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MENTAL HEALTH & PSYCHIATRIC CONDITIONS

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According to the World Health Organisation (WHO), mental health corresponds to a state of well-being in which a person is able to realise their full potential, cope with the normal difficulties of life, work successfully and productively and be able to make a contribution to the community.

At the present time, in the world mental illness represents the 5th leading cause of mortality and disability and the 3rd leading cause of sick leave and invalidity. 400 million people are affected by mental or neurological disorders, or suffer from psychosocial problems.

Mental Health

On the positive side, mental health concerns positive effects, that is to say being happy or unhappy, just as much as it concerns the different dimensions of the personality: self-control, self-esteem, resilience, optimism, impression of coherence. On the negative side, mental health covers two aspects: psychological distress, whose degree of intensity must be assessed, and mental illnesses, which come under the DSM classification (Diagnostic and Statistical Manual of Mental Disorders 4th or 5th edition) or the International Classification of Diseases (ICD 10 or 11, Chapter V).

DEPRESSION: MULTIPLE RISK FACTORS

In the mental health field, risk factors are multiple and interlinked.

First of all, there are **predisposing factors:** connected in some cases to pregnancy and birth, they can also originate in experiences in early childhood, the family environment, social circumstances, the material environment, upbringing and education, conditions of employment, work, housing...

In addition to these elements, there are **precipitating factors,** events that occur during a person's life, as well as within **a social context.** The interaction between all these factors leads to a more or less greater likelihood of depression.

TREATMENT AND CARE

Provision for the mentally ill varies from country to country and region to region, according to the resources available.

Thus the more hospital beds available, the more likely a patient is to be admitted to hospital. Similarly, the fewer psychiatrists there are, the more common it is for patients to be treated by general practitioners. Finally, when psychotherapy is not paid for by the health service, the consumption of psychotropic drugs increases without any connection with the existence of an actual mental illness.

These disparities result in substantial variations in the care and treatment of these conditions. For the same illness, treatment will also vary according to where the patient lives. The results observed therefore should be qualified.

PSYCHOSOCIAL RISK FACTORS IN THE WORKPLACE

The notion of psychosocial risk (PSR) is still quite vague. Occupational PSRs have only emerged over the last few years. They refer to situations that can adversely affect the physical integrity and mental health of employees, such as stress, harassment, violence, psychological distress or musculoskeletal disorders.

BURNOUT: A FORM OF PSYCHOLOGICAL DISTRESS

Burnout is not a mental illness, but a particular form of psychological distress related to working conditions. It was originally described in the caring professions before being extended to teachers and then other occupations where workers are in contact with the public. An assessment tool, the MBI (Maslach Burnout Inventory), defines burnout using three criteria: emotional exhaustion (fatigue, coldness), depersonalisation of the relationship with other people (cynicism), the loss of the feeling of personal accomplishment in one's work (frustration, loss of motivation, feeling of uselessness). People suffering from mental illnesses are more susceptible to burnout because they have a greater tendency to see their work as stressful and in a negative light.

Psychiatric conditions

Psychiatric conditions are extremely varied and include illnesses whose treatment and prognosis are different: depression, bipolar disorder, schizophrenia, etc. Sleep disorders, for example, often appear as indicators of psychiatric vulnerability. Thus, insomnia in those aged 30-40, in particular, is a predictor of depression, while residual insomnia, persisting after treatment, is a predictor for recurrence.

DIFFERENT TYPES OF DEPRESSION

By 2020, according to the WHO, clinical depression will represent the 2nd leading cause of disability in the world, after cardiovascular disease. Depression therefore represents a very significant global problem.

Several types of depression coexist. These include:

- **reactive depression,** triggered by an event,
- **neurotic depression,** due to poor handling of dissatisfaction,
- **an inability to cope** with emotional problems and conflicts,
- **depression caused by exhaustion** (in particular in single parent families),
- **endogenous depression,** where there are no specific trigger factors.

Depression is due to multiple causes and the associated symptoms are numerous. The symptoms can be physical, with a lack of energy, impaired concentration, eating and sleep disorders; they can be emotional: feelings of guilt, suicidal ideas, loss of interest, sadness; or they can be associated symptoms such as regression, obsessive thinking and rumination, irritability, excessive somatic preoccupation, pain, crying, anxiety and phobias.

THE MAJOR DEPRESSIVE EPISODE

A major depressive episode (MDE), or major (clinical) depression, is characterised by symptoms occurring together (coincidence) and present almost every day (intensity) for a period of at least two weeks.

At least five of the symptoms below must be present, including at least one of the first two in the list:

SIGNS OF MAJOR (CLINICAL) DEPRESSION
1. Seriously depressed mood present practically all day.
2. Markedly diminished interest or pleasure in all activities.
3. Significant weight gain or loss without being on a diet.
4. Insomnia or hypersomnia almost every day.
5. Restlessness or psychomotor retardation almost every day.
6. Fatigue or loss of energy almost every day.
7. Feeling of worthlessness or excessive or inappropriate guilt (may be delusional) almost every day.
8. Impaired ability to think or concentrate or indecisiveness almost every day.
9. Recurring thoughts of death (not only a fear of death) or suicide.

Three levels of severity have been identified: mild (wherein at least 5 symptoms present), moderate (6 symptoms), severe (7 symptoms). In all cases, there is an impact, i.e. a significant interference with everyday life (work, social life).

An MDE is treated according to a precise approach, which includes treatment of the acute phase, then of the consolidation phase. The length of the treatment with antidepressants will not be less than 6 months. It can reach a year or more if there is a recurrence.

SUICIDE: AN OUTCOME THAT IS DIFFICULT TO PREDICT

Although the major risk of depression is disability, we should not overlook the risk of suicide.

According to the WHO, more than 800,000 people die as a result of suicide each year; it was the 15th most common cause of death in the world in 2012. These figures show disparities from one country to another. For example, in middle and low-income countries, the suicide rate among women is higher. On the other hand, in high-income countries, the highest rate concerns middle-aged men. This disparity results in a 57% higher suicide rate in men than women worldwide.

Suicide occurs when the patient wants to escape his or her suffering. Warning signs are difficult to detect. 60% of people who commit suicide have consulted a GP in the month before they attempt to take their life, 36% in the week before the act. Suicide is connected to particular type of fragility and is never the consequence of a single «stressor.» The greater the number of comorbid disorders that are present, the higher the risk of suicide.

According to the Directorate for Research, Studies, Evaluation and Statistics (DREES - 2001), 155,000 suicides are attempted every year in France. On average 10,500 of these attempts prove successful, accounting for 2% of all deaths annually. 43% of successful suicide attempts are not first attempts. Attempted suicide concerns women more than men, but men succeed in their attempts three to four times more often than women. 30% of suicides in men are related to alcohol problems. Older people also commit suicide more often than the young.

BIPOLAR DISORDER: A COMPLEX CONDITION

Bipolar disorder affects 1%-2% of the world's population. It is characterised by cycles alternating phases of feeling "high" (mania) and depressive episodes, with calm periods in between. These fluctuations in mood are not generally connected to any precise cause and the intensity and frequency of the cycles vary. 20% of people suffering from bipolar disorder die by suicide, which means that they present a risk 30 times higher than the general population.

This complex condition suffers from delayed diagnosis and treatment. And yet effective treatments do exist: antidepressants, mood stabilisers, anti-epileptic and antipsychotic drugs. Mood stabilisers, which have proven to be effective as disease-modifying drugs in the acute phases, must be maintained.

TREATMENTS AND RISK OF RECURRENCE

The aim of treatment is to reduce the severity of the symptoms, the psychological and behavioural disorders and the risk of suicide. Antidepressants are often recommended, but other solutions can also be effective, such as anti-epileptic drugs, antipsychotic drugs, light therapy, psychotherapy, electroconvulsive therapy, natural products and physical exercise.

The factors influencing the risk of recurrent suicidal behaviour are known: a history of recurring depressive episodes, extended depressive episodes, family history, episodes occurring closer together, residual symptoms, poor adaptation to work or married life and inappropriate treatment. The probability of recurrence is 50% after one MDE, 70% after two episodes and 90% after three episodes.

Certain factors constitute obstacles to remission: acute and chronic stressors, the severity and duration of the depressive episode, failure of previous treatments, anxiety, painful somatic symptoms, personality disorders, psychoactive substance abuse and somatic illnesses, to name a few.

COMORBIDITIES AND PSYCHOSOCIAL IMPACT

Other conditions can also occur at the same time as depression. The comorbidities associated with depression are both somatic and psychiatric. From the somatic point of view, the comorbidity rate is:

- 26%-34% for cerebrovascular accidents,
- 15%-33% for myocardial infarction,
- 33%-35% for chronic pain.

Likewise, from the psychiatric point of view, it has been observed[1] that 58% of patients suffering from depression have a lifelong anxiety disorder, more than 24% have a phobia, almost 20% are suffering post-traumatic stress, 17% from generalised anxiety and 37% have an addiction, either to drugs or alcohol. Patients suffering from depression die earlier, in particular due to their associated organic medical conditions (heart conditions, for example).

Absenteeism from work due to depression is higher than in other chronic illnesses: it is 2.5 times higher than in the general population.

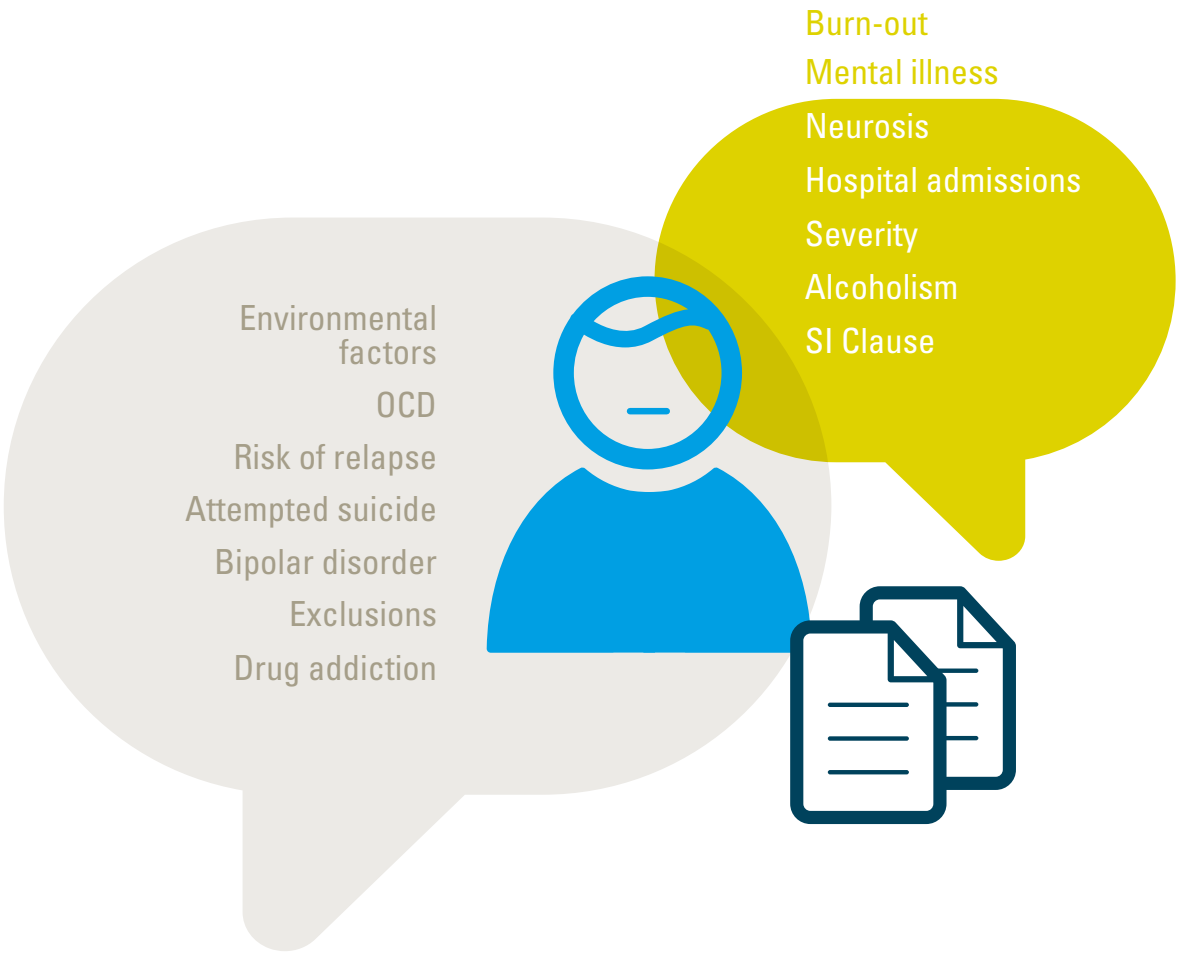
(1) Kessler et al. Comorbidity of DSM-III-R Major Depressive Disorder in general population: Results from the US National Comorbidity Survey. British Journal of Psychiatry 1996; 168 (suppl.30): 17-30

The insurer's approach

In Western countries, psychological disorders are among the three leading causes of sick leave and disability. When assessing this risk, the insurer is confronted with the difficulties inherent in the non-measurable, subjective nature of mental disorders (subjective illness - SI). If such disorders are not properly evaluated, the insurer could suffer from antiselection, adverse experience and disproportionate losses on that block of business.

The constitution of the underwriting file provides information in a precise format. The current system is based on a general medical questionnaire completed at the time of application by the person concerned. When a response connected to a psychological disorder appears, a second medical questionnaire specifically targeting neuropsychological conditions is then sent to the applicant, who has it completed by the attending physician or psychiatrist.

These questionnaires tend to be imprecise or incomplete, which makes their interpretation and use difficult. One of the areas for improvement for the insurer therefore would be the use of better adapted, specific questionnaires to obtain the most reliable information possible on the prognosis for the illness.



SIX CRITERIA FOR RISK ASSESSMENT

The assessment of psychiatric risk rests on six unavoidable criteria:

- **Diagnosis:** importance of the clinical course of the illness.
- **Case history:** date of the last episode, number of episodes.
- **Treatments:** nature, chronology, efficacy.
- **Hospital admissions:** based on the patient's status report and the hospital discharge summary.
- **Risk of suicide:** assessed using a well-defined assessment grid. Reserved risk for the insurer after three attempts.
- **Environmental factors:** professional and family context.

Consideration of time element is key: a minimum period of hindsight is necessary before studying the insurability of a psychiatric risk. Depressive episodes ten or twenty years apart cannot be linked. If the depressive episode occurred more than 25 years ago, it is possible to talk of recovery.

LONG TERM CARE, DEATH, COMPLEMENTARY COVER - HOW TO RATE?

The insurer's approach will vary according to the cover requested.

Approach to Long Term Care cover: psychiatry is the main cause of refusal for long term care contracts. The only possibility of acceptance for partial or total long term care cover concerns subjects with stable depression, treated by tranquillisers or antidepressants, or a recovered subject.

Approach to Death cover: **neurotic disorders** (OCD - Obsessive-Compulsive Disorder, depression, bipolar disorder) are the simplest to rate for death cover as they generally have «reasonable» excess mortality. **Psychotic conditions** (schizo-affective psychosis, paranoia, other delusional conditions), even when stabilised, are complex to grasp. If the environmental factors are favourable, a rating taking into account a high excess mortality can be envisaged.

Approach to Complementary Cover: complementary cover (sick leave, disability) involves risks that are difficult to consider insurable. Nonetheless, if the context is favourable, they can be accepted with exclusions for psychological disorders. Adaptations are possible, such as extending the waiting period or shortening the duration of the cover provided.

Generally speaking, exclusion will be automatic for neuropsychiatric conditions.

Ideally partial exclusion will apply to endogenous, reactive and neurotic depression, anxiety disorders, exhaustion, burnout, chronic fatigue syndrome and/or chronic fatigue related to alcohol or substance abuse, but also manifestations such as fibromyalgia and other chronic pain with no organic cause, manifestations related or attributable to stress, sleep disorders with hypersomnia or insomnia, or any other mental illness.

The insurer's approach remains reserved in the case of mood, behavioural and personality disorders, OCDs and acute or chronic psychotic disorders.

UNDERWRITING

CONSTITUTION	GUARDED APPROACH	NUANCED UNDERWRITING APPROACH DEPENDING ON
MEDICAL CERTIFICATE • Precise diagnosis • Episodes *(date, number and hindsight)* • Treatments *(current and previous)* • Any hospital admissions *(dates and length of stays)* • Any time off work *(dates and length of sick leave)* • Or any disability	History of alcoholism or drug addiction	The exact diagnosis (neurosis VS psychosis)
	Between the 1st and 2nd year, depending on the diagnosis	The severity criterion (minor, moderate and major)
	In the 1st year, in the event of hospitalisation	The stability of the illness
Environmental factors Socio-professional status	The first 2 to 3 years, in the event of a suicide attempt	General Conditions and any restrictions (exclusions of psychiatric disorders): partial or total
	Comorbidity factors (non-compliance…)	The cover taken out ➔ increased vigilance for the complementary cover
Any suicide attempts ➔ to be rated separately		Length of time over which the illness and socio-professional status have developed

TWO PRINCIPLES OF CLAIMS MANAGEMENT

Claims management in connection with psychiatric disorders is based on early analysis, as soon as the file is opened, of the assessment of the person's current status and of the diagnosis. The analysis will depend on the covers involved and their definition, but also on the wording of the exclusions clause.

In the absence of exclusions: psychiatric disorders and sick leave are covered in the standard way. The first question is whether the sick leave is justified. The answer will be found by studying the documents in the file, to see what reasons were given on the initial sick note and the extensions. It is also necessary to look at previous status, current status and the diagnosis.

In the case of partial exclusions: the cover will depend on specific conditions and these will be relatively simple to manage. This can be done quickly, subject to having precise information about the cause of the sick leave and extensions. 90% of such claims will be dealt with by simple examination of the documents, with no need for the opinion of a medical evaluator.

In the case of total exclusions: the analysis of a case will also be based essentially on examination of the documents. Cover is refused on the basis of the strict application of the contract, with well-expressed grounds and a clear exclusion. There is no need to involve a medical evaluator straight away.

INVOLVEMENT OF A MEDICAL EVALUATOR: AT WHAT POINT?

A psychiatric assessment, usually carried out by a general practitioner, is a serious assignment with precise objectives: establishment of the patient's history and analysis of the insured's abilities. The history must be taken meticulously and include the environmental factors (patient's psychological, emotional and economic environment).

As the average duration of depression is 8 months and the average hospital stay is about a month, medical evaluators will become involved for the first time around the 5th or 6th month. At this stage, nine times out of ten, the medical evaluator approves the sick leave.
A second evaluation will be requested about the 9th month: very often, at this stage the evaluator will decide that the patient is fit to return to work and the case will be closed.
Faced with a serious situation, sick leave may be extended for even longer and a 3rd medical evaluation will then be necessary, in this case a psychiatrist will be brought in.

CONCLUSION

Notwithstanding the difficulties in evaluating a subjective illness, the assessment of psychiatric risk can, nevertheless, be based on objective criteria obtained from specific questionnaires.

SCOR Global Life's R&D Centres work on specific areas in risk assessment and claims management. With this expertise, our teams work closely with our partners to help them develop specific underwriting strategies.

Do not hesitate to contact the local teams and to consult our different medical publications: www.scor.com.

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