships, involved in carrying out the work. The problem for health is excess.	21b) Do emotionally draining moments or situations occur in your work? 21p) In your job do you have to deal with other people's personal problems? 22e) Is your work emotionally draining?	In caring, helping, protecting people (and other) occupations, exposure to emotional demands has to do with the nature of the task and cannot be eliminated (we cannot "eliminate" patients, pupils...). Thus, training in the development of management skills and the provision of sufficient time to be able to manage them effectively, together with reducing the time and intensity of exposure (changing hours, ratios, breaks, etc.) are relevant prevention measures. In addition, you may need to set aside time for therapy.

Demands to hide emotions		
Definition	**Questions in the questionnaire**	**Origin**
These are the demands to maintain a neutral appearance regardless of the behaviour of the other people we interact with at work (users, clients, colleagues, suppliers, bosses...). The problem for health is excess.	21d) Does your job require you to keep your opinion to yourself? 21f) Does your job require you to treat everyone equally, even if you don't feel like it? 22f) Does your job require you to hide your emotions? 22g) Are you required at work to be nice to everyone regardless of how they treat you?	In jobs involving the care, assistance and protection of people (and others), these demands are part of the nature of the job and cannot be eliminated. The development of protective coping skills and strategies and the reduction of exposure time are important preventive measures (see emotional demands). In other cases, they may be related to the management policy of providers and clients (for example, with a deficient staff that causes queues of users waiting for attention...) or with the lack of participation of workers (emotions must be hidden when they cannot express their opinion) and, in general, with deficiencies in personnel management policies (when individual competitiveness is encouraged, when tasks are assigned or timetables are changed arbitrarily, etc.).

Work-life conflict		
Definition	**Questions in the questionnaire**	**Origin**
Work-life conflict is about the consequences of the demands of employment on family and personal life. This refers to the need to combine work tasks and times with family and social tasks and times, which can involve excessive and often simultaneous burdens *(double presence*), creating an unfavourable situation for health.	22j) Do you have to change your plans for personal and family activities due to the demands of your job? 21l) Are there times when you would need to be at work and at home at the same time? 21m) Do you feel that your work in the company consumes so much of your energy that it takes away from your domestic and family tasks? 21n) Do you feel that your work in the company takes up so much of your time that it takes away from your domestic and family tasks?	In the area of work, it has to do with staff shortages, the number of hours worked, the asocial organisation of working hours or their modification, and the level of autonomy over working hours, e.g. working hours or working days that are incompatible with caring for dependants.

Influence		
Definition	**Questions in the questionnaire**	**Origin**
It is the margin of autonomy in day-to-day work in general, and also particularly in relation to the tasks to be carried out (the what and how much) and in the way it is carried out (the how). The problem for health is the lack thereof.	21h) Do you have influence over the amount of work assigned to you? 21i) Do you have a lot of influence over decisions affecting your work? 21j) Do you have influence over how you do your work? 21k) Do you have influence over what you do at work?	It has to do with the participation that each worker has in decisions on fundamental aspects of his or her daily work, i.e. with the working methods applied by management in the company and whether or not these are participatory and whether or not they allow or limit autonomy. It may be related to development possibilities.

Development possibilities		
Definition	**Questions in the questionnaire**	**Origin**
They are the opportunities that performing the job offers for workers to apply their knowledge, skills, and experience, as well as to acquire new ones. The problem for health is insufficiency.	22c) Does your job allow you to learn new things? 22d) Does your job give you the opportunity to improve your knowledge and skills? 22h) Does your job allow you to apply your skills and knowledge?	It has to do with levels of involvement and with the complexity and variety of tasks, with simple, standardised and repetitive work being the paradigm of harmful exposure. It is rooted in business practices relating to working methods and the design of work content. It may be related to influence.

Peer social support		
Definition	**Questions in the questionnaire**	**Origin**
It is receiving the necessary help from coworkers in carrying out one's work. The problem for health is insufficiency.	24a) Do you receive help from your colleagues in carrying out your work, if needed? 24b) Are your colleagues willing to listen to your problems at work if you need them? 24c) Do your colleagues talk to you about how you do your work, if needed?	Lack of peer support may have to do with personnel management practices that hinder cooperation and the formation of real working teams. For example, when individual competitiveness is encouraged through variable salaries based on individual targets, or by assigning tasks, changes in working hours, location, etc., in an arbitrary or non-transparent manner. It can also be related to the high pace of work or high quantitative demands that do not allow for support for others.

Social support from superiors		
Definition	**Questions in the questionnaire**	**Origin**
It is receiving the necessary help from immediate supervisors in carrying out one's work. The problem for health is insufficiency.	24g) Is your immediate supervisor willing to listen to your problems at work, if needed? 24h) Do you receive help from your immediate supervisor in carrying out your work, if needed? 24i) Does your immediate supervisor talk with you about how you do your work, if needed?	The lack of support from immediate supervisors is related to the absence of concrete personnel management procedures that promote the supervisor's role as a support element for the team or department they manage, or to a lack of time to implement them. It is also related to unclear directives from management regarding the fulfilment of the support function and to insufficient training for it.

Recognition		
Definition	**Questions in the questionnaire**	**Origin**
It is the fair evaluation and treatment by management at work. The problem for health is its absence.	26a) Is your work valued by management? 26b) Are you treated fairly in your work?	This is related to multiple aspects of personnel management, for example, whether work methods are participatory (without a "voice," there can be no recognition), the presence of arbitrariness and inequity in promotions, task assignments, scheduling…, and whether pay corresponds to the work performed.

Job insecurity		
Definition	**Questions in the questionnaire**	**Origin**
It is the concern about the future regarding one's employment. The problem for health is its existence.	Are you worried about.. 25d) being dismissed or not having your contract renewed? 25f) how difficult it would be to find another job if you became unemployed?	It is related to business practices concerning hiring and the employability opportunities in the local labour market.

Insecurity about working conditions		
Definition	**Questions in the questionnaire**	**Origin**
It is the concern for the future in relation to unwanted changes in fundamental working conditions. The health problem is one of excess.	Are you worried that you might… 25a) be transferred to another workplace, unit, department or section against your will? 25b) have your schedule changed (shift, days of the week, start and end times) against your will? 25c) have your tasks changed against your will? 25e) have your salary reduced (pay cut, introduction of variable pay…)?	It relates to threats of change or worsening of particularly valuable working conditions. These can arise both from the current situation (for example, if the assignment of work hours, tasks, and salary supplements is arbitrary) and from the possibility of future changes (for example, due to corporate restructuring, outsourcing of a position or service, a merger…); especially if there are worse working conditions in the external context of the company/organization (sector, region…). It could also be secondary to job insecurity, so that workers—particularly those with lower employability opportunities—might accept the deterioration of valuable working conditions under the threat of job loss.

Justice		
Definition	**Questions in the questionnaire**	**Origin**
Refers to the extent to which workers are treated fairly at work. The problem for health is its absence.	26e) Are conflicts resolved in a fair manner? 26f) Are you recognised for work well done? 26g) Does management take proposals from all employees equally seriously? 26i) Is the distribution of tasks fair?	It is related to the existence of procedures that can prevent arbitrariness in decision-making.

From other questionnaires and methodologies:

Situations of injustice		
Definition	**Questions in the questionnaire**	**Origin**
The worker experiences unfair work situations in the workplace because he or she is a woman (or man) or because of his or her gender identity.	Has training been offered and not made available to you compared to other colleagues? Do you have experience and qualifications, but have not been considered for promotion on the basis of sex/gender? Have you ever been harassed at work by a superior? Have you been harassed at work by a colleague? Have you ever been sexually harassed or abused by someone in the company, a customer or a supplier? Have your tasks (or those corresponding to your job position) been reduced or withheld without reason? Has your workload been increased compared to other colleagues without reason?	The risk is associated with power dynamics, sexism, or intolerance present in society and, therefore, also in companies.

These questions about psychosocial work risks should be contextualised. It is first necessary to know the profession or job position and the labour management practices applied to workers in the workplace, in addition to sociodemographic data. Some example questions for this, not meant to be exhaustive, used in population surveys (Llorens et al., 2010; Navarro et al., 2024) and clinical history are:

- What is your occupation? What job position do you hold? What tasks do you perform?
- What type of contract do you have with your current company/organisation?
- How long have you been working for this company/organisation in total?
- Regardless of the hours stated in your contract, how many hours per week do you actually work for this company/organisation?
- What are your working hours? Does your schedule include working most mornings and/or afternoons past 5:30 PM? Do you work at night?
- How often are you required to start work earlier or finish later than your scheduled hours?
- Do your working days include weekends or holidays?
- Are you ever not paid or paid late? Is this common?
- How often does your current salary cover the basic needs of your household?
- Do your supervisors usually consult you on how to improve the way you perform your tasks?
- Considering the amount of work you have and the time assigned, would you say your department/section is understaffed?
- Do you have dependents under your care?
- Outside of your paid work, on average, how many hours per week do you spend cooking and performing other household tasks?
- Outside of your paid work, on average, how many hours per week do you spend caring for dependents (children, elderly, or people with disabilities)?
- Sex
- Age
- Gender identity and sexual orientation
- Country of origin
- Length of residence in Spain

It is understood that the healthcare professional may already know some of these aspects, especially the last ones on this non-exhaustive list.

All of the above constitute invaluable tools that can be used during the clinical interview to identify mental disorders caused or worsened by work.

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3. Clinical approach: diagnosis, assessment of suspicion and treatment

3.1. Work-related mental health problems

As numerous national and international studies have shown, psychosocial risks in the work environment have a high incidence and are widely linked to negative effects on the health of workers. These effects can be assessed from three complementary perspectives: self-perceived health, understood as physical, mental and social well-being; functional health, which refers to the ability to perform tasks effectively; and adaptive health, or the degree of adjustment to the work and social environment. The main consequences associated with exposure to psychosocial risks are described below:

- **Physical.** These include gastrointestinal, cardiovascular, respiratory, nervous system, endocrine, muscular, dermatological, immunological and sexual disorders, among others.
- **Psychological.** The most frequent harms are anxiety disorders, depressive disorders and burnout. An increase in sleep disorders and problematic substance use is also observed.
- **Labour.** Presenteeism, temporary and permanent disabilities, and an increase in the potential number of workplace accidents.

According to the WHO (2024), approximately 12 billion workdays are lost globally each year due to work-related mental health problems, resulting in an estimated productivity loss of 1 trillion euros annually. In Europe, work-related stress disorders account for more than 25% of absences of two weeks or longer for work-related health reasons (EU-OSHA, 2024).

In 2024 in Spain, 643,861 procedures for temporary incapacity related to "mental and behavioral disorders" were initiated. That same year, a total of 6,897,615 temporary incapacity cases were recorded. Thus, procedures related to mental health accounted for 9.33% of the total Ministerio de Inclusión, Seguridad Social y Migraciones (Ministry of Inclusion, Social Security, and Migration, 2025).

In the study "Update of the fractions of cardiovascular diseases and mental disorders attributable to psychosocial work factors in Europe" (Niedhammer et al., 2022), the fractions of mental disorders attributable to psychosocial work factors in Europe were updated. It found that eliminating these exposures in the European Union would reduce the burden of depression by 17-35%, and in Spain, depression would decrease by 8.63% by reducing high work stress and by 13.44% by reducing high job insecurity.

A study conducted in Spain analysing episodes causing sick leave in 2010 (with a study population of 971,580 affiliates) estimated that the fraction of mental disorders attributable to occupational risk factors was 10.8% (13.14% for men and 8.29% for women), with different values depending on the type of disorder (García Gómez M,

Castañeda R, Urbanos R, de la Cruz O, López P, 2011).

Research by Pérez Zapata and Álvarez Hernández (Pérez Zapata and Álvarez Hernández, 2021) concluded that adequate employment/working conditions could reduce the incidence of poor mental health among female and male workers by 60 and 80 per cent, respectively.

Women and young people (ages 16-35) accumulate the highest number of mental health-related absences. The most affected sectors in 2024 were health and social work activities, commerce, hotels and restaurants, administrative activities, manufacturing and education. Mental health-related absences had an average duration of 108 days, making them the third-longest, after absences due to tumours and circulatory diseases (Mental health-related absences had an average duration of 108 days, making them the third-longest, after absences due to tumours and circulatory diseases (Ministerio de Inclusión, Seguridad Social y Migraciones [Ministry of Inclusion, Social Security and Migration], 2025).

In this context, the International Labour Organization (ILO, 2002), in its list of occupational diseases (Recommendation 194), calls for the commitment of States to recognise mental disorders arising from work whenever there is a link between the disease and the work. In our current regulatory framework, as will be developed in the following chapter, Article 157 of the Ley General de la Seguridad Social (General Law on Social Security) (Royal Legislative Decree 8/2015) defines the concept of occupational disease as any disease contracted as a result of work that is also included in the list of occupational diseases approved by Royal Decree 1299/2006. There are no references to mental disorders in the current list of occupational diseases.

In this sense, the lack of administrative recognition of the damage that working conditions can cause to mental health contributes to undermining the potential of the preventive field. Moreover, their care is channelled through the health system, which does not result in any improvement in the working environment, even though this would have been its origin.

Currently, patients presenting with work-related mental health disorders are seen within the health system, but these disorders are neither reported by clinicians nor investigated by occupational health units. The lack of administrative recognition, and the difficulties in reporting mental disorders as occupational diseases, leads to a lack of attention in the investigation of the occupational causes of these disorders, and as a consequence, an underestimation of the problem by clinicians and administrations.

In a context where the number of patients attending primary care and mental health services has increased significantly, and where, as evidence suggests, work-related causes would be a significant factor, identifying which disorders could be solved by changing working conditions is imperative. Unlike other clinical cases where professionals can intervene in contexts such as the family or school environment, there are currently no coordinated interventions to address work-related problems in patients with work-related disorders. This lack of coordination prevents integrated action on the root cause of the discomfort, which hinders clinical recovery. As a result, symptoms tend to be prolonged and often result in longer and more costly temporary incapacity for work than necessary.

This situation generates great frustration for patients, as they do not perceive a significant improvement in their health because they are unable to intervene at the root of the problem. They often feel guilty about their symptoms, while the root cause -the work environment- remains unaddressed.

Work-related psychopathology

Any clinical manifestation or mental disorder may appear related to discomfort or distress at work. From stress-related adaptive anxiety reactions, adaptive, anxious, mood, substance addiction or behavioural disorders, to conditions traditionally considered more severe such as psychosis or post-traumatic stress disorder. A distinction should be made between conditions that appear for the first time and make their debut in the work environment or those disorders that workers already suffer from and are aggravated by work-related stressors.

As discussed in the second section of this paper, there is abundant evidence linking psychosocial risk factors at work with certain mental health diagnoses. Certain work contexts generate significant harm to individuals. It is therefore essential that these cases are properly diagnosed, reported and investigated. While in the mental health field it is not always straightforward to identify psychosocial risk factors as the direct cause of a disorder, clinicians may be suspicious when certain symptoms or disorders are directly related to the person's work context, overcoming structural and biographical vulnerabilities or strengths.

Primary, secondary and tertiary prevention, together with health promotion measures in the workplace, will enable the development of occupational mental health through early diagnosis and effective treatment of the various disorders and their related work-related aspects.

3.2. Clinical assessment

In case the medical professional suspects a mental health problem of work-related origin, the steps to be taken are as follows:

1. Detection of mental health disorders
2. Assessment of suspicion of occupational origin
3. Reporting of suspicion

3.2.1. Detection of mental health disorders

In the course of their activity, the doctor will be able to establish the presence of a Mental Disorder by means of their usual tool, the Clinical History. On this basis, a diagnosis can be made in accordance with the criteria in force in our regulatory framewor: the International Classification of Diseases. The electronic edition of the ICD is available at this link: https://www.eciemaps.sanidad.gob.es/browser/metabuscador

The clinical interview

In order to establish a proper diagnosis, the fundamental tool is the clinical interview. The semi-structured modality -combining open-ended questions with a guided script- is often the most appropriate, as it allows for systematic exploration without losing the spontaneity of the account. It should take place in a climate of trust, in a friendly and unhurried style, which facilitates the expression of discomfort.

A rigorous anamnesis is essential, and includes ruling out possible medical, toxic or pharmacological causes that may explain the symptoms. It is necessary to

collect detailed information on the characteristics of the symptoms, their intensity, duration, evolution and possible triggers, including those of occupational origin. This assessment will subsequently enable the formulation of an individualised therapeutic plan, adapted both to the clinical situation and to the characteristics and preferences of the person being treated.

In Table 1 we develop a semi-structured clinical interview structure that can help to understand the phases, the tasks of each phase and the tools to be used.

Table 1. Phases of the clinical interview

Phase	Goals	Clinical tasks	Specific exploration of the work context
1. Empathetic listening.	To understanding the reason for the consultation and the patient's discomfort, encouraging free expression.	- Listening without interrupting. - Recording symptoms, emotions and explanations given by the patient for their discomfort. - Identifying first causal attributions.	- Care for the patient mentions work spontaneously: conflicts, stress, workload or recent changes.
2. Targeted anamnesis.	To delve into related biographical, medical, social and occupational factors.	- Screening for other causes: medical illnesses, substance use, non-work-related stressful life events. - Assessing risk of crisis or suicide.	- Exploring employment conditions: type of contract, job stability, salary, work hours, shifts. - Investigating working conditions/psychosocial risks: shifts, work-life balance opportunities, mental and physical workload, demands, pace, autonomy, available resources, supervision and control, relationships with supervisors or colleagues, work climate, perceived support, recognition, organizational justice, harassment or workplace violence. - Assessing whether the stressor is one-off, ongoing or recent. (For a more complete anamnesis, see the second part of this document).
3. Shared problem construction.	Agreeing with the patient an initial hypothesis of the problem and validating the patient's experience.	- Linking symptoms to working conditions if appropriate. - Exploring what the patient expects from the consultation. - Returning a first integrative formulation.	- Clearly naming the occupational factors identified as possible triggers or aggravating factors. - Validating the suffering generated by the work environment.
4. Clinical formulation and resignification.	To generate a deeper shared understanding of the distress.	- Co-constructing a clinical narrative with the patient. - Proposing a realistic and consensual therapeutic strategy.	- Including occupational factors in the formulation as an aetiological or aggravating hypothesis, if applicable. - Exploring possible ways of coping from the clinical and social/occupational perspectives.
Phase	**Goals**	**Clinical tasks**	**Specific exploration of the work context**
5. Closing.	To conclude the interview and plan the next steps.	- Proposing follow-up or discharge according to need. - Agreeing, if appropriate, on temporary incapacity or referral to mental health or occupational health services.	- Jointly assessing the possibility of reporting suspicion of an employment relationship (with Z-code + diagnosis). - Informing about available resources (social, trade union, legal, company programmes, communication mailbox of the Labour and Social Security Inspectorate, etc.).

3.2.2. Assessment of suspicion of occupational origin

The identification of mental disorders related to work stressors largely depends on the description of events and the interpretation by the worker. In this sense, individual perception plays a central role. However, establishing a suspected link between a work stressor and a mental disorder involves a clinical interpretation that cannot be proven with absolute certainty, but is based on a reasoned probability judgement.

The response to a psychosocial work stressor is mediated by the interaction of multiple individual and contextual factors. Each person faces these challenges based on their personality structure, life history, prior experiences with stress, support network and characteristics of the work environment. Organisational policies and access to social and health resources also play a role. This combination of elements can make a work stressor act as a trigger or aggravating factor for a clinically diagnosable mental disorder.

The complexity of the phenomenon, combined with the stigma that still surrounds mental health, has hindered its recognition within the workplace and healthcare settings. While other diseases have been recognised as occupational for decades, work-related mental health problems have only recently begun to be made visible. The relationship between mental health and occupational health is therefore complex, dynamic and multifactorial. Nonetheless, it is undeniable that a significant portion of individuals seen in healthcare services reference work stressors as elements that trigger or exacerbate their psychological distress. Clinical evaluation will ultimately allow suspicion of this relationship and initiate the appropriate reporting mechanisms.

Clinical criteria for suspecting work-related origin

To support the clinical suspicion that a mental disorder may be related to work activity, the professional should consider the following criteria in an integrated manner:

1. **Diagnostic criterion:** existence of a clinically recognizable mental disorder. Suspicion of work-related origin must necessarily start from the presence of a mental disorder. Without a diagnosis, a report of suspected work-related origin cannot be made. The combined use of F-code (diagnosis) and Z-code (factors related to the work environment) allows this suspicion to be recorded in the clinical history.
2. **Exposure criterion:** existence of potentially harmful work conditions. Exposure to psychosocial risk factors related to the development or worsening of mental disorders must be identified. These include conditions such as overload, lack of control, emotional demands, harassment, violence, job insecurity or effort-reward imbalance, among other psychosocial risks. Exposure may be reported by the worker or identified by the professional and should be assessed using clinical criteria.
3. **Temporality criterion:** chronological relationship between exposure and symptoms. It must be established that the onset of symptoms occurred after the start or intensification of exposure to the work stressor. In the case of aggravation of a pre-existing condition, it must be shown that the work exposure preceded the worsening.
4. **Clinical consistency criterion:** this criterion refers to the need to evaluate whether the clinical symptoms are consistent with the reported exposure to psychosocial risk factors. The assessment should avoid automatic attribution

of suspicion when there is clear evidence that the distress is predominantly due to intrapsychic or structural factors unrelated to work (e.g., severe cognitive distortions, marked attributional biases, or personality traits that make the work problem a consequence rather than a trigger of the disorder). However, this criterion must be applied with particular clinical sensitivity, especially in individuals diagnosed with Severe Mental Disorders (SMD). This is a particularly vulnerable population for whom work stressors may act as decompensation or aggravation factors for an underlying disorder. In such cases, the presence of a pre-existing psychopathology does not exclude the possibility of a significant relationship with adverse employment and work conditions. On the contrary, it may require enhanced monitoring and protection.

Clinical judgement should therefore balance carefully: neither automatically attributing distress to the work context without reasoned evidence, nor dismissing the suspicion of work-related origin simply because a prior psychiatric diagnosis exists. The perspective of the person being treated should be considered, especially when they describe a clear link between their deterioration and working conditions.

It is important to remember that reporting clinical suspicion does not imply establishing causality, but rather activating mechanisms for a more detailed evaluation by the competent authorities. The healthcare professional's goal is not to prove causation but to identify cases where there is a reasonable possibility that work stressors are acting as a cause, aggravating factor, or trigger of distress. This evidence-based clinical perspective enables a more just and effective preventive approach.

Assessment of Suspected Work-Related Origin: Clinical perspective and subsequent classification

It should be noted that reading this section should be complemented with the reading of the following chapter, Chapter 4, which describes in detail the attribution of work-related causality, the criteria, definitions, and the algorithm for assessing the work-related connection in cases of mental disorders.

The role of the healthcare professional in the face of a possible work-related mental disorder is to identify and communicate a **reasoned clinical suspicion**, based on the criteria previously described (diagnosis, exposure, temporality, and clinical consistency).

It is not the clinician's role to definitively determine the work-related origin of the disorder or to formally assign it as a work contingency. A more exhaustive assessment falls within the competence of occupational risk prevention services, occupational health units, labour authorities or, where applicable, the competent bodies in public health and social security.

However, it is useful for healthcare professionals to have an overall understanding of the possible **classifications of a case** that may result from the subsequent investigative process. This perspective helps to understand the purpose and importance of reporting a suspicion as part of the protection system for workers' health.

Thus, based on the application of the criteria of exposure, temporality and clinical consistency, the responsible investigative units may conclude that the case falls into one of the following situations:

On the one hand, it may be a **non-work-related mental disorder**, when no relevant work-related stressors are identified, the time sequence does not suggest a significant relationship and the condition can be explained mainly by non-work-related factors. In such cases, the existence of an occupational injury shall not be considered.

Alternatively, the case may be determined to be a **work-related mental disorder**. This occurs when the disorder has arisen because of or in connection with work, fulfilling the criteria of exposure to psychosocial risks and temporality, without the identification of relevant extra-occupational factors. This situation coincides with the definition of occupational injury in the Law on Occupational Risks Prevention, and may lead to its recognition as an accident at work or occupational disease, depending on the applicable regulations.

Finally, it can be concluded that there is a **mental disorder aggravated by work**, i.e. a pre-existing mental disorder that has suffered a worsening attributable to working conditions. In these cases, although the initial origin of the disorder is not work-related, work acts as a factor of decompensation or aggravation of the signs and symptoms, and is therefore also covered by the aforementioned legislation.

This subsequent classification depends on a comprehensive assessment that includes investigation of work conditions, supplementary interviews, analysis of exposure to psychosocial risks and review of the patient's clinical history, as detailed in occupational health surveillance procedures and outlined in the final section of this document.

Therefore, the clinician should not be responsible for deciding which of these categories the case falls into. Its role is to formulate and communicate a well-founded suspicion, allowing the activation of the specialised investigative process corresponding to the field of occupational health.

These issues are explored in more detail in Chapter 4 of this document.

3.2.3. Communication of suspected work-related or work-aggravated mental disorder

The suspicion of a relationship between a Mental Disorder, coded according to the ICD, and a work situation, coded using the Z-code in that classification, will be forwarded to the designated authority in each Autonomous Community and cities with a Statute of Autonomy. Reports will be made for both patients in whom the clinician suspects a causal relationship derived from work and those in whom a relationship aggravated by work is suspected. In both situations, the suspicion concerns the connection between work and the symptoms presented by the person.

As previously mentioned, such reporting requires the patient's approval, who must receive complete information about the procedure, including the implications of making—or not making—the report. If the patient refuses this notification, it cannot be carried out.

At this point, it is important to understand that the ultimate goal of submitting this suspicion report is to ensure that work-related mental health disorders are recognised as such.

In the following chapter, Chapter 4, the communication circuits and specific coordination mechanisms are described, especially when coordination between multiple administrations, agencies, and entities is required.

3.2.3.1. Advantages of recognising a disease as occupational

Recognising a condition as linked to an occupational risk gives that risk priority attention: the threat is made visible, specific protective measures are designed and implemented, and controls are strengthened where danger exists. When we talk about work-related diseases, this preventive approach acquires a multiplying effect, as the same exposures that harm one worker can simultaneously affect all individuals per-

forming similar tasks in that environment (García Gómez and Castañeda López, 2006).

Proper reporting of a work-related pathology generates far-reaching positive impacts: it ensures that the patient receives clinical, legal and financial management tailored to their situation; it provides the occupational risk prevention system with real data to guide effective actions; it shifts the cost to the occupational contingencies insurance, relieving public finances; and, ultimately, it promotes safer and more responsible workplaces for society as a whole (García Gómez, 2014).

The suspicion report, always subject to the patient's informed consent, aims to ensure that mental disorders related to work are eventually recognised as occupational diseases. This recognition provides benefits in four fundamental areas:

1. **Improvement of prevention:** Officially identifying a harm as work-related highlights the potential risk and mandates the design and implementation of specific protective measures. Furthermore, when a disease is recognised as occupational, the preventive effect is amplified: not only is the patient protected, but so are all individuals exposed to similar conditions in the same work environment.
2. **Benefits for the worker:**
   a. **Early intervention.** A prompt diagnosis, as soon as the first signs and symptoms appear, allows treatment in its most reversible phase and facilitates timely correction of risk conditions.
   b. **Economic coverage.** Recognition as an occupational disease entails higher financial compensation and 100% coverage of pharmaceutical, medical and therapeutic costs.
   c. **Epistemic repair and meaning of distress.** Recognising the suffering as a response to adverse work conditions allows the individual to make sense of their experience—an essential step in recovery and in activating self-care capacities. This justice-oriented approach shifts responsibility to the individual, their immediate environment, and the structural context, prevents individual stigmatisation and strengthens the worker's autonomy to transform their work situation.
3. **Information for the occupational risk prevention system:** Reliable data on how many illnesses and harms stem from specific exposures, and in which sectors or workplaces they occur, allows inspections and training or organisational improvement actions to be much more effectively directed.
4. **Cost redistribution and employer responsibility**: Recognising a disease as occupational shifts the cost burden to occupational accident and disease insurance, via Social Security funds contributed by workers and employers (with mutual insurance companies as system managers), rather than the Sistema Nacional de Salud (National Health System). This:
   a. **Internalises the cost.** Places it on the party generating the risk, incentivising investment in prevention.
   b. **Relieves pressure.** Reduces budgetary strain on public health services, avoiding unfair cost displacement to society at large.

3.2.3.2. Clinical management of patients with work-related or work-aggravated mental disorders

In Spain, the most common pathway for initial detection and management of mental health problems related to work stressors is primary care (PC). Therefore, the following outlines general clinical strategies based on the level of care.

It is important to remember that the healthcare professional's role at this stage is primarily care-focused: diagnosing the disorder, identifying the suspicion, reporting it when appropriate, providing therapeutic support, and facilitating access to other support services if necessary. The clinician is not responsible for the definitive attribution of work-related causation, a task carried out by occupational health units and competent authorities after proper investigation.

Patients whose clinical management should be carried out in Primary Care:

Patients considered suitable for management in PC are those presenting with mild reactive conditions, without personal history of severe mental disorders or prolonged contact with mental health services, who have an adequate social support network and retain sufficient psychosocial resources.

Diagnoses in these cases typically fall into categories such as adjustment disorders, anxiety disorders, mild depressive episodes, or acute stress reactions (often coded complementarily with Z-codes in the ICD).

In these cases, the lines of action include:

- **Diagnosis of the mental health problem.**
- **Communication of suspicion:** Inform the patient about the possibility of reporting a suspicion that their mental disorder may be work-related. This report must have their informed consent, clearly explaining its benefits and risks. If the patient has doubts or shows reluctance, time can be offered to reflect, and if the refusal persists, consider referral to mental health for a more in-depth assessment.
- **Notification independent of temporary incapacity (TI):** It is important to emphasise that a suspicion report does not necessarily imply the initiation of temporary incapacity. The professional will assess the need for TI based on the severity of the condition and its impact on the patient's functionality.
- **Clinical management during TI (if applicable):** Temporary incapacity should not be seen as mere waiting time for spontaneous improvement. During this period, it is recommended to activate behavioural activation and problem-solving programs, both within the health centre and through available community resources.
- **Therapeutic work in consultation:**
  - Set coping and adaptation goals.
  - Identify possible courses of action to address the labour conflict or improve the situation.
  - Evaluate alternatives in coordination with social work, social services, trade unions, legal advice or emotional wellbeing programmes of companies, communication mailbox of the Labour and Social Security Inspectorate, etc., always respecting the autonomy of the patient.
- **Coordination with mental health:** If there is diagnostic doubt or difficulty in

management, consult mental health teams in the framework of collaboration programmes with PC.

Patients who should be referred to Mental Health

Referral to mental health is recommended in the following cases:

- Moderate to severe clinical picture.
- History of severe mental disorder or long history of mental health care.
- High complexity in clinical management or significant resistance to intervention from PC.

The most frequent diagnoses in these patients include moderate to severe depressive disorders, severe anxiety disorders, post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), eating disorders (ED), bipolar affective disorders, psychotic episodes or personality disorders, as well as harmful substance use or dependence triggered or aggravated by working conditions.

Management by the mental health specialist should be along these lines:

– **Evaluation:** Conduct a comprehensive assessment of the clinical situation, personal and work history, impact of stressors and support network.

- **Confirmation of the suspicion and reporting:** If the probable work-relatedness is confirmed, also proceed to the reporting of suspicions to the occupational health units, including cases where the injury has been aggravated by the work environment.
- **Comprehensive treatment:** Design an adapted therapeutic plan, combining psychotherapeutic intervention (prioritising trauma-oriented approaches, problem-solving and strengthening of personal resources) and pharmacological treatment if necessary.
- **Psychosocial and occupational rehabilitation:** In cases of patients with a diagnosis of Severe Mental Disorder (SMD), work should be coordinated with psychosocial rehabilitation centres or specialised work rehabilitation programmes.
- **Assessment of permanent disability:** Depending on the clinical evolution, functional impact and history, the possibility of initiating procedures for permanent disability may be considered, in coordination with the patient and his or her healthcare network.

Patients under follow-up in Mental Health: identifying occupational harm in vulnerable populations

In specialised clinical practice, it is essential to recognise that the suspicion of an employment relationship is not limited to new cases referred from primary care or the emergency department. A significant number of patients under follow-up in mental health services, including those with severe mental disorders (SMD), may suffer an aggravation of their health status as a consequence of work-related stressors.

These people are more vulnerable due to several concurrent factors: clinical frailty, the social and occupational stigma associated with their diagnosis, and a lower capacity to defend themselves against situations of abuse, discrimination or exposure to psychosocial risks in the work environment. This reality has been widely recog-

nised in the scientific literature and in international recommendations on mental health and work.

It is therefore essential that second-level care professionals remain particularly sensitive to any clinical deterioration in patients under follow-up. It should not be automatically assumed that a crisis, a relapse or the appearance of new symptoms are exclusively attributable to the natural course of the underlying disease. Systematically, it should be assessed whether:

- There have been recent changes in working conditions.
- There have been situations of overload, harassment, violence, job insecurity or other forms of exposure to recognised psychosocial risks.
- The patient has reported conflicts, persistent discomfort or relevant incidents in the work environment.

The omission of this examination can lead to the erroneous classification of these episodes as a crisis or pathology not related to work, depriving the patient of adequate legal and social protection, as well as the activation of occupational risk surveillance circuits and perpetuating the situation of discrimination.

The following points in this section can be summarised and highlighted:

- **An occupational stressor can act as a trigger or aggravating factor** in people with previous mental pathology, contributing to clinical deterioration or the appearance of new associated pathologies.
- **The reporting of suspicion by the clinician does not imply certainty of occupational origin,** but merely triggers the investigation procedure by the occupational health units and the competent authorities.
- **Persons with severe mental disorders should be subject to special protection** in this process, in accordance with the principles of health equity, prevention of discrimination and guarantee of labour rights.

Systematically integrating this perspective into the clinical management of patients under follow-up represents not only a clinical imperative but also an ethical commitment to the rights of the most vulnerable individuals.

Table 2 develops the clinical strategies and coding for the suspicion reporting of work-related mental disorders.

Table 2. Overview of task strategies from primary care and mental health

Care level	Patient profile	Frequent diagnoses	Recommended ICD codes	Main clinical actions
First level of care (Primary Care).	- Mild reactive picture. - No psychiatric history. - Good previous performance. - No substance use disorders.	Adaptive disorder (F43.2). Mild anxiety disorders (F41.0, F41.1). Mild depressive episode (F32.0). Acute stress reaction (F43.0).	Corresponding diagnostic F-code. Z-code for work-related stressors (Z56 and subcategories).	- Communication of suspicion with informed consent. - Temporary Incapacity (TI) assessment if applicable. - Behavioural activation and problem-solving. - Coordination with community supports. - Follow-up in Primary Care (PC).
Second level of care (Mental Health).	- Moderate or severe condition. - Prolonged or severe history. - High social vulnerability. - Substance use disorders. - Difficulty in the PC approach.	Moderate or severe depressive disorders (F32.1, F32.2). Generalised anxiety disorder (F41.1). PTSD (F43.1). OCD (F42). Personality disorder (F60-F69). Acute psychotic episodes (F23). Bipolar disorders (F31). Substance use (F10-F19).	Corresponding diagnostic F-code. Z-code for work-related stressors (Z56 and subcategories).	- Comprehensive assessment. - Reporting of suspicion if appropriate. - Comprehensive therapeutic plan. - Coordination with rehabilitation programmes. - Assessment of permanent disability.
Care level	**Patient profile**	**Frequent diagnoses**	**Recommended ICD codes**	**Main clinical actions**
Patients under follow-up at the second level of care (Mental Health).	- Relevant previous diagnosis (including severe mental disorders [SMDs]). - Clinical worsening or new symptoms. - Presence of recent work-related stressors. - High vulnerability to discrimination or abuse.	Previous relevant diagnosis (F20-F99). New adaptive or anxiety disorders. Relapses of affective or psychotic episodes.	Current diagnostic F-code. Z-code for work-related stressors (Z56 and subcategories).	- Systematically assess work impact. - Report suspicion if appropriate. - Update therapeutic plan. - Inclusion of community support. - Preventing the invisibilisation of occupational harms.

3.3. Supplementary coding for suspicion based on exposure to occupational stressors (Relevant Z-codes)

Table 3 lists the relevant z-codes to be used in the supplementary coding for suspicion based on exposure to occupational stressors.

Table 3. Relevant Z-codes

Factors influencing health status	Z56	Problems related to employment and unemployment
	Z56.0	Unemployment, unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
	Z56.3	Stressful working hours
	Z56.4	Disagreements with superiors and colleagues at work
	Z56.5	Unpleasant working environment
	Z56.6	Other work-related physical and mental stress
	Z56.8	Other employment-related problems*

* High quantitative demands, high emotional demands, high workload, low autonomy, limited opportunities to apply skills and knowledge, working weeks exceeding 55 hours, lack of workplace recognition, etc. (see Chapter 2 on psychosocial occupational risks).

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4. Surveillance and monitoring of work-related harms

4.1. Work-related mental disorders: epidemiological surveillance

The most common work-related mental health harms are common mental health disorders (CMD) (Stansfeld S, Candy B. 2006), including mood, anxiety and adjustment disorders. There is hardly any data on their incidence as the insurance systems do not recognise these harms as occupational diseases. However, its importance is reflected in the European Strategic Framework for Health and Safety at Work 2021-2027 which includes, among the key strategic objectives, the management of emerging risks, the prevention of work-related pathologies, and the identification and dissemination of good practices for the prevention of mental health problems at work. And also in the Spanish Strategy for Safety and Health at Work 2023-2027, which makes a firm commitment to the priority pillars of the European Strategic Framework, and includes a special action on mental health among its objectives.

Quality information is an indispensable element for decision-making in the field of Public Health and Occupational Health. Public health surveillance (PHS), classically epidemiological surveillance, is one of the essential functions of public health (Estrategia de Vigilancia en Salud Pública del Sistema Nacional de Salud [Public Health Surveillance Strategy of the National Health System], 2022) and is defined as a set of activities aimed at collecting, analysing, interpreting and disseminating information related to the state of health of the population and the factors that condition it, with the aim of providing a basis for public health actions (Law 33/2011).

The COVID-19 pandemic has posed a major challenge to health systems around the world, which have tried to take measures at different levels to contain or mitigate its spread with very different results (Han, 2020). Measures have been aimed at controlling transmission chains. However, the pandemic has had more complex repercussions such as the interaction with other health problems such as chronicity or mental health (Horton, 2020) and social inequalities in health (Ministero de Sanidad [Ministry of Health], 2021). Never before has it been so necessary to apply new paradigms that facilitate the adoption of transversal public health policies, highlighting the importance of collaborating with multiple areas of knowledge and agents usually outside the health sector, such as the economic or social sectors, strengthening solid collaboration networks that generate synergies so that these policies are not only effective in theory but also feasible and applicable in practice.

Decision-making for the control of health problems in the population must take into account the information collected by public health surveillance systems. And labour, as the main determinant, is still hardly included in them. The *information for action* principle is the foundation for PHS in a modern state. Workplaces are fundamental scenarios for deploying this action (García Gómez, 2023).

The recently created State Public Health Surveillance Network aims to extend surveillance to all aspects of interest for Public Health, beyond communicable diseases, integrating the surveillance of the state of health of the population in terms

of well-being, morbidity and mortality, as well as the risks, determinants, inequalities and factors that condition it (RD 568/2024 of 18 June). And, among them, work (or the lack thereof) as a fundamental determinant of health.

The surveillance systems created by the Network include the **Occupational Health Surveillance System**, which must regulate the purposes, the events subject to surveillance, the information to be obtained, the mechanism, form and frequency of data collection, the communication circuit and the specific coordination mechanisms when coordination between several administrations, bodies and entities is required, as well as any other aspect deemed necessary.

The organisational context in which PHS, in general, and Occupational Health Surveillance is situated is complex. The Autonomous Communities and the General State Administration have a very diverse degree of development of surveillance systems and lack a framework of harmonisation, interrelation and shared goals. The modernisation of surveillance implies the need to consolidate existing systems and create those that are lacking, ensuring the coordination of diverse systems and agents, reducing territorial inequalities, reducing the workload of data collection, focusing on data analysis and its transformation into useful information and knowledge for decision-making.

With regard to mental health and work, the previous sections have described the theoretical framework of the relationship between work and mental health and the psychosocial risks at work that influence mental health disorders and the clinical pictures that can appear with work-related stress as the main trigger in workers who suffer from it.

The objective of this chapter is to address the development and implementation of a system for the detection and reporting of mental disorders of possible occupational origin, which will make it possible to determine the disease burden of work-related mental disorders and to implement control and prevention measures for psychosocial risks in the working population.

4.2. Attribution of occupational causation

One of the fundamental problems in occupational mental health care lies in the non-inclusion of mental disorders in the occupational diseases of the Social Security system. As they do not appear in this table, their recognition as occupational conditions is only acquired by being declared as *work accidents* or as *non-traumatic work-related pathologies (diseases not included in the table of occupational diseases and which have been classified as work accidents for coverage by Social Security)*, which results in the significant under-recognition of these ailments as occupational contingencies.

El Real Decreto Legislativo 8/2015, de 30 de octubre, por el que se aprueba el texto refundido de la Ley General de la Seguridad Social (Royal Legislative Decree 8/2015, of 30 October, approving the revised text of the General Social Security Law), defines, in Article 157, the concept of **occupational disease** as follows: "*occupational disease shall be understood to mean a disease contracted as a result of work performed as an employee in the activities specified in the table approved by the provisions for the application and development of this Law*". With the passing of Ley 20/2007 (Law 20/2007), self-employed workers are also entitled to benefits for occupational contingencies. In the case of the economically dependent self-employed, the contribution and therefore the benefit is compulsory, and for the rest of the self-employed this contribution is voluntary. Domestic workers are in the same situation after the approval of Real Decreto 1596/2011 (Royal Decree 1596/2011).

Article 157 leaves open the possibility that in the future "new occupational diseases deemed necessary may be included in the table". In this regard, the ILO list of occupational diseases has included mental and behavioural disorders since 2010.

On the other hand, Article 156 of RD Legislativo 8/2015, de 30 de octubre (Royal Legislative Decree 8/2015, of October 30), defines the concept of a **work accident** as any bodily injury suffered by a worker on the occasion of or as a consequence of the work performed for an employer. And it incorporates, among other assumptions, one that may be important for the recognition as professionals of certain mental disorders: "*Illnesses, not included in Article 157, contracted by the worker in connection with the performance of their work, provided that it is proved that the illness was exclusively caused by the performance of the work*.

The possibility for the diagnosing medical professional (whether from the health system or the occupational risk prevention system) to report a suspected relationship between work conditions and a mental health problem opens an extraordinary opportunity to uncover hidden occupational diseases and to activate the prevention of occupational risks that cause such harm.

4.3. Damage aggravated by work

Our legislation provides for the consideration of an illness prior to the performance of the work activity as an injury aggravated by work. There are situations in which a disease, initially not classified as occupational, may be aggravated by working conditions, raising the possibility of being treated as a work accident.

Indeed, the definition of an accident in Article 156 of the Ley General de la Seguridad Social (General Social Security Law) includes, in section 2.f), that diseases or defects previously suffered by the worker that are aggravated as a consequence of the injury constituting the accident shall be considered work accidents.

Spanish jurisprudence has on several occasions addressed the question of when an illness aggravated by work can be considered an accident at work. A relevant case is the Tribunal Supremo (Supreme Court) ruling of 10 October 2006 (RJ 2007\825), where it was established that "*when there is a direct relationship between the work performed and the aggravation of the pre-existing illness, this aggravation must be considered as an accident at work*". This criterion has been reiterated in various rulings, where the causality between the work activity and the worsening of the worker's health has been assessed. The key is to demonstrate that the working conditions have contributed significantly to the aggravation of the worker's pathology.

For an illness aggravated by work to be considered an accident at work, certain **requirements** must be met:

1. Existence of a pre-existing disease: The worker must be suffering from an illness which, although not occupational, is diagnosed prior to the aggravation.
2. Causal relationship: A direct and significant relationship between the work performed and the aggravation of the disease must be demonstrated. This implies that the conditions of the working environment have had a significant influence on the worsening of the worker's health (see chapter 2 on psychosocial risks at work).

3. Medical evidence: Medical reports certifying the aggravation of the disease due to working conditions are essential. These reports should be clear and detailed, showing the evolution of the disease and its relation to work.

4.4. Criteria, definitions and algorithm for the assessment of the work-relatedness of mental disorder

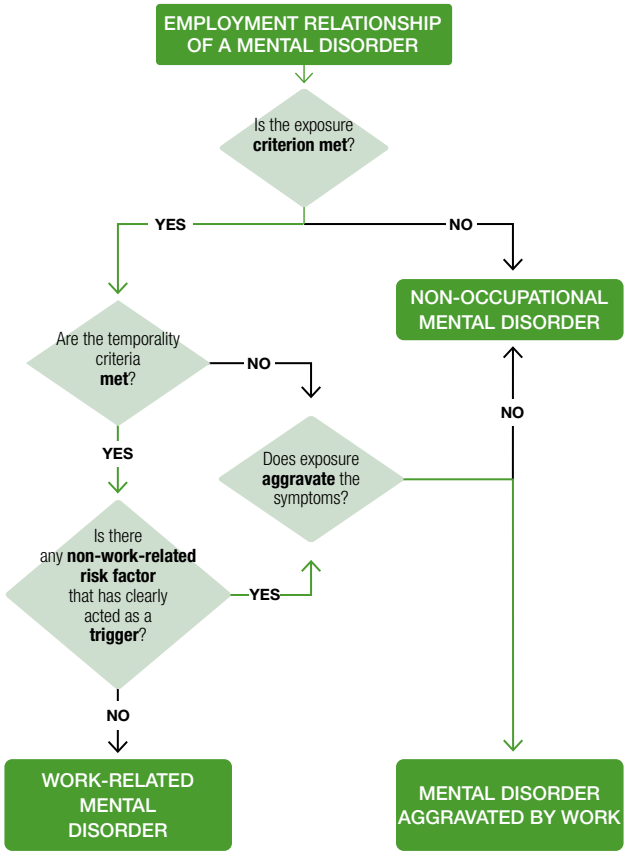
In the case of a worker with a mental disorder of possible occupational origin, the following criteria should be assessed:

1. **Diagnostic criterion**: for a mental disorder: ICD F-code plus Z-code.
2. **Exposure criterion**: there is occupational exposure to the risk factors causing the mental disorder (see Chapter 2 on psychosocial occupational risks).
3. **Temporality criterion**: occupational exposure precedes the onset of the mental disorder. Alternatively, occupational exposure occurs afterward when it involves the aggravation of a condition.

The application of these criteria will result in a case classification:

- **Non-occupational mental disorder**: there is no evidence of an occupational origin for the mental disorder, nor is it aggravated by work activity.
- **Mental disorder arising from work:** mental disorder suffered as a result of or in connection with work. It coincides with the definition of work-related harms in Article 4 of the Ley de Prevención de Riesgos Laborales (Law on Occupational Risks Prevention). For its classification, the case meets the criteria of exposure and temporality, and there is no extralabour factor that clearly acted as a trigger.
- **Mental disorder aggravated by work:** mental disorder not arising from work, whose signs and/or symptoms are aggravated by work activity. For classification in this group, the case meets the exposure criteria, but does not meet the temporality criteria (onset of the disorder is prior to occupational exposure).

Figure 4. Algorithm for the assessment of the employment relationship



Source: Created by the author.

4.4.1. Clusters of cases

In addition to the individual cases mentioned above, clusters of epidemiologically linked cases and their circumstances will be considered and reported.

4.4.2. System procedures manual

The proposed Surveillance System Procedures Manual will detail the definitions of the mental disorders under surveillance, and the classification and coding of cases according to clinical criteria.

As defined in Article 17 of Real Decreto 568/2024, de 18 de junio, por el que se crea la Red Estatal de Vigilancia en Salud Pública (Royal Decree 568/2024 of 18

June, creating the State Public Health Surveillance Network), the Manual will be agreed by the Technical Committee of the Surveillance System and validated by the Network Management Committee. The approval of the procedure manuals corresponds to the Consejo Interterritorial del Sistema Nacional de Salud (Interterritorial Council of the National Health System), through the Comisión de Salud Pública (Public Health Commission).

Surveillance Systems Procedures Manual means the document that defines the actions necessary to develop the activities proposed in each surveillance system in an organised manner and the form and sequence in which they should be carried out in order to achieve their objectives efficiently and to a high standard of quality.

4.5. Surveillance mode

The reporting of suspected work-related mental disorders will be done on an individual basis on the platform established for the Sistema de Vigilancia de Salud Laboral (Occupational Health Surveillance System) (García Gómez, 2014, 2017 and 2023; García López, 2011; Moreno-Sueskun, 2015).

4.5.1. Sources of reporting

Initial case report information will be submitted by:

- Primary Care physicians.
- Second Level Care physicians (Mental Health and others).
- Physicians from the Health Services Inspection.
- Occupational Health physicians from Prevention Services.

4.5.2. Information pathways

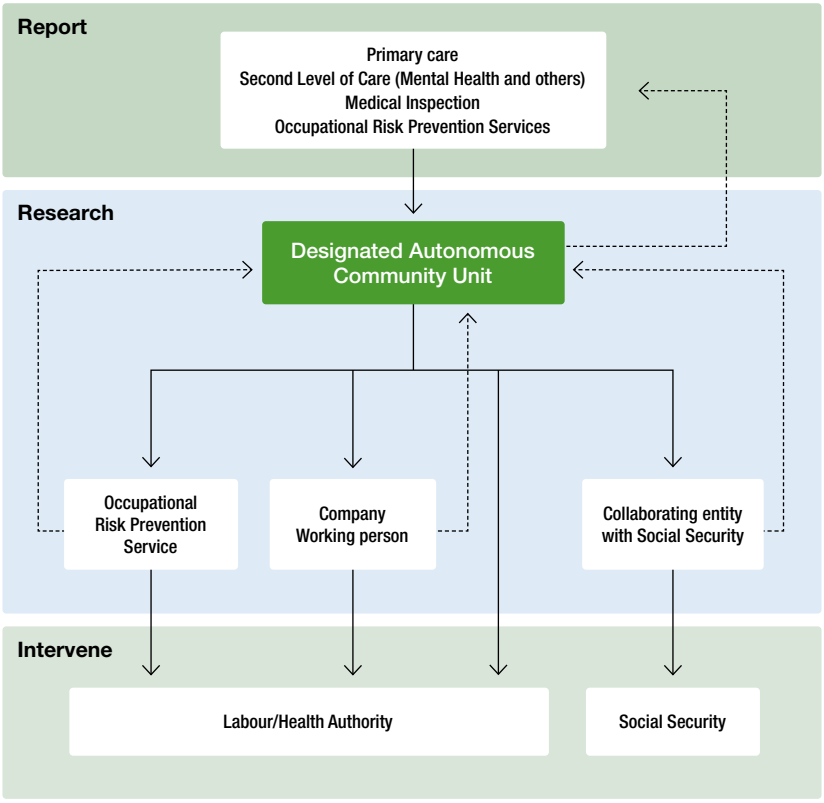
Communication from any of these physicians will be directed to the competent authority designated in each Autonomous Community and in cities with a Statute of Autonomy, taking into account the coordination provisions established in Article 38 of Real Decreto 39/1997, de 17 de enero, por el que se aprueba el Reglamento de los Servicios de Prevención (Royal Decree 39/1997 of January 17, approving the Regulations of Prevention Services).

In order to complete the investigation of the case, as well as to propose the appropriate preventive measures, this body of the Autonomous Community will communicate the case to the person responsible for health in the company's prevention service. If necessary, the labour authority of the Autonomous Community will be contacted. It will also be notified to the Social Security managing or collaborating entity (Mutual Society, MCSS) for the purposes of its classification as an accident at work, if applicable.

If there is a clustering of cases in a company, the body that has been determined in each Autonomous Community and cities with Statute of Autonomy shall be notified, on the same platforms, of the results of the investigation within a period of time not exceeding one month after the study has been completed. In addition, individualised information on the cases of the outbreak shall be reported.

Within the framework of the development of the Occupational Health Surveillance System of the State Network for Public Health Surveillance, the events under surveillance, the information to be obtained, the mechanisms, form and periodicity of data collection, the communication pathway, and specific coordination mechanisms (when coordination between multiple administrations, agencies, and entities is required) will be harmonised, as well as any other aspect deemed necessary.

Figure 5. Procedure for the management of cases of Common Mental Disorders of occupational origin



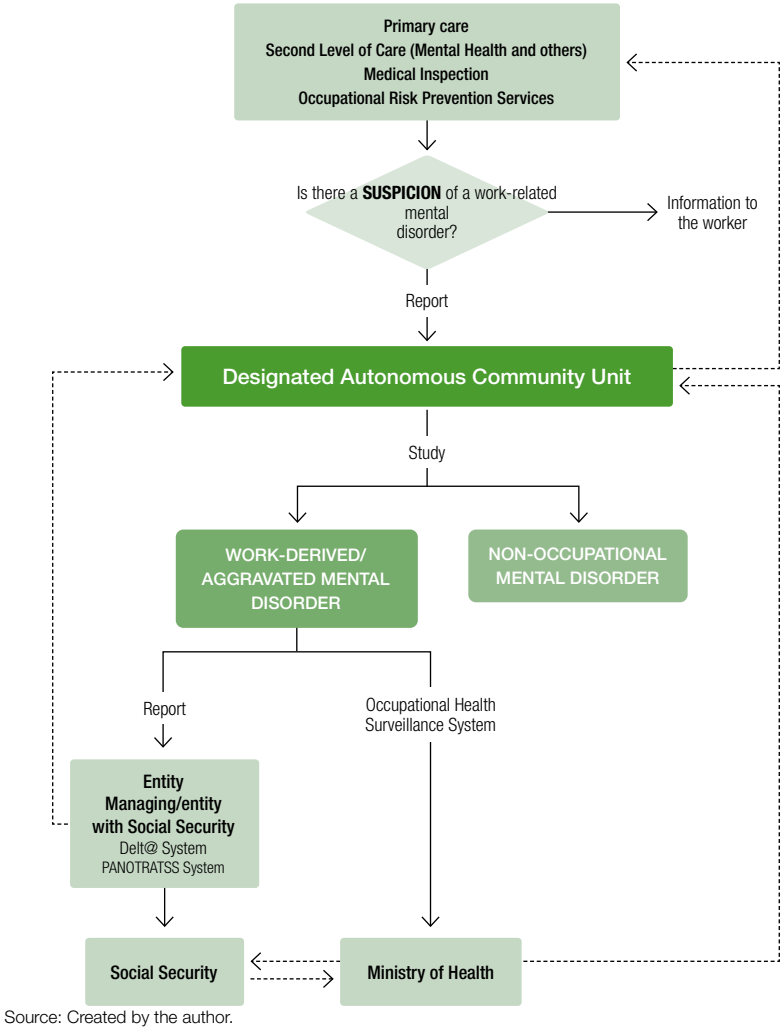
Source: Created by the author.

Once this investigation process is completed, the designated Unit of the Autonomous Community will classify suspected cases into one of the three possible categories, according to the definitions outlined previously:

- Non-occupational mental disorder.
- Work-related mental disorder.
- Mental disorder aggravated by work.

If a suspicion of a work-related or work-aggravated mental disorder remains, the case will be forwarded, on one hand, to the Ministry of Health through the platform established for the Occupational Health Surveillance System, and, on the other hand, to the managing/collaborating Social Security entity, in cases where applicable.

Figure 6. Information pathway



Source: Created by the author.

The Surveillance System will have a central unit and a regional unit in each of the communities and cities with a Statute of Autonomy, in accordance with the provisions of Article 15.1 of Real Decreto 568/2024, de 18 de junio (Royal Decree 568/2024 of 18 June).

The central unit and the regional units will have the necessary professionals and resources in each territorial area to be able to efficiently collect, analyse, interpret and disseminate the information obtained by the system.

The central unit will assume the coordination and technical secretariat of the surveillance system, including among its functions the elabouration of the manual of procedures of the surveillance system, as well as the proposal of events to be monitored, their protocols and the coordination of their application.

The regional units will develop the objectives of the system in their territorial area, coordinating the application of the processes included in the manual of procedures and in the system's protocols.

4.6. Example of good practice: Surveillance of common work-related mental disorders in Navarra

Since 1998, there has been a Sentinel Event Surveillance Programme in Navarra (García López V, 2011a and 2011b) that allows Primary Care Physicians (PCP) to report suspected occupational harms to the Instituto de Salud Pública y Laboral de Navarra (Navarra Institute of Public and Occupational Health – ISPLN). The Programme included Occupational Sentinel Events of a musculoskeletal, dermal, respiratory and vocal cord nature. Subsequently, a pilot study was proposed for mental pathology of possible occupational origin, even if it did not correspond to work-related pathology recognised as occupational (Moreno-Sueskun and García López, 2015).

Because of its interest, this pilot study is described below.

Purpose: Implementation of a system for the detection/notification of mental disorders potentially of occupational origin, in order to assess the population's mental morbidity possibly related to work and to implement measures for the control and prevention of psychosocial risks among the working population.

Patients and Methods: It consisted of a longitudinal descriptive study of patients at a Mental Health Centre of the Servicio Navarro de Salud-Osasunbidea in Pamplona-Comarca, based on Mental Health and Primary Care medical records. The centre served 60,743 inhabitants, of whom, according to Social Security data, 33,891 were salaried workers. Common mental disorders of possible occupational origin were identified, and population incidence was estimated between 2009 and 2012.

The diagnoses selected for notification (according to ICD-10 classification) were:

F43.2 Adjustment disorders,

F41.1 Anxiety disorders,

F41.2 Mixed anxiety-depressive disorder and

F32.1 Moderate depressive episode.

Damage of occupational origin was considered when explicitly stated by the worker during the anamnesis in consultation. Patients with a recent adverse life event, comorbidity of other mental disorders, or personality disorders were excluded.

Results: In the study, 17.5% of disorders were of possible occupational origin (7.2 per 1,000 workers/year). Among the reported cases, higher incidence was observed in feminised economic activities, service sectors and lower-skilled occupations. Seventy percent of cases were derived from hostile behaviours, and 14.2% from organisational work factors. Directors and managers were at higher risk of harassment (RR 3.92, 95% CI 2.35-6.53) than from other risks Overall, 20% of cases ended in dismissal, occurring more frequently in situations of abuse or moral harassment (RR 1.64, 95% CI 1.24-2.16). The most relevant notified CMDs were anxiety disorders (42.6%), adjustment disorders (27.3%), and mixed disorders (20.5%), accounting for 90% of cases. Cases of post-traumatic stress syndrome, somatisations, and phobias were also reported. 83.2% of analysed cases involved temporary incapacity (TI), with a mean duration of 173.3 days.

Conclusions: It is necessary to implement reporting systems and preventive programs for common occupational mental disorders, particularly among workers with higher-risk profiles.

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Work and mental health: a roadmap for health administrations in Spain proposes a transformation in the way the healthcare system addresses work-related mental health issues. In a context marked by the rise of job insecurity and increasing complexity of working conditions, this report provides a clear and evidence-based guide to promote healthier, fairer and more sustainable work environments.

The document, prepared by a multidisciplinary team of experts, is structured in four parts: a theoretical framework that recognises work as a key social determinant of mental health; a review of psychosocial risks at work and their impact on health; clinical guidelines for the detection and treatment of work-related mental disorders; and a proposal for an epidemiological surveillance system to make these harms visible and prevent them.

This roadmap not only provides clinical and organisational tools but also calls for a shift in perspective: moving from individual medicalisation of suffering to a structural approach that recognises the social causes of distress. An essential document for advancing toward more equitable public health committed to the well-being of workers.

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