Liza H. Gold
Donna L. Vanderpool *Editors*

Clinical Guide to Mental Disability Evaluations

Springer

Clinical Guide to Mental Disability Evaluations

Liza H. Gold · Donna L. Vanderpool
Editors

Clinical Guide to Mental Disability Evaluations

Springer

Editors
Liza H. Gold
Georgetown University School of Medicine, Department of Psychiatry
Washington, DC
USA

Donna L. Vanderpool
Risk Management PRMS, Inc
Arlington, VA
USA

ISBN 978-1-4614-5446-5 ISBN 978-1-4614-5447-2 (eBook)
DOI 10.1007/978-1-4614-5447-2
Springer New York Heidelberg Dordrecht London

Library of Congress Control Number: 2012947853

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

We dedicate this volume to the memory of Professor Daniel W. Shuman, JD

Acknowledgments

Many people have made this volume possible. We thank the contributing chapter authors for their time, perseverance, and patience with the editing process. We thank Jill J. Chmelik, our Editorial Manager, for her organizational skills, attention to detail, and her unflagging support. We thank Salima Ali, JD, Risk Manager at Professional Risk Management Services, Inc., for her legal research assistance. We thank Tina Coltri-Marshall for her hard work getting the manuscript ready for publication. We also thank Springer for publishing this volume.

And as always, we thank the many patients and evaluees who have taught all of us about the complexities of psychiatric disability.

LHG: We grow through relationships. I would like to thank Donna L. Vanderpool, MBA, JD, for agreeing to undertake this project, her invaluable contributions, and her friendship. I thank my mentors, colleagues, and friends, for their support and encouragement. I gratefully acknowledge the role of the American Academy of Psychiatry and the Law in facilitating many of these relationships as well as my professional development. Finally, I am grateful for the love and support of my husband, Ian J. Nyden, Ph.D., and my children, Josh and Alix.

DLV: I would like to thank Liza Gold, MD for the opportunity to collaborate on this project and my family for their support.

Contents

Contributors

Stuart A. Anfang Adult Outpatient Psychiatry, Baystate Medical Center, Tufts University School of Medicine, Main Street Suite 3D 3300, Springfield, MA 01199, USA, e-mail: saanfang@aol.com

Albert M. Drukteinis Department of Psychiatry, Dartmouth Medical School, 1750 Elm Street #601, Manchester, NH 03104, USA, e-mail: aldruk@aol.com

Liza H. Gold Department of Psychiatry, Georgetown University School of Medicine, 2501 N. Glebe Rd., Arlington, VA 22207, USA, e-mail: lhgoldmd@gmail.com

Samara E. Harms Maple Key Consulting, 910 Hope Street #5B, Stamford, CT 06907-2322, USA, e-mail: Samara.harms@gmail.com

Andrew P. Levin Westchester Jewish Community Services, Columbia University College of Physicians and Surgeons, 141 North Central Avenue, Hartsdale, NY, USA, e-mail: aplevin2@cs.com

Barbara McDermott Napa State Hospital, Department of Psychiatry and Behavioral Sciences, UC Davis Medical Center, UC Davis Clinical Demonstration Unit, Stockton Blvd 2230, Sacramento, CA 95817, USA, e-mail: bemcdermott@usdavis.edu

Donald J. Meyer Beth Israel Deaconess Medical Center, Boston, MA, USA; Harvard Medical School, 1105 Massachusetts Ave. Suite 11E, 02138 Cambridge, MA, USA, e-mail: donald_meyer@hms.harvard.edu

Debra A. Pinals Forensic Education, Law and Psychiatry Program, UMass Medical School, 55 Lake Avenue North, Worcester, MA 01655, USA, e-mail: dspinals@pol.net

Marilyn Price Law and Psychiatry Service, Massachusetts General Hospital, Harvard Medical School, 15 Parkman St WAC 812, Boston, MA 02114, USA, e-mail: mprice3@partners.org

Patricia Ryan Recupero Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906, USA, e-mail: precupero@butler.org

Ronald Schouten Law and Psychiatry Service, Massachusetts General Hospital, Harvard Medical School, 15 Parkman St WAC 812, Boston, MA 02114, USA, e-mail: rschouten@partners.org

Charles Scott Division of Psychiatry and the Law, Department of Psychiatry and Behavioral Sciences, UC Davis Medical Center, Sacramento, Stockton Blvd 2230, Sacramento, CA 95817, USA, e-mail: charles.scott@ucdmc.ucdavis.edu

William J. Stejskal Curry Programs in Clinical and School Psychology, University of Virginia, Woodbridge Psychological Associates, PC, 4320 Pr. Williams Parkway, Suite 109, Woodbridge, VA 22192, USA, e-mail: wstejskal@mac.com

Donna L. Vanderpool Risk Management, PRMS, Inc., 1401 Wilson Blvd #700, Arlington, VA, USA, e-mail: vanderpool@prms.com

Barry W. Wall Eleanor State Hospital, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, 8269, Cranston, RI 02920, USA, e-mail: barrywwall@gmail.com

Robert M. Wettstein University of Pittsburg, 401 Shady Avenue Suite B103, Pittsburg, PA 15206, USA, e-mail: wettsteins@aol.com

C. Donald Williams 402 E Yakima Ave #1080, Yakima, WA 98901, USA, e-mail: cdonald@aol.com

Cheryl D. Wills Case Western Reserve University, 5247 Wilson Mills Road #452, Cleveland, OH, 44143, USA, e-mail: cwforensic@earthlink.net

Introduction

Liza H. Gold

Years ago, I was asked to perform a fitness for duty evaluation. I had never heard of this type of psychiatric evaluation in residency training, and I set out in search of information. I found very little. I broadened my search to include information on conducting psychiatric disability evaluations in general. Of course, I had heard of disability evaluations, and as a resident had filled out forms for some patients' disability claims, such as Social Security Disability Insurance claims (SSDI) and short-term leave. However, I had received no training in conducting disability evaluations, and like most of the rest of my colleagues in residency, typically viewed disability issues as simply creating annoying paperwork.

So, I turned to my colleagues for guidance on conducting a fitness for duty examination. Surprisingly, and in contrast to their other extensive areas of expertise, even experienced forensic psychiatrists could offer relatively little guidance in conducting disability evaluations generally and fitness for duty evaluations specifically. Although most clinicians I consulted, both general and forensic, had conducted disability examinations or documented disability claims, few had received specialized training in such evaluations.

Unfortunately, many mental health professionals have shared my early experiences. They are unsure how to respond when asked to document work capacity or incapacity, especially in adversarial or complicated employment claims. General clinicians and forensic specialists alike may feel discomfort when asked to provide information or opinions about impairment or disability, because most clinicians receive little or no training in how to evaluate their patients' ability to function in the workplace (Shakespeare et al. 2009; Talmage and Melhorn 2005). Despite the pervasiveness of the personal, financial, and social problems and costs associated with occupational impairment due to mental disorders, few mental health professionals have had any formal training in performing disability and other occupational assessments during their clinical training (Christopher et al. 2010, 2011). Later opportunities for training in continuing education settings are extremely limited.

In *Evaluating Mental Health Disability in the Workplace* (Springer 2009), Professor Daniel Shuman and I attempted to fill some of this gap in mental health training by providing a model for assessment of impairment and disability and discussion of the salient aspects of disability evaluations. This *Clinical Guide* is also intended to address this gap in training, but from a practical perspective, essentially as a companion volume. We hope it will assist general mental health professionals and forensic mental health specialists alike in understanding how to address requests for psychiatric disability and other mental health occupational evaluations, how to conduct them, and how best to respond to the needs that prompted the request.

Mental Health Professionals and Disability Evaluations

Many individuals in the workforce experience psychiatric disorders that create impairment and disability. Mental health impairments that compromise work functioning may precipitate voluntary or involuntary withdrawal from the workplace, claims for disability, or requests for accommodations. They can also result in workplace behavioral problems and conflicts, litigation, and even violence. Mental health professionals are consulted in order to provide information to assist employers, benefits managers, administrative systems, or legal systems in making decisions related to the claimant's employment or benefits.

Sometimes, the employees experiencing workplace problems are our own patients, and ask us to certify work disability, need for accommodation, or some other required employment documentation. Sometimes, employers or referral sources are seeking opinions from a non-treating mental health professional who has never met the evaluee prior to the workplace problem. These requests are intended to provide the referral source, which may already have the treating clinician's information, with either supplementary or corroborating information. Regardless of the source of the request, disability and other mental health evaluations create issues that can affect treatment or objectivity of evaluations, and may even give rise to liability for evaluators if not approached with expertise, care, and thoughtfulness.

Disability and occupational capacity evaluations arise in a variety of contexts in the world of competitive employment. These include public Social Security Administration disability programs and private disability insurance programs; employers' concerns about an employee's fitness for duty (FFD), including the potential for workplace violence; and employers' legal obligations under the Americans with Disabilities Act (ADA) and the more recent Americans with Disabilities Amendment Act (ADAAA) to provide accommodations to disabled employees. Workers' compensation boards often require information from general clinicians and forensic specialists to adjudicate mental health disability claims. State medical boards, other regulatory agencies, or employers may seek information about potentially compromised individuals in order to meet obligations to protect public safety.

Mental health disability and other occupational functional capacity evaluations can be as complex as the relationship people have with their work, careers, or family (see Gold and Shuman 2009), and mental health clinicians' experience and level of comfort with these types of evaluations vary widely. Most general clinicians have some familiarity with relatively routine requests to provide information for a patient's SSDI application. General practitioners less commonly encounter long-term psychiatric disability evaluations, FFD evaluations, violence risk assessments associated with employment, and ADA evaluations. In addition, whether straightforward or complex, general mental health practitioners and forensic specialists alike may find themselves entangled in boundary issues, adversarial interactions, and litigation in the course of responding to requests for opinions regarding work capacity.

Mental Health Disability: The Statistics

The gap created by the lack of training in recognizing and assessing potential work impairment is all the more notable considering that psychiatric work disability is one of the major consequences of mental illness. Between 20 and 25 % of adults of working age suffer from a diagnosable psychiatric disorder in any given year (Centers for Disease Control and Prevention 2011; United States Department of Health and Human Services 1999.) Individuals with mental disorders are employed at lower rates than individuals without mental illnesses (Erickson and von Schrader 2010; Jans et al. 2004); large numbers of individuals with psychiatric illness are nevertheless employed (Jans et al. 2004). Moreover, these individuals work in the same range of occupational categories as do people with no mental illness (Jans et al. 2004).

In the United States, 76–87 % of all adults are employed; of individuals with any psychiatric illness, 48–73 % are employed (Jans et al. 2004). Among individuals with psychiatric disorders in any given year, 30 %, approximately 6.1 million people, report some form of work disability (Jans et al. 2004). In one epidemiological study, 10.4 % of working age people (ages 21–64) in 2008 reported some form of disability. Of these employed individuals reporting a disability, 28 % or just over 2 million people reported a cognitive disability (formerly classified in this epidemiological study as mental disability) (Erickson and von Schrader 2010).

Regardless of which statistical database or study is reviewed, mental health disabilities are repeatedly cited as one of the most common reasons for unemployment, underemployment, "presenteeism," absenteeism, and insurance disability claims (Alpren and Bolduc 2010; Dewa and Lin 2000; Gold and Shuman 2009; Kessler et al. 2003; Lim et al. 2000; Sanderson and Andrews 2006; Schultz and Rogers 2011; Stewart et al. 2003; Waghorn et al. 2005; Waghorn and Chant 2005). The World Health Organization (WHO) reports that mental illnesses account for more disability in developed countries than any other group of illnesses, including cancer and heart disease (World Health Organization 2008).

Psychiatric disorders consistently rank individually and collectively in the top ten leading causes of disability among adults in the United States as well as other parts of the world (Centers for Disease Control and Prevention 2009; Dewa et al. 2010; Erickson and von Schrader 2010; National Institutes of Mental Health 2011; World Health Organization 2008).

Not surprisingly, the most common psychiatric disorders that impair functioning in a competitive employment environment are those that are the most prevalent: mood disorders, anxiety disorders, and substance use disorders (Kessler et al. 2005a, b). Notably, all of these disorders are often marked by episodic recurrences. Depression is one of the leading worldwide causes of disability (Murray and Lopez 1996) and is believed to have the largest impact on work disability (Elinson et al. 2004; Smith et al. 2003; Stewart et al. 2003). Anxiety disorders as a combined group have rates of work impairment and disability comparable to mood disorders.

Both mood disorders and anxiety disorders have higher rates of work impairment than many chronic medical conditions (El-Guebaly et al. 2007; Elinson et al. 2004; Kessler et al. 1999, 2006; Stewart et al. 2003; Wittchen et al. 2000). Substance use disorders, often found comorbidly with mood and anxiety disorders, have long been recognized as causes of significant occupational impairment (Cohen and Hanbury 1987; El-Guebaly et al. 2007; Kessler and Frank 1997; Vik et al. 2004). Comorbidity of any kind, between mental disorders or between mental and physical disorders is associated with greater levels of work impairment than any single disorder alone (Kessler et al. 2005a, b; Kessler and Frank 1997).

The costs associated with mental health disability are high and are borne by the affected workers, their families, employers, public and private insurers, health care systems, society, and government (Dewa et al. 2007; Kessler et al. 2008; Stewart 2003). The number of disability claims and the cost in lost earnings due to psychiatric disorders has been steadily rising over the past two decades and has now reached hundreds of billions of dollars (Jans et al. 2004; Harwood et al. 2000; Kessler et al. 2008; Marcotte and Wilcox-Gok 2001; National Institutes of Mental Health 2011). In a study examining the comparative incidence and costs of physical and mental health-related disabilities in an employed population, researchers found that the highest costs were associated with mental/behavioral disorder-related episodes (Dewa et al. 2010). In the United States, occupational impairment and disability associated with depression alone is estimated to cost between 36.6 and 5.1 billion dollars annually in lost productivity (Greenberg et al. 2003; Kessler et al. 2006; Stewart et al. 2003).

Disability insurance benefits are available to employed individuals from a variety of sources. Psychiatric disorders are the leading basis of claims awarded through federally funded SSDI benefits, are associated with the longest entitlement periods, and are the fastest growing segment of SSDI recipients (Social Security Administration 2010). In 2010, the percentage of disabled workers under age 50 receiving SSDI benefits for mental disability was 39.9 %, comprising by far the single largest diagnostic group. Disability insurance is also available through workers' compensation programs and private insurers. In 2009, workers'

compensation programs covered approximately 130 million people (National Academy of Social Insurance 2011). In 2010, short- and long-term disability benefits were available to 38 and 32 % of workers in the private industry respectively, and nearly all individuals who had access to disability benefits participated in the programs available to them (United States Department of Labor 2011).

National statistics regarding benefits related to psychiatric disability in workers' compensation and private insurance programs are difficult to access. Workers' compensation programs are administered on a state-by-state basis, and federal workers' compensation programs are available only to certain federal employees. Each state and federal government program compiles its own statistics. Private insurers compile statistics on disability claims and costs, but typically consider this information proprietary.

Available information indicates that in 2002, mental disorders and substance dependency accounted for 9 % of new long-term disability claims and 5 % of short-term disability claims (Society of Actuaries 2004). Between 2005 and 2009, mental disorders consistently ranked among the top ten causes of both long- and short-term disability claims. In 2009, mental disorders accounted for 7.1 % of long-term disability claims among the largest private insurance companies, and 4.1 % of all new short-term disability claims (Alpren and Bolduc 2010).

One large private insurance provider, UnumProvident, reported that depression was one of the top five causes of long-term disability in 2001, representing 5 % of all claims (EFMoody 2011). UnumProvident also reported that of the top seven causes of "preventable" absenteeism in its own 11,000 employees in 2004, depression, anxiety, and other mental health disorders combined ranked first at 66 %. Addictions and substance abuse issues were considered a separate category, but still ranked in the top seven, representing 20 % of absenteeism. Taking these two categories together, mental disorders represented 86 % of the preventable causes of UnumProvident's own employee absenteeism in 2004 (Duncan 2005).

Other sources that gather information regarding private long- and short-term disability programs consistently report that mental disorders rank among the highest percentages of long- and short-term claims and constitute a large portion of their costs (Dewa et al. 2002; Salkever et al. 2000). In 2009, the average long-term disability duration for psychiatric disorders was among the top ten longest long-term claim durations, with the average length of 32 months, and among the top five longest short-term claim durations, with the average length of 76 days (Alpren and Bolduc 2010).

Litigation associated with mental health disability claims represents another associated cost. The question of what constitutes a mental disability has been one of the most disputed issues in federal and state courts over the last decades. Mental and emotional injuries constitute the bulk of exposure in most employment litigation (Lindemann and Kadue 1992; McDonald and Kulick 2001). Of all the charges filed with the Equal Employment Opportunity Commission (EEOC) in 2010, 25 % were based on discrimination due to disability. Of these, 24.3 % of all disability discrimination charges were based on psychiatric disability, the highest

single category represented besides "Other Disability" (United States Equal Employment Opportunity Commission 2011).

The Consequences of the Training Gap in Mental Health Disability Evaluations

As the numbers of disability and other work capacity evaluations has increased over the years, the gap in mental health disability training has become increasingly problematic. The lack of postgraduate and continuing education training opportunities has resulted in a distressing variability in the quality of disability and other occupational capacity evaluations. Clinicians utilize idiosyncratic methods, which lack grounding in the available data regarding mental health and work dysfunction, and which increase the risk of the influence of bias, particularly advocacy bias, influencing opinions (Anfang 2011; Christopher et al. 2010, 2011; Gold et al. 2008; Gold and Shuman 2009).

As a general rule, clinicians often do not appreciate the scope and magnitude of the problems that can develop for employers and employees, for their patients, and sometimes even for themselves, when the issues involved in disability and occupational capacity evaluations are not adequately addressed. When patients ask a treating clinician for assistance with a disability claim, or authorize their insurers or benefit administrators to obtain information, psychiatrists and psychologists typically will fill out paperwork, often without doing any specific evaluation of work capacity. The paperwork may appear relatively straightforward and simple; however, the employment issues in question may be more subtle and complex than the paperwork might suggest. Consequently, many of these evaluations fail to meet the needs for which they have been solicited and not infrequently cause additional administrative or legal problems for the patient or the referral source.

These problems can potentially include professional liability for clinicians, an outcome rarely considered when complying with paperwork requests. Although relatively limited, liability related to disability and occupational evaluations does exist. Professional liability may arise from the role conflict, blurred boundaries, and confidentiality conflicts inherent in conducting mental health evaluations for the purpose of reporting what is typically confidential information and technically protected health information to third parties such as insurers or employers (Gold and Davidson 2007; Vanderpool 2011; see also Vanderpool, Chap. 2 in this volume). Clinicians who provide disability and functional capacity evaluations should be aware that should questions regarding their evaluations arise, they may be held to the standards of practice of forensic specialists (*Sugarman v. Board of Registration in Medicine* 1996). Conversely, forensic psychiatrists should be aware that some states consider forensic diagnosis and testimony the practice of medicine, and require licensure and compliance with the same rules

that govern treating clinicians (Federation of State Medical Boards 2008; Simon and Shuman 1999).

Some disability documentation needs are indeed straightforward enough that no particular training or expertise beyond that of the general mental health clinician is necessary. An SSDI application for a chronically disabled patient that does not create boundary or treatment issues may not require further exploration, and simply filling out the necessary paperwork will suffice. In contrast, evaluations relating to fitness for duty, the ADA, or violence risk assessment in the workplace are usually well outside a general clinician's expertise. Yet clinicians may offer opinions regarding these complex assessments without undertaking the necessary evaluations, often unaware that doing so may draw them into a complex labyrinth of legal and administrative adjudication that can sometimes rival that of criminal matters. At times, even claims that begin as apparently simple disability insurance evaluations can result in litigation, drawing unsuspecting clinicians into court to defend diagnosis, treatment, and opinions on disability.

Who Can Use the Information in this Book

This text is intended to provide practical information and guidance to mental health clinicians undertaking disability or occupational capacity evaluations at all levels of experience. It will assist general clinicians in developing enough familiarity with the various types of disability and occupational evaluations to understand what they can reasonably offer patients and referral sources if asked to provide opinions regarding disability and occupational functioning. This clinical guide will also offer guidance on recognizing and addressing the boundary issues that arise when patients ask treating clinicians to provide disability or other functional capacity documentation. In addition, we hope the information provided will help clinicians recognize when an evaluation involves complex issues and assessment that may lie outside general clinical expertise, or, if undertaken, when an evaluation becomes more complex than anticipated, and how to address these challenges.

Forensic mental health specialists can also benefit from the information presented here. The chapters reviewing highly specialized forms of disability and occupational mental health evaluations will assist forensic subspecialists in providing competent and thorough evaluations in complex cases. The difficulties and ambiguities that arise at the interface of mental health fields and the law take on another dimension of complexity when psychiatry and psychology interact with the world of paid employment. This world is extensively regulated and governed by different administrative and judicial systems charged with protecting rights of employers and employees, resolving conflicts, and administering benefits. Even experienced forensic clinicians can find the integration of these disparate worlds challenging.

This text is divided into two parts. Part I contains chapters that address issues with which anyone undertaking a disability evaluation should be familiar. Part II reviews the practical information and provides guidance on how to conduct specialized types of functional capacity and disability evaluations. Experienced mental health and legal professionals have shared their extensive experience in disability evaluations. The chapters themselves are organized to emphasize the practical orientation of the text. Chapters will begin with a case example used to highlight important aspects of discussion. In addition, each chapter will provide three to five key "key points" to emphasize the main themes of each chapter.

Part I contains chapters intended to enhance understanding of the basics elements and issues in disability assessments. Chapter 1 discusses a model for the assessment of disability that clinicians at any level of training can utilize to conduct a comprehensive disability evaluation. Chapter 2 reviews the legal, ethical, and liability issues associated with providing disability and occupational capacity assessments. Chapter 3 discusses negotiating the unavoidable boundary issues that arise when patients request disability or other occupational functioning documentation from their treating clinicians and suggests options for approaching and discussing such requests.

Part I concludes with discussions of additional subjects that are relevant to any level of disability evaluation. Chapter 4 examines balancing the options of working with accommodations and work withdrawal, and the assessment of the ability to return to work, including maintaining returning to work as a treatment goal. Chapter 5 reviews the role and types of psychological testing in disability evaluations and how to get the most out of a collaborative relationship when another mental health professional conducts testing. Chapter 6 addresses the knotty problem of malingering in disability claims, a significant issue that can adversely affect treatment relationships when clinicians feel pressured to document disability or functional impairment that they suspect is not present or is exaggerated.

Part II offers a review of the information about specific types of disability and occupational functioning evaluations and guidance in how to conduct them. The first chapters in this section will review the most common types of disability evaluations: SSDI, Workers' Compensation, and private insurance. These are evaluations typically needed when claimants report functional impairment on the basis of mental disorders, seek to withdraw from the workplace, and collect insurance benefits. However, general clinicians and forensic specialists should bear in mind that each type of claim requires an understanding of the administrative system upon which it is based to effectively provide the needed information and assessment. In addition, despite their frequency, these evaluations are not necessarily as straightforward as they may at first appear. Conflict, adversarial interaction, and litigation can result from any of these types of claims.

Chapter 7 will explore Social Security Disability Insurance from the perspective of both general practitioners and the consultative examiner, a non-treating clinician who evaluates and supplements the information provided by the claimant's own mental health provider. Chapter 8 will review workers' compensation claims, in which mental health claims pose unique challenges involving role

conflict and the potential for litigation. Chapter 9 will review issues related to evaluations for private long-term disability insurers, evaluations that can lead to intensely adversarial interactions between insurance companies and claimants.

The final chapters of the book will discuss the issues and the conduct of evaluations related to specific types of complex disability evaluations. Although primarily directed towards forensic specialists, general clinicians hopefully will find the reviews of these specialized evaluations informative. These complex mental health evaluations are distinguished from those discussed in earlier chapters. In the disability evaluations discussed in the first chapters in this section, evaluees typically wish to withdraw from the workplace. In contrast, these final chapters review evaluations that arise when employees wish to remain at work but their employers question their ability to function or maintain safety due to mental health issues. This difference of opinion between employee and employer generally results in conflict or crisis. Requests for evaluation may arise at any point in the crisis, up to and including litigation or fears of aggressive behavior in the workplace.

Chapter 10 reviews the ADA and associated evaluations related to this civil rights legislation. Evaluations for issues related to potential workplace violence are reviewed in Chap. 11. The final three chapters address Fitness for Duty evaluations, which often arise in the contexts of concerns regarding safety of the employees, coworkers, or the public. Chapter 12 will review elements of a general Fitness for Duty examinations. Chapter 13 discusses the singular issues associated with Fitness for Duty evaluations of health care providers and their public safety implications. Finally, Chap. 14 reviews Fitness for Duty for law enforcement and weapons carrying employees, evaluations that also must take public safety into consideration.

Readers should be aware that this text focuses on disability and occupational function evaluations that arise in paid, competitive employment contexts as opposed to those related to sheltered or supported employment environments. In addition, this text addresses evaluations that arise due to disorders typically encountered in the workplace, rather than disorders that prevent individuals from entering the workplace. Although serious psychiatric illness does not necessarily preclude competitive employment, labor force participation among people with serious psychiatric disorders, especially in non-sheltered employment, is relatively low.

This book will also not address areas the editors believe are adequately covered elsewhere or do not represent a significant number of evaluations. For example, pre-employment evaluations are common, and may include a mental health evaluation, but will not be addressed in this text. Certain highly regulated and specialized disability evaluations, such as those conducted within the military and Veterans Administration, are well covered in those administrative systems, and so will also not be addressed here.

Further, this discussion will not directly address any of the professional fields associated with employment-related attempts to prevent illness or disability or return disabled individuals to the workplace. Although relevant to the ability to reenter the workplace and maintain employment, the literature and evaluations related to

vocational rehabilitation, occupational illness, employee assistance programs, and other employment-related fields are beyond the scope of this discussion. Finally, the issues addressed here are not intended to address the concerns and needs of occupational mental health professionals whose primary obligation is to their employers. For example, the challenges encountered by mental health professionals employed by insurance companies for claim review purposes will not be discussed.

In conclusion, this text is intended to address an identified gap in mental health training by providing practical information and guidance to general mental health clinicians and forensic mental health specialists and by reviewing the variety of disability and functional capacity evaluations that may require mental health evaluation, documentation, and opinions. These evaluations can create boundary issues, affect treatment, and subject both treatment providers and non-treating forensic specialists to pressures and conflicts with which they may be unfamiliar.

General clinicians' patients will inevitably encounter workplace problems, bringing disability and functional capacity issues into the mental health professional's clinical practice. It is also inevitable that disability and employment problems will result at times in the need for forensic evaluations and expert testimony. Understanding how to provide these evaluations, managing role conflict, treatment and boundary issues, and recognizing when a forensic specialist may need to be consulted will assist mental health professionals at all levels of practice and experience meet their responsibilities to patients and to the administrative and legal systems that govern the world of paid labor.

References

Alpren, H., Bolduc, L. (eds.): Gen Re Disability Fact Book, 6th edn. Gen Re Life Corporation, Maine (2010)

Americans with Disabilities Act of 1990, Pub. L. No. 101–336, 104 Stat. 327 (1990) (current version at 42 U.S.C. § 12101 et seq, 2006)

Anfang, S.A.: Disability evaluations—are the evaluators able? J. Am. Acad. Psychiatry Law **39**, 194–6 (2011)

Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report Mental Illness Surveillance Among Adults in the United States. Supplements September 2, 2011 / 60(03);1–32 CDC. www.cdc.gov/mentalhealthsurveillance/. Accessed 11 Oct 2011

Centers for Disease Control and Prevention: Number of US Adults Reporting a Disability is Increasing. www.cdc.gov/Features/Disabilitycauses (2009). Accessed 2 Oct 2011

Christopher, P.P., Arikan, R., Pinals, D.A., et al.: Evaluating psychiatric disability: Differences by forensic expertise. J. Am. Acad. Psychiatry Law **39**, 183–8 (2011)

Christopher, P.P., Boland, M.D., Recupero, P.R.: Psychiatric residents' experience conducting disability evaluations. Acad. Psychiatry **34**(3), 211–215 (2010)

Cohen, M.J., Hanbury, R.F.: Psychiatric disability and substance use disorders. In Meyerson, A.T., Fine, T. (eds.) Psychiatric Disability: Clinical, Legal and Administrative Dimensions, pp. 83–117. American Psychiatric Press, Inc., Washington (1987)

Dewa, C.S., Chau, N., Dermer, S.: Examining the comparative incidence and costs of physical and mental health-related disabilities in an employed population. J. Occup. Environ. Med. **52**(7), 758–62 (2010)

Dewa, C.S., Goering, P., Lin, E., et al.: Depression-related short-term disability in unemployed population. J. Occup. Environ. Med. **44**, 628–633 (2002)
Dewa, C.S., Lin, E.: Chronic physical illness, psychiatric disorder and disability in the workplace. Soc. Sci. Med. **51**(1), 41–50 (2000)
Dewa, C.S., McDaid, D., Ettner, S.L.: An international perspective on worker mental health problems: Who bears the burden and how are costs addressed? Can. J. Psychiatry **52**(6), 346–56 (2007)
Duncan, D.: The Unum Corporation Wellness Program. www.safetyxchange.org/financing-safety/the-unumprovident-corporation-wellness-program (2005). Accessed 13 Oct 2011
El-Guebaly, N., Currie, S., Williams, J., et al.: Association of mood, anxiety, and substance use disorders with occupational status and disability in a community sample. Psychiatric Serv. **58**, 659–667 (2007)
Elinson, L., Houck, P., Marchus, S.C., et al.: Depression and the ability to work. Psychiatric Serv. **55**, 29–34 (2004)
Erickson, W., Lee, C., von Schrader, S.: Disability Status Report: The United States. Ithaca, NY: Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics. http://digitalcommons.ilr.cornell.edu/edicollect/1285/ (2008). Accessed 12 Oct 2011, 2010
EF Moody: Disability Probability. www.efmoody.com/insurance/disability statistics.html (2011). Accessed 11 Oct 2011
Federation of State Medical Boards. Expert Witness Qualifications, last updated 7/1/08. From the Federation of State Medical Boards website, http://www.fsmb.org/pdf/GRPOL_ExpertWitness.pdf. Accessed 24 Oct 2011
Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: American Academy of Psychiatry and the Law Practice Guideline for the Forensic Evaluation of Psychiatric Disability. J. Am. Acad. Psychiatry Law **36**, S3–S50 (2008)
Gold, L.H., Davidson, J.E.: Do you understand your risk? Liability and third party evaluations in civil litigation. J. Am. Acad. Psychiatry Law **35**, 200–210 (2007)
Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. Springer, New York (2009)
Greenberg, P.E., Kessler, R.C., Birnbaum, H.G., et al.: The economic burden of depression in the United States: How did it change between 1990 and 2000. J. Clin. Psychiatry **64**, 1465–1475 (2003)
Iezzoni, L.I., Freedman, V.A.: Turning the disability tide: The importance of definitions. J. Am. Med. Assoc. **299**(2), 332–334 (2008)
Jans, L., Stoddard, S., Kraus, L.: Chartbook on Mental Health and Disability in the United States. An InfoUse Report. Department of Education, National Institute on Disability and Rehabilitation Research, Washington, DC, US (2004)
Harwood, H., Ammen, A., Denmead, G., et al.: The Economic Cost of Mental Illness. National Institute of Mental Health, Rockville (2000)
Kessler, R.C., Akiskal, H.S., Ames, M., et al.: Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers. Am. J. Psychiatry **163**, 1561–1568 (2006)
Kessler, R.C., Berglund, P., Demler, O., et al.: Lifetime prevalence and age-of-onset distributions of DSM-IV in the National Comorbidity Survey Replication. Arch. Gen. Psychiatry **62**, 593–602 (2005a)
Kessler, R.C., Chiu, W.T., Demler, O., et al.: Prevalence, severity, and comorbidity of the 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch. Gen. Psychiatry **62**, 617–627 (2005b)
Kessler, R.C., Dupont, R.L., Berglund, P., et al.: Impairment in pure and comorbid generalized anxiety disorder and major depression at 12 months in two national surveys. Am. J. Psychiatry **156**, 1643–1678 (1999)

Kessler, R.C., Frank, R.G.: The impact of psychiatric disorders on work loss days. Psychol. Med. **27**, 861–873 (1997)
Kessler, R.C., Heeringa, S., Lakoma, M.D., et al.: Individual and societal effects of mental disorders on earnings in the United States: Results from the National Comorbidity Survey Replication. Am. J. Psychiatry **165**, 703–711 (2008)
Kessler, R.C., Ormel, J., Demler, O., et al.: Comorbid mental disorders account for the role impairment of commonly occurring chronic physical disorders: results from the National Comorbidity Survey. J. Occup. Environ. Med. **45**(12), 1257–66 (2003)
Lim, D., Sanderson, K., Andrews, G.: Lost productivity among full-time workers with mental disorders. J. Ment. Health Policy Econ. **3**(3), 139–146 (2000)
Lindemann, B., Kadue, D.D.: Sexual Harassment in Employment Law. The Bureau of National Affairs, Inc., Washington, D.C. (1992)
Marcotte, D.E., Wilcox-Gok, V.: Estimating the employment and earnings costs of mental illness: recent developments in the United States. Soc. Sci. Med. **53**, 21–27 (2001)
McDonald, J.J., Kulick, F.B.: Preface. In McDonald, J.J., Kulick, F.B. (eds.): Mental and Emotional Injuries in Employment Litigation; 2nd edn. pp. xxxvi–xlv. The Bureau of National Affairs, Inc., Washington, D.C. (2001)
Mont, D.: Measuring Disability Prevalence. The World Bank Special Protection Discussion Paper, No. 0706. http://siteresource.worldbank.org/DISABILITY/Resource/Data/MontPrevalence.pdf (2007). Accessed 2 Oct 2011
Murray, C., Lopez, A.D. (eds.): The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Disease, Injuries and Risk Factors in 1990 and Projected to 2020. Harvard University Press, Cambridge (1996)
National Institute of Mental Health: Leading Individual Diseases/Disorders. www.nimh.nih.gov/statistics/index.shtml. Accessed 2 Oct 2011
National Academy of Social Insurance, Workers Compensation: Benefits, Coverage, and Costs (2009). www.nasi.org/sites/default/files/research/Workers_Comp_Report_2009.pdf (2011). Accessed 2 Oct 2011
Salkever, D.S., Goldman, H., Purushothaman, M., et al.: Disability management, employee health and fringe benefits, and long-term-disability claims for mental disorders: An empirical exploration. Milbank Q **78**(1), 79–113, (2000)
Sanderson, K., Andrews, G.: Common mental disorders in the workforce: Recent findings from descriptive and social epidemiology. Can. J. Psychiatry **51**(2), 63–75 (2006)
Shakespeare, T., Iezzoni, L.I., Groce, N.E.: The art of medicine: Disability and the training of health professionals. Lancet **374**, 1815–1816 (2009)
Schultz, I.Z., Rogers, E.S. (eds.): Work Accommodation and Retention in Mental Health. Springer, New York (2011)
Simon, R.I., Shuman, D.W.: Conducting forensic examinations on the road: Are you practicing your profession without a license? J. Am. Acad. Psychiatry **27**, 75–82 (1999)
Smith, C.S., Folkard, S., Fuller, J.A.: Shiftwork and working hours. In: Quick, J.R., Tetrick, L.E. (eds.) Handbook of Occupational Health Psychology, pp. 163–183. American Psychological Association, Washington D.C. (2003)
Social Security Administration: Social Security Online: Annual Statistical Report on the Social Security Disability Insurance Program. www.ssa.gov/policy/docs/statcomps/di_asr/2010/index.html (2010). Accessed 21 Oct 2011
Society of Actuaries Disability Chart Book Task Force. Disability Insurance: A Missing Piece in the Financial Security Puzzle. www.actuarialfoundation.org/consumer/disability_chartbook.pdf (2004). Accessed 2 Oct 2011
Stewart, W.F., Ricci, J.A., Chee, E., et al.: Cost of lost productive work among US workers with depression. J. Am. Med. Assoc. **289**, 3135–3144 (2003)
Sugarman v. Board of Registration in Medicine, 662 N.E.2d 1020 (Mass. 1996)
Talmage, J.B., Melhorn, J.M.: Preface. In: Talmage, J.B., Melhorn, J.M. (eds.) A Physician's Guide to Return to Work. pp. xi–xiv. American Medical Association Press, Chicago (2005)

United States Department of Health and Human Services. Web site: www.surgeongeneral.gov/library/mentalhealth/ (1999). Accessed 22 Oct 2011

United States Department of Labor. Bureau of Labor Statistics August 2007 National Compensation Survey: Employee Benefits in Private Industry in the United States. www.bls.gov/ncs/ebs/sp/ebsm0006.pdf (2007). Accessed 12 Oct 2011

United States Department of Labor. Bureau of Labor Statistics: Life, Short-term Disability, and Long-term Disability Insurance Benefits. www.bls.gov/ncs/ebs/benefits/2011/ownership_private.htm#life (2011). Accessed 21 Oct 2011.

United States Equal Employment Opportunities Commission, Enforcement and Litigation Statistics. www.eeoc.gov/eeoc/statistics/enforcement/. Accessed 12 Oct 2011

United States Social Security Administration: Annual Statistical Supplement 2010. www.socialsecurity.gov/policy/docs/statcomps/supplement/2010/index.html. Accessed 13 Oct 2011

Vanderpool, D.L.: Risks of harm to the forensic expert: The legal perspective. In Sadoff, R.L. (ed.): Ethical Issues in Forensic Psychiatry: Minimizing Harm. Wiley, Hoboken, 197–211 (2011)

Vik, P.W., Cellucci, T., Jarchow, et al.: Cognitive impairment in substance abuse. Psychiatr. Clin. North Am. **27**, 97–109 (2004)

Waghorn, G.R., Chant, D.: Disability, employment and work performance among people with ICD-10 anxiety disorders: Characteristics from a population survey. J. Anxiety Disord. **19**, 642–657 (2005)

Waghorn, G.R, Chant, D., White, P., et al.: Employment restrictions among persons with ICD-10 anxiety disorders. Aust. N. Z. J. Psychiatry **39**, 55–66 (2005)

Wittchen, H.U., Carter, R.M., Pfister, H., et al.: Disabilities and quality of life in pure and comorbid generalized anxiety disorder and major depression in a national survey. Int. Clin. Psychopharmacol. **15**, 319–328 (2000)

World Health Organization: The global burden of disease—2004 update, Geneva: WHO. www.who.int/healthinfo/global_burden_disease/2004_report_update/en/ (2008). Accessed 11 Oct 2011

Part I
General Issues in Mental Health Disability Evaluations

Chapter 1
Mental Health Disability: A Model for Assessment

Liza H. Gold

Introduction

Mental health occupational disability is often associated with severe psychotic disorders or profound and pervasive developmental disorders. However, individuals with these severe disorders are rarely encountered in routine employment mental health disability requests and referrals, since they typically preclude competitive employment. Occupational impairment in the world of competitive employment is most commonly associated with the most prevalent psychiatric disorders in the general population: mood disorders, anxiety disorders, and substance use disorders (Kessler 2005). This is not surprising, as these conditions do not typically preclude competitive employment. Nevertheless, even mild impairments associated with these common disorders can result in occupational disability.

Disability and other occupational capacity evaluations arise in a variety of contexts. However, all disability programs typically require medical documentation to support submitted claims. Mental health professionals are most familiar with disability claims and evaluations associated with public Social Security Disability Insurance (SSDI), administered by the Social Security Administration (SSA), and with private disability benefit insurance. Many will also have had some interaction with their patients' workers' compensation claims, which also require clinical documentation, and which may explicitly place the mental health clinician in the dual role of treatment provider and disability evaluator.

Other employment circumstances give rise to less common but often high stakes mental health disability evaluations. The Americans with Disabilities Act (ADA) may result in referrals for mental health disability evaluations as employers

L. H. Gold (✉)
Department of Psychiatry, Georgetown University School of Medicine,
2501 N. Glebe Rd., Arlington, VA 22207, USA
e-mail: lhgoldmd@gmail.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_1,

strive to meet their legal obligations to provide accommodations to certain disabled employees. State medical boards, other regulatory agencies, or employers may seek information about or evaluations of potentially compromised individuals in a number of industries and professions in order to meet obligations to protect public safety. Employers' concerns regarding an employee's ability to perform the essential functions of the job safely can give rise to fitness for duty evaluations (FFD), including the evaluation of the potential for workplace violence.

Although the information mental health professionals provide is essential to the adjudication of claims and some employment conflicts, mental health professionals do not make disability determinations. The definition of disability is specific to that type of evaluation, and employers, insurance companies, administrators, or sometimes judges are the final arbiters of a claimant's eligibility for benefits or any other associated outcome. Therefore, even when mental health professionals provide disability evaluations and documentation for their own patients, they are more akin to forensic clinical evaluations such as competency to stand trial or criminal responsibility, in which mental health evaluators do not have a treatment relationship with the evaluee.

Most mental health clinicians are unlikely to be asked to provide a competency to stand trial evaluation in the course of their clinical practice. In contrast, most are asked at some time in their professional lives to provide a disability evaluation or document impairment in support of a patient's disability claim. Some clinicians may choose to provide disability evaluations as independent medical evaluations (IME) for non-patient evaluees as a standard part of their mental health practices. These mental health professionals may or may not have forensic training, as IMEs are a type of forensic evaluation. Some disability or occupational functioning evaluations are so legally and administratively complex that they require forensic training and experience, and will only be referred to mental health professionals with these qualifications.

The specific type of disability evaluation will provide the context for the evaluation, and clinicians should understand these contexts. The American Academy of Psychiatry and Law has published a practice guideline that addresses the general elements related to conducting disability evaluations (Gold et al. 2008). Although this guideline is forensically oriented, the general issues section reviews information relevant to both general mental health clinicians and forensic subspecialists. Subsequent chapters in this volume will review salient aspects of specific types of disability evaluations, and will review many of these general issues as they relate to the type of evaluation under discussion.

Regardless of the level of training, orientation of practice, status of relationship with an evaluee, or type of disability evaluation, mental health professionals should be able to articulate a narrative case formulation hinging around the different but related questions, "What has changed?" and "Why is this individual placing a disability claim at this time?" The case formulation is an account of the process by which evaluees have come to identify themselves, or be identified, as so impaired as to be occupationally disabled, and facilitates addressing the questions common to all types of disability evaluations. This chapter offers a

model for constructing these narratives and applying them to guide responses to the "Frequently Asked Questions" (FAQs) of mental health disability evaluations.

Case Example

Ms. Smith is a 45-year-old, single, woman who was a vice-principal at a public high school. After working as a language teacher for 22 years, she was promoted to vice-principal, with responsibility for managing staffing, budgeting, and scheduling of the language arts program. Ms. Smith had a history of Major Depression, Recurrent, diagnosed at age 25, but had managed her disorder on an outpatient basis with individual psychotherapy, medication, and the strong support of her mother, with whom Ms. Smith lived. Ms. Smith's depression had limited some aspects of her social and occupational functioning, but she was able to maintain employment in her chosen career as a language teacher.

In the year prior to her promotion to vice-principal, Ms. Smith's mother was diagnosed with leukemia. The summer prior to beginning her first academic year as vice-principal, Ms. Smith's mother died. As she began her new position, Ms. Smith, grieving for her mother, appeared to have an exacerbation of depression. A close friend came to live with her for six months, and Ms. Smith was able to go to work, although she acknowledged her job performance was less than she had hoped.

Over the next months, Ms. Smith became increasingly sensitive to criticism. The principal's mid-year performance review of Ms. Smith noted problems in organization, concentration, and interpersonal functioning, but also noted that Ms. Smith's mother had recently passed away and that Ms. Smith needed more time to adjust to her new job responsibilities. Ms. Smith, who took great pride in her work and who had in the past struggled to meet job expectations even when depressed, was distressed by this review, which although not bad, was the worst she had ever received. She interpreted her principal's attitude toward her as unfairly critical, and Ms. Smith became fearful of her principal, with whom she had previously had a good relationship, avoiding him whenever possible.

Shortly after the mid-year review, Ms. Smith's friend moved out. Once living alone, Ms. Smith became increasingly fatigued, but could not sleep well. Her appetite decreased and she began to lose weight. She became so anxious that she developed panic attacks before scheduled meetings at which the principal would be present. Ms. Smith began to express her belief to colleagues, who had seen Ms. Smith become more tearful and anxious, that the principal intended to fire her no matter what she did. She began to call in sick and stopped leaving the house.

Ms. Smith's friend became alarmed at Ms. Smith's condition and encouraged Ms. Smith to admit herself to a psychiatric hospital. Ms. Smith took medical leave for the last few months of the school year. Ms. Smith spent three weeks at an inpatient unit, but developed symptoms of agitated depression despite aggressive medication treatment. She underwent a course of ECT, and her mood, vegetative

symptoms, and functioning improved enough for Ms. Smith to be discharged from the hospital.

Nevertheless, Ms. Smith was still symptomatic and less functional than she had been in the past. Ms. Smith's anxiety and depressive symptoms increased as she anticipated returning to work at the start of the new academic year. Ms. Smith applied for long-term disability benefits through the teacher's union group private insurance policy and through Social Security, believing herself no longer capable of working.

Diagnosis, Impairment, and Disability: A Complicated Relationship

A case formulation, based on understanding the process of disability development specific to each individual, begins with the understanding of the complicated and often misunderstood relationship between psychiatric diagnoses, impairment, and mental health disability. The presence of a psychiatric diagnosis does not automatically imply any significant functional impairment, nor does it provide specific information about a given individual's symptoms, impairments, history, prognosis, or functional status. Moreover, functional impairment and disability are not an inevitable part of the clinical presentation of any disorder (Sanderson and Andrews 2006). Even when present, functional impairment does not necessarily result in disability.

For example, depression is widely acknowledged to be a major source of disability (Jans et al. 2004; Murray and Lopez 1996). However, not all individuals with depression experience symptoms that cause functional impairment. In the case example, Ms. Smith has had a diagnosis of Major Depression for 20 years. Despite intermittent episodes of depression associated with some impairment, she had only recently come to experience work impairment severe enough to consider herself disabled.

Diagnostic assessment typically incorporates functional status as a criterion of severity of illness. Nevertheless, diagnoses do not provide and were not designed to provide the type of information that administrative or legal systems considering disability seek or require to determine eligibility for benefits, accommodations, or damages (American Psychiatric Association 2000). It is not the disorder "depression" itself that is disabling. Rather, symptoms of depression such as psychomotor retardation, insomnia, and impaired concentration can result in functional impairment.

Diagnoses are of course relevant and appropriate for use in disability evaluations. From a practical perspective, statutes or regulations may require that a diagnosis be present for benefit eligibility. For example, in order to qualify for SSDI benefits, an individual has to meet the criteria for a recognized DSM diagnosis. From an assessment perspective, diagnostic categories provide a

validated means of organizing thinking and using evidence-based data to understand symptom profiles that can direct an examiner to explore relevant psychiatric issues, such as patterns of symptom presentation and potential impairment (Gold 2002; Gold and Shuman 2009). In addition, diagnostic categories also provide information that informs opinions regarding appropriate treatment, reasonableness of claims of impairment and disability, prognosis and, to some degree, the likelihood of future impairment and disability.

However, a potentially wide range of functional difficulties is associated with any diagnostic category. Not everyone with a specific disorder will have all the possible impairments associated with that disorder. Even the severity of psychiatric symptoms and illness do not necessarily equate with functional impairment. Although generally speaking severity of illness and degree of impairment should have some proportional relationship, the loss of function may be greater or less than the impairment might imply, and the individual's performance may fall short of or exceed that usually associated with the impairment (Bonnie 1997; Simon 2002).

Another challenge in conceptualizing the relationship between an individual's diagnosis, impairments, and the development of disability lies in the confusing relationship between the terms "impairment" and "disability." Although often used synonymously, these terms represent two different, albeit clearly related, concepts. Impairment is "a significant deviation, loss, or loss of use of any body structure or body function in an individual with a health condition, disorder or disease" (American Medical Association 2008, p. 5). Impairment constitutes an observational description that should be measurable in some way and related to a health condition.

Disability, in contrast, is "activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease" (American Medical Association 2008, p. 5). Disability is really a legal term of art, defined differently in different legal or administrative contexts, only one of which is usually relevant in any given case. Disability is circumstance specific; it is the result of the relationship between an individual's impairment and the demands placed upon that individual. For example, an individual with Bipolar Disorder might be not be able to work excessive, irregular, night hours. This might be disabling for a solo practitioner obstetrician, but may not represent a significant problem for an office-based dermatologist.

Although, as noted, degree of impairment should be proportional to the severity of the mental disorder, degree of disability is not associated with any particular diagnosis and may not be proportional even to the degree of impairments. Identifying impairments and associated work dysfunction is the central task in a mental health disability evaluation. For example, individuals with episodic Bipolar Disorder may also experience chronic symptoms even between episodes that impair their workplace functioning, while individuals with Paranoid Delusional Disorder may be able to maintain certain types of employment if those jobs do not escalate or interact with their delusional thinking.

Disability: The Balance Between Internal and External Circumstances

Consideration of all the factors that may be relevant to a disability claim is part of the analysis of the disability process and case formulation. The relationship between impairment and disability is difficult, if not impossible, to predict. Some individuals may become disabled even when experiencing a mild impairment in function, if that impairment affects an essential job skill. Others may experience severe impairments and not become disabled if those impairments do not affect job requirements (American Medical Association 2008). Even the most profoundly impaired individuals may maintain remarkable productivity in their own occupations, if they are highly motivated and are able to draw upon psychological resources, social support, resiliency, and adaptational capacities.

Most individuals with psychiatric disorders who become disabled or who perceive themselves to be disabled have reached that point after a process involving many factors other than psychiatric symptoms. Retrospective assessment demonstrates different patterns of development of disability. The balance and progression toward disability depend on the nature of the disorder, the job requirements, and a variety of other medical and non-medical factors.

The complexity of the relationships between psychiatric impairment and functional limitations of any kind is further complicated by the fact this relationship is not linear or unidirectional. Activity limitations and participation restrictions are not static, and may vary over time as a result of numerous physical and psychological factors (American Medical Association 2008). Patterns of development of disability involve a dynamic balance between internal factors unique to the individual and external factors that affect the individual's ability to work. The balance may fluctuate in breadth and severity at different points in a person's lifetime depending on internal and external changes or circumstances.

In the case example, Ms. Smith has a history of good functioning even when experiencing symptoms. For 20 years, the balance of internal circumstances, i.e., intermittent episodes of depression, with Ms. Smith's external circumstances, i.e., good social support and static job demands, resulted in a reasonably good functional status. Ms. Smith's occupational functional capacity deteriorated not due to a change in diagnosis, but due to changes in her internal and external circumstances: an exacerbation of depressive disorder, loss of a crucial supportive relationship, and an increase in job demands.

Regardless of diagnosis, the assessment of symptoms, impairment, and compromised work functions depends on the interaction between the individual's symptoms, job requirements, and a host of other factors that may be only tangentially related, if at all, to psychiatric disorders and impairment. A worker's decision to withdraw from the workplace, opt for a disability status, and apply for benefits may be the solution to social, employment, or psychological conflicts that have little do with impairment due to psychiatric illness, even if an illness is present.

For example, an individual nearing retirement experiencing conflict with a new supervisor may find the emotional conflict associated with applying for disability retirement benefits less difficult than the emotional conflict associated with continuing to work with the new supervisor. The employee may have a history of psychiatric disorder, such as depression, and may be experiencing more emotional distress due to problems with the supervisor. However, the actual level of impairment associated with depression may not have changed; rather, the individual may misattribute current emotional distress to the pre-existing diagnosis and claim that the depression has worsened to the point where he or she is now disabled.

Some individuals, for whom a disabled status is psychologically unacceptable, may attempt to avoid disengaging from work even if continuing to work aggravates or irreparably worsens the underlying condition. Sadly however, many people find it psychologically less difficult to adopt the position that they cannot work due to illness rather than acknowledge they are withdrawing from the workplace because of internal or external conflict. Paid employment is such a highly valued and socially significant activity that absent a retirement status (with its implied productive work history), many people cannot bring themselves to admit they are opting to withdraw from the workplace, even if they make this choice for compelling personal, social, or economic reasons.

Similarly, some claimants may find it less distressing to claim disability based on psychiatric illness rather than acknowledge they no longer like or cannot tolerate the stress of their job. If they acknowledge they dislike their job circumstances, then they must acknowledge they bear the burden of seeking new employment. Looking for a new job is difficult, stressful, and anxiety provoking under the best of circumstances; in difficult economic times, or when an individual is experiencing personal problems, it can be overwhelming. Many of these individuals are experiencing job stress or burnout (Gold and Shuman 2009). They often genuinely mistake their emotional state for disorders such as depression. In addition, such individuals may be able to meet dependency or entitlement needs by receiving disability benefits or adopting a "sick" role, a role that also implies no moral failure on their part if they do not seek alternate employment.

Therefore, in mental health disability evaluations, the most significant factor in the assessment of the effect of any psychiatric disorder on work function is the interaction of specific impairments with the specific job requirements. Absolute diagnostic clarity may be difficult to determine under the circumstances of many disability evaluations. Patients, employers, insurers, benefit administrators, and other involved parties often become fixated on disagreements over differences of opinion regarding diagnosis. Nevertheless, the ability to assess and explain how symptoms associated with a diagnosis affect a specific set of work skills is usually more important than a diagnostic label and more relevant to an adjudication of disability.

Case Formulation, Causation, and the FAQs of Disability Evaluations

Disability evaluations require mental health professionals to provide opinions or answers to a number of relatively standard questions. The mental health professional will not have to answer all these questions in every disability evaluation. For example, SSDI benefits programs (see Chap. 7) and private disability benefits programs (see Chap. 9) are not concerned with issues of causation of disability, whereas causation is a central issue in a worker's compensation evaluation (see Chap. 8). Some evaluations request mental health clinicians to provide opinions on whether evaluees are disabled for their own type of work or any type of work. Others specifically request that mental health clinicians refrain from providing an opinion regarding disability at all. Nevertheless, as a group, these questions are the "FAQs" of disability evaluations. Table 1.1 lists questions common to disability evaluations and illustrates the context of the subsequent discussion.

Ms. Smith's SSDI benefits application requires information from her treating clinicians, but her private long-term disability insurance company requests an IME. Both claims encompass requests for a combination of the information and opinions listed in the FAQs (see Table 1.1). Ms. Smith's treating clinician and the independent mental health professional will find the task of providing the needed information and opinions facilitated by a case formulation that asks why Ms. Smith is claiming disability at this time. What has changed that has resulted in Ms. Smith's belief she can no longer engage in competitive employment?

Table 1.1 Disability Evaluations: Common Referral Questions

1. What is the claimant's diagnosis?
2. What are the claimant's psychiatric symptoms and related work impairments?
3. What has caused the claimant's condition?
4. Is the claimant disabled
    a. for their own type of work?
    b. for a specific type of work?
    c. for any type of work?
5. What kind of past and current treatment has the claimant received?
    a. Is the treatment adequate?
    b. Has the claimant responded to treatment?
    c. Does the evaluating mental health professional have treatment recommendations, including recommendations for medical consultations or psychological testing
6. Is the claimant motivated to return to work?
7. What is the claimant's prognosis?
8. Has the claimant reached maximum medical improvement?
9. Does the claimant have restrictions and limitations?
    a. What are the restrictions and limitations?
    b. How long will the claimant require these be in place?
10. Is there evidence of malingering, or primary or secondary gain affecting the claimant's disability claim or medical condition?

The "why now" and "what has changed" questions may be referred to more formally as "causation." Identifying the event that triggers the process of changing psychological impairments into work-related disabilities is essential to understanding the dynamics of the process in which the individual's current claim of disability evolved. Certain types of disability evaluations, such as workers' compensation claims and disability evaluations associated with personal injury litigation, may require mental health clinicians to provide an opinion regarding causation. However, in many disability evaluations, causation is not relevant to the adjudication of the claim and the mental health evaluator will not be asked to provide an opinion on this issue. Nevertheless, even when causation is not relevant to eligibility for disability benefits, it is always relevant to a mental health case formulation.

Therefore, as mental health disability evaluators collect clinical and documentary information regarding the evaluee, even if they are the treating clinicians, they should formulate a hypothesis, including causation, describing the process by which their patients or evaluees have come to see themselves as disabled. Understanding the process by which individuals come to be or to consider themselves disabled is central to the evaluation of disability and the development of a case formulation. Understanding the elements of this process will facilitate answering the questions posed in a disability evaluation.

The information needed for a disability case analysis generally requires more information than can be obtained from a single interview with the evaluee or patient. Collateral information is usually necessary to provide enough information to understand a dynamic process that unfolds over time and involves many variables, especially since an individual's level of functioning may vary considerably over time and in different circumstances. This information can come from a variety of collateral sources, including medical records, insurance records, employment records, and third-party informants (see Gold et al. 2008). The types of information that might be reviewed are provided in Appendix I. The specific type of evaluation, reviewed in subsequent chapters in this volume, will typically suggest the type and degree of collateral information required, and of course, evaluators may not have access to or be legally entitled to all possible sources of information. Regardless of the type of disability evaluation, however, enough information to provide an adequate longitudinal assessment is necessary for a case formulation.

The Work Capacity Model[1]: Factors in the Equation

One model for developing these hypotheses utilizes the concept of work capacity, an assessment of the balance between a person's work supply and work demand (Battista 1988). Disability occurs when supply does not exceed demand. People

[1] The work capacity model discussed in this chapter is a model for analysis of mental health disability. The work capacity model is unrelated to the social science debates regarding

Table 1.2 Work capacity equations

Adequate work capacity = work supply ≥ work demand
• higher supply than high work demand
• high supply and low work demand
• low supply but lower work demand
Inadequate work capacity = work supply ≤ work demand
• high work supply but higher work demand
• low work supply and high work demand
• lower work supply than low work demand

rarely become disabled due to mental disorders overnight. Therefore, work capacity usually must fall below some minimal functional level for some period of time for people to consider themselves or be determined to be disabled due to mental disorders. Various combinations of work supply and work demand levels can result in adequate or inadequate work capacity (see Table 1.2).

The relationship between work supply and work demand is essential to understanding the functional impact that impairment has on a person's ability to perform the tasks associated with a specific job. Although work supply and demand assessments are not traditional mental health concepts, they translate into a series of assessments familiar to mental health professionals. These involve understanding and appreciation of

1. Job description, i.e., work demand
2. Previous and current performance and employment history, historical work supply
3. Current diagnosis, symptoms, impairments, and treatment, i.e., possible decreased work supply due to mental health issues
4. Psychosocial history and stressors, i.e., possible decreased work supply due to non-mental health issues

The analysis of changes in an individual's work capacity based on work supply and demand requires the type of longitudinal assessment also familiar to mental health professionals from their clinical training.

1. Work Demand: The Job Description

A detailed job description and an understanding of specific job demands are central to the determination of whether work capacity exceeds or falls below demand.

Most jobs can be described through the use of four categories of work demands (Gold and Shuman 2009; Leclair and Leclair 2001):

(Footnote 1 continued)
whether the medical or social models of defining disability best serves public policy and social needs relating to addressing problems associated with disability.

a. Physical: e.g., type and degree of physical exertion
b. Cognitive: e.g., attention, concentration, memory, problem solving
c. Affective: e.g., emotional responses to work requirements, work stress, job "fit"
d. Social: e.g., ability to work with a group, to supervise others, to be supervised

A written job description, although helpful, often does not cover all areas of job demand. A more detailed function-oriented job analysis may need to be obtained from the evaluee or another knowledgeable source.

Evaluators should attempt to determine whether the demands of the job have changed. For example, promotions may result in increased job responsibilities. In the case of Ms. Smith, the fact that she had taken on new and unfamiliar administrative responsibilities is critical to understanding her difficulties in functioning. Other events can also create changes in job demand. Lay-offs or reductions in force can result in increased workloads as well as increased job stress and decreased morale. Increased job demand may also involve physical changes rather than workload, such as relocation from a private office to an open, cubicle environment with less privacy and elevated noise levels.

2. Work Supply: Performance and Employment History

The assessment of an individual's baseline work supply requires a review of performance and employment history. These may provide historical evidence of high or low work functioning. Documented performance problems, frequent job transfers, or performance improvement plans might support a pattern of long-term functional impairments and a historically low work supply regardless of job demands. Long-term stable employment, consistent promotions and raises, and consistently good performance evaluations would support a pattern of relatively high baseline work supply. Because the workplace itself may be a significant source of stress, if individuals have attempted to withdraw from the workplace but then tried to return, examiners should look for evidence of repeated deterioration upon the claimant's return to work.

Assessment of work supply also requires assessment of the ability of a number of work-related functions. In addition to specific tasks unique to any job, certain basic work skills that parallel the physical, cognitive, affective, and social domains mentioned above must be available. Many work tasks involve more than one domain of functioning. Therefore, the assessment of these domains can be combined and reviewed as certain general work abilities (Enelow 1988; Gold and Shuman 2009; Lasky 1993). These fall into two broad categories: individual functions that typically do not have a social or interpersonal component, and functions that by their nature require social capacities.

Work demands such as completing a normal workday or week, or reporting to work on time do not typically rely on others. The ability to perform complex tasks includes the ability to make generalizations, evaluations, or decisions without immediate supervision. Evaluators should also assess whether individuals can handle routine work pressures, such as meeting normal deadlines, and whether they can handle more than routine or customary work stressors or pressures, such

as working overtime or covering the responsibilities of others as well as doing their own job in the event of a work shortage. The ability to work without supervision, to think independently, make decisions, and initiate and carry through self-directed activities, are higher order work functions present in numerous jobs and always present in managerial positions.

Work functions that involve social skills require both communication and interpersonal skills. Evaluators should consider whether an individual can accept and respond appropriately to routine supervisory comments, performance evaluations, and constructive criticism. Many jobs require a joint effort for completion of a task. In such jobs, individuals have to be able to communicate with and respond appropriately to fellow workers. The ability to supervise others requires the ability to delegate responsibility in an appropriate manner and direct other individuals who operate in support roles (Lasky 1993).

Ms. Smith's treating mental health clinician has to provide information for Ms. Smith's SSDI claim. The SSA uses a similar method of assessing categories of work functioning in describing impairments due to symptoms of mental illness. Ms. Smith's treating clinician should be familiar with the SSA's categories (see Chap. 7) in order to adequately address them in his report of Ms. Smith's impairments. The independent mental health evaluator has not been asked to evaluate categories of functioning. Nevertheless, regardless of which categories of assessment are utilized, mental health professionals providing disability evaluations should routinely consider standard elements associated with general and specific work abilities that comprise a person's immediate and historical work supply.

Mental health evaluators should bear in mind that a high baseline work supply does not necessarily indicate the absence of any impairments due to symptoms of psychiatric disorders. A high baseline work supply may reflect extraordinary adaptational skills or profound work commitment. At times, individuals with impairments will prioritize work functioning to maintain work supply and sacrifice other areas of functioning, such as social functioning and maintaining medical health, to do so. In addition, long-term impairment of work capacity and supply may be due to factors other Axis I psychiatric diagnosis. Nevertheless, assessing changes in functional capacity requires a good longitudinal understanding of the evaluee's baseline work supply.

3. Decreased Work Supply: Diagnosis, Symptoms, Impairments, and Treatment

Mental health evaluators should understand the evaluee's claimed psychiatric diagnosis, claimed impairments, and the impairments research and experience have indicated are typically associated with that diagnosis (see Gold and Shuman 2009). Mental health evaluators should also understand the kind of treatment, if any, the claimant is receiving. Evaluators should consider the effects of medication, past and present, on the individual's functioning.

Ms. Smith's treatment, particularly the long-term use of medication, by her own report and as documented in her medical records, was essential to her occupational functioning. Based on this history, any attempt to return Ms. Smith to work will

likely include ongoing use of medication. Unfortunately, some individuals may demonstrate impaired functioning due to psychiatric disorders even when receiving adequate treatment. Ms. Smith is still taking medication, and has received even more aggressive treatment in the form of hospitalization and ECT, but is still symptomatic. The question is whether these symptoms cause impairment that is disabling.

4. Decreased Work Supply: Psychosocial history and stressors

An exacerbation of psychiatric disorder, though aggressively treated with medication and therapy without significant response, in the presence of a history of stable work demands would indicate a possible decline in work supply due to psychiatric illness alone. A history of stable symptoms, minimal or no impairment, and good response to treatment but onset of impaired functioning in the event of new social or occupational stressors may focus evaluation more on the role of non-work-related factors affecting work capacity. In the case of Ms. Smith, her psychosocial stressors include an increase in work demands due to a promotion, and a decrease in her social supports due to the death of her mother. Ms. Smith's social stressors are also increased by living alone for the first time in her life, a profound change in her lifestyle.

Any of a myriad of non-vocational psychosocial stressors can result in changes in stresses that may affect underlying psychiatric disorders or exacerbate symptom presentation. These in turn can increase impairments or decrease motivation to work and thus decrease work supply. An individual with a pre-existing psychiatric disorder and adequate although impaired functioning may be especially vulnerable to a decrease in work supply if faced, for example, with new stressors such as loss of an important relationship or physical illness. In the case of Ms. Smith, even if she had not taken on a new administrative job, the loss of her mother alone might have resulted in an exacerbation of her depressive illness, increased impairments, and decreased occupational functioning.

Conversely, non-work-related factors such as social support or care from a family member may support strengths and increase work supply despite impairments caused by psychiatric symptoms and other stressors. Ms. Smith, although more symptomatic than she had been in the past, was still able to maintain some adequate level of functioning while her friend stayed with her. After her friend left and Ms. Smith was living alone, Ms. Smith's symptoms escalated and precipitated work withdrawal and a claim of disability. Thus, living alone can also be presumed to be a social stressor significant in Ms. Smith's case formulation.

These non-work and non-psychiatric factors figure prominently in any work supply–demand assessment. Mental health evaluators should inquire about personal and family health issues, finances, social responsibilities, support network, marital status, living circumstances, and other relevant social or personal factors. These factors are particularly significant in the discussion of disability-related questions such as motivation for treatment and rehabilitation, prognosis, and future ability to function.

Work Capacity Models: Patterns of Disability Development

The concept of work capacity can be utilized as a model with which to conceptualize common patterns of disability development. Application of the work capacity model results in the projection of six prototypic patterns of disability development:

- Pattern 1: Change in work capacity due to sudden illness and impairment
- Pattern 2: Change in work capacity due to sudden illness and impairment with relatively rapid recovery to baseline
- Pattern 3: Increasing impairment and decreasing work capacity over time due to progression of illness
- Pattern 4: Prior impaired function with new impairment resulting in decreased work capacity
- Pattern 5: Change in work demands outpacing available work supply, resulting in decreased work capacity
- Pattern 6: Repeated episodes of impairment with decreasing baseline work capacity between episodes

These patterns are stereotypical to some degree. Individuals may meet some of the features of one pattern at certain times, and others at another time, depending on circumstances. However, these patterns of disability development provide a framework for understanding the development of disability in any given case. They can facilitate developing a case formulation that describes how an individual's work capacity changes from "adequate" to "inadequate" relative to the minimal functional capacity needed to satisfy work demand (Battista 1988). This in turn facilitates responding to questions regarding future work capacity, prognosis, length of disability, return to work issues, restrictions, limitations, and accommodations, and other opinions commonly requested in disability evaluations.

Pattern 1. Change in Work Capacity Due to Sudden Illness and Impairment

Mental health disability can develop relatively suddenly as a result of an acute psychiatric crisis. Decreased work capacity in a previously unimpaired individual whose work supply falls below demand in a relatively brief time even though threshold job requirements are stable, as illustrated in Fig. 1.1, is likely to describe work capacity associated with an acute episode of illness.

For example, Mr. Able, a 25-year-old low level office manager, with no previous psychiatric history, working at his first job since graduating from college, develops relatively acute onset of insomnia, racing thoughts, a thought disorder, and grandiosity over a period of weeks. Mr. Able demonstrates a pattern of development of disability represented by Fig. 1.1. However, this pattern is the least common in a long-term or permanent disability claim. Many of the cases that fit the pattern in Fig. 1.1 are more likely to present primarily to mental health clinicians for treatment. Mental health evaluators who identify this pattern of disability development should proceed cautiously, and consider whether the evaluee's primary need is an urgent or even emergent psychiatric treatment evaluation. Depending on the outcome of treatment, the issue of a disability claim may never arise.

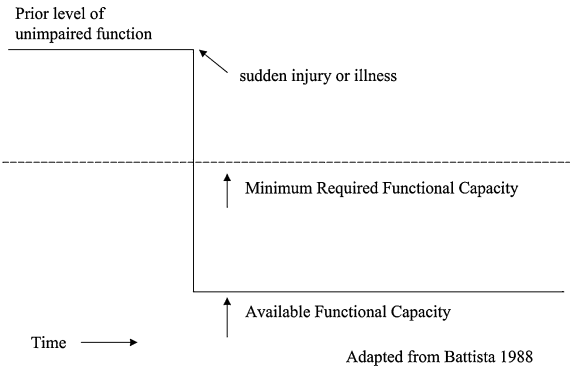

Fig. 1.1 Sudden onset of impairment resulting in disability

An evaluation for insurance or other benefits for individuals in competitive employment situations is more likely to occur after a period of acute crisis, and typically, more longitudinal information about response to treatment and functional recovery is available. The pattern in Fig. 1.1 raises the question of what treatment is being provided and whether the evaluee has had a good response to that treatment. Absent treatment and evaluation of treatment response, FAQs such as prognosis, length of leave needed, restrictions, limitations, or other issues regarding return to the workplace, such as whether work capacity will remain below minimal required levels, cannot be answered. Not enough time has passed in either case to determine whether inadequate work capacity is temporary rather than permanent. Treatment providers and evaluators in such cases should indicate they do not have enough information to answer those questions.

These cases may require some short-term disability, medical leave, or Family and Medical Leave Act (FMLA) documentation. Before making a determination regarding long-term permanent disability, mental health professionals should consider whether they are evaluating a discrete event that is likely to resolve. Although Mr. Able's symptoms appear to represent a manic episode, they may turn out to be a time-limited substance-induced episode rather than an episode of Bipolar Disorder. A clinician who supports a permanent disability claim on the basis of Bipolar Disorder before treatment and treatment response can be assessed may be supporting the beginning of a lifetime of disability claims, substance abuse, and poor mental health.

Pattern 2. Change in Work Capacity Due to Sudden Illness and Impairment with Relatively Rapid Recovery to Baseline

If sudden psychiatric disability does occur, a number of outcomes is possible. Hopefully, the outcome of such a sudden change in work capacity will be a relatively robust recovery with treatment to previous levels of functioning, a pattern illustrated by Fig. 1.2.

Pattern 2 is the most positive outcome to the sudden onset of illness, regardless of whether the illness is short-lived or chronic and episodic. In this pattern, the individual had a temporary disability, adequately managed by use of short-term

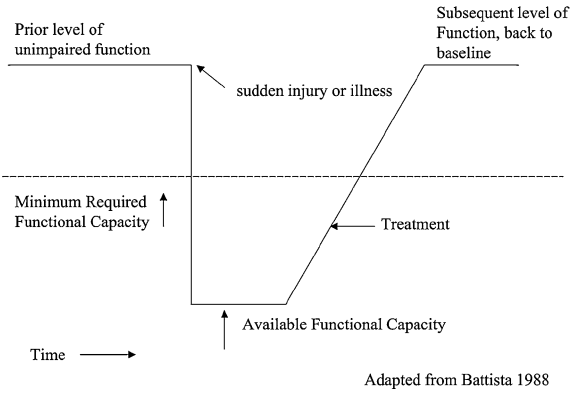

Fig. 1.2 Sudden onset of impairment with full recovery

disability leave, medical leave, or FMLA, and would be able to return to previous job responsibilities. Using the example of Mr. Able from the first pattern: Mr. Able is treated with a mood stabilizer, responds well to treatment, and returns to baseline mental status. There is no indication of substance abuse. Within weeks, he is able to return to work although mood disturbances may recur in the future.

In these cases, not enough time has passed to reliably predict chronic illness or recurrence, and if so, its effect on work capacity. Figure 1.1 does not allow description of recovery, with or without treatment. Figure 1.2 represents recovery but only for one episode or instance of impairment. Regardless, in the patterns represented by Figs. 1.1 and 1.2, work demand is not a significant factor. Rather, work supply, primarily affected by symptoms of illness or possibly changes in personal, social, or medical circumstances, dictates work capacity.

The patterns depicted by Figs. 1.1 and 1.2 are not representative of the development of more persistent, severe, or permanent psychiatric disorders and associated impairments that result in disability. The patterns discussed below involve a combination of psychiatric and non-psychiatric factors and are more typical in the types of disability evaluations reviewed in this volume. For example, many psychiatric disorders have a gradual onset over months or years or may present comorbidity with other psychiatric or physical disorders. Disability associated with these disorders often involves a slow or episodic loss of work capacity with potentially different outcomes.

Pattern 3. Increasing Impairment and Decreasing Work Capacity over Time Due to Progression of Illness

When psychiatric illness occurs at a later age, after the development of work skills, individuals with slow illness onset and progression often are able to successfully adapt their functioning to minimize the effects of slowly increasing impairments. This can result in a more gradual decline in work capacity, as depicted in Fig. 1.3.

The pattern of disability represented in Fig. 1.3 is often found, for example in individuals with Alzheimer's dementia. This disorder develops slowly over time, resulting in incremental but progressive loss of work as well as other capacities.

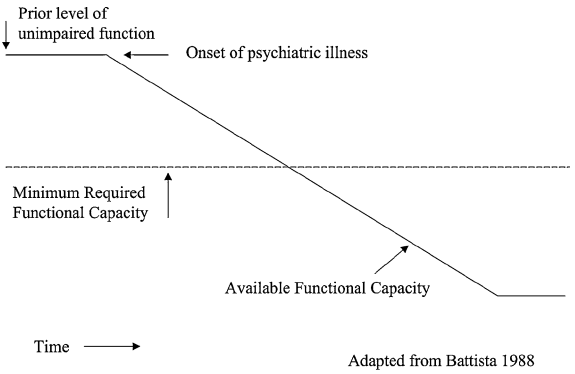

Fig. 1.3 Gradual onset of disability

Other chronic anxiety, mood, or substance use disorders may also show a slow but steady decrease in work capacity over a long period of time, especially in the event of external stressors exacerbating illness or increasing work demand.

The circumstances of the first case example, that of Ms. Smith, do not demonstrate the slow progressive decline in function seen in Pattern 3. As long as Ms. Smith was working at a job with which she was familiar and had adequate social support, she was able to maintain functioning. However, in the event of symptoms of a chronic disorder with slow decline despite stable psychosocial circumstances and work demands, individuals such as Ms. Smith may be able to slow the decline of their functional capacity by relying on years of adaptational coping skills. These individuals can draw upon these skills, despite progressively increasing impairments, to try to avoid work demands outstripping their work supply.

The line in Fig. 1.3 has a steady downward slope that eventually crosses below the minimal required functional capacity, depicting decreasing overall work due to gradually increasing impairment. In reality, the slope of this line is far less consistent and predictable. Individuals whose symptoms worsen over time, or whose circumstances create additional obstacles to functioning, typically demonstrate a more stepwise pattern of decline. Nevertheless, the general slope of the line representing functional capacity is negative, and at some point, crosses from adequate work capacity to inadequate work capacity, and may not cross back again. At this point, a disability claim may be filed. In this pattern, mental health evaluators should ask what caused the individual's work capacity to finally fall below the level of required functional work capacity.

This pattern of disability development can be particularly heartbreaking in individuals for whom work is an important aspect of self-esteem and identity. Individuals who have functioned successfully and productively for years often suffer severe psychological distress when forced to acknowledge their decreased work capacities. For these individuals, gradual and incipient psychiatric illnesses may result in losses that threaten their identity and psychological stability. When their work capacity falls below the minimum level required to remain functional, denial, anger, and projection of blame for mistakes or problems onto others are

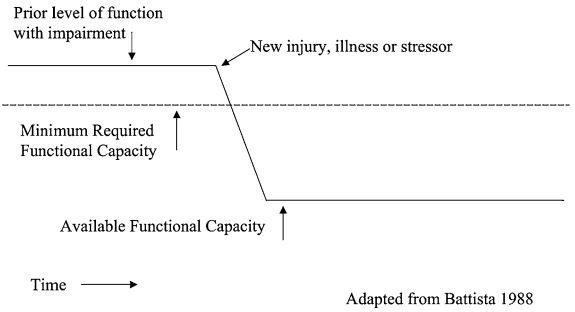

Fig. 1.4 Cumulative effects of prior impairment with additional impairment

frequent psychological responses. These circumstances can result in referrals for fitness-for-duty evaluations and at times, employment litigation.

Pattern 4. Prior Impaired Function with New Impairment Resulting in Decreased Work Capacity

Another pattern of disability development occurs when individuals with a pre-existing disorder and some impairments, who are nevertheless functional, develop new psychiatric or psychosocial problems that overwhelm their ability to function, as illustrated in Fig. 1.4. The pre-existing condition and its associated impairments, combined with new comorbid psychiatric disorders or social problems, or increased work demands, might produce a greater impact on functional capacity than the sum of the impact expected from each disorder or stressor separately (Gold and Shuman 2009).

For example, an individual with long-term impairments associated with anxiety and panic attacks may have adequate work capacity in a certain type of work completed successfully for years. However, if this person develops another disorder, such as the common comorbid disorders of depression or alcohol abuse, functioning may deteriorate below the minimum level required for work demand. This may happen relatively rapidly if the individual already has a compromised work supply but has been working hard to maintain functioning.

Does Ms. Smith of the case example fit into Pattern 4? Ms. Smith's functional adaptation to the requirements of teaching, despite intermittent impairment in work skills involving concentration, attention, and social withdrawal, had been good for 22 years. Ms. Smith had a severe exacerbation of her illness after the death of her mother, developed agitated depression, and required hospitalization and ECT treatment. Ms. Smith could fit into Pattern 4, but she was also contending with increased job demand. Could Ms. Smith have tolerated the increased demands of her new administrative position with her chronic impairments in concentration, attention, and social functioning, even if her mother had not passed away?

Pattern 5. Change in Work Demands Outpacing Change in Work Supply, Resulting in Decreased Work Capacity

This pattern of disability development occurs when an individual with a stable impairment who has had good, adequate, or even marginal functional capacity

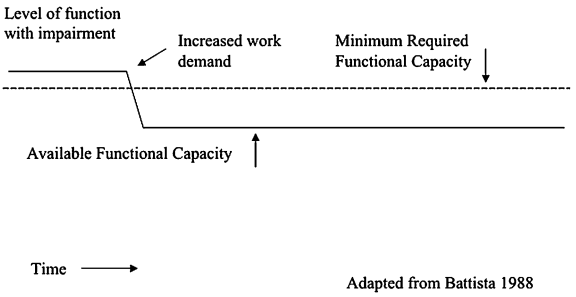

Fig. 1.5 Disability due to increased demand in context of prior functional impairment

relative to specific job requirements is confronted with increased job demands, as depicted in Fig. 1.5.

Another pathway to this pattern includes changes in work environment or supervision that remove a critical source of support or add a new degree of physical or interpersonal stress, even if these do not represent increased work demands. A change in job demands, with or without an increase in work responsibility or workload, can overcome an individual's ability to adapt to the pre-existing impairments. This pattern of development of disability is more likely if the new problem directly affects the functional capacity the individual relied upon to adapt to prior impairment (Battista 1988). This may occur with a change as routine as the retirement of a familiar and friendly supervisor.

Consider Mr. Charles, a 34-year-old technical writer with a Schizoid Personality Disorder who poorly tolerated social relationships. He worked primarily from home for many years, and was assessed only on the ability to meet deadlines. He had arranged these informal work accommodations with his supervisor. When a new company policy required that the technical writers work collaboratively in an office with coworkers, supervisors, and clients, Mr. Charles' work capacity declined. He was not able to get to work consistently, to work full days, or participate effectively in writing meetings. Although the actual work required remained the same, the increased social interaction and structure represented increased work demands that overwhelmed Mr. Charles' ability to adapt to his impairments, resulting in inadequate work capacity. If Mr. Charles wished to continue working for this company, he might consider requesting accommodations under the Americans with Disabilities Act (ADA).

Changes in scheduling, physical conditions, work location, or personnel can also create increased work demands even though they do not entail new responsibilities. In these types of cases, the individual's impairments and work supply have not changed. Rather, changed job circumstances result in increased job demands, despite stability of workload, causing a decrease in work capacity. This may change the balance between work supply and work demand to the point where work capacity falls far enough past minimal functional requirements that the person becomes disabled.

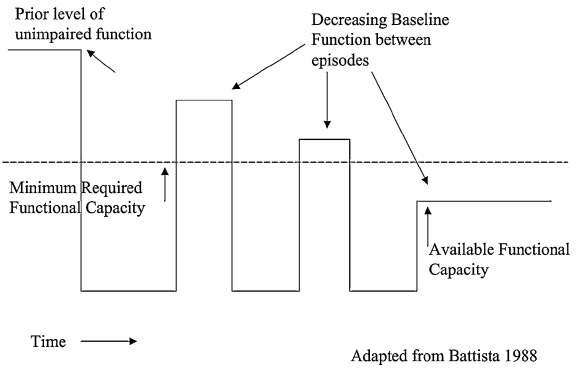

Fig. 1.6 Episodic impairment with decreasing levels of functional recovery

Pattern 5 may also be encountered in individuals who have received a promotion but, despite previous adequate work capacity, are incapable of meeting new and increased job responsibilities. The first case example, Ms. Smith, also fits this pattern. Ms. Smith functioned well as a teacher. She developed increased symptoms and problems with functioning only after a promotion to the administrative position of vice-principal. The increased workload and new job responsibilities could have resulted in stress severe enough to precipitate or exacerbate a psychiatric disorder, even if her mother had not died, resulting in decreased work capacity and a claim of disability.

Individuals who display this pattern of disability development frequently become distressed by their inability to meet the new work demand. However, they also often lack insight into the reasons the new work demands have created problems in their work capacity. Their previously good work capacity validates their belief that new work problems are caused by a worsening of their disorder or by the new situation and possible ensuing work conflict. The stress associated with failing to successfully meet new job demands may ultimately result in exacerbation of the disorder and further decrease work supply. These individuals may attempt to remain in the workplace despite worsening symptoms or, as in the case of Ms. Smith, may withdraw claiming disability. Nevertheless, the precipitating factor in the perception of disability is the change in job demand, and not change in the underlying disorder or work supply.

Pattern 6. Repeated Episodes of Impairment with Decreasing Baseline Work Capacity Between Episodes

The final pattern of disability development commonly encountered is one in which an individual experiences episodic changes in the balance between work supply and demand, as a result, for example, of episodic psychiatric disorder, such as Major Depression, Bipolar Disorder, or Anxiety Disorder with panic attacks. With each episode, the individual experiences decreased work capacity, perhaps even to the point of disability, but then is able to regain functioning as symptoms resolve. However, with each episode, the individual's baseline work capacity is somewhat decreased. Such individuals often reach the point where

they are no longer able to "bounce back" due to residual impairments, external problems that accrue as a result of the psychiatric disorder, such as job loss and financial problems, or social losses, such as divorce. Figure 1.6 illustrates this pattern.

For example, Mr. Fox, a 38-year-old construction worker with Bipolar I Disorder and adequate work capacity, when euthymic, experienced manic episodes during which he also abused alcohol. Despite extended periods of mood stability, the consequences of his poor judgment and functional impairments from repeated manic episodes associated with alcohol abuse accumulated. In his early 20s, Mr. Fox recovered from these episodes relatively quickly. By age 38, he had lost multiple jobs, had severe financial problems, been divorced twice, and faced legal charges related to the use of alcohol. As these problems compounded, Mr. Fox's baseline work capacity after each episode decreased and his functional impairments became more chronic. Ultimately, Mr. Fox was no longer able to meet the minimal functional requirements needed to maintain employment, and sought disability benefits.

The Work Capacity Model: Advantages and Disadvantages

The patterns of disability development based on a work capacity model are inevitably simplified. As the case of Ms. Smith demonstrates, an individual can experience decreased work capacity as a result of personal loss and exacerbation of a mood disorder and at the same time, be faced with an increase in work demands. Either factor alone might result in reducing work capacity to the point of disability, and each set of circumstances has different implications for prognosis, treatment, return to work, etc. When more than one pattern is applicable, mental health evaluators have to consider all the relevant circumstances.

These models also do not necessarily predict whether work capacity that falls below a job's minimum functional requirements will be temporary or permanent. Figures 1.1 and 1.2 are likelier to describe cases where disability might be temporary; Figs. 1.3–1.6 are likelier to describe cases where disability could be permanent. But even individuals who initially present with the patterns illustrated in Figs. 1.1 and 1.2 may go on to develop permanent disability, and individuals who fit the patterns in Figs. 1.3–1.6 may recover work capacity.

In any given case, whether disability is permanent or temporary may be evident from the nature of the impairments, the functional disability, the history of the disorder and its treatment, and an assessment of the individual's social and personal circumstances. If Ms. Smith went back to teaching, a job at which she was proficient despite intermittent impairment due to depressive symptoms, and was able to do so with adequate social support, might she be able to regain an adequate level of functioning to maintain employment? Or has Ms. Smith's work capacity decreased to a point where even improvement in her depressive symptoms and

social support would not result in minimum functional capacity necessary to go back to her previous job, teaching, at which she had been proficient? The work capacity model does not necessarily incorporate enough of these factors to provide an adequate predictive tool for the critical issue of whether inadequate work capacity is temporary or permanent.

Nevertheless, the work capacity model is useful in mental health disability evaluations. For example, identifying the pattern of disability development that best fits the circumstances of a case allows evaluators to assess the proportionality of claimed symptoms to the degree of the claimed impairment. As noted, impairments should, generally speaking, bear some proportional relationship to the severity of symptoms. Mild or minor symptoms, such as mild anxiety or slightly decreased concentration, should not create severe impairment unless they directly affect an essential job skill. If mental health clinicians find marked disproportionality between claimed symptoms and claimed work impairments, they may need to consider other motivations for claiming symptoms and impairment, including facilitating work withdrawal due to interpersonal conflict, pending adverse employment action, or frank malingering.

The work capacity models also allow mental health clinicians to formulate opinions regarding improving overall work capacity by minimizing work demand or supporting the evaluee's strengths to improve work supply. Certain types of disability evaluations may ask for these suggestions. ADA evaluations, for example, often ask clinicians to suggest reasonable accommodations. Understanding the balance between the evaluee's work supply and demand will facilitate making suggestions that can minimize work demand, perhaps with a flexible schedule, and maximize support, perhaps with regular meetings with supportive supervisors to review functioning and progress. Suggestions for treatment or work rehabilitation may hinge on identifying these factors, which evaluators utilizing a work capacity model to formulate a case narrative have perforce already considered.

In addition, when individuals do not fit into one of these work capacity models, or when their claims seem to fit one of the models but are not supported by corroborating information, mental health evaluators may be able to identify alternate lines of inquiry into issues relevant to disability. For example, an individual who claims previously unimpaired work capacity whose history reveals only marginal work functioning does not fit any of the illustrated patterns. Disability claims may not focus on the history of marginal work capacity, but mental health professionals may find that this is the single most significant issue in the particular case. Similarly, an individual whose claims seem to fit the patterns illustrated by Fig. 1.1 or 1.4, but whose reported history is not consistent with documented work capacity, raises issues involving alternative agendas for filing a disability claim or the possibility of malingering.

Applying the Work Capacity Model to the FAQs of Disability Evaluations

Table 1.1 reviewed the most common opinions requested in disability evaluations. The work capacity model and the patterns it projects provide a method for conceptualizing a narrative case formulation that can assist mental health professionals in responding to the FAQs. As noted, the narrative centers on the question, "what has changed?" Understanding causation helps to identify which of the work capacity models best describes the evaluee's development of disability. Identifying a pattern does not necessarily identify all the relevant factors that have resulted in a disability claim. However, once mental health evaluators have identified a pattern that broadly fits the claimant's history, questions regarding treatment, motivation, non-work-related issues that might affect functioning, changes in job demand or structure, and other relevant issues are often brought into clearer focus.

For example, an individual who fits in the pattern illustrated by Fig. 1.1 is someone whose functional capacity has suffered a dramatic decline over a relatively brief period of time due to acute onset of illness. Although the work capacity model does not indicate whether this is permanent or temporary, the model does imply that the primary issues in attempting to answer questions related to this individual's inadequate work capacity, especially going forward, are adequacy of current treatment and the evaluee's response to treatment. Figure 1.1 also implies that the question of how much function this individual will regain, especially absent treatment, cannot be answered at the time of evaluation.

Over time, it may become evident that this individual's work capacity is more consistent with that depicted in Fig. 1.2, an individual who with treatment recovers to previous baseline level of functioning. Such a pattern indicates that the individual is a treatment responder and may have a relatively good prognosis. Disability opinions in such a case should center on need for treatment, prognosis, and restrictions and limitations upon return to work to ensure successful re-entry into the workplace (see Chap. 4).

However, it may become evident over time that the pattern of disability development is closer to that represented by Fig. 1.6, an individual who experiences acute episodes and dysfunction regains functional capacity between episodes, but whose baseline deteriorates between episodes. This may not be evident until several episodes have occurred. This specific pattern directs inquiry and opinions toward why this individual is unable to return to at least a minimal work capacity relative to minimal functional capacity at the time of the evaluation when he or she has done so in the past. This raises issues related to treatment, prognosis, motivation, maximum improvement, changes in external circumstances or work demand, whether return to a work environment itself causes deterioration in function, restrictions and limitations, and possibly accommodations.

Ms. Smith's mental health clinicians are able to construct a narrative of the development of Ms. Smith's perception of herself as disabled based on the work capacity model Patterns 4 and 5. The applicability of a combination of models is

not unusual in complex cases. She had a history of adequate work capacity of over 22 years as a language teacher despite recurrent depressive illness and episodes of symptoms that at times caused impairment in concentration, attention, energy levels, and social functioning. After promotion to a new and unfamiliar administrative position and the death of her mother, Ms. Smith's depressive symptoms increased and her work capacity deteriorated markedly. She received aggressive and appropriate outpatient treatment, but her mental status continued to decline, she withdrew from work, and required hospitalization and ECT to stabilize her symptoms. Ms. Smith now considers herself totally and permanently disabled, and has applied for SSDI and private insurance disability benefits.

In Ms. Smith's case, the work capacity model cannot differentiate which "causation" factor is most significant: the loss of her mother, the exacerbation of her pre-existing depression, or the increased work demands of a new job. Would Ms. Smith have successfully adapted to the position of vice-principal had her mother not passed away? Would the stress associated with the new position have triggered an episode of depression regardless of social support? Would Ms. Smith have had adequate work capacity to maintain functioning even in her previous teaching position in the event of her mother's death? Although the work capacity model cannot answer these questions, it indicates that regardless of the determination of causation, the increased demands of a new and unfamiliar job and the loss of Ms. Smith's primary source of support have resulted in the most severe episode of depression Ms. Smith has ever experienced.

Diagnosis is usually the first question asked in all types of disability evaluations. Ms. Smith's diagnosis of Major Depression, Recurrent, is well documented. Ms. Smith's symptoms and their relationship to impairments in functioning are also well documented, and impair her abilities to function in the cognitive, social, and affective domains that need to be specifically identified in detail in the mental health reports (see Gold et al. 2008). Questions regarding causation are not relevant to either the SSDI or to private insurance benefits claim. However, the work capacity model draws mental health clinicians' attention to the combination of personal loss, loss of social support, increased job responsibilities, and a severe exacerbation of Ms. Smith's recurrent depression.

Treating clinicians and the independent evaluator agree on treatment needs, Ms. Smith's response to treatment, and her prognosis. Patterns 4 and 5 indicate that an individual functioning at a somewhat lower level due to ongoing impairments related to mental disorders, when faced with an exacerbation of illness and increased job demands, may have additional symptoms that result in decreased work supply. By themselves, these symptoms might not decrease work supply to the point of inadequate work capacity. However, in an individual already functioning with some impairment, a smaller decrease in work supply, due to cumulative effects of prior impairments, may be all that is necessary to result in inadequate work supply and disability. These patterns explain why a new job and the death of Ms. Smith's mothers, stressors that would be unlikely to cause disability in an individual with good and unimpaired work capacity, have resulted in such a severe clinical outcome for Ms. Smith.

SSDI does not want treatment providers to opine on whether the claimant, their patient, is disabled. Ms. Smith's treating clinicians, in response to the SSDI application, document that Ms. Smith has reached a new and more impaired mental health baseline and she has profound impairments in multiple spheres of functioning.

In contrast, Ms. Smith's private insurer provides a definition of total disability and asks the independent mental health evaluator if Ms. Smith is totally disabled, as per this definition, to work in her own occupation. Ms. Smith applied for these private disability benefits as a vice-principal. The independent evaluator states that based on the number and severity of Ms. Smith's impairments due to depressive symptoms (already specifically discussed in her report) and despite adequate treatment, Ms. Smith's impairments are such that she would not be able to meet the essential job requirements of a high school vice-principal.

The SSA provides standardized forms that guide clinicians in providing the information the SSA requires to adjudicate SSDI claims (see Chap. 7). However, most other types of disability evaluations require clinicians to write a report. Referral sources may provide a general format or categories of information they want clinicians to address. Some referral sources ask a series of written questions. The independent mental health clinician conducting Ms. Smith's IME for the long-term insurance company submits a report that follows a standardized format, including opinions responsive to the claim adjudicator's specific questions (see Appendix II for a suggested general disability report format).

The Work Capacity Model and Clinical Considerations

Many disability evaluations will end with these opinions, although some referral sources may provide some leeway for disability evaluators to add a "discussion" section to their report, in which they can review the case formulation, if they think it is relevant and helps adjudicators understand clinicians' opinions. Ms. Smith's private insurer, for example, asks some additional questions: has Ms. Smith reached maximum medical improvement? If not, can the independent evaluator provide treatment recommendations to help Ms. Smith reach maximum improvement? Mental health clinicians will find that the work capacity model also provides guidance for interventions that might potentially assist Ms. Smith in regaining some occupational functioning.

Like causation, even if these questions regarding rehabilitation are not relevant to the adjudicators of Ms. Smith's insurance claims, they are relevant to Ms. Smith's mental health, and therefore should be relevant to her treating clinicians and a standard feature of a case formulation. The inability to work as a result of psychiatric illness, whether temporary or permanent, is a serious crisis. Occupational disability can become a chronic and treatment-resistant psychosocial condition. Chronic disability and long-term unemployment are associated with multiple negative psychological consequences. People who become disabled lose self-esteem, become

discouraged, and hopeless, making the prospect of returning to work increasingly challenging. In addition, the longer Ms. Smith remains out of the workplace, the more "deconditioned" she will become, and the harder it will be for her to regain even partial occupational functioning. (Dooley 2003; Gold and Shuman 2009; Kessler et al. 1987; Murray et al. 2003; Pernice 1997; Price et al. 2002).

In the case of Ms. Smith, the work capacity model in both Patterns 4 and 5 document many years of adequate work capacity. Ms. Smith had successfully adapted to and managed intermittent and chronic symptoms of depression while maintaining adequate work capacity for 22 years as a language teacher, socially supported by her mother. Ms. Smith's treatment providers should consider the nature of Ms. Smith's occupational strengths, as indicated by her previous work supply and work capacity, and the causation of her current impaired state.

Ms. Smith's independent mental health evaluator opined that Ms. Smith was totally disabled from working as a vice-principal. The mental health evaluator was not convinced that Ms. Smith could not regain some occupational functioning in regard to teaching foreign language. The mental health evaluator included this opinion, adding that a return to even partial occupational function as a language teacher, either part-time or in a tutoring capacity, would likely be an important step in Ms. Smith's recovery and maintenance of mental health gains. The independent mental health clinician also noted that to do so, Ms. Smith would likely need to broaden and increase her social supports. The independent clinician recommended that a copy of the report be forwarded to Ms. Smith's treating clinicians and encouraged them to explore with Ms. Smith the practicality of possible interventions and treatment goals or regaining functioning and increasing social support given her personal resources.

The work capacity model cannot predict whether such interventions are possible or whether they would be successful. Ms. Smith's work capacity model, as reflected in Patterns 4 and 5, indicates that she will continue to have some degree of impairment due to depression even under the best of circumstances, and may have even more given recent circumstances. However, the model suggests that possible interventions do exist that could result in recovering at least some occupational functioning, which may assist in maintaining her functional status in areas other than occupational functioning and minimize the negative mental health consequences of a chronic disability status.

Malingering and Motivation: Does the Work Capacity Model Inform These Opinions?

The work capacity model does not assist directly in answering these two standard disability evaluation questions. Referral sources often want to know whether a claimant is motivated to return to work; and whether the claimant is malingering, or relevant primary or secondary gain issues are affecting the claim. However, the work capacity model does indirectly provide some guidance in formulating answers

Table 1.3 Factors that may affect motivation to work

Medical	1. Psychiatric illness
	2. Physical illness
	3. Traumatic brain injury
	4. Real or perceived effect of workplace on disorder
	5. Side effects of medication
	6. Substance use
Non-medical	7. Demoralization due external problems, such as chronic illness or family conflict
	8. Length of time not engaged in employment and "deconditioning"
	9. Availability and strength of support network
	10. Attitude toward job, workplace or company
	11. Personality style: dependent, regressive vs. resilient, adaptive
	12. Fear of losing entitlement
	13. Secondary gain

to these questions. When a claimant's presentation does not fit any of the work capacity model patterns, either in terms of proportionality of symptoms to impairments, or claimed causation to consequences in work supply, it is possible that the key to the case formulation lies in the assessment of malingering and motivation.

The assessment of malingering and motivation in disability evaluations requires that mental health clinicians provide opinions that are not strictly medical or psychiatric. Both are complicated psychological phenomena, often questioned when individuals stand to gain financially for not working. In addition, lack of motivation is a widely recognized symptom of multiple psychiatric disorders. Malingering in disability evaluations will not be further addressed here, as it is discussed at length in Chap. 6. However, individuals who lack motivation to return to work may have compelling reasons other than symptoms of psychiatric illness for their amotivational states.

Motivation to work, although perhaps one of the most difficult characteristics to assess, is nevertheless one of the most significant links between impairment and disability. Motivation is the factor that can make the most difference in work capacity between two individuals with equivalent impairments and work demands. Whether Ms. Smith will implement the recommended changes that might restore at least partial occupational functioning will depend, in part, on whether Ms. Smith is motivated to return to work. Many times, an individual's motivation is not well understood even after careful consideration and assessment (American Medical Association 2008). Nevertheless, motivation to overcome or adapt to impairments so as to avoid or minimize disability and motivation to seek and comply with treatment are essential aspects of disability evaluations.

Many factors, medical and non-medical, influence an individual's motivation to work. An in-depth discussion of the interrelationship of these and other factors to motivation is beyond the scope of this chapter (see e.g. Rothman and Cooper 2008). Some of the more salient factors that may affect motivation to work are listed in Table 1.3.

Certain circumstances may indicate the presence or absence of motivation to work. Many of these circumstances will be evident when a work capacity model is applied to the specific circumstances of the evaluee's claim. For example, an individual who files a long-term disability claim asserting permanent psychiatric disability before treatment has been obtained or has had sufficient time to be effective suggests lack of motivation to work. Non-mental health reasons for work withdrawal should be explored in such cases. Similarly, noncompliance with efforts at rehabilitation, medication, and other treatment, in conjunction with an evaluee's decision early in the disability process that he or she can never work again, should also raise suspicion that mental health impairments alone are not preventing occupational functioning. Motivation to work may be a key factor in such circumstances as well.

Although often asked to opine on malingering and motivation, mental health clinicians should bear in mind that opinions regarding these two issues may reflect personal and social beliefs that are influenced by a multitude of factors and are based on a combination of medical and non-medical evidence. Thus, in providing opinions regarding malingering and motivation, mental health evaluators should be certain their assessments consider all relevant factors while attempting to minimize their own biases (Gold and Shuman 2009).

Cultural and Ethnic Issues

Finally, mental health evaluators at times conduct mental health disability evaluations for individuals whose cultural or ethnic backgrounds differ from their own. If evaluators cannot identify a work capacity pattern of disability development that seems to adequately describe the circumstances of the case, they should consider the possibility that cultural factors may be a significant issue in the evaluee's relationship to the workplace and attitudes toward psychiatric illness, impairment, and disability. These factors can create issues in language, cognition, culture-related beliefs, values, and attitudes held both by the evaluator and the evaluee (Tseng et al. 2004).

Sometimes, cultural and ethnic factors, although present, have no relevance to the issue under evaluation. However, sometimes these may be critical to an accurate evaluation. For example, culture often plays a considerable role, both from the etiological perspective and in the expression of symptoms, in many of the disorders commonly encountered in the workplace, such as anxiety disorders, mood disorders, and personality disorders. In addition, cultural attitudes toward seeking of compensation differ, and may be relevant in disability evaluations.

Therefore, each evaluee should have potentially relevant cultural factors taken into account. Mental health professionals conducting disability evaluations should actively maintain a cultural sensitivity when assessing immigrants, people of ethnic or racial minorities, hearing or speech impaired individuals, or people who

are different from the majority in terms of age or gender (i.e. women), or whose backgrounds differ from that of the evaluator. Evaluators should be perceptive enough to sense cultural differences among people and to know how to appreciate them without bias, prejudice, or stereotypes (Tseng et al. 2004). If cultural issues with which the evaluator is unfamiliar seem prominent, evaluators may need to state this directly and seek consultation to clarify their concerns.

Conclusion

Narrative case formulations in disability evaluations describe how individuals came to be or to perceive themselves as disabled. The work capacity model offers one method of conceptualizing the process of disability development. A case formulation based on this model usually correlates with one of six common patterns described by the work capacity model. By determining which pattern in this model is most relevant in a disability evaluation, treating clinicians and mental health evaluators can provide a narrative that will guide their examination of the relevant issues. These relevant issues, including diagnosis, treatment, maximum improvement, etc., are the opinions most often requested of mental health professionals in conducting disability evaluations. The work capacity model may also suggest interventions to improve occupational functioning.

Key Points

1. Mental health disability evaluations are facilitated when treating clinicians and independent evaluators have enough information to construct a narrative case formulation.
2. Case formulations for disability evaluations include a review of the association between psychiatric illness and work capacity, as well as the multiple other factors that can affect work capacity.
3. Utilization of a work capacity model, based on the assessment of work supply and work demand over time, and correlated with psychiatric, medical, social, and personal history, can facilitate formulating answers to the questions commonly asked in disability evaluations.
4. Mental health disability evaluators need to gather enough information to allow them to form a historical view of an evaluee's work capacity and the factors that may affect occupational functioning, as well as current issues, in order to provide an adequate disability evaluation.

Appendix I: Possible Sources of Collateral Information in Disability Evaluations

Written records

1. Employment Records
    a. Job description
    b. Performance Reviews
    c. Personnel records, such as letters of commendation, complaints, awards, disciplinary actions
2. Mental health records
    a. Outpatient counseling and/or psychopharmacology records
    b. Inpatient mental health records
    c. Substance use treatment records
    d. Psychological or neuropsychological testing
3. Medical records
    a. Primary care records
    b. Specialist records
    c. Laboratory testing results
    d. Neuroimaging reports
4. Pharmacy records
5. Disability records
    a. Insurance and medical documentation submitted to support current claim
    b. Insurance and medical documentation submitted to support prior claims
    c. Other experts' evaluations in current or prior claims
        i. Mental health
        ii. Medical, including neurological
        iii. Vocational/Occupational

Third-party information

1. Verbal contacts:
    a. Family members and friends
    b. Coworkers and/or supervisors
    c. Mental health and medical treatment providers
2. Written statements, including depositions or affidavits

Appendix II: Suggested Disability Report Format

There is no single, standard style or format for writing a disability evaluation report. A variety of report formats have been suggested (Buchanan and Norko 2011; Gold et al. 2008; Melton et al. 2007; Piechowski 2011; Silva et al. 2003). Reports will vary depending on the type of disability evaluation. Mental health evaluators will not be asked to document all elements listed here in every disability evaluation. If the referral source asks specific questions, mental health evaluators should answer these questions and limit themselves to providing opinions responsive only to these questions, unless they feel some significant aspect of the case is being overlooked. Generally, however, all disability reports should contain the following elements, unless the referral source indicates otherwise.

1. Evaluee's identifying information
2. Identification of referral source
3. Referral issue: What are the questions being asked by the referral source?
4. Documentation of Informed Consent (see Chap. 2)
5. All sources of information:
    a. Records reviewed, with summary of relevant information, including imaging, diagnostic, and psychological tests findings
    b. Dates and duration of interviews of the evaluee
    c. Collateral sources (may include dates, duration, manner, and nature of contact)
    d. Any psychological tests or evaluation instruments used
6. History of Current Mental Health Problems
    a. Onset and course of current symptoms
    b. Claimed impairments
    c. Observed impairments
    d. Recent occupational status and relationship to impairments
    e. Treatment and response to treatment
    f. Present psychiatric medication
7. Past Mental Health History
    a. Onset of symptoms
    b. Treatment, including medications used in past
8. Substance Use History
9. List of all medications taken currently
10. Occupational history
    a. Job history, including reasons for leaving a job
    b. Grievances
    c. Workers' compensation claims for work-related illnesses and injuries

d. Any previous public or private disability insurance claims
e. Any previous employment related litigation

11. Psychosocial history
    a. Childhood and Adolescence
    b. Educational history, including highest level of education attained
    c. Social, including relationships, current living situation, financial problems
    d. Family history (if relevant; see Chap. 2).
    e. Criminal history
    f. Military history
12. Mental status examination
13. Discussion with case formulation if requested or indicated
14. Opinions:
    a. When referral sources ask specific questions, opinions should be organized as responses to each question, which should be listed before the response
    b. If no questions have been provided, include findings and opinions relevant to the disability issues in the case. These may include (but are not limited to):
        (1) Multiaxial diagnosis, including GAF score
        (2) Impairments in work function and the relationship to psychiatric symptoms
        (3) Adequacy of and response to past treatment
        (4) Treatment recommendations
        (5) Prognosis, including the expected course of the evaluee's disorder(s), likelihood of chronicity, and expected duration of the impairment
        (6) Restrictions or limitations if requested, and projected length of time restrictions will be present

References

American Medical Association: Guides to the Evaluation of Permanent Impairment, 6th edn. American Medical Association Press, Chicago (2008)

American Psychiatric Association: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (Text Revision). American Psychiatric Association, Washington, DC (2000)

Battista, M.E.: Assessing work capacity. J. Insur. Med. **20**(3), 16–22 (1988)

Bonnie, R.J.: Mental disorder and labor force participation: An epidemiological perspective. In: Bonnie, R.J., Monahan, J. (eds.) Mental Disorder, Work Disability, and the Law, pp. 11–12. The University of Chicago Press, Chicago (1997)

Buchanan, A., Norko, M.A.: The Psychiatric Report: Principles and Practice of Forensic Writing. Cambridge University Press, Cambridge (2011)

Dooley, D.: Unemployment, underemployment, and mental health: Conceptualizing employment status as a continuum. Am. J. Community Psychol. **32**(1–2), 9–19 (2003)
Enelow, A.J.: Assessing the effect of psychiatric disorders on work function. J. Occup. Med. **3**, 621–627 (1988)
Gold, L.H.: Psychiatric diagnoses and the retrospective assessment of mental status. In: Simon, R.I., Shuman, D.W. (eds.) Retrospective Assessment of Mental States in Litigation: Predicting the Past, pp. 335–367. American Psychiatric Publishing, Washington, DC (2002)
Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. Springer, New York (2009)
Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**(4), S3–S50 (2008)
Jans, L., Stoddard, S., Kraus, L.: Chartbook on Mental Health and Disability in the United States. An InfoUse Report. U.S. Department of Education, National Institute on Disability and Rehabilitation Research, Washington, DC (2004)
Lasky, H.: Psychiatric Claims in Workers' Compensation and Civil Litigation, Vol. 1. Wiley, New York (1993)
Leclair, N.J., Leclair, S.W.: Impairment and disability: Mental and behavioral disorders. Clinics Occup. Environ. Med. **1**, 729–748 (2001)
Kessler, R.C., Berglund, P., Demler, O., et al.: Lifetime prevalence and age-of-onset distributions of DSM-IV in the National Comorbidity Survey Replication. Arch. Gen. Psychiatry **62**(6), 593–602 (2005)
Kessler, R.C., House, J.S., Turner, J.B.: Unemployment and health in a community sample. J. Health Soc. Behav. **28**(1), 51–59 (1987)
Melton, G.B., Petrila, J., Poythress, N.G., et al.: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd edn. Guilford Press, New York (2007)
Murray, C., Lopez, A.D. (eds.): The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Disease, Injuries and Risk Factors in 1990 and Projected to 2020. Harvard University Press, Cambridge (1996)
Murray, C.L., Gien, L., Solberg, S.M.: A comparison of employed and unemployed women in the context of a massive layoff. Women Health **37**(2), 55–72 (2003)
Pernice, R.: Employment attitudes and mental health of long-term unemployed people with disabilities: Implications for rehabilitation counselors. J. Appl. Rehabil. Couns. **28**, 21–25 (1997)
Piechowski, L.D.: Evaluation of Workplace Disability (Best Practices in Mental Health Assessment). Oxford University Press, New York (2011)
Price, R.H., Choi, J.N., Vinokur, A.D.: Links in the chain of adversity following job loss: How financial strain and loss of personal control lead to depression, impaired functioning, and poor health. J. Occup. Health Psychol. **7**(4), 302–312 (2002)
Rothman, I., Cooper, C.: Organizational and Work Psychology. Hodder Education, London (2008)
Sanderson, K., Andrews, G.: Common mental disorders in the workforce: Recent findings from descriptive and social epidemiology. Can. J. Psychiatry **51**(2), 63–75 (2006)
Silva, J.A., Leong, G.B., Weinstock, R.: Forensic psychiatric report writing. In: Rosner, R. (ed.) Principles and Practice of Forensic Psychiatry, 2nd edn., pp. 31–36. Oxford University Press, New York (2003)
Simon, R.I.: Forensic psychiatric assessment of PTSD claimants. In: Simon, R.I. (ed.) Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, 2nd edn., pp. 41–97. American Psychiatric Press, Washington, DC (2002)
Tseng, W.S., Matthews, D., Elwyn, T.S.: Cultural Competence in Forensic Mental Health: A Guide for Psychiatrists, Psychologists and Attorneys. Brunner-Routledge, New York (2004)

Chapter 2
Legal and Ethical Issues in Providing Mental Health Disability Evaluations

Donna L. Vanderpool

Introduction

The practice of psychiatry generally entails a low liability risk when compared to other medical specialties (Physicians Insurers Association of American 2011). The two greatest professional liability risk areas for psychiatrists are treating patients with suicidal behaviors and psychopharmacology issues (Professional Risk Management Services, Inc. 2010). Nonphysician clinicians have an even lower liability risk. When providing an evaluation for non-treatment purposes, such as disability evaluations or fitness for duty evaluations, the risk of being sued for malpractice is minimized even further. Moreover, the fact that a lawsuit is filed against the clinician does not mean that the defendant clinician will be found liable. Many cases filed against clinicians are not pursued, or are dismissed during litigation. Thus, performing disability evaluations presents low professional liability risk for mental health clinicians.

Nevertheless, the risk, though small, cannot be ignored. Mental health professionals conducting disability evaluations should understand what aspects of this practice present liability risks and how to effectively manage these risks to decrease the possibility that they may inadvertently engage in practices that create liability. This is easier said than done, as this is a relatively new area of legal scrutiny. Case law defining liability and risks is new and evolving. The following discussion reviews the current legal decisions, and their implications, which define areas of risk and assist mental health clinicians in managing risks. Case examples in the form of specific legal cases will be provided throughout the chapter to illustrate these points.

D. L. Vanderpool (✉)
Risk Management, PRMS, Inc, 1401 Wilson Blvd #700, Arlington, VA, USA
e-mail: vanderpool@prms.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_2,

Patients or Evaluees

In those situations where the disability evaluation is performed on a non-patient, the evaluation is viewed as a type of independent medical evaluation (IME). For the purposes of this chapter, liability will be discussed in terms of IMEs. The issue of what duties, if any, are owed by a clinician evaluating a non-patient evaluee is a legal question that courts have only begun to address and some duties remain undefined. Moreover, there are other problems that can arise when a treating clinician takes on the additional role of objective reporter or expert for purposes of disability evaluation (see discussion below on dual roles).

The Mental Health Disability Evaluation

Regardless of whether the disability evaluation is being performed for a patient or a non-patient, mental health clinicians should be aware that disability evaluations differ in significant ways from clinical evaluations for treatment purposes. Unlike a treatment evaluation, the disability evaluation is conducted for the sole purpose of sharing clinical information with a third party, such as a disability insurance company or an employer. The evaluee should understand the purpose of the evaluation and should also understand that treatment is not a primary or additional goal.

Another difference between mental health treatment evaluations and disability evaluations is that various types of disability evaluations inherently carry a risk of moving into litigation, resulting in the need for the evaluating clinician to testify in legal or administrative proceedings. Mental health evaluators can be required to provide deposition or trial testimony, or testimony in an administrative tribunal (such as in disputes regarding Social Security Disability Insurance claims or Workers' Compensation claims). Clinicians unfamiliar with or lacking training in defending their opinions in a legal arena may find themselves unprepared to provide adequate testimony.

Finally, many mental health disability evaluations require expertise beyond that provided by most general psychiatry or psychology post-graduate training programs. Disability evaluations require a detailed evaluation of work issues (ability to perform work tasks as described in a job description), beyond that typically required in an evaluation conducted for treatment purposes. In addition, there may be specific federal and state laws relevant to conducting and reporting the results of mental health disability evaluations (such as workers' compensation laws) that mental health evaluators must understand and with which they must comply. For example, as discussed in Chap. 10, Americans with Disabilities Act evaluations often request answers to questions involving statutorily defined terms not typically addressed in a clinical evaluation conducted for treatment purposes or even other types of forensic evaluations.

Liability, While Limited, Is Increasing

While the risk of liability associated with performing disability evaluations is relatively low, as noted above, there are some legal risks and ethical standards that should be understood. Historically, there was little professional liability risk for mental health clinicians performing an IME, such as a disability evaluation. Courts and state licensing boards were not interested in allegations that were not related to treatment or were outside the treatment relationship.

However, more recently, courts have been asked to consider evaluator liability in such non-treatment relationships. Licensing boards have also expanded their regulatory interest to cover IME activities. As a result, there is expanding liability for mental health clinicians providing disability evaluations. Accordingly, clinicians performing disability evaluations should have an understanding of the various existing legal and ethical obligations imposed by legislatures, regulators, courts, and professional associations. Mental health clinicians should also confirm with their malpractice liability insurance carrier that conducting disability evaluations outside of a treatment relationship is covered under their policy.

This chapter presents case law examples illustrating the aspects of practice for clinicians providing disability evaluations and other types of IMEs that have become the subject of debate in the courts. These cases illustrate the dynamic process by which the legal system is continuing to assess and define the duties and responsibilities that IME clinicians owe evaluees, despite the fact that no treatment relationship exists. By becoming familiar with some themes of the cases, mental health clinicians can minimize the risk associated with the provision of disability evaluations. Moreover, by understanding the legal expectations associated with these evaluations, clinicians should be better able to assess when a referral to an independent evaluator is appropriate for their own patients who require a disability evaluation.

A glossary of legal terms is provided in Appendix I, and a more comprehensive survey of appellate IME liability case law is presented in Appendix II. Clinicians should be mindful that the law in the area of IME liability continues to evolve. The cases discussed here are always subject to being reversed, being overruled, and being affected by subsequent changes in administrative and statutory law. Also, while many of the cases discussed in this chapter do not involve a mental health IME, the impact of the decisions would be applicable to other types of IMEs, including mental health disability evaluations.

Dual Roles

When treating clinicians take on the additional role of objective reporter or expert for purposes of disability evaluation, the dual roles can bring with them the very real possibility, even the inevitability, of conflicting obligations (i.e., the patient's

clinical needs vs. the patient's legal needs). Conflicting obligations can increase the risk of clinical, ethical, and even legal problems.

When performing a disability evaluation, clinicians are expected to strive for objectivity. As noted by the American Medical Association (AMA) in Ethics Opinion 10.03 *Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations* (American Medical Association 1999), physicians should "evaluate objectively the patient's health or disability. In order to maintain objectivity, [physicians] should not be influenced by the preferences of the patient-employee." In the related Council on Ethical and Judicial Affairs Report, the AMA gives the following example: "even though a patient may not want to return to work, an exam could reveal that he or she is able to resume employment duties" (American Medical Association, Council on Ethical and Judicial Affairs 1999).

According to the *Specialty Guidelines for Forensic Psychology* (*Forensic Psychology Guidelines*) developed by the American Psychological Association and the American Psychology-Law Society (APLS), "when conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact" (American Psychological Association and American Psychology-Law Society 2011).

Disability evaluations are clinical evaluations conducted for non-treatment purposes. As such, they are similar in many, and at times all, respects to forensic mental health examinations. The American Academy of Psychiatry and the law (AAPL), the professional organization of forensic psychiatrists, has provided *Ethics Guidelines for the Practice of Forensic Psychiatry* (*Ethics Guidelines*). These address many issues that arise in disability evaluations. AAPL's guidance in respect to objectivity is similar to that of the AMA's and in the section "Striving for Objectivity" states:

> Psychiatrists who take on a forensic role for patients they are treating may adversely affect the therapeutic relationship with them. Forensic evaluations usually require interviewing corroborative sources, exposing information to public scrutiny, or subjecting evaluees and the treatment itself to potentially damaging cross-examination. The forensic evaluation and the credibility of the practitioner may also be undermined by conflicts inherent in the differing clinical and forensic roles. Treating psychiatrists should therefore generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes (American Academy of Psychiatry and the Law 2005).

Similarly, the *Forensic Psychology Guidelines* state:

> Providing forensic and therapeutic services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm. Therefore, when requested or ordered to provide either concurrent or sequential forensic and therapeutic services, forensic practitioners are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another provider (American Psychological Association and American Psychology-Law Society 2011).

Certain inherent conflicts may be unavoidable when mental health clinicians attempt to provide disability evaluations for their own patients (Strasburger et al.

1997). Clinicians' assessments, recommendations, and opinions that do not meet the disability documentation expectations of a patient could be detrimental to a patient's interests if benefits are denied. This can have serious implications for the therapeutic relationship. If, on the other hand, clinicians tailor their assessments, recommendations, and opinions to the patient's disability documentation expectations, then their effectiveness as a treating clinician is seriously compromised, if not destroyed. In addition, such actions may create risk and liability because, if challenged, they may be found to fall below the standard of care. In either situation, if patients think they have been harmed by the clinician's involvement, patients may be inclined to sue the clinician claiming either the treatment or the evaluation was negligently provided.

As discussed below related to informed consent, it is important for clinicians to ensure their patients understand the different obligations that accompany the different roles by explaining the limits of the roles of treatment provider and disability evaluator and outlining the potential conflicts. In some situations, "wearing both hats" may be unavoidable. For example, Social Security Disability Insurance bases decisions regarding award of benefits almost solely on information provided by the mental health treatment provider. Alternatively, evaulees may live in communities where access to an independent mental health clinician is limited. Nevertheless, treating clinicians should think carefully before undertaking to provide disability evaluations for their own patients, since the problems this potentially can precipitate may not be easily resolved and may increase liability exposure.

Qualified Mental Health Clinicians

Another consideration when providing disability evaluations for a mental health clinician's own patients is that of qualifications. The issue of qualifications may become highly relevant in more complex evaluations, or evaluations in the context of litigation or potential litigation. AAPL's *Practice Guideline for Forensic Evaluation of Psychiatric Disability* (*Practice Guideline*) (Gold et al. 2008), AAPL's *Ethics Guidelines* (American Academy of Psychiatry and the Law 2005), and the *Forensic Psychology Guidelines* (American Psychological Association and American Psychology-Law Society 2011) address the need to develop and maintain competency. For example, AAPL's *Practice Guideline* states, "it is expected that any clinician who agrees to perform forensic evaluations in this domain has the appropriate qualifications" (Gold et al. 2008).

Moreover, courts may expect all clinicians doing forensic activities to follow ethics codes of forensic specialty organizations. In *Sugarman v. Board of Registration in Medicine*, the state medical board sanctioned a psychiatrist who had been retained as an expert witness in a highly publicized custody dispute and, in violation of the court's order, as well as AAPL's *Ethics Guidelines*, had shared in a very public manner details of the litigation. The physician appealed the board's

sanctions and the state Supreme Court, relying on AAPL's ethical guidelines on confidentiality, affirmed the board's decision and found that the psychiatrist had violated her ethical obligations as a forensic psychiatrist. The court said that it did not matter that she was not a member of AAPL; when undertaking tasks that are performed by forensic psychiatrists, she was expected to follow AAPL's guidelines. As stated by the court:

> Sugarman was, or should have been aware of the Ethical Guidelines for the Practice of Forensic Psychiatry (AAPL Guidelines) promulgated by the American Academy of Psychiatry and the Law (AAPL)…and the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (1986) promulgated by the American Psychiatric Association (Principles of Medical Ethics). As she was engaged in the practice of forensic psychiatry in this case, Sugarman's lack of membership in the AAPL is immaterial. (*Sugarman v. Board of Registration in Medicine* 1996).

Informed Consent

Just as professional ethics require that informed consent be obtained before providing clinical treatment to patients, mental health clinicians also have an ethical duty to obtain informed consent for disability evaluations, as noted in AAPL's *Practice Guideline* (Gold et al. 2008), in the *Forensic Psychology Guidelines* (American Psychological Association and American Psychology-Law Society 2011). There should be discussions advising an evaluee of the nature and purpose of the evaluation so the evaluee can provide informed consent to proceed before the clinician conducts the disability evaluation. As stated in the *Forensic Psychology Guidelines*:

> Because substantial rights, liberties, and properties are often at risk in forensic matters, and because the methods and procedures of forensic practitioners are complex and may not be accurately anticipated by the recipients of forensic services, forensic practitioners strive to inform service recipients about the nature and parameters of the services to be provided (American Psychological Association and American Psychology-Law Society 2011).

Moreover, evidence of the discussions and the evaluee's understanding and consent to proceed should be documented in a form signed by the evaluee. If the evaluee refuses to consent to the conditions of the evaluation, the risk management advice is to not proceed with the evaluation until the referral source can address this problem.

In addition to being ethically required, the practice of obtaining explicit and documented informed consent is a good risk management strategy. Many evaluees do not understand the nature or implications of a disability evaluation, and feel "forced" to undergo the evaluation. They often perceive that they are required to undergo an intrusive examination in order to access monetary benefits or as a condition of their employment. While evaluees may experience this as involuntary, unlike a court ordered evaluation, evaluees do in fact have a choice as to whether

to undergo the evaluation. Mental health clinicians can avoid misunderstandings and manage the evaluee's expectations through the informed consent process. Clinicians should be certain that evaluees understand that they have this choice, albeit between less than optimal options, such as forgoing a disability claim or voluntarily relinquishing employment.

AAPL's *Practice Guideline* (Gold et al. 2008) specifies the elements of informed consent for disability evaluations. This guideline recommends that mental health clinicians advise evaluees prior to beginning the evaluation that:

1. The evaluation is not for treatment purposes and the evaluee is not and will not become the evaluating clinician's patient.
2. The purpose of the evaluation is to provide an opinion about the evaluee's mental state and level of impairment or disability.
3. The information and results obtained from the evaluation are not confidential, in that they will be shared with the referral source and may be disclosed to the court, administrative body, or agency that makes the final determination of disability.
4. The evaluation is voluntary and that breaks are allowed and encouraged when needed.
5. The evaluee has the right not to answer questions, but that refusal to answer specific questions may influence the results of the evaluation and will be reported to the referral source.
6. Although the evaluating clinician renders an opinion, the regulatory agency, employer, or a jury will make the ultimate determination of disability.
7. A written report will be produced and will be turned over to the retaining third party. Once the report is released to the third party, the evaluating clinician does not control it or determine who has access to it.

Confidentiality

Obligation to Maintain Confidentiality

Historically, clinicians have believed that in the absence of a treatment relationship, the traditional obligation to maintain confidentiality is also absent. Despite this widespread misapprehension, it is clear that even in the absence of a treatment relationship, mental health clinicians are ethically and legally obligated to maintain a certain degree of confidentiality. In addition to courts finding IME clinicians liable for breach of confidentiality (i.e. *Pettus v. Cole* 1996), ethics codes, such as those from the AMA, AAPL, and the AMA, specifically address the IME clinician's duty to maintain confidentiality.

AAPL's *Ethics Guidelines* address the general issue of confidentiality as follows:

> Respect for the individual's right of privacy and the maintenance of confidentiality should be major concerns when performing forensic evaluations. Psychiatrists should maintain confidentiality to the extent possible, given the legal context. Special attention should be paid to the evaluee's understanding of medical confidentiality. A forensic evaluation requires notice to the evaluee and to collateral sources of reasonably anticipated limitations on confidentiality. Information or reports derived from a forensic evaluation are subject to the rules of confidentiality that apply to the particular evaluation, and any disclosure should be restricted accordingly (American Academy of Psychiatry and the Law 2005).

AAPL's *Practice Guideline* specifically addresses confidentiality in disability evaluations as follows:

> The purpose of a disability evaluation is the collection of information about an individual that will be communicated to a third party…Despite the lack of confidentiality inherent in disability evaluations, psychiatrists are ethically obligated to maintain confidentiality as much as possible. This necessity should also be explained to evaluees in the context of discussing the limits of confidentiality. Information obtained should be released only to the party who has been authorized to receive it (Gold et al. 2008).

Similarly, according to the *Forensic Psychology Guidelines*, "forensic practitioners recognize their ethical obligations to maintain the confidentiality of information relating to a client or retaining party, except insofar as disclosure is consented to by the client or retaining party, or required or permitted by law" (American Psychological Association and American Psychology-Law Society 2011).

Note that as with treatment relationships, there can be exceptions to confidentiality, such as for the safety of the evaluee or third party (discussed below).

Have the Evaluee Authorize Release of Information

The sole purpose of the disability evaluation is to provide information to the entity requesting the evaluation. Accordingly, clinicians should be certain to discuss the limits of confidentiality with the evaluee prior to the evaluation in the consent process. Prudent clinicians should consider having the evaluee sign an authorization for release of information prior to the evaluation, as part of the informed consent discussion and process, making certain that the authorization includes permission to disclose information to the appropriate parties. If the evaluee refuses to sign, the evaluation should not go forward.

Covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are allowed by regulation [45 C.F.R. § 164.508(b)(4)(iii)] to condition performance of the IME on the evaluee signing an authorization for release of information to the third party requesting the IME. HIPAA considerations aside, release of health information is strictly regulated by federal and state confidentiality laws. Therefore, in addition to possible ethical violations, clinicians may create liability exposure should disputes regarding unauthorized disclosure of information arise after information has been released. In addition, for the same

reasons, if after the evaluation has been completed, the evaluee withdraws the authorization to release information, clinicians should be certain not to release the information unless and until a signed authorization is again provided. Clinicians should also ensure that they disclose information only pursuant to the written authorization signed by the evaluee.

Clinicians should ensure the authorization form for release of information complies with applicable state law and federal law, including HIPAA's Privacy Rule [45 C.F.R. §164.508(c)] and Confidentiality of Substance Abuse Treatment Records (42 C.F.R. Part 2) [42 C.F.R. §2.21]. These laws specify the exact elements that are to be included in an authorization form for the release of health information, such as the reason for the disclosure, entity to whom records are to be released, and expiration date or event, among other specific elements.

Release Only the Minimum Necessary

Part of the duty to maintain confidentiality is to disclose only relevant information. This duty may be included in state regulations. For example, New Jersey Administrative Code § 13:35-6.5(f) states in part that licensees rendering IME services "shall…avoid the unnecessary disclosure of diagnoses or personal information which is not pertinent." Also, case law in any particular state or jurisdiction may have developed to require only the minimum necessary information be disclosed. According to AMA Ethics Opinion E-5.09, *Confidentiality: Industry-Employed Physicians and Independent Medical Examiners* (American Medical Association 1999), "the physician should release only that information which is reasonably relevant to the employer's decision regarding that individual's ability to perform the work required by the job." Similarly, according to AAPL's *Practice Guideline*:

> …information that is not relevant to the disability evaluation should be considered confidential. Consent to release information in disability evaluations does not give a psychiatrist *carte blanche* to reveal all information obtained during the evaluation to anyone who is interested in it…The matter of confidentiality is particularly relevant because of the relationship between FFD [fitness for duty] examinations and the workplace. For example, it is often unnecessary for FFD reports to describe an evaluee's background (e.g. family and social histories) except to the extent that such information is directly related to the specific referral questions" (Gold et al. 2008).

The *Forensic Psychology Guidelines* also state, "forensic practitioners are encouraged to limit discussion [in reports and testimony] of background information that does not bear directly upon the legal purpose of the examination or consultation" (American Psychological Association and American Psychology-Law Society 2011).

A relatively recently implemented federal law, the Genetic Information Nondiscrimination Act of 2008 (GINA) is also relevant to issues of confidentiality and disclosure. Title II of GINA went into effect in November 2009 and prohibits employers from using genetic information, defined to include family medical

history, in employment decisions. The United States Equal Employment Opportunity Commission (EEOC) enforces Title II, and under the EEOC's regulations [29 C.F.R. §1635], employers must inform healthcare providers in advance NOT to provide genetic information (including family history) in response to a request for health information.

In 29 C.F.R. §1635.8(b)(1)(B), the EEOC provided the following "safe harbor," that is, model language for this warning to be included in information requests:

> The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers or other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

When processing requests for information, clinicians should release information only with the evaluee's authorization, and only that information that is relevant to the purpose of the evaluation and that is consistent with the request for information.

Evolving Legal Duties

The case law developing the legal duties related to the provision of IMEs, and thus the liability associated with breach of those duties, is evolving. There is no uniformity in decisions among jurisdictions or even within the same jurisdiction. Even judges hearing the same case disagree with each other, and judges in many cases regarding liability in IMEs have entered opinions dissenting from the majority.

Duties Owed—If Any—to Evaluees Vary by Jurisdiction

To prevail in a medical malpractice lawsuit, the plaintiff must prove that the defendant clinician breached a duty owed to the plaintiff and that the breach caused the plaintiff to suffer damages. The courts have not been consistent in their determinations of what duties, if any, are owed by the IME clinician to the evaluee. Courts have adopted a range of positions when analyzing the potential duties owed to evaluees in evaluations conducted for non-treatment purposes such as disability evaluations. Some courts say that since no traditional physician–patient relationship exists in such evaluations, no duties exist, so there can be no breach of duty, and

therefore no malpractice (*Smith v. Radecki* 2010; *Joseph v. McCann* 2006). Some courts take the opposite view and have ruled that the duty of care owed to evaluees is the same as that owed to patients (*Lambley v. Kameny* 1997). Some courts have taken a middle position and have ruled there is a limited duty owed in IMEs, such as the duty to not injure the evaluee (*Ramirez v. Carreras* 2004).

The current general trend is for courts to impose malpractice liability for breaches of certain duties owed to evaluees despite the absence of the traditional clinician–patient relationship. The main types of medical malpractice liability imposed by courts on IME clinicians are discussed below. These cases help establish general principles for conducting disability and IME evaluations, and so assist mental health clinicians in managing the risk of liability associated with the provision of disability evaluations.

Duty to Protect Evaluee's Confidentiality

As discussed above, mental health clinicians performing disability evaluations are expected to maintain the evaluee's confidentiality. This obligation can be met by obtaining the evaluee's written authorization prior to releasing information, and releasing only that information authorized to be released. Releasing clinical information without the evaluee's authorization can result in a finding of liability due to breach of the duty of confidentiality, as in the following case.

Case Law Example I

A psychiatrist performed a disability evaluation on an employee. Without authorization from the evaluee, the psychiatrist discussed the evaluee's clinical information with the employer and suggested the employer send the evaluee to a second psychiatrist for a substance abuse evaluation. After the second evaluation, the second psychiatrist also discussed the evaluee's alcohol use with the employer, also without a release to do so from the evaluee. Based on the reports from the two psychiatrists, the employer required the evaluee to complete a 30-day inpatient alcohol treatment program as a condition of returning to work. The employee/evaluee refused and was fired; he then sued both psychiatrists, along with the employer. Along with other findings, the court held that both psychiatrists violated state confidentiality law by releasing clinical information to the employer without an authorization (*Pettus v. Cole* 1996).

In addition, even with authorization, only the minimum necessary information should be released. The following case example demonstrates the potential liability associated with the release of more than the minimum necessary as recommended by the AMA and AAPL (discussed above).

Case Law Example II

A psychiatrist (who was also a lawyer) performed a fitness for duty evaluation on a police officer. The clinician saw the evaluee for three sessions and produced a 21-page fitness for duty report. The report included various aspects unrelated to fitness for duty such as many inappropriate details about the evaluee's home life. The federal trial court granted summary judgment to the clinician. The appellate court reversed and allowed the evaluee's case against the clinician to go to trial, stating that the evaluee "is entitled to have a jury hear his claim and determine whether the disclosure exceeded the scope necessary to determine fitness for duty" (*McGreal v. Ostrov* 2004).

Another type of disclosure that can violate the confidentiality associated with an IME involves requests for an IME clinician to disclose IME reports prepared in other, unrelated cases. As always, there has to be a legally valid basis for disclosure, such as an authorization, as illustrated by the case below.

Case Law Example III

A neurologist was retained by the defense in an automobile accident case to perform an IME on the plaintiff. The physician's IME reports from other, unrelated cases, were subpoenaed by plaintiff's attorney to show bias on the part of the physician. The defense filed a motion to quash the subpoena for the unrelated IME reports. The trial court denied the motion and ordered the physician to disclose reports from prior, unrelated examinations of personal injury plaintiffs. The court allowed the physician to redact the name of the evaluees in these reports. The defense appealed the trial court's order and the appellate court quashed the order. The appellate court held that the trial court erred by compelling disclosure without notice to subjects of the IME reports and without adequate privacy protections. The court also noted that state law regarding confidentiality of medical information was to be followed (*Graham v. Dacheikh* 2008).

This case indicates that mental health clinicians requested to provide copies of IME reports from other cases should not automatically do so simply based upon the request. If this circumstance arises, clinicians should discuss the issue with the retaining party, and if disclosure is required, request that the reports be de-identified or "sanitized."

All three cases discussed above (*Pettus, McGreal*, and *Graham*) also illustrate the expectation of compliance with all state and federal confidentiality laws by clinicians performing disability evaluations. In the *Pettus* case, the court found that both evaluating psychiatrists violated state law requiring an authorization for release of information prior to releasing information. While not addressed by the court, clinicians should note that the second psychiatrist, described by the court as "a psychiatrist with expertise in chemical dependency" may also have been required to comply with 42 CFR Part 2, the federal regulations that govern the release of substance abuse treatment records. Moreover, had the *Pettus* case been

decided after HIPAA's Privacy Rule was in effect, and if the physicians were "covered entities" subject to this federal regulation, releasing information without the evaluee's authorization would have been in violation of HIPAA's regulations.

Similarly, the court in the *Graham* case held that state law related to confidentiality of medical information was to be followed. It was also noted by the court in the *McGreal* case that the evaluating clinician's consent form failed to comply with state confidentiality law, which lists the elements to be included in a valid consent for release of information form.

Duty to Warn or Protect

As mental health clinicians are aware, the duty to maintain confidentiality in treatment settings has certain important exceptions based on overriding legal duties regarding patient safety or safety of others. This same exception holds true in non-treatment settings such as disability evaluations. Most states have statutes that require clinicians to warn or protect third parties from dangerous patients. In the context of disability evaluations, AAPL's *Practice Guideline* addresses this as follows:

> An important exception to confidentiality may arise if the evaluee threatens his or her own safety or the safety of others. If an evaluee discloses suicidal ideation or intent or threatens to harm a coworker, supervisor, or employer, the psychiatrist is ethically and perhaps legally obligated to take appropriate steps to ensure the safety of the evaluee or potential victims (Gold et al. 2008).

Courts may expect this duty to warn or protect from IME clinicians as well as treating clinicians, as the following case illustrates.

Case Law Example IV

This suit was filed against the IME psychologist, not by the evaluee, but by a third party. After the evaluee pled guilty to stalking his neighbors (plaintiffs in this case), the probation department retained a psychologist to conduct an IME. The IME psychologist met with the evaluee one time during which the psychologist said that the evaluee had never indicated that he intended or planned to harm the neighbors. The IME psychologist did not advise the probation officers of any particular concerns. Thirteen days after the IME, the evaluee attempted to break into the neighbors' home but was apprehended by the police. He was charged with various felonies and sentenced to prison. Plaintiffs alleged the IME psychologist negligently failed to warn them or the probation office of the threat to them posed by the evaluee. Although the federal trial court granted summary judgment for the IME psychologist, the court made it clear that the duty to warn or protect under state law does apply to IME mental health providers. In this case, however, the court found the duty was not triggered. The case was affirmed on appeal (*Fredericks v. Jonsson* 2010).

Duty to Not Harm the Evaluee

Most courts also agree that IME clinicians can be liable for injuring an evaluee during the evaluation. The duty not to injure the evaluee may include mental harm in addition to physical harm, as indicated by the case below.

Case Law Example V

The *pro se* evaluee sued the psychiatrist who had performed an IME for misrepresentation, deceit, invasion of privacy, intentional infliction of emotional distress, and many other allegations. The appellate court held that emotional harm during the examination may be actionable, and cited the state Supreme Court's language in a different case: "It is entirely possible that a duty of care could arise while a physician or other health care provider conducts an evaluation of an examinee's mental health" (*Dalton v. Miller* 1999).

In another case, *Harris v. Kreutzer* (2006), a psychologist's allegedly verbally abusive behavior during an IME of an evaluee asserting traumatic brain injury resulting in psychological trauma was recognized as actionable. Thus, the obligation of the examiner to discover relevant information regarding the evaluee's injuries and impairments must be balanced against the obligation not to worsen those injuries or impairments in the process of learning about them. Among other reasons, including the ethical obligation to treat evaluees with dignity and respect, mental health clinicians should endeavor to minimize additional distress or adverse circumstances associated with what for many evaluees is a stressful, intrusive, and/or unwarranted mental health evaluation.

However, losses allegedly caused by the IME clinician's report are generally not actionable. As stated by another court, "the IME physician, acting at the behest of a third party, is not liable to the examinee for damages resulting from the conclusions the physician reaches or reports" (*Dyer v. Trachtman* 2004, p. 315).

Duty to Diagnose

There have been a few decisions where the court imposed on IME clinicians the duty to properly diagnose (*Ritchie v. Krasner* 2009; *Lambley v. Kameny* 1997); however, none of the cases under which this duty has been imposed involved mental health evaluations.

Duty to Notify Evaluee of a Serious Medical Condition

Courts may also find that the clinician performing a disability evaluation has the duty to inform the evaluee about a potentially serious medical condition. In addition to case law (*Stanley v. McCarver* 2004; *Reed v. Bojarski* 2001), liability

for failure to notify an evaluee of a serious medical condition may be predicated on a violation of state law (such as New Jersey Administrative Code § 13:35-6.5) and ethical obligations (such as AMA Ethics Opinion E-10.03, *Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations*). While most of the cases imposing this duty involve a significant radiological finding, mental health clinicians should keep this duty in mind should an evaluee present with a serious medical condition, such as a neurological condition, the significance of which does not seem to be appreciated by the evaluee.

Liability Exposure

Litigation

As discussed above, performing disability evaluations is not an activity with a high risk of liability, but courts are showing an increased willingness to find liability on the part of clinicians performing disability evaluations and other IMEs if they breach the limited duties owed to evaluees. While this chapter has focused on medical malpractice cases, unhappy or dissatisfied evaluees can file other types of claims, such as infliction of emotional distress or defamation. However, it is worth noting that IME liability cases also share what is typical in medical malpractice litigation: an adverse event involving the evaluee. The following case illustrates this observation.

Case Law Example VI

The employer sent the individual for psychiatric evaluation to determine fitness for duty. The evaluating psychiatrist saw the evaluee twice and returned him to full duty. The evaluee was under the care of a treating psychiatrist. More than three months after the IME was performed, the evaluee committed suicide. Along with the treating providers, the psychiatrist who performed the evaluation was named in the medical malpractice lawsuit based on the suicide. The evaluating psychiatrist's motion for summary judgment, dismissing him from the case, was granted (*Eckman v. Cipolla* 2009).

Even if the independent mental health clinician is ultimately not found liable, the time and stress associated with defending such a claim is significant.

In response to an evaluee filing a legal claim against an IME mental health clinician, the defendant clinician may be entitled to immunity from such lawsuit. There are two general types of immunity relevant to IME activities. The first type is quasi-judicial immunity which provides immunity from suit only for "judicial" activities. These are typically limited to evaluations paid for by the court rather than the parties. For example, a disability evaluation performed as part of a workers' compensation case would not be protected by judicial immunity. The second type of immunity relevant to independent mental health evaluations is witness immunity, which provides immunity from suit for testimony in judicial

proceedings, including depositions. Witness immunity also generally precludes suit based on contents of the written reports, as illustrated in the following case.

Case Law Example VII

This suit was filed against the evaluating physician not by the evaluee, but by the evaluee's treating physician. In his IME report, Dr. M criticized Dr. Y's treatment of the IME evaluee. Dr. Y sued the IME physician alleging defamation and invasion of privacy. The trial court granted summary judgment to the IME physician, holding that he had immunity. The appellate court affirmed the IME physician's summary judgment holding that witness immunity precludes liability based on the content of the report (*Yeung v. Maric* 2010).

Nevertheless, immunity will not shield IME clinicians from all liability. For example, IME mental health clinicians can be sued for negligent performance of an IME even if they are immune from liability based on their report. Accordingly, as previously mentioned, mental health clinicians conducting disability evaluations should conduct themselves professionally, avoid being rude, or intentionally creating discomfort.

State Licensing Boards and Disability Evaluations

Administrative actions, such as investigations by state licensing boards, can be an area of professional liability risk exposure when performing disability evaluations. Filing a licensing board complaint is relatively easy for an unhappy evaluee. There is no cost involved and evaluees are not required to show that damages were sustained, as is required in medical malpractice actions. While not all licensing boards will address complaints regarding IMEs, some regulators will. For example, under Arizona law (A.R.S. §32.1451), the medical licensing board may take action against a physician who commits unprofessional conduct while performing an IME.

Mental health clinicians are encouraged to check with their licensing board(s) to determine if there are any regulations, guidelines, or policy statements related to performing disability evaluations and other types of IMEs. Understanding the expectations of the applicable boards can assist mental health clinicians in meeting the standards of professionalism. As an example, boards may discourage independent evaluators from becoming the evaluee's treating clinician after the evaluation is complete. This is the expectation of the Rhode Island Medical Board, as evidenced by its policy statement *Independent Medical Examinations*:

> The Board considers it generally inappropriate for a physician to perform an IME/Independent Insurance Evaluation and to offer or serve as the subsequent treating provider for a patient. If a physician who performs an IME is to serve as a treating provider, then a sufficient span of time must elapse such that no reasonable individual could conclude a

> contingent relationship between the IME determination and the decision to pursue subsequent care with the IME physician or the IME physician's practice group. (Rhode Island Medical Board 2011)

Issues involving professional licensure may also be relevant when doing IMEs. For example, Alaska law (Administrative Code 12 § 40.945) provides that physicians performing a face-to-face IME are practicing medicine. The possible implications of an IME being deemed the practice of medicine include, at least, that appropriate licensure is required in that state, and that the clinician may be subject to oversight by the medical board in that jurisdiction. Licensure requirements should be determined prior to performing disability or IME evaluations in states other than those where the IME mental health clinician is licensed. The unauthorized practice of medicine or the unauthorized practice of psychology would not be covered by liability insurance policies. Therefore, prudent clinicians performing IMEs outside of the states where they are licensed should check with those states' licensing boards before performing the IME to determine if a license is needed.

Other Types of Administrative Actions

Other types of administrative actions, such as complaints filed with professional organizations, and complaints filed with governmental agencies other than licensing boards, are also potential areas of risk for mental health clinicians performing disability evaluations or other types of IMEs related to disability. For example, an evaluee could file a complaint alleging that the IME clinician has violated federal HIPAA regulations.

Most HIPAA complaints filed against IME clinicians involve lack of access to the clinician's information. As discussed above, the information collected during a mental health IME is considered protected health information (PHI), although it is not collected for treatment purposes. Under the Privacy Rule, evaluees are entitled to access their own PHI held by a covered entity. The Privacy Rule is enforced by the Office for Civil Rights (OCR), and OCR has made it clear in its enforcement case examples that an IME evaluee is to be provided access to records held by an IME clinician who is a covered entity under HIPAA, including copies of disability reports (Office for Civil Rights 2011).

The practical implications of the Privacy Rule's requirements have yet to be worked out. Many mental health disability evaluation referrals include explicit instructions that clinicians should refer evaluees' requests for reports to the referral agency or insurer, and not release reports to evaluees. Even the federal government has not provided consistent instruction in regard to releasing reports to evaluees. The Social Security Administration, for example, specifically directs clinicians to not provide disability reports to evaluees (Social Security Administration 2003).

The issue of releasing reports directly to evaluees is still so new that no case law has directly addressed a legal conflict that would provide guidance on this matter. Nevertheless, prudent mental health clinicians who are covered entities under HIPAA or who practice in states where state law requires that evaluees have access to the IME report, should at a minimum ensure that any contracts entered to provide disability evaluations do not preclude the release of reports to evaluees.

Conclusion

Even in the absence of a clinician–patient treatment relationship, performing disability evaluations can lead to professional liability exposure. However, the risk is very low and can be managed with an understanding of the exposure and the expectations of the courts and regulatory agencies. Informed consent discussions with the evaluee are crucial for ensuring patients/evaluees have a true understanding of the evaluation and the role of the evaluating clinician. Non-patient evaluees need to understand that the evaluation is being conducted at the request of a third party, and that the evaluating clinician is not providing treatment.

While keeping the low risk exposure in mind, it is helpful to review cases decided by the courts involving disability evaluations and other IMEs. Such a review indicates that courts have been particularly willing to allow cases alleging that the evaluating clinician breached confidentiality, injured the evaluee (physically or emotionally) during the performance of the evaluation, and failed to disclose to the evaluee a serious medical condition. Finally, clinicians should keep in mind that licensing boards are taking an increased interest in regulating the performance of evaluations in terms of licensure requirements, particularly for out-of-state clinicians, and investigating complaints against the evaluating clinician filed by the evaluee.

Key Points

1. Avoid performing a disability evaluation for a patient if doing so could present an ethical or treatment conflict.
2. Understand the professional liability exposure associated with performing disability evaluations and IMEs. Be familiar with relevant state and federal laws, ethical obligations, and clinical guidelines related to evaluating disability.
3. Contact your professional liability insurance company to discuss coverage for disability evaluations and other forensic activities.
4. If performing disability evaluations outside of the states where you are licensed, check with those states' licensing boards prior to conducting the evaluation to see if a license is needed.
5. Have the evaluee sign a written consent to the evaluation prior to the evaluation.

6. Understand obligations to maintain confidentiality.
7. Discuss the limits of confidentiality with the evaluee prior to the evaluation.
8. Have the evaluee sign an authorization for release of information prior to the evaluation, allowing you to disclose information to the appropriate parties.
9. Ensure your authorization form for release of information complies with applicable state law and federal law, such as the Privacy Rule under HIPAA.
10. Disclose information only pursuant to the written authorization signed by the evaluee.
11. Release only that information that is relevant to the purpose of the evaluation.
12. If only specific information is requested to be disclosed, limit disclosure to only the requested information.
13. Ensure that any contracts entered to provide disability evaluations do not preclude notifying the evaluee directly of any serious medical condition found during the evaluation.
14. If you are a covered entity under HIPAA, or if state law requires that evaluees have access to the IME report, ensure that any contracts entered to provide disability evaluations do not preclude releasing your report to the evaluee.
15. Do not assume that courts in your jurisdiction will not find clinicians liable for the performance of disability evaluations, even if they have previously declined to impose such liability.
16. Remember that immunity, if available, will not shield clinicians performing IMEs from all liability. For example, clinicians can be sued for negligent performance of the IME, even if they are immune from liability based on consequences of their report.

Appendix I: Glossary of Legal Terms

Actionable	What the plaintiff alleges the defendant did wrong is sufficient to support a legal cause of action seeking to impose liability on the defendant
Cause of action	What is alleged by plaintiff to have occurred that is the basis for a lawsuit (e.g., medical malpractice, defamation, invasion of privacy, and battery); each cause of action has specific elements that plaintiff must prove; the elements and requirements for filing a lawsuit vary by state
Defendant	The party that is being sued by the plaintiff
Dissenting opinion	Written by judges hearing a case who do not agree with the opinion of the majority of judges; in their dissenting opinion (which follows the majority opinion), they explain their legal reasoning for their opinion that the judges in the majority decided the case incorrectly
Plaintiff	The party that filed suit against the defendant
Pro se	Without attorney representation in litigation

Quash	To declare void, such as when a court quashes a subpoena for records
Remand	After reviewing the case, and disagreeing with the lower court, the appellate court sends the case back down to the trial court with instructions, such as proceeding with a trial consistent with the appellate court's opinion
Summary judgment	Requested by a party in litigation prior to trial, asking for judgment to avoid an unnecessary trial
Tort	Type of legal action allowing recovery by those harmed by the acts of others; civil action involving private parties as opposed to a crime where the government prosecutes criminal actions

Appendix II: IME Physician Liability

Survey of Recent Appellate Case Law (Decided 1993–2011)

Note: The cases listed below are subject to being heard by the trial court on remand, being reversed on appeal, or being overruled by subsequent court opinions. The cases listed below could also be affected by regulatory and statutory changes in the law.

Significance of ordinary negligence versus medical malpractice action

Case	Type of case	Language from the court	IME provider liable?
Bazakos v. Lewis, 911 N.E.2d 847 (N.Y. 2009) Alleged injury during IME; case filed as ordinary negligence action, outside statute of limitations for medical malpractice actions	Question certified to state's highest appellate court by lower appellate court	"We hold that a claim against a doctor for his alleged negligence in performing an independent medical examination (IME) is a claim for malpractice, governed by CPLR 214-a's two-year-and-six-month statute of limitations…[T]he relationship between a doctor performing an IME and the person he is examining may fairly be called a 'limited physician-patient relationship'" Note: There is a dissenting opinion	No
Gentry v. Wagner, 2009 WL 1910959 (Tenn.Ct.App. 2009) Alleged injury during IME; case filed as ordinary negligence; no expert testimony offered Pro se plaintiff	Appeal from trial court's grant of IME physician's summary judgment	"We agree with the conclusion of the trial court: 'An implied patient-physician relationship did exist between the Plaintiff Gentry and the Defendant Wagner. This is a medical malpractice action.…' The medical malpractice statutes require expert testimony to establish the applicable standard of care…Because Mr. Gentry failed to offer any expert testimony, the trial court properly granted the defendant's motion for summary judgment"	No

(continued)

(continued)

Case	Type of case	Language from the court	IME providerliable?
Devitre v. Orthopedic Center of St. Louis, 349 S.W.3d 327 (Mo. 2011) Alleged injury during IME; case filed as assault and battery; affidavit required for medical malpractice claim was not filed	Appeal from trial court's dismissal for failure to file affidavit required in medical malpractice action; transferred from Court of Appeals	"Having reviewed persuasive authority from other jurisdictions, this Court concludes that a physician who only provides an independent medical examination but does not treat the examinee 'has a limited physician-patient relationship with the examinee that gives rise to limited duties to exercise professional care.'…'The limited relationship…imposes a duty on the independent medical examination physician to perform the examination in a manner not to cause physical harm to the examinee.'…The factual allegations in Mr. Devitre's petition state the claim that Dr. Rotman caused personal injury to him during the course of the independent medical examination when he manipulated Mr. Devitre's arm…The claimed injuries allegedly were caused by the health care service Dr. Rotman provided to Mr. Devitre. Such a claim is a medical malpractice…claim….Mr. Devitre's allegations of personal injury constitute a claim for medical malpractice, not assault and battery. Therefore, he was required to file a health care affidavit pursuant to section 538.225.1. His failure to file the affidavit warrants a dismissal…" Note: There is a dissenting opinion	No

(continued)

(continued)

Case	Type of case	Language from the court	IME provider liable?
Canfield v. Grinnell Mut. Reinsurance Co., 610 N.W.2d 689 (Minn. App. 2000) Alleged injury during IME; expert affidavit was insufficient for medical malpractice action	Appeal from trial court's grant of IME physician's summary judgment	"The issue in this case is whether the expert affidavit requirement applies to a claim against a doctor who was not providing care and treatment, but was conducting an IME required and paid for by an insurer. We hold that because this is not a claim for medical malpractice, Minn. Stat. § 145.682 [requiring an expert affidavit] does not apply"	Unknown; reversed and remanded for trial; no subsequent opinion reported
Yoder v. Cotton, 758 N.W.2d 630 (Neb. 2008) Alleged injury during IME; case filed as ordinary negligence, not medical malpractice	Appeal from trial court's grant of IME physician's summary judgment; state Supreme Court moved case from Court of Appeals	"The Yoders argued that because there was no physician-patient relationship, their claim cannot be defined as a medical malpractice actions and therefore is not governed by the Nebraska Hospital-Medical Liability Act or any other statutory limitations on recoverable damages…we conclude that a physician conducting an IME is performing a professional service. Our law requires a plaintiff to present expert testimony of causation in a medical malpractice case in order to overcome summary judgment and Yoder failed to do so"	No

The issue of duty owed to IME evaluee

Case	Type of Case	Language from the Court	IME Provider Liable?
Heller v. Peekskill Community Hospital, 198 A.D.2d 265 (N.Y. 1993) Alleged premature return to work caused further injury	Appeal from trial court's denial of IME physician's summary judgment	"In order to maintain an action to recover damages arising from medical malpractice, a doctor-patient relationship is necessary…In general, this [doctor-patient relationship] is not formed when a doctor examines a patient solely for purposes of rendering an evaluation for an employer or potential employer…However, an important exception to this rule occurs when the examining doctor causes further injury by either affirmatively treating the patient or affirmatively advising the patient as to a course of treatment…Dr. Winokur affirmatively advised him as to a course of treatment by suggesting that he seek physical therapy from a specified physical therapist and by directly advising him that he was fit to return to work without restriction as to the type of physical activity he was to perform there. Further, he alleges, this latter advice, which caused or exacerbated his injuries, was both incorrect and foreseeably relied upon. These allegations are sufficient to withstand a motion to dismiss for failure to state a cause of action and/or for summary judgment"	Unknown; denial of summary judgment affirmed; no subsequent opinion reported
Lawliss v. Quellman, 38 A.D.3d 1123 (N.Y. 2007) Alleged negligent advice caused further injury	Appeal from trial court's denial of IME physician's summary judgment	"While an IME performed at the request of a third party does not ordinarily give rise to an actionable physician-patient relationship….such a relationship may be implied where the IME physician affirmatively advises the patient…plaintiff presented evidentiary facts tending to show that defendant affirmatively advised him as to the inappropriateness of surgery and recommended physical therapy as an alternate course of treatment…..[W]hether defendant's advice was negligent and plaintiff's reliance was foreseeable and detrimental also present questions of fact which should be resolved by a jury"	Unknown; denial of summary judgment affirmed; no subsequent opinion reported

(continued)

(continued)

Case	Type of Case	Language from the Court	IME Provider Liable?
Badolato v. Rosenberg, 67 A.D.3d 937 (N.Y. 2009) Alleged premature return to work caused further injury	Appeal from trial court's denial of IME physician's summary judgment	"The [trial court] properly denied….summary judgment dismissing the complaint on the ground that no physician-patient relationship existed…plaintiff's deposition testimony…raised triable, material issues of fact as to whether (1) the defendant affirmatively advised the plaintiff as to a course of treatment by recommending that the plaintiff return to work without any restrictions on his physical activities, (2) the advice was incorrect, (3) it was foreseeable that the plaintiff would rely on the advice since the plaintiff testified that two other treating physicians advised him not to return to work, and (4) the plaintiff relied on the advice to his detriment"	Unknown; denial of summary judgment affirmed; no subsequent opinion reported
Webb v. T.D., 951 P.2d 1008 (Mont. 1997) Alleged misdiagnosis and failure to limit work activity caused further injury	Appeal from trial court's grant of IME physician's summary judgment	"We do not, by this opinion, conclude that physicians retained by third parties who perform independent medical examinations have the same duty of care that a physician has to his or her own patient…..a health care provider in Montana who is retained by a third party to do an independent medical examination has the following duties: 1. To exercise ordinary care to discover those conditions which pose an imminent danger to the examinee's physical or mental well-being and take reasonable steps to communicate to the examinee the presence of any such condition; and 2. To exercise ordinary care to assure that when he or she advises an examinee about her condition following an independent examination, the advice comports with the standard of care for that health care provider's profession"	Unknown; reversed and remanded for trial; no subsequent opinion reported

(continued)

(continued)

Case	Type of Case	Language from the Court	IME Provider Liable?
Ramirez v. Carreras, 165 S.W.3d 371 (Tex. App.—Corpus Christi 2004) Alleged injury during IME	Appeal from trial court jury's finding IME physician was not negligent	"When a physician examines a person for the benefit of a third party and no physician-patient relationship exists, the only duty owed by the physician is the duty not to injure the examinee…[W]e find that the jury's finding [of no negligence] was not against the great weight and preponderance of the evidence"	No
Smith v. Welch, 967 P.2d 727 (Kan. 1998) Alleged assault, battery, outrageous conduct, and invasion of privacy	Appeal from trial court's grant of IME physician's summary judgment	"Does a physician performing an independent medical examination have a duty not to negligently injure the person examined? Yes…Is the duty of a physician not to injure the person being examined affected by the fact that the physician was employed by a third party? No"	Unknown; reversed and remanded for trial; no subsequent opinion reported
Joseph v. McCann, 147 P.3d 547 (Utah App. 2006) Alleged incorrect psychiatric IME evaluation of police officer led to termination	Appeal from trial court's grant of IME physician's summary judgment	"Without the existence of a physician-patient relationship between McCann and Joseph, Joseph cannot maintain a medical malpractice claim against McCann. Because Joseph was not McCann's patient seeking psychiatric treatment and because the contract for medical services was between McCann and the City, not McCann and Joseph, we conclude that there was no physician-patient relationship between McCann and Joseph. Therefore, the trial court did not err when it held that McCann 'owed no legal duty to [Joseph] from which a [medical malpractice] action could be commenced'"	No

(continued)

(continued)

Case	Type of Case	Language from the Court	IME Provider Liable?
Smith v. Radecki, 238 P.3d 111 (Alaska 2010) Alleged harm during IME Pro se plaintiff	Appeal from trial court's grant of IME physician's summary judgment	"We are not persuaded that a physician who performs an IME undertakes a traditional physician-patient relationship or owes an examinee the duty of care that attends such a relationship…[W]e acknowledge that courts in several other states have held that physicians owe a limited duty of care in an IME setting. For example, the Tennessee Court of Appeals held that a limited physician-patient relationship exists when an IME is conducted, such that the physician has a duty not to injure the patient during the examination…Other courts have held that physicians have limited duties of care encompassing the duty to discover and warn an examinee of conditions which pose an 'imminent danger' to the examinee's health, and to provide correct information to a patient about his condition in the event the IME physician 'gratuitously undertakes to render services which he should recognize as necessary to another's bodily safety'…Though we acknowledge this growing body of case law, we also recognize that it is not implicated by the evidence Smith offered." Footnote: "We agree with Smith that the absence of a physician-patient relationship does not *immunize* a physician performing an IME from all tort liability, and we do not rule out the possibility that a physician could be liable for conduct committed during an IME…"	No

(continued)

(continued)

Case	Type of Case	Language from the Court	IME Provider Liable?
Lambley v. Kameny, 682 N.E.2d 907 (Mass. App. Ct. 1997) Alleged misdiagnosis in pre-employment psychological fitness screening	Appeal from trial court's dismissal of claim for lack of proof	"In short, Lambley's claims realistically constitute a charge that Dr. Kameny was 'negligent or mistaken in terms of [his] medical judgment' regarding Lambley's psychological condition; such an impugning of Kameny's psychiatric judgment would appear to be well within the jurisdiction of a medical malpractice tribunal…In our view, the duty to exercise reasonable professional care and skill…is practically indistinguishable from the duty owed by a physician to his conventional patient, at least with respect to the tortious, as opposed to the contractual, consequences of the relationship"	Unknown; dismissal of claim was vacated; no subsequent opinion reported

Allegations Made Against IME Physicians

Alleged injury during the evaluation—physical injuries

Case	Type of Case	Language from the Court	IME Provider Liable?
Dyer v. Trachtman, 679 N.W.2d 311 (Mich. 2004) Alleged injury during IME	Lower courts unclear on type of action—ordinary negligence or medical malpractice; state Supreme Court guidance sought	"Having reviewed persuasive authority from other courts, we conclude that an IME physician has a limited physician-patient relationship with the examinee that gives rise to limited duties to exercise professional care…the relationship is not the traditional one. It is a limited relationship. It does not involve the full panoply of the physician's typical responsibilities to diagnose and treat the examinee for medical conditions. The IME physician, acting at the behest of a third party, is not liable to the examinee for damages resulting from the conclusions the physician reaches or reports. The limited relationship that we recognize imposes a duty on the IME physician to perform the examination in a manner not to cause physical harm to the examinee…Thus we overrule *Rogers* and its progeny…"	Unknown; reversed and remanded for trial; no subsequent opinion reported
Mero v. Sadoff, 37 Ca..Rptr.2d 769 (Cal.App.2.Dist. 1995) Alleged injury during IME	Appeal from trial court's grant of IME physician's summary judgment	"Imposing liability for negligence in the examination even in the absence of a physician-patient relationship would serve the policy of preventing future harm by precluding a situation in which a physician could negligently injure an examinee with impunity…In the instant case, the trial court granted summary judgment, in part on the ground there was no physician-patient relationship between defendant and plaintiff, so defendant could not be held liable for injuries incurred by plaintiff during his examination of her. This was error"	Unknown; reversed; no subsequent opinion reported
Greenberg v. Perkins, 845 P.2d 530 (Colo. 1993) Alleged injury from testing ordered by IME physician	Appeal from appellate court's reversal of trial court's summary judgment to IME physician	"…our conclusion that [IME physician] owed to [evaluee] a duty to act with reasonable care so as to not cause her injury by referring her for testing of a type that foreseeably would result in injury based on information known to him"	Unknown; affirmed reversal of summary judgment; no subsequent opinion reported

See also ***Ramirez*** (above), ***Smith*** (above), and cases under "Significance of Ordinary Negligence vs. Medical Malpractice Action" (above)

Alleged injury during the evaluation—emotional injuries/infliction of emotional distress

Case	Type of Case	Language from the Court	IME Provider Liable?
Harris v. Kreutzer, 624 S.E.2d 24 (Va. 2006) Alleged intentional infliction of emotional distress and malpractice during IME	Appeal from trial court's grant of IME psychologist's demurrer and dismissal of evaluee's motion for judgment	"[W]e hold that a cause of action for malpractice may lie for the negligent performance of a Rule 4.10 [required IME] examination. However, a Rule 4.10 physician's duty is limited solely to the exercise of due care consistent with the applicable standard of care so as not to cause harm to the patient in actual conduct of the examination…[plaintiff alleged the IME psychologist] 'failed to provide appropriate psychological care in performing his examination and evaluation.' Specifically, Harris averred Dr. Kreutzer 'verbally abused [her], raised his voice to her, caused her to break down in tears in his office, stated she was 'putting on a show' and accused her of being a faker and a malingerer' during the Rule 4.10 examination, despite his alleged prior knowledge of her fragile mental and emotional state. If such conduct was proven at trial, and appropriate expert testimony showed such conduct breached the applicable standard of care for a reasonably prudent clinical psychologist in Virginia, then a trier of fact could conclude that malpractice occurred…[Regarding the intentional infliction of emotional distress] Harris failed to state facts sufficient to establish that Dr. Kreutzer's conduct was outrageous or that her distress was severe"	Unknown; remanded for trial; no subsequent opinion reported
See also ***Martinez*** (below) and ***Dalton*** (below)			

Alleged misdiagnosis

Case	Type of Case	Language from the Court	IME Provider Liable?
Martinez v. Lewis, 969 P.2d 213 (Colo. 1998) Alleged misdiagnosis and report resulted in further injury due to terminated benefits	Appeal from appellate court's affirmation of trial court's grant of IME physician's summary judgment	"…we hold that Dr. Lewis did not owe Martinez a duty of care. We note that this conclusion is in accord with virtually every other court to consider this issue. For example…[t]he *Felton* court stated: 'We independently have reviewed out-of-state authorities and find overwhelming agreement that a physician has no liability to an examinee for negligence or professional malpractice absent a physician/patient relationship, except for injuries incurred during the examination itself.'…[Also] because the alleged misrepresentations did not significantly impact the public as consumers of Dr. Lewis's services, Martinez was also precluded from pursuing a claim against him for violations of the CCPA [Colorado Consumer Protection Act]." FOOTNOTE REGARDING ACTIONABLE EMOTIONAL HARM DURING IME: "…a determination of whether or not a duty exists under *Greenberg* does not turn on a physician or health care provider causing *physical* injury to the examinee. It is entirely possible that a duty of care could arise while a physician or other health care provider conducts an evaluation of an examinee's mental health. For instance, if the physician or health care provider conducted an evaluation in a manner that worsened the examinee's mental health and the physician or health care provider knew or should have known about information that would have cautioned against conducting the examination in that manner, a duty may well arise under *Greenberg*"	No

(continued)

(continued)

Case	Type of Case	Language from the Court	IME Provider Liable?
Ritchie v. Krasner, 211 P.3d 1272 (Ariz. App. Div.1 2009) Alleged misdiagnosis caused evaluee's death four years after IME	Appeal from jury verdict finding IME physician liable	"We do not hold that every IME physician has a duty of care in every situation. In this case, Krasner was hired to determine the extent of Jeremy's work-related injury and make treatment recommendations. By agreeing to do so, he assumed a duty to 'conform to the legal standard of reasonable conduct in light of the apparent risks'…Therefore, we hold the trial court correctly held that Krasner owed a duty of reasonable care to Jeremy…Based on the record in this case, we cannot find that the jury erred in finding Krasner's misdiagnosis was partially the proximate cause of Jeremy's injury, and ultimately, his death. The jury heard testimony from expert witnesses and reviewed volumes of evidence. Based on this, it reasonably could have found it foreseeable that Krasner's report prevented Jeremy from seeking treatment either because he relied on Krasner's report or because [insurer] relied on the report, causing it to terminate Jeremy's workers' compensation coverage. Further, the jury could have found Jeremy's physical deterioration and reliance on medication foreseeable" REGARDING IME PHYSICIAN'S IMMUNITY: "…a witness has absolute immunity when testifying in a judicial proceeding….however…the testimony must have some relation to the subject judicial proceeding…Although we consider workers' compensation hearings that occur before administrative law judges judicial proceedings, the administrative process involved in reviewing a claim for compensation is not…Krasner's conduct and IME report fall outside the scope of witness immunity. He conducted the IME for the benefit of [insurer], not for a judicial proceeding"	Yes
See also ***Lambley*** (above) and ***Webb*** (above)			

Alleged failure to notify evaluee of serious medical condition

Case	Type of Case	Language from the Court	IME Provider Liable?
Stanley v. McCarver, 92 P.3d 849 (Ariz. 2004) Alleged breach of duty to inform evaluee timely of pre-employment x-ray results	Appeal of appellate court's reversal of trial court's grant of IME physician's summary judgment	"We do agree with the court of appeals that the duty imposed is to act as a reasonably prudent health care provider in the circumstances….But whether this duty requires direct communication with the subject of the x-ray regarding any abnormalities discovered may depend upon factors, such as whether there is a treating or referring physician involved in the transaction, whether the radiologist has means to identify and locate the patient, the scope of—including any contractual limitations on—the radiologist's undertaking, and other factors that may be present in a particular case". Note: There is a dissenting opinion	Unknown; remanded; no subsequent opinion reported
Reed v. Bojarski, 764 A.2d 433 (N.J. 2001) Alleged breach of duty to report directly to evaluee serious medical condition found on pre-employment IME	Appeal from appellate court's affirmation of trial court's jury verdict for IME physician	"…we are confronted with the question whether a physician, performing a pre-employment screening, who determines that the patient has a potentially serious medical condition, can omit informing the patient and delegate by contract to the referring agency the responsibility of notification. The answer is no"	Unknown; reversed and remanded for trial; no subsequent opinion reported

Alleged breach of confidentiality

Case	Type of Case	Language from the Court	IME Provider Liable?
McGreal v. Ostrov, 368 F.3d 657 (7th Cir. 2004) Alleged wrongful disclosure of police officer's mental health fitness for duty report	Appeal from federal trial court's grant of IME psychologist's summary judgment	"The crux of McGreal's complaint is that the department had no valid reason to order him to submit to the fitness exam in the first place. He maintains they were simply trying to manufacture a reason to fire him in retaliation for his exercise of his First Amendment rights. Even under *Sangirardi* the department would not be entitled to require a mental health exam for this purpose. Moreover, under *Sangirardi*, the defendants were not entitled to disclosure of anything other than the fitness for duty determination. They were not entitled under any Illinois law to force the disclosure of the intimate and irrelevant details of McGreal's home life. Finally, McGreal claims that dissemination of the report was broader than necessary to determine his fitness for duty and also that the defendants republished the information without further consent as required by the Confidentiality Act. Under these circumstances, McGreal is entitled to have a jury his claim and determine whether the defendants reasonably ordered the exam and whether the disclosure and republication exceeded the scope necessary to determine fitness for duty"	Unknown; reversed and remanded for trial; no subsequent opinion reported

(continued)

(continued)

Case	Type of Case	Language from the Court	IME Provider Liable?
Pettus v. Cole, 49 Cal.App.4th 402 (Cal. App. 1 Dist. 1996) Alleged wrongful disclosure of IME reports to the employer without evaluee's authorization	Appeal of trial court's grant of IME physicians' motion for judgment	"The issues presented… include (1) Whether and to what extent medical information complied during the psychiatric examination of an employee may be disclosed to the employer by a psychiatrist without employee authorization or consent, where the employee has requested leave from work because of a stress-related disability, the examination is required under the employer's short-term disability policy, and the examination has been arranged and paid for by the employer…We conclude as a matter of law that [IME psychiatrists] violated the [state confidentiality of medical information statute] by providing [the employer] a detailed report of their psychiatric examinations of Pettus without a specific written authorization for such disclosure…we conclude that Pettus made a prima facie showing of invasion of privacy by the psychiatrists, but, based on evidence presented by [the employer] in its defense case, there is a serious question whether Pettus waived this claim by voluntarily disclosing to his supervisors… much of the sensitive personal information that was subsequently transmitted in the psychiatrists' reports"	Unknown; reversed and remanded for trial; no subsequent opinion reported

Alleged breach of duty to warn

Case	Type of Case	Language from the Court	IME Provider Liable?
Fredericks v. Jonsson, 609 F.3d 1096 (10th C.C.A. 2010) Third-party alleges IME psychologist breached duty to warn	Appeal from federal trial court's grant of IME psychologist's summary judgment	"…the relevant analysis conducted by the mental health provider—determining whether the person being evaluated is a danger to others—would seem to be the same whether or not the person is being treated by the provider. It would therefore be reasonable to assume that the legislature intended the statute to address the entire subject—that is, all such assessments by mental health providers…Because the Plaintiffs have not pointed to any evidence that [the evaluee] communicated to Dr. Jonsson 'a serious threat of imminent physical violence against a specific person or persons,' …Dr. Johnsson is not subject to liability under Section 117 and summary judgment was appropriate"	No

Immunity

Case	Type of Case	Language from the Court	IME Provider Liable?
Dalton v. Miller, 984 P.2d 666 (Col. App. 1999) IME psychiatrist seeks immunity from evaluee's allegations Pro se plaintiff	Appeal from trial court's grant of IME psychiatrist's summary judgment	"…quasi-judicial immunity is generally not extended to an examination conducted at the request of one of the parties to the litigation….Here defendant was chosen by the insurer to conduct an independent psychiatric examination of plaintiff and report back to the insurer…Accordingly, we hold that professionals conducting an independent medical or psychiatric examination pursuant to a C.R.C.P. 35 request are not entitled to absolute quasi-judicial immunity for their activities…[W]e hold that defendant is entitled to absolute immunity from civil liability for any statements he made during the course of his videotaped trial preservation deposition testimony that would have been played at trial in lieu of actual testimony from defendant. In addition, he is entitled to immunity for the contents of the report he prepared for counsel for insurer, which detailed his conclusions from his examination of plaintiff…As to any remaining claims based on the conduct of defendant during his examination plaintiff, the judgment is reversed, and the cause is remanded for further proceedings…"	Unknown; remanded for trial; no subsequent opinion reported
Yeung v.Maric, 232 P.3d 1281 (Ariz. App. Div. 1 2010) Treating MD alleged defamation in IME report See also ***Ritchie*** (above)	Appeal from trial court's grant of IME physician's summary judgment	"The issue we must address is whether a witness in a private, contractual arbitration is protected by the absolute privilege that is afforded to participants in judicial proceedings. Because the socially important interests promoted by the privilege are present in arbitrations as well as judicial proceedings, we agree with the trial court and conclude the privilege does apply…[A]n absolute privilege protects [IME physician] from potential liability for allegedly defamatory statements made in his IME report…"	No

References

American Academy of Psychiatry and the Law: Ethics guidelines for the practice of forensic psychiatry. http://www.aapl.org/ethics.htm (2005). Accessed 20 Dec 2011

American Medical Association: CEJA report patient-physician relationship in the context of work-related and independent medical examinations. http://www.ama-assn.org/resources/doc/code-medical-ethics/1003a.pdf (1999). Accessed 20 Dec 2011

American Medical Association: Code of medical ethics, opinion. 5.09 confidentiality: Industry employed physicians and independent medical examiners. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion509.page? (1999). Accessed 20 Dec 2011

American Medical Association: Code of medical ethics, opinion 10.03 Patient-physician relationship in the context of work-related and independent medical examination. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1003.page? (1999). Accessed 20 Dec 2011

American Psychological Association and American Psychology-Law Society: Specialty guidelines for forensic psychology. http://www.ap-ls.org/aboutpsychlaw/SpecialtyGuidelines.php (2011). Accessed 1 June 2012

Dalton v. Miller, 984 P.2d 666 (Colo. App. 1999)

Dyer v. Trachtman, 679 N.W.2d 311 (Mich. 2004)

Eckman v. Cipolla, 24 Misc.3d 1222(A) (N.Y. Supp. 2009)

Fredericks v. Jonsson, 609 F.3d 1096 (10th C.C.A. 2010)

Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**, S3–S50 (2008)

Graham v. Dacheikh, 991 So.2d 932 (Fla. App. 2 Dist. 2008)

Harris v. Kreutzer, 624 S.E.2d 24 (Va 2006)

Joseph v. McCann, 147 P.3d 547 (Utah App. 2006)

Lambley v. Kameny, 682 N.E.2d 907 (Mass. App. Ct. 1997)

McGreal v. Ostrov, 368 F.3d 657 (7th Cir. 2004)

Office for Civil Rights: HIPAA enforcement case example private practice revises process to provide access to records regardless of payment source. http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/allcases.html#case11 (2011). Accessed 19 June 2012

Pettus v. Cole, 57 Cal.Rptr.2d 46 (Cal. App. 1 Dist. 1996)

Physician Insurers Association of America: Risk Management Review (Psychiatry). Physician Insurers Association of America, Rockville (2011)

Professional Risk Management Services: Two top liability risks for psychiatrists: Patients with suicidal behavior and psychopharmacology. http://www.psychprogram.com/news/2010-top-risks.html (2010). Accessed 19 June 2012

Ramirez v. Carreras, 165 S.W.3d 371 (Tex. App. – Corpus Christi 2004)

Reed v. Bojarski, 764 A.2d 433 (N.J. 2001)

Rhode Island Medical Board: Policy statement independent medical examination. http://www.health.ri.gov/publications/policystatements/BoardOfMedicalLicensureAndDiscipline.pdf (2011). Accessed 1 June 2012

Ritchie v. Krasner, 211 P.3d 1272 (Ariz. App. Div. 1 2009)

Smith v. Radecki, 238 P.3d 111 (Alaska 2010)

Social Security Administration: HIPAA and the Social Security Disability Programs—Information for Consultative Examination Providers. http://www.socialsecurity.gov/disability/professionals/hipaa-cefactsheet.htm (2003). Accessed 18 June 2012

Stanley v. McCarver, 92 P.3d 849 (Ariz. 2004)

Strasburger, L.H., Gutheil, T.G., Brodsky, A.: On wearing two hats: Role conflict in serving as both psychotherapist and expert witness. Am. J. Psychiatry **154**, 448–456 (1997)

Sugarman v. Board of Registration in Medicine, 662 N.E.2d 1020 (Mass. 1996)

Yeung v. Maric, 232 P.3d 1281 (Ariz. App.Div. 1 2010)

Chapter 3
What Should I Do? When Patients Seek Disability Documentation

Andrew P. Levin

Introduction

In the last decade, mental health conditions have comprised an increasing portion of disability claims. Addressing a patient's request to complete a disability application requires the mental health practitioner to undertake a multi-step process. This chapter will assess the practicalities that face the clinician including discussing the request with the patient, grappling with issues of confidentiality, gathering appropriate information, translating this information into language for administrative processing, processing the outcome with the patient, and assisting in a possible appeal process. At each step the practitioner should be attuned to the tension between the therapeutic alliance and the ethical demands of completing an accurate assessment.

At the start of the application process clinicians should frankly discuss with patients their appraisal of their condition and its impact on their ability to work. When clinicians do not believe the symptoms are disabling they should not avoid sharing this appraisal with the patient. In these instances the clinician can utilize the discussion as an opportunity to focus on treatment goals and return to work. If they feel they cannot or should not be involved in the patient's disability benefits application either because they lack sufficient information, lack expertise related to the patient's condition, or feel unable to be objective, clinicians should consider referring the patient to another mental health provider specifically for purposes of a disability assessment or evaluation. When they do feel they can provide information in support of a disability claim, the clinician should begin by reviewing the details of the process with the patient with particular attention to issues of confidentiality.

A. P. Levin (✉)
Columbia University College of Physicians and Surgeons,
141 North Central Avenue, Hartsdale, NY, USA
e-mail: aplevin2@cs.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_3,

At the outset the clinician should also utilize the disability process to discuss and educate patients about "disability status," including the feasibility and desirability of maintaining their highest level of function, including return to work. Clinicians should also monitor their bias in favor or against a patient's request because it may affect their ability to provide objective information to the disability benefits administrator. Providing inaccurate information is neither consistent with professional standards nor is it ultimately in the patient's best interest.

After agreeing to the request, the clinician will need to gather information and translate it into the framework requested by the disability administrator, with particular emphasis on providing a description of the interaction between symptoms and function. When possible the clinician should either complete the form with the patient, or at least share the details of the report with them. If the administrator requests an independent medical evaluation (IME), the clinician should prepare the patient for this meeting and then debrief him. When the individual is administratively deemed disabled, the clinician should discuss how this might affect self-esteem, daily activities, and relationships with others. In the instance where the patient does not receive a determination of disability, the clinician and patient should discuss next steps. The appeals process may include providing additional information and/or engaging legal assistance. Regardless of the outcome, disability status should not eliminate or undermine efforts to assist individuals in reaching their highest level of function.

The following case summary describing a patient who applied for disability benefits from both the Social Security Administration (SSA) and a private insurer serves as a starting point in understanding the steps for addressing patient requests to complete disability evaluations.

Case Example

Mr. H is a married man in his late fifties with adult children. He had no history of psychiatric treatment or disability until he entered treatment two years prior to requesting disability. College educated, Mr. H initially worked in non-profit fundraising before taking over the family business. Following more than two decades of success, Mr. H decided to sell the business to a large conglomerate in preparation for retirement. A poorly structured deal left him with little payout and no security.

Mr. H rapidly descended into depression characterized by high levels of anxiety and agitation, hopelessness, guilt, loss of energy and interest, and disturbed sleep. Initial treatment with psychotherapy and antidepressants triggered mood instability with periods of dysphoric mania, resulting in a revised diagnosis of Bipolar Disorder. Despite treatment with mood stabilizers and neuroleptics, Mr. H deteriorated further and was hospitalized following a suicide attempt by overdose. He improved with a new combination of mood stabilizer and antidepressant but continued in a demoralized and depressed state.

At this point, friends attempted to support re-entry into the non-profit workplace and, subsequently, into a sales position. Mr. H was unable to sustain either of these positions due to depressed mood, low energy, high anxiety, and poor concentration. Following these failed efforts to return to work, Mr. H requested that his clinician provide information for an application for Social Security Disability Insurance (SSDI).

Subsequent adjustment of Mr. H's medication and participation in Dialectical Behavior Therapy yielded some improvement although he continued demoralized and guilty about his past poor judgment. He and his wife decided to recreate the former business from an office in their home. These efforts met with mixed results given the industry's shift to overseas manufacturers. Mr. H complained that he could only work a limited number of hours each day due to low energy, poor concentration, and high anxiety. Despite this he was able to make regular trips to inspect production facilities, attend industry functions, and meet customers. He also reported improvement in mood during weekend time spent with children and grandchildren. As the business limped along he requested that his clinician provide documentation for an application for partial disability through his private disability insurance.

Mental Health Disability Claims

As noted above, mental health conditions represented a significant proportion of disability claims long before the current downturn. According to a 2007 report from the National Institutes of Mental Health, psychiatric disorders were the leading cause of disability in the United States and Canada for individuals aged 15–44 (NIMH 2007). The World Health Organization reported that depression was the fifth leading cause of disability worldwide and predicted that it will rise to the second leading cause after heart disease by 2020 (Murray and Lopez 1996). In 2003, 28 % of SSDI recipients based their claims on a psychiatric disorder (International Center for Disability Information 2005). Consistent with the expectation that economic hard times foster an increase in disability claims overall, a recent study found an increase in disability from 2.0 % in 1997–1999 to 2.7 % in 2007–2009 (Levin 2011). The SSA reported a 260 % increase in the number of Americans disabled by mental illness during the period 2000–2007, representing nearly one-third of all SSA disability beneficiaries (Christopher et al. 2011).

Given these statistics, most mental health clinicians can expect to regularly encounter requests from patients to provide documentation in support of a disability claim. A 2010 survey of junior and senior psychiatry residents found that more than 97 % had completed at least one disability evaluation, and 17 % had completed more than 10 such evaluations (Christopher et al. 2010). In the majority of cases disability evaluations are submitted to either the SSA for one of its two public programs, SSDI or Supplemental Security Income (SSI) (or to both), or to a private insurer or to a workers' compensation board.

When confronted with a request from a patient to provide information for a disability benefit, mental health professionals may feel ill-equipped. Nearly 75 % of psychiatric residents surveyed by Christopher et al. (2010) reported receiving no didactic training on psychiatric disability. Gold (2011) observed that whereas disability administrators and attorneys receive extensive training in the complexities of the disability process, the mental health community has lagged in providing training in this area. The lack of training in assessing the relationship between psychiatric illness, functional capacity, and disability may lead the mental health professional to delay or refuse to complete an evaluation.

When embarking upon the disability process, treating clinicians should be sensitive to issues of confidentiality and dual agency. Although the process of supplying information to a third party represents a departure from the confidentiality inherent in a treatment relationship, nearly half of a sample of general and forensic psychiatrists reported that they did not address issues of confidentiality with patients when completing SSA forms (Christopher et al. 2011). Regarding the issue of dual agency, disability requests require that the clinician provide objective information that will likely have a direct financial impact on the patient. This creates the potential for tension between a therapeutic stance that accepts the patient's self-perception and defines the mental health professional as a supportive helper against the objective demands of a disability evaluation.

In addition to their own internal struggle to disentangle the tension inherent in navigating dual roles, clinicians generally experience an additional expectation from the patient that they will advocate for disability. This is particularly likely to occur, as is often the case, when the patient initiates the disability process before discussing it with the mental health provider, thereby increasing the pressure on the clinician to provide information that will support a disability determination. Christopher et al. (2011) found that compared with forensic psychiatrists, general psychiatrists more frequently reported that the dual role conflict had a negative impact on the disability determination process, suggesting that forensically trained psychiatrists are more comfortable identifying and addressing the conflict. Christopher et al. (2011) further reported that a substantial minority of both forensic and general psychiatrists surveyed provided information indicating that a patient was disabled even when they believed the patient could work. The researchers concluded that this "likely reflects the difficulty psychiatrists have in performing a forensic task [supplying disability information] when it poses a risk to the therapeutic alliance" (Christopher et al. 2011, p. 187).

Responding to Requests to Certify Disability: A Process, Not an Event

In order to respond to requests to provide information for disability applications, the clinician should undertake a multi-step process as delineated in Table 3.1.

Table 3.1 Systematic approach to a patient's disability request

1. Explore meaning and effects of possible outcomes with patient
2. Review process with special attention to issues of confidentiality
3. Clarify criteria and gather clinical information
4. Translate findings into language for administrative processing
5. Process the outcome with patient
6. Provide additional documentation in appeal process
7. Consider recommending an independent evaluation by another clinician

Initiation of the Disability Process and Clinicians' Responses

The initiation of an application for disability may evolve in a variety of ways, each of which may elicit a different reaction from treatment providers. In some instances, the patient makes the request at the start of treatment, at times even during the initial evaluation. This scenario usually triggers discomfort and suspicion in the clinician who fears that the individual is only seeking treatment to obtain the benefit. The patient may abruptly terminate treatment when the clinician initiates a discussion to detail the nature of the disability rather than immediately fulfill the request.

This pattern is more commonly seen in patients with a history of substance abuse and/or erratic work history who may believe obtaining disability benefits is a "better deal" than continued low-paying work. Michoulon (2002) observed that clinicians "who are faced with such patients may experience anger or hostility, especially if the individual exhibits antisocial traits and appears to be malingering or exaggerating symptoms for financial gain (p. 300)."

A second pattern that clinicians frequently encounter is a disability request from a patient with a chronic condition such as schizophrenia. This patient may have either never worked or held only marginal positions. After several years of symptomatic illness and inability to work, the patient, often with the urging of family, seeks disability through the federally administered Supplemental Security Income (SSI) program. In contrast to requests in which the patient seems to be manipulating disability systems for their own benefit, clinicians tend to feel sympathy for these chronically ill patients and readily initiate the disability process.

A third pattern, as illustrated in the case example of Mr. H, evolves in a patient who has had a strong work history but develops a serious psychiatric illness that does not fully remit. Gold and Shuman (2009) have observed that one's work identity is a central pillar of self-esteem, particularly given the value placed on work in American society. Individuals such as Mr. H generally prefer to be productive to maintain self-esteem but recognize that their condition has become chronic and that they require income from their disability benefits to meet basic economic needs. In these cases the request to provide information to support a disability claim tends to evolve from ongoing discussions during the treatment.

Here again, clinicians typically sympathize with the patient and proceed in a supportive way with the application.

A related scenario is the patient who is seeking continued disability through a private insurer following a period of short-term disability (30 days up to 2 years depending on the policy) and/or after the patient has utilized available sick time. Application for and receipt of short-term disability under an employer's plan, a state disability system, or a private insurer is generally routine. The challenge in these cases occurs when the condition does not resolve and the individual must seek longer term disability. A patient may need more time than is available from short-term disability insurance coverage to recover, but not so much as to be considered disabled for a year or more.

At this point, individuals may apply for additional leave time from the workplace under the Family and Medical Leave Act (FMLA). FMLA leave is a federally guaranteed option of taking up to 12 weeks of job-protected leave in a 12-month period if an employee has a serious health condition that makes the employee unable to perform the essential functions of his or her job. Clinicians may want to explore the pros and cons of utilizing FMLA leave. FMLA leave also protects the individual's group health insurance coverage, so the patient can continue to access medical benefits. During the FMLA leave period the patient may pursue ongoing treatment to maintain and enhance recovery with the goal of returning to work, thereby avoiding long-term "disabled" status. Clinicians typically only need to complete a brief form to support an FMLA leave request. This form contains a minimum amount of information, which assists in protecting patient confidentiality.

Although FMLA leave is job-protected, meaning the employee cannot be fired for utilizing FMLA leave, it is also unpaid. Thus, patients whose circumstances predict a longer recovery period may not be able to manage financially without long-term disability benefits. However, clinicians and their patients should be aware that, unlike the brief FMLA forms which typically go unchallenged by employers, private insurers typically require extensive documentation of long-term psychiatric disability claims. In addition, private insurers are often skeptical of these claims, particularly if the individual claims disability after leaving employment in a sector of the economy with few opportunities (see Chap. 9.)

A variation on this pattern is the individual who has recovered from a disabling illness but cannot find work and asks the clinician to collude with him or her to obtain disability. This pattern is likely to occur more frequently in patients during a severe economic downturn or when conditions change in a given industry. Again, although this pattern is more common among individuals with diagnoses of substance abuse and/or Antisocial Personality Disorder, it may be seen during difficult times in patients who might not otherwise be inclined to manipulate a disability system. For example, Wall and Appelbaum (1998) observed that insurers reported an increase in disability claims by physicians, a group that has historically made relatively few disability claims, concurrent with the increased work demands imposed by the advent of managed care. In these situations, the clinicians have the difficult task of explaining to the individual that they cannot support a disability

application. This may trigger a painful discussion regarding the patient's need to seek a lower level position or even public assistance. The patient may leave treatment or seek another provider who will support his disability application.

In some instances the patient may experience both medical and psychiatric symptoms. Early in the process the mental health clinician needs to clarify with the patient whether the most significant impairments are caused by the psychiatric condition, the medical condition, or both. This scenario typically arises in conditions characterized by chronic pain such as spinal injuries. In these instances, the individual experiences severe pain and decreased mobility limiting function as well as symptoms of depression and/or anxiety.

The mental health clinician must attempt to parse out the contribution of the psychological symptoms to functional impairment. Among mental health clinicians, psychiatrists are likely best equipped, in consultation with the individual's medical providers, to sort out the contributions of physical and mental symptoms to disability. If psychiatric symptoms play a minor role, mental health clinicians should indicate that although they can submit information for the disability application, the report(s) from the orthopedist, neurologist, or other medical specialist may contain more relevant information.

At times patients request a report on their physical disability from the mental health clinician because they do not feel a strong alliance with and/or sympathy from the medical specialist who, for a variety of medical and perhaps countertransferential reasons, may not support the patient's request for disability documentation. While empathizing with the patient, mental health clinicians should explain that they cannot provide documentation outside their field of expertise, and instead suggest that the patient seek another medical provider to assess the physical disability.

Discussion of the Meaning of the Request and Possible Outcomes

In each of these instances, the clinician should first explore the request with the patient, focusing on the patient's understanding of the impact of the psychiatric symptoms on the ability to work, the criteria for the particular benefits being requested, and the process of the application. A frank discussion with patients about the nature of their impairments, as well as strengths, is a good starting point. Are they unable to perform any type of work versus limited work? How do they feel about working compared to being disabled?

In all cases, and particularly those in which the patient's inability to work is not clear cut, the clinician should also foster discussion of the drawbacks of disability status. Individuals placed on disability run the risk that they will come to be defined as "disabled," both in their own self-concept and in the appraisal of others. As Gold and Shuman (2009) point out, for most people, work identity is a critical

element in self-esteem and should be supported whenever possible. Thus, the clinician may want to frame disability as a bridge period for the individual to recover and work toward returning to employment. In the case of the severely ill, employment enhances long-term outcome (see Bonnie et al. 1997), reinforcing the need for the clinician to maintain a focus on employment, or at least activity that reinforces the patient's strengths and self-esteem, even after disability benefits are realized.

This initial stage of the process is perhaps the most delicate because the clinician's appraisal may be at odds with the individual's belief about his or her capacity to work. Michoulon (2002, p. 301) suggests a "direct and firm, yet empathic and non-judgmental" approach in which the clinician lays out a forthright appraisal and recommendations for maintaining or returning to productive work. He further observes that "the clinician" may feel pressured to give the patient what he or she wants, and the patients may expect their trusted physician will do every thing possible to get them what they want" (Michoulon 2002, p. 301).

The belief by patients, as well as by mental health providers, that clinicians must "do everything possible" to support a patient's disability claim represents a distortion of the concept of advocacy. True advocacy means that the clinician works in the best interest of the patient. Just as a clinician would not prescribe a treatment that is harmful, even if requested, documenting disability where none exists does not advance the best interests of the individual (see Gold 2011). Not only may it rob the individual of self-esteem and the benefits of work, it introduces dishonesty in the treatment relationship and in the patient's dealings with others.

Alternately, clinicians may feel they are unable to provide information for a disability claim because they lack sufficient information (e.g., their contact with the patient is limited and/or it is not feasible logistically to gather needed information), the disabling condition is outside their expertise (e.g., a condition such as Dissociative Identity Disorder), or they feel that they cannot provide an objective report. Although this scenario should be relatively rare, it would make sense for the clinician to refer the individual to a colleague with greater availability and/or expertise to perform an independent evaluation. In addition, because most applications require a physician's signature, the non-medical mental health provider will often need to refer the patient to a psychiatrist to perform an evaluation and complete the documentation. Patients may experience referral for the disability process as abandonment, so it is important for the clinician to carefully explain the rationale for the referral and prepare the patient to work with the other clinician.

When patients insist on completion of the application despite evidence that they are able to work, particularly in a situation where is it clear that they are not disabled, clinicians should clearly indicate that they do not believe that particular patient is so impaired as to be disabled and cannot provide information that will support the disability claim. Michoulon (2002) recommends counseling these individuals to seek appropriate employment training opportunities. For some individuals, obtaining disability becomes an end in itself as a means to let others care for them. This pattern may be seen in antisocial individuals and/or entitled

patients who feel that they deserve to be cared for to compensate for previous wrongs. Similarly, if this type of individual is in fact disabled for a period of time, the clinician may encounter resistance to return to work following symptomatic recovery. It is not uncommon for the individual, if denied support for a disability claim, to leave treatment and seek support for the claim from another clinician.

In the case of Mr. H, at the point in his treatment when he applied for SSDI benefits, he was clearly unable to work. Mr. H was deeply concerned that he had become disabled, feeling he had let down his family. At the same time, his financial needs required that he seek benefits. He was able to rationalize applying for the disability status, but his guilt around failure to fulfill his role as provider continued to pervade his self-appraisal and the treatment. Mr. H responded to a reframing that time spent "disabled" could provide an opportunity for strengthening function with a long-term goal of return to work.

The disability process may also provide an opportunity to engage family to support the individual, an important dimension in the treatment of the severely ill. In addition, the process may enhance the alliance with the family and increase their productive participation in the treatment by educating them about the symptoms and impact of the illness. In Mr. H's case his wife took a lead role in trying to recreate the business and his children spent more time at home. In terms of his treatment, the wife actively monitored his symptoms and treatment participation.

For individuals who minimize or deny their symptoms despite significant functional impairment, an honest appraisal of their capabilities by the mental health professional may result in a significant blow to self-esteem (see Michoulon 2002). The clinician can utilize the application process to provide a supportive and more realistic picture to the patient, potentially stimulating an increase in the individual's therapeutic efforts. For the severely impaired individual it is particularly important for the clinician and patient to not lose sight of the goal of re-entry into the workplace in whatever form is appropriate, e.g., part-time work, sheltered positions, volunteer work, etc.

Finally, clinicians need to clarify that although they will supply information and offer opinions about functional capabilities, the insuring party makes the determination. This clarification is important in joining with the patient to emphasize that the disability application involves interaction with an outside system that is not under the clinician's control.

Educating the Patient About the Process and Confidentiality

Once the clinician and patient agree that filing a claim for disability benefits is the best option given the circumstances, the clinician will need to educate the patient about the process. This includes review of the applicable standards for disability, the specific information requested, and issues of confidentiality. Clinicians should inform patients that the disability process may be arduous, including repeated

submissions of information, requests for records, possible independent medical examination, initial rejection, and a lengthy appeals process.

For example, Social Security applications typically require months, and on occasion, years to adjudicate, particularly if the individual undertakes an appeal after initial rejection. Further, even when it appears clear that the individual is disabled, the outcome of applying for disability benefits is unpredictable. Given that the Social Security standard demands that the individual be unable "to engage in any substantial gainful activity," (see Chap. 7 in this volume), the possibility of rejection must always be kept in mind. An SSA examiner once told this writer that if the claimant was capable "of moving paper clips from one box to another," he was not disabled!

Clinicians are not expected to be experts in every form of public and private disability insurance, but some familiarity with the parameters of commonly accessed benefits programs, such as Social Security and Workers' Compensation, is useful. Details of standards and information requested in these and other disability benefit programs are discussed in-depth in other chapters in this volume. Quotations that follow from the SSA form utilized in the case of Mr. H are taken from New York State Office of Temporary Disability Assistance Division of Disability Determinations form DDD-3883, 2008. This form has been essentially unchanged for several decades.

Regarding confidentiality, although the clinician need not share intimate and irrelevant details of the patient's early life or personal behavior on the disability application itself, this information may be inadvertently released when the insurer requests records to accompany the application. Sometimes insurers will accept a summary letter rather than the whole file. Redacting the records to remove sensitive, irrelevant information may be appropriate, although the insurer may deny the application because the record is incomplete. Further, clinicians should remind patients that they cannot remove evidence that indicates they may have been working at some time during the course of their illness, including part-time or informal work at the time of the application.

Gathering Relevant Clinical Information

During routine clinical treatment clinicians often rely solely on the individual to provide information about his function. Given the challenges of self-appraisal even among those who do not suffer a psychiatric condition, the clinician should recognize that patients can rarely provide a full and accurate account of their activities and function. Although the practicing clinician cannot feasibly strive for the thoroughness expected of the independent medical examiner or forensic specialist who may review several years of records, reports from the employer, and perhaps even the report of a private investigator, the clinician should seek records of prior treatment and input from other treating clinicians. The latter is particularly

relevant because treatments split between non-medical providers and medicating psychiatrists have become the rule rather than the exception.

When available, information from family describing daily activities should be sought, particularly to assess activities of daily living. For example, in the case of Mr. H, his wife played a crucial role in describing his low energy, difficulty in getting out of bed, and high levels of anxiety with resultant paralysis for much of the day.

During the information gathering and winnowing process clinicians must be alert to their own tendencies to be selective. When clinicians are sympathetic and believe the patient deserves to be awarded disability benefits, they may emphasize information favoring a finding of disability. This pattern is frequently seen in both medical and non-medical clinicians who are unfamiliar with the process and believe that their role is one of vigorous, unquestioning advocacy for the disability claim. Similarly, a therapist working closely with the individual in weekly psychotherapy may feel the need to advocate for the patient's claim more strongly compared with a medicating psychiatrist who has less frequent patient contact and perhaps more experience with the disability process, although both must be on guard.

Another source of bias may be the clinician's perception that the disability insurer is a large, faceless institution that will not be injured by granting benefits to the patient. In fact, increasing costs for disability payouts have had a significant impact on both private insurers and public agencies, resulting in some private carriers dropping disability products all together (Hayes 2011). Thus, in addition to the ethical and treatment implications of providing selective or biased information to support a patient's disability benefits application, mental health professionals should be sensitive to the social implications of doing so as well.

Because the insurer may request the complete record, the clinician should take care to present an accurate picture on the application that does not contradict or minimize elements in the record. As noted, at times patients may directly or indirectly suggest that the clinician shade the presentation to "make me look disabled on the application." This may occur when the case is marginal and the individual has secondary motives, such as a desire to escape a negative work environment. Here again, clinicians must respectfully explain that they have an obligation to be truthful. A discussion with the patient that the clinician does not feel the patient is disabled may lead to deferment of the application in favor of new treatment efforts and/or efforts to seek an alternative work situation.

Translating Mental Health Information for the Disability Form

Most disability benefits administrative systems provide forms for completion and may request part or all of the provider's treatment record. All completed forms should be kept on file to serve as reference when completing requested updates.

In a split treatment situation, the form may be completed by one provider with the input of the other, or perhaps jointly. Often, benefits administrators will require that both providers complete the forms and provide their respective records. It is therefore important for the providers to understand each other's assessments regarding the individual's symptoms and functioning. If permitted, non-medical therapists can complete all sections except those detailing medication treatment, which the physician can complete. Regardless of who completes the form, benefits providers generally require the signature of a physician, although at times a licensed psychologist may also be the signatory.

It is often useful to complete the form with patients, or, at a minimum, share the content with them before submission. This facilitates patients' participation in and understanding of the process, and provides an opportunity for their input and suggestions, particularly if the clinician is uncertain about specific symptoms and/or impairment. This process can also facilitate treatment by identifying areas of strength, and designing treatment for areas of impairments.

In the SSA process, applicants sign an authorization to disclose information to the SSA that is sent to each of the providers they list. This authorization accompanies the forms and requests for medical records. Once clinicians receive the authorization, they should make sure to complete and send the documentation in a timely manner, because SSA (as well as private insurers) will defer consideration of an application when information is delayed or not supplied from all providers. Clinicians should alert patients that they have received the application and keep them abreast of the progress in completing and submitting forms and other documentation.

The SSA guidelines request that the treating clinician determine first if there is a severe impairment that affects basic work activities such as understanding, remembering, and carrying out instructions, and second, whether the impairment is expected to last at least 12 months (SSA criteria and process are described in more depth in Chap. 7 of this volume). In service of these goals, the SSA form itself requests information falling into two major categories: (1) Description of the psychiatric condition and its prognosis; and (2) Descriptions and conclusions about functional capacity. The clinical portion queries diagnosis, clinical course, treatment response, and current mental status, all elements familiar to the practicing clinician given their congruence with routine clinical documentation. In the case of Mr. H, his stormy bipolar course was relatively easy to summarize—unstable moods and incomplete response to treatment, hospitalization following a suicide attempt, current medication including lithium, valproate, lamotrigine, mirtazapine, and olanzapine, and current mental status reflecting severe depression without psychosis.

At times it may be more convenient and succinct to use the treatment record to complete the clinical section of the SSA application. Specifically, the initial intake or psychiatric evaluation, if thoroughly documented, will contain the necessary information detailing course, prior treatments, and presenting symptoms. The clinical picture can be rounded out by providing the most recent progress note, particularly if that note contains a complete description of the current symptoms, mental status examination, and treatments. It is often useful to write a somewhat

longer than usual progress note to fulfill this purpose. Once this information is included, the clinician need only complete the section focused on functional impairment described below.

One major challenge in the clinical section comes in the area of prognosis. Given that there is scant scientific literature to guide prediction of long-term function for a specific condition, the clinician must call on clinical experience. The SSA standard requires that the condition be expected to last for a continuous period of not less than 12 months. This kind of determination is vulnerable to clinician bias in favor of obtaining benefits for the patient. Specifically, clinicians should be cautious in characterizing their prognostic opinions, avoiding language such a "permanent disability" or "no chance for recovery." It is sufficient to predict that the current condition is, in fact, expected to continue for at least the next 12 months. For Mr. H this determination was relatively straightforward because he had already been functioning poorly for almost 2 years. The SSA may request additional information if they have difficulty coming to a determination.

The second category of information requested by SSA relates to function. The SSA standard states that disability is the inability to engage in any "substantial gainful activity" by reason of any "medically determined physical or mental impairment…" (see Chap. 7 in this volume). In order to make this determination, the SSA form requests the clinician report function under two major categories: "Activities of Daily Living" and "Ability to Function in a Work Setting." Activities of Daily Living (ADLs) include self-care and hygiene and extend to areas such as maintenance of residence, shopping, cooking, and travel capabilities. Significant impairment in these areas is consistent with severe illness. It is best whenever possible to provide specific examples. In the case of Mr. H, although he was generally able to negotiate ADL's, there were points in his illness when he could not care for himself independently, requiring his wife to assist with organizing himself in the home, travel, shopping and cooking, and maintaining a schedule of activities.

"Ability to Function in a Work Setting" is broken down into specific areas of "Understanding and Memory," "Sustained Concentration and Persistence," "Social Interaction," and "Adaptation." These areas comprise "Residual Functional Capacity" (RFC), defined as what the claimant can still do in a work setting despite the limitations caused by impairments. In assessing these capacities the clinician should, whenever possible, draw on the most recent work experience, particularly if the individual, as in Mr. H's case, failed in his most recent attempts at gainful employment.

However, these specific areas of residual function may be difficult to evaluate without collateral information. For example, without testing, the clinician may only be able to make a general appraisal of understanding and memory required for work, except when these are grossly abnormal. Testing is difficult to obtain given that it is not routinely covered by private or public medical insurance programs and is expensive to obtain on a fee-for-service basis. Barring testing, the clinician will need to draw on experience during clinical sessions and attempt to supplement this with input from family or significant others. For example, at the

depth of his depression, Mr. H had difficulty recalling recent activities during session and reported frequent forgetfulness, e.g., losing keys, missing appointments, etc. Despite his memory deficits he was not impaired in the area of "Understanding" because he was able to understand the details of his work and the methods to accomplish required tasks.

The SSA form defines "Sustained Concentration and Persistence" as the ability to comply with simple or detailed instructions, follow schedules, work at a reasonable pace with ordinary supervision, and maintain customary attendance, and punctuality. Although Mr. H was consistently able to come to appointments on time, it was clear in session that he could not sustain attention. He reported that during the period when he attempted work in sales, he was unable to manage the necessary level of detail, frequently becoming confused when gathering information on the telephone. His capacity for "Social Interaction" was also greatly diminished. He and his wife reported that he frequently became tearful in social situations. Regarding "Adaptation," Mr. H was easily overwhelmed by obstacles such as changes in plans, glitches at the computer, or routine mechanical malfunctions around the home. On the basis of the information provided, Mr. H was deemed disabled and began receiving SSDI benefits.

Finally, the SSA form asks if the patient is capable of handling funds. As Michoulon (2002) notes, this area is fraught with risk of diminishing patient autonomy and precipitating a further blow to self-esteem. Because Mr. H had a strong support system with wife and family, his clinician did not feel a need to confront this issue, assuming the family would assist in managing his funds. If, on the other hand, he had been an isolated individual and/or family involvement was minimal, he may have required another individual or an organization to function as a "representative payee" to manage his funds. The SSA will appoint a representative payee based on information provided by the clinician and a formal application by the individual or organization serving this function. The clinician should initiate a discussion with the patient and involve family and/or case management to apply for a representative payee.

The SSA form does permit the provider to indicate that "he cannot provide a medical opinion regarding this individual's ability to do work-related activities" rather than complete this section. Clinicians should utilize this option if they feel they have insufficient information to make judgments about a claimant's functional capacities. If this is the case, clinicians should indicate to the patient that they are not able to complete an essential part of the form. In the case where a medical condition is the main source of disability, the mental health clinician should suggest that the patient's medical provider can supply the needed information.

In contrast to the SSA application, the administrative processes associated with Workers' Compensation insurance plans and private insurance disability plans entail a shorter format for the clinicians' reporting and usually involve submission of the clinical record to the insurer. Mr. H's private insurer requested completion of an "Attending Physician's Statement of Disability," a form which is relatively uniform across the private industry. The form used by Mr. H's carrier began with information regarding the onset of the condition, date the individual ceased to

work due to the disability, and whether the condition was related to employment (see Chap. 8 in this volume). In addition these forms generally request the clinician identify the professional that initially referred the patient as well as the names of other current providers. At times patients request that the clinician not include information identifying other providers for fear that it may indicate a pre-existing condition and void the benefit. This is another instance when clinicians need to reinforce that they are obligated to be truthful. As noted, insurers will routinely delay consideration of an application for disability until all providers submit reports and records.

Like the SSA form, the private insurers' form should be accompanied by an appropriate release. As noted, clinicians should notify the patient that they have received the form and then review issues of confidentiality and the content that they will provide. Private insurers generally request information about the condition and current treatment, although this is usually limited to include only diagnosis, major symptoms, and current treatment. The clinician's submitted records should provide a complete picture of the clinical evaluation and ongoing care.

The next section on Mr. H's private insurer's form, "Extent of Disability," was more challenging because it requested a direct judgment about disability, i.e., "Do you consider the patient to be totally disabled from his/her occupation" and from "any occupation"? Unlike this application, many insurers will specifically ask that clinicians not provide an opinion about disability, but limit opinions to impairments and their effect on relevant work and social functioning. Clinicians should be extremely careful, if given this instruction, to follow it specifically. Supplying an opinion about disability in these circumstances may result in significant problems between the insured and the benefits management company, up to and including litigation.

If the form does request an opinion about disability it may be difficult for clinicians to address the "ultimate issue" of disability because they may have little familiarity with the specific demands of the patient's job. Similarly, clinicians may not be able to accurately gauge if an individual is incapable of any work. When clinicians feel they cannot make a determination regarding disability, they should indicate this on the form. When possible, clinicians should describe limitations and restrictions in specific job-related functions, e.g., the individual cannot sustain concentration for more than a few minutes at a time and therefore cannot handle interactions with customers, rendering him unable to perform his prior work that involved frequent customer interaction.

When Mr. H requested support for his private disability application, he was working a few hours per day from home. After discussion, Mr. H's treating clinician agreed that he was partially disabled. In addition to questions about disability *per se*, Mr. H's company requested that the clinician indicate where he fell under "Classification of Impairment," an anchored scale provided on the form. The clinician classified Mr. H as "Class 3" on this scale, signifying, "Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)." Some insurance companies do not specify how they want the clinician to rate level of impairment. If not specified, the

Global Assessment of Function (American Psychiatric Association 2000) should be utilized. If the insurer provides a rating system that is unclear and/or unknown, the clinician should request clarification from the insurer before filling this out.

The form from Mr. H's private insurer ended with sections requesting information about efforts at rehabilitation and vocational counseling, and then general remarks. This questionnaire also asked if Mr. H would be undertaking "trial employment." Like other sections of the inquiry, these questions demand honesty from the clinician and may become a source of conflict with the patient who does not follow up on recommendations for rehabilitation or training. In addition, some forms request information regarding the individual's compliance with treatment recommendations such as taking medications, attending sessions, or participating in adjunctive treatments. An insurer may deny or limit benefits when the individual fails to participate in a recommended, recognized, and appropriate treatment modality, and/or is being treated by an unlicensed practitioner or a practitioner utilizing methods that grossly deviate from the standard of care (Hayes 2011). According to Mr. H, his private company denied his disability request because the policy did not provide coverage for partial disability.

Independent Medical Evaluations

Unlike SSA, which no longer routinely requires an examination by an independent medical examiner (but may upon occasion), private insurers and workers' compensation boards more often than not request the claimant submit to an outside evaluation, referred to as an "IME" (see Chap. 9). Typically IMEs focus on confirming or clarifying the diagnosis, ascertaining level of functional impairment, assessing the adequacy of the treatment offered and the patient's compliance, and evaluating possible exaggeration or malingering (see Gold et al. 2008).

Patients are usually quite anxious in anticipation of these examinations and may initially refuse to participate in the IME, feeling angry that the insurer does not accept the judgment of their treatment provider(s). Clinicians should acknowledge this anxiety, educate patients that an IME is a routine part of the disability process, and alert them that refusal may disqualify the benefits application. Further, clinicians should assist patients in developing strategies to minimize anxiety and provide an accurate picture of their symptoms and function to the examiner. Given the stressful nature of IMEs, clinicians will often need to devote a session to debriefing following the examination.

The discussion with the patient will also need to include the fact that the treating provider may be called upon to communicate directly with the independent examiner. The patient may wish to prevent this contact, but it may be required for the benefits claim to proceed. If the patient refuses to give permission, however, clinicians should not talk with insurance case managers or claims examiners, whether medical professionals or not. When patients do allow clinicians to talk with the insurance company employee, clinicians should review with the patient

how they would respond to questions about symptoms and function. These responses will necessarily need to reflect the record as well as the clinician's prior statements on disability forms.

Processing the Outcome with the Patient

It is important that the clinician review the disability determination with the patient. If the individual is administratively deemed disabled, the clinician should discuss how this might affect self-esteem, daily activities, and relationships with others. As emphasized above, disability status should not eliminate or undermine efforts to assist individuals in reaching their highest level of function. Under the SSA disability program, the individual may receive training and vocational support through vocational service programs. In addition, individuals may work gainfully for up to 9 months without a change in SSDI disability benefits. Thereafter benefits may be reduced or discontinued depending on the extent of earnings. Nevertheless, the purpose of these programs and regulations is to promote the goal of returning to employment, a goal the clinician and patient should proactively discuss.

Ongoing Reviews

Private insurers, including those involved in workers' compensation cases, and at times the SSA, require periodic updates or reviews of a claimant's status from the clinician or an independent evaluator. Private insurers and workers' compensation boards may ask for this information monthly or quarterly. When directed toward the treating clinician, these periodic requests for update forms ask for a brief description of the current symptoms and treatment and the clinician's judgment regarding continued disability. In addition, the private insurer generally asks what efforts the individual is making toward return to the workplace. Periodic updates provide an occasion for discussion with the patient about progress toward employment and/or rehabilitation goals. The private insurer may also require annual or biannual re-evaluations by an independent medical examiner, particularly in complex cases involving both physical and psychiatric symptomatology and/or when the disability benefit is substantial.

Appealing Denials

If the application is denied, the patient and the clinician need to discuss next steps. Even though clinicians may not know all the administrative details of each type of disability benefits program, they can discuss the practical implications and options as well as the emotional effects of a denial of benefits. Although it would be useful

to learn why the application was denied, SSA and private insurers generally do not provide specifics beyond stating that the individual does not meet the criteria for disability. Patients and clinicians are often left in a position of making decisions without all the useful information. Should the individual reapply or appeal? Is there additional or new information that can supplement the application? Are there other sources of financial support (such as public assistance) that the individual should seek? Should the patient seek legal assistance if he or she wants to go forward despite an initial denial?

Patients can initiate an appeal of the SSA determination through an online process. A number of private law firms as well as public non-profit legal services offer assistance in the appeal process. Typically they will assist the individual in gathering additional materials and presenting them to disability determination services. The private law firm, who stands to collect a fee if successful, may request that the clinician complete the law firm's own forms to provide more in depth information as part of the appeals process. This paperwork is not strictly necessary for the patient to prevail in an appeal and can represent a considerable time outlay for the clinician. With the patient's consent, providing updated records that may contain additional documentation not supplied in the initial application (or, in fact, the complete record) is a reasonable response to these inquiries and is less time intensive. The clinician should explain to the individual that sending records to the outside agency or law firm is in lieu of completing their form. Alternatively, in some cases, the clinician can discuss whether the patient wishes to reimburse the physician directly for time spent completing the attorney's forms.

Appeals to private insurers are less arduous. The clinician is routinely asked to supply new records that document changes in the applicant's symptoms and resultant function or to supply new information in the form of narrative answers to specific questions exploring diagnosis, treatment, and functioning. Alternatively, the insurer may request that the applicant submit to an IME (or perhaps a second IME if one has already been conducted), particularly when the insurer has questions regarding the clinician's diagnosis, treatment plan, and prognosis. Similarly, the patient may request a second IME if he and/or the clinician feel that the initial IME is inaccurate.

Conclusion

Requests for information to support a disability application are a common part of mental health practice. If current economic circumstances and recent trends are any indication, clinicians should expect a continued increase in disability applications. Clinicians should be honest with themselves and patients in regard to how much involvement they are willing or able to have in this process. If willing to go forward, clinicians should approach the disability benefit claim process systematically, addressing the issues discussed above. Particular attention should be paid to the psychological meaning of the disability application, the potential effects of being

deemed disabled, and issues of confidentiality. The clinician will also need to understand the specific informational demands of the insurer.

Throughout the process, clinicians should provide both education and emotional support to the patient, with particular attention toward restoring the patient to the highest level of function possible. In addition, clinicians should be alert to the role conflicts inherent in the process and their own biases regarding the systems involved, particularly because patients frequently expect their clinicians to support disability applications without hesitation. First and foremost, mental health professionals need to adhere to the ethical demand for truthfulness. Although this may strain the relationship between the clinician and the patient, it can also facilitate a frank discussion about the nature of the patient's illness, strengths and functional limitations, and goals for employment and/or meaningful activity. With the exception of individuals who believe that the clinician must support their request regardless of the actual facts or out of concern for the patient's financial welfare, a systematic and honest approach to the process should enhance the treatment relationship. In fact, a forthright evaluation of the patient's function is consistent with advocacy on the patient's behalf because it ultimately advances the patient's best interests.

Key Points

1. When patients request that mental health clinicians provide information to support a disability benefits claim, clinicians should discuss their positions frankly with them.
2. If clinicians feel they cannot or should not be involved in the patient's disability benefits application, they should consider referring the patient to another mental health provider specifically for purposes of a disability assessment or evaluation.
3. If clinicians feel they can and should provide the requested information, they should follow a step-by-step process outlined above in conjunction with the patient.
4. Clinicians should use the disability application process to discuss and educate patients about "disability status" issues as well as the feasibility and desirability of maintaining the highest level of function, including return to work.
5. Clinicians should monitor their bias in favor or against a patient's request because it may affect their ability to provide objective information to the disability benefits administration.

References

American Psychiatric Association: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. (Text revision). American Psychiatric Association, Washington, DC (2000)

Appelbaum, P.: A theory of ethics for forensic psychiatry. J. Am. Acad. Psychiatry Law **25**(3), 233–247 (1997)

Bonnie, R., Monahan, H.: Mental Disorder, Work Disability and the Law. The University of Chicago Press, Chicago (1997)
Christopher, P., Boland, R., Recupero, R., et al.: Psychiatric residents' experience conducting disability evaluations. Acad. Psychiatry **34**(3), 211–215 (2010)
Christopher, P., Arikan, R., Pinals, D., et al.: Evaluating psychiatric disability: Differences by forensic expertise. J. Am. Acad. Psychiatry Law **39**(2), 183–188 (2011)
Gold, L.: Commentary: Challenges in providing psychiatric disability evaluations. J. Am. Acad. Psychiatry Law **39**(2), 189–193 (2011)
Gold, L., Shuman, D.: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. Springer, New York (2009)
Gold, L., Anfang, S., Druktenis, A., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**(4), S3–S50 (2008)
Hayes K.: The psychiatric independent medical examination. Presented at the Tri-State Chapter of the American Academy of Psychiatry and the Law 37th Annual Conference, New York, 21 Jan 2011
International Center for Disability Information. Accessed 12 Aug 2005 from International Center for Disability Information website: http://www.icdi.wvu.edu/ (2005)
Levin, A.: Mental disability rises especially among physically disabled. Psychiatr. News **46**(22), 6B (18 Novemb 2011)
Mischoulon, D.: Potential pitfalls to the therapeutic relationship arising from disability claims. Psychiatr. Ann. **35**(5), 299–302 (2002)
Murray, C., Lopez, A.D. (eds.): The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Disease, Injuries and Risk Factors in 1990 and Projected to 2020. Harvard University Press, Cambridge (1996)
National Institutes of Mental Health. Statistics. Accessed 26 May 2007, from the National Institutes of Mental Health Website: http://www.nimh.nih.gov/health/topics/statistics/index.shtml (2007)
Sederer, L., Clemens, N.: Economic grand rounds: The business case for high quality mental health care. Psychiatr. Serv. **53**(2), 143–145 (2002)
Wall, B., Appelbaum, K.: Disabled doctors: The insurance industry seeks a second opinion. J. Am. Acad. Psychiatry Law **26**(1), 7–19 (1998)

Chapter 4
Weighing Work Accommodations, Work Withdrawal, and Return to Work

Cheryl D. Wills

Case Example

Larry is a 38-year-old engineering supervisor who struggled emotionally after his niece died unexpectedly. Three months later, he remained sad, distractible, irritable, socially withdrawn, anergic, and had difficulty falling asleep. Larry's wife became concerned after he lost 20 pounds. At her request, Larry began to meet with mental health professional, Dr. Gee. During the third therapy session, Larry disclosed that he was making errors in judgment that could endanger his staff and damage the company inventory.

Balancing Work and Mental Illness

Although mental health clinicians routinely encounter situations like Larry's, there is no simple formula to determine when employed patients should take a leave of absence, commence a modified work schedule, or return to work after taking medical or personal leave. Patients with mental illness may want to withdraw from the workplace for a variety of reasons, including emotional or physical inability to meet the requirements of the job. Conversely, patients who are impaired to the point of being incapable of performing the job may not want to withdraw from work or may want to resume working before they are ready to meet the demands of the job. Perhaps most troubling are patients who choose not to return to work or to petition for long-term disability benefits even though adopting disability status

C. D. Wills (✉)
Case Western Reserve University, 5247 Wilson Mills Road #452,
Cleveland, OH 44143, USA
e-mail: cwforensic@earthlink.net

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_4,

may become permanent and may not serve their best mental health or financial interests.

Clinicians must sensitively negotiate these challenges in the course of clinical practice, while striving to do what is in their patients' best interests, including fostering emotional rehabilitation; maintaining patient, workplace, and community safety; and maintaining a therapeutic alliance with the patient. When the patient and clinician concur about the level of the patient's impairment and recommended interventions, the process of collaborating toward a beneficial outcome may proceed relatively smoothly. However, when the patient and clinician disagree about degree of impairment and what interventions are indicated, the therapeutic alliance may deteriorate, at times irreparably. For example, it is not uncommon for patients and their clinicians to disagree about both withdrawal from and return to the workplace. A change in the patient's work status due to psychiatric problems usually requires documentation from the clinician, who may not be comfortable with conforming with the patient's request, especially if the clinician disagrees with the patient's self-assessment and plan for managing work issues and/or documenting impairment involves violating the clinician's ethical boundaries.

Employers may also have concerns about workers with mental disabilities returning to the workplace. The stigma of having an employee with a mental disorder in the workplace may be disconcerting. Additionally, the employer may be concerned about the employee's ability to meet the safety, interpersonal, cognitive, reliability, and productivity demands of the job. The employer may seek assurance and clarification by requesting information from the treating clinician or by obtaining an independent fitness-for-duty (FFD) evaluation.

Beginning the Discussion

One thing is clear: when a mental disorder causes a patient to have a significant gap between their job requirements and work capacity, occupational impairment is present. If the patient has not already brought up issues involving workplace functioning, the clinician should educate the patient about the mental disorder and how it can affect daily activities, including occupational functioning. This dialogue may serve as the backdrop for a review of treatment options, including medication, therapy, and when applicable, lifestyle changes, including employment modifications such as temporary or permanent withdrawal from the workplace.

Diagnostic criteria for more than half of the disorders listed in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV TR) recognize the significance of functional impairment in psychiatric diagnoses; these diagnoses require the affected individual to experience "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (e.g., American Psychiatric Association 2000, pp. 356, 381, 492, 654). When a mental disorder prevents patients from performing

their jobs at the level of safety and productivity that is required by the employer, then the patients may be suffering from a mental "disability."

Clinicians should assess a patient's capacity to work effectively on a regular basis. When a clinician determines that a patient's mental disorder is causing occupational impairment, work modifications, ranging from changes in job responsibilities to withdrawal from the workplace, even if just for a day or two, may be in the patient's best interest. Unfortunately, there is no set formula or flowchart for the mental health professional to follow when determining workplace impairment; how best to help the patient maintain the ability to return to the workplace; or how to plan to return to the workplace after the patient has withdrawn from it. However, mental health professionals' clinical skill sets will assist them in working with their patients to address these challenging problems.

Exploring employment modifications may create anxiety for both the clinician and the patient. A clinician may not be comfortable with the responsibility and implications associated with discussing whether an emotionally distressed patient should consider withdrawing from the workplace or recommending workplace modifications. The clinician may be less conflicted about having this discussion when the patient is sufficiently impaired to warrant admission to an inpatient or partial hospitalization program. However, when a person has sufficient community supports to be rehabilitated in an outpatient mental health setting, a reduced workload or temporary separation from work may serve that patient's therapeutic best interests. This is especially true if the patient is at risk for engaging in unsafe workplace practices, not meeting productivity expectations, or not communicating effectively with coworkers and/or clients. Under these circumstances, patients are at risk of having their employment terminated, and voluntary withdrawal for medical reasons may prevent this adverse outcome.

A patient may feel the need to withdraw from the workplace for reasons other than mental illness. For example, when workplace demands change, such as when a company is being sold or downsized, the clinician may face increasing pressure from the patient to provide documentation supporting a mental health disability claim. Patients may report feeling overwhelmed due to increased work demands and workplace stress, especially when they are struggling to meet other lifestyle needs, such as childcare, eldercare, etc. The clinician should obtain sufficient clinical information including, when possible, corroborative data prior to rendering a conclusion in these cases. However, when a patient's occupational impairment is clear, it is prudent to support the patient's request for a temporary separation from work, or workplace modification, while the treatment progresses.

Workplace Accommodations

Work capacity (see Chap. 1) can be an indicator of mental impairment, but may also be used to monitor a patient's progression toward and maintenance of mental health. When the clinician and patient discuss how the mental disorder affects the

patient's capacity to work, the clinician should ascertain the extent to which the patient is able to resume their occupational duties. Although many people who have mental disorders are capable of working without accommodations, some need to withdraw from the workplace, temporarily or partially, until they regain the capacity to resume their professional duties. At times, the clinician and patient may decide that the patient may be able to continue working or return to the workplace with job modifications.

Workplace accommodations can be invaluable to employees who are seeking to maximize their strengths while minimizing work-related impairments. The clinician should discuss with the patient what informal and formal workplace accommodations are available, and the associated benefits and risks of implementing these options. Patients often may not be aware of their employer's policies regarding accommodations or leave, and may need to be directed to the company's human resource officer to gather this information.

The most significant decision for which a risk/benefit ratio needs to be assessed is whether patients should disclose information about their mental illness to their employers. This decision may be difficult for patients who wish to maintain their privacy and to avoid the stigma often associated with a mental disorder diagnosis. In addition, even an informal disclosure may trigger formal, legally mandated responses from an employer that the patient/employee may not have anticipated and may find objectionable.

The mental health professional can serve a critical role in the decision-making process by helping patients examine and work through the options for formal or informal workplace accommodations as well as the strong emotions that may accompany the decision to disclose problems with mental illness. In some situations, patients informing their employers of their condition may be the only way to obtain the necessary workplace accommodation. Although the notification may diminish the patient's privacy, the disclosure can provide multiple benefits, including protection under the Americans with Disabilities Act (ADA) against discrimination (see Chap. 10).

Disclosure can facilitate negotiating a job modification that helps patients work more effectively, avoid some disciplinary actions, and prevent possible termination of employment due to poor work performance. In contrast, if the patient does not notify the employer of the disability, or if the employer has not treated the patient/employee as if he or she has a disability, then the patient/employee will not be afforded protection under a work accommodation law, such as the ADA. Clinicians who have a working understanding of the ADA and other employee disability and privacy protections will be in a better position to have meaningful discussions with patients regarding employer-related disclosures and requests.

The risks associated with disclosure should be thoroughly discussed. The patient who informs an employer about a mental disability cannot rescind the disclosure; it will always be known in that particular work environment. The clinician should advise patients to think about whether disclosure will create ongoing problems in the workplace. When the employer is notified that an employee has a mental disorder, the employee loses some privacy, risks stigma,

and may be subjected to prejudice on the job despite laws that protect individuals against employment discrimination on the basis of disability and public disclosure of an employee's disability by an employer.

Job Modifications

Informal job modifications, if available, offer certain advantages over formal job modifications or accommodations. Informal modifications or accommodations do not require the patient to disclose the mental disorder to the employer, thus preserving the patient's privacy. Informal accommodations may be available to employees as a matter of employment policy and the choice to request them need not include any indication of the employee's motivation for making the change. Such informal modifications may include working on a flexible time schedule, modifying break times, telecommuting at least part time, or using accrued vacation time to take "mental health days" to reduce stress and foster emotional rehabilitation.

However, informal job modifications do not afford a patient/employee additional employment-related protections, such as those provided by the ADA or applicable workers compensation laws (when the mental disorder is causally connected to the workplace; see Chap. 8). Employers are not obligated to intervene in any way unless they are aware of an employee's disability and workplace impairment. Thus, if the informal accommodations implemented do not address the impairment, patients/employees may be disciplined or involuntarily separated from their jobs without the recourse that may be available to an employee who obtains a formal work modification. Also, the patient/employee who uses paid leave as an informal work accommodation will have fewer resources, in terms of vacation and personal days, for recreation and other activities. This, too, may increase the stress experienced by the patient.

A patient/employee who favors a "mental health day" concept and who lacks sufficient accrued time may consider making a formal request for unpaid leave. The Family Medical Leave Act (FMLA) requires many employers to grant an eligible employee up to 12 weeks of job-protected unpaid leave each year for a serious medical condition that renders the employee unable to work, or for a chronic serious health condition which requires periodic health visits, and may require occasional periods of incapacity (Family Medical Leave Act 2011). Clinicians should review the pros and cons of invoking FMLA with their patients. Although job protection may be an advantage, the fact that the patient/employee will not be compensated for FMLA leave time may make this option less attractive. In contrast, for example, patients who make a successful short-term disability claim typically have both job protection as well as some compensation during their leave.

Accessing continuous or intermittent FMLA leave requires that the patient have a "serious health condition," which must be documented with a description of the health condition precipitating the leave and the signature of the health care

provider. The form (see Appendix I) that requests this federally mandated information is usually provided by the patient, but can also be accessed on the Internet (at www.dol.gov/whd/forms/wh-380-e.pdf). It requires only a few minutes to complete, and is returned to the patient who is responsible for submitting it to his or her employer.

When additional interventions are required to craft a suitable work modification plan, the patient may consider requesting a temporary or permanent shift in job assignment or reduced work hours. The clinician may review the viability of these options with the patient, although available worksites and assignment flexibility will vary with employer. The clinician and patient should examine how a change of this type may alter the patient's workplace support network, work hours, job duties, employee benefits, etc. These changes may or may not be desirable.

Patients often believe they can informally manage work accommodations by disclosing the mental disability to their immediate supervisor but asking the supervisor to keep it "just between us." This assumption is incorrect. In fact, supervisors who comply with such a request place the employer at risk of being found liable if the employee later claims discrimination on the basis of disability. The supervisor is an agent of the employer who is considered to be officially notified of the disability as soon as the employee makes the disclosure to the supervisor. The ADA requires employers to treat employees as if they have a disability as soon as the disclosure is made (EEOC Enforcement Guidance 2002). Thus, sharing information about a mental disorder with an employer or supervisor, even if not intended to be a formal notification, is in fact always a formal notification (see Chap. 10).

In the case example, Larry discusses his preference to maintain privacy about his mental disability with Dr. Gee. Larry decides to use flex and vacation time so that he may focus on managing his symptoms and improving his functioning. His leave time is approved by the employer and Larry makes reasonable progress in treatment until he experiences another personal crisis. His emotional state deteriorates along with his work capacity, and he has no remaining vacation time. Larry tells Dr. Gee that it will be difficult for him to find another job with similar collegiality, work conditions, and compensation. Larry decides to make a formal request to his employer for workplace accommodations under the ADA because he does not wish to be terminated from his job for poor work performance.

Withdrawing from the Workforce

When a clinician determines that a person is unfit to work due to impairments associated with a mental disorder, withdrawal from the workplace may be indicated. The clinician and patient should review the pros and cons of a leave of absence from work. The decision to withdraw from the workplace may be the most expedient path to mental health rehabilitation as well as improved social and occupational functioning. However, a temporary disruption of employment also

may jeopardize the patient's finances, family and other relationships, self-esteem, emotional stability, and lifestyle. The mental illness and "temporary" work withdrawal can lead to permanent disability, which may be an undesirable if not disastrous outcome for the patient, practically speaking, and which rarely is a good prognostic indicator for quality of life.

If the clinician and patient together decide that temporary workplace withdrawal is in the patient's immediate best interest, the clinician should frame the discussion as part of a comprehensive and aggressive treatment plan that includes counseling, medication, lifestyle changes, etc. The treatment plan should be proactive and dynamic to foster the patient's timely rehabilitation and return to the workplace, and to minimize the risk of establishing permanent disability. It should include methods to monitor and to encourage advancement of the patient's rehabilitation. Additionally, the clinician and patient should explore the anticipated effects of being out of work, the challenge of reentering the work force, and the need for a return-to-work plan.

Returning to Work

Although the leave of absence is a temporary, yet common, rehabilitative intervention (EEOC Interpretive Guidance 2000), the longer patients are away from the job, the harder it will be to resume their former baseline level of productivity and social engagement in the workplace. Consequently, the forward thinking clinician should introduce the goal of returning to work to the patient as soon as the subject of withdrawing from work is discussed. The clinician who empowers the patient to return to work from the outset of discussion of work withdrawal is fulfilling the therapeutic contract and working in the best interests of the patient's mental health, which may not, in many cases, be served by the patient adopting a permanent disability status.

The clinician should work with the patient to set up a treatment plan that includes concrete goals for returning to work as well as the most effective use of leave time, and advise the patient that progress toward returning to work will be addressed during each clinical session. This discussion should establish a framework for patients as they strive to return to the workplace. At times, the discussion about returning to work may lead to a plan that helps the patient resume working sooner if the employer provides work modifications or "reasonable accommodations."

The ADA permits clinicians to facilitate the process of returning to work by crafting potential workplace accommodations with patients that they can then discuss with employers. Clinicians should be aware, however, that the ADA does not obligate employers to adopt accommodations if employers can show the accommodations impose undue "hardship." Also, if there is more than one possible reasonable accommodation for the employee, the employer may choose from among the modifications. Job reassignment may occur as a reasonable accommodation when the employer and employee voluntarily agree that job

reassignment is preferable; involuntary reassignment may be construed as a form of discrimination or retaliation.

Clinicians should discuss with their patients that when they disclose a mental disability to the employer, the ADA permits the employer to request reasonable documentation from an appropriately credentialed mental health professional. The employer is entitled to obtain information about the mental disorder and related functional limitations, and to substantiate the existence of the mental disability and the need for a workplace accommodation. The ADA does not permit the employer to ask for information that exceeds these parameters, although employers sometimes seek more information than they are entitled to under the ADA. Patients may choose to allow additional disclosure.

The clinician should notify the patient when the employer requests information directly from the clinician about the patient's work-related impairment. The discussion should include a review what the patient is comfortable permitting the clinician to share with the employer. This discussion should include a review of possible and foreseeable uses of disclosed information (see Chap. 2). Although employers are legally constrained in how they may use information, legal constraints do not always guarantee that disclosed information will not be misused in some way. The clinician should document the discussion in the patient's record. Written consent should be obtained from the patient before the clinician submits the completed disability forms to the employer.

Whether a patient permits the clinician to release more information than is required or not, the clinician should limit the disclosure to what is necessary. Although some patients believe that including highly personal details will result in a more sympathetic reception of their requests from their employers, this is not usually the case. Excessive disclosure of personal details of illness compromises the patient's privacy and potentially increases stigma in the workplace. Clinicians should therefore work with patients to help them understand what information may be helpful and what should be withheld.

At times, patients will not permit the clinician to release sufficient information to their employers. In these cases, the clinician should discuss the concerns that are causing the patient to withhold information the employer needs to provide the requested or recommended accommodations. Some patients believe that simply asking for the accommodations without providing the necessary information should be sufficient. Exploring patients' assumptions and providing some education about the process facilitates the discussion of the risks and benefits of disclosure.

Patients should understand that refusal to release sufficient information can result in delays in obtaining accommodations and denial of the financial, healthcare, and other benefits that they might otherwise be entitled to receive as a person with a disability. Also, a patient who requests accommodations under the ADA but who has not complied with the ADA's disclosure requirements is at risk of not receiving employment interventions and the ADA's protections. The person's employment may be terminated due to poor work performance, even though recommended accommodations have not been implemented. Some patients may

be willing to take the risks associated with nondisclosure; others may change their minds and allow adequate disclosure.

In the case example, Larry resists disclosing sufficient information to his employer. He has been discreet about his mental health history and pays the full price for his medication so that the company that provides his pharmacy benefits, though supposedly confidential, does not have data that may leak back to his employer. Although he is not aware of any privacy violations involving employees with disabilities in his company, he recalls how an older family member with a mental disorder was treated by a former employer. The clinician and Larry schedule an additional session, during which they reach a consensus about what should be disclosed on the forms that the employer wants Dr. Gee to complete.

Security Clearances and Disclosure

Patients whose jobs depend on maintaining a security clearance require a somewhat different discussion regarding the risks and benefits of disclosure. Patients whose jobs depend on maintaining a security clearance invariably will have some anxiety about whether past, present, and/or future treatment will compromise their clearances. Clinicians should have an understanding of their role in security clearance investigations in order to reassure their patients and be able to have a practical risk/benefit discussion regarding disclosure.

A wide variety of jobs that involve access to classified information and/or making discretionary decisions about public safety, national security, or protected information (e.g., law enforcement, banking, national security, nuclear research, Internet security, etc.) require that an employee have a security clearance. These patients invariably have concerns that formal requests for accommodations or disclosure of psychiatric illness places their security clearances, and therefore their jobs, at risk. Patients often assume that any mental health-related disclosure will result in denial of renewed clearance and result in job loss, and may therefore be hesitant to seek accommodations that would require even minimal disclosure.

Contrary to this common misconception, psychiatric disorders and mental health treatment will not automatically result in disqualification for security clearance. Guideline I of the federal "Adjudicative Guidelines for Determining Eligibility for Access to Classified Information" states in regard to "Psychological Conditions" that no negative inference regarding meeting the requirements for a security clearance may be raised solely on the basis of seeking mental health counseling (United States Department of State 2006). For example, a review of the US Army Central Clearance Facility adjudicative history indicates that 99.98 % of cases with psychological concerns obtained or retained their security clearance eligibility (Haire 2009). In fact, the overwhelming majority of security clearance denials are based on other issues, such as financial considerations and personal conduct (Henderson 2009) and also typically involve providing false information,

rather than nondisclosure of potentially unfavorable information (Henderson 2010).

Security concerns arise when the possibility of future unreliable or dysfunctional behavior is indicated by either abnormal behavior or the opinion of a qualified mental health practitioner. Guideline I of the Adjudicative Guidelines lists conditions that could raise a security concern and may be disqualifying. These include:

- emotionally unstable, irresponsible, dysfunctional, violent, paranoid, or bizarre behavior;
- an opinion by a qualified mental health professional that the individual has a condition that may impair judgment, reliability, or trustworthiness;
- or that the individual has failed to follow treatment advice related to a diagnosed emotional, mental, or personality condition, such as failure to take prescribed medication.

Guideline I also lists circumstances that mitigate security concerns even if the above conditions are present (United States Department of State 2006). These include:

- the identified condition is readily controllable with treatment, and the individual has demonstrated ongoing and consistent compliance with the treatment plan;
- the individual has voluntarily entered a counseling or treatment program for a condition that is amenable to treatment, and the individual is currently receiving counseling or treatment with a favorable prognosis by a qualified mental health professional;
- recent opinion by a qualified mental health professional that an individual's previous condition is under control or in remission, and has a low probability of recurrence or exacerbation;
- the past emotional instability was a temporary condition (e.g., one caused by a death, illness, or marital breakup), the situation has been resolved and the individual no longer shows indications of emotional instability;
- there is no indication of a current problem.

Individuals undergoing a federal or military security clearance investigation are required to report all health conditions and treatment, including mental health issues. Mental health professionals have an obligation not to conceal information in response to questions within the scope of authorized disclosure (American Psychiatric Association 2006), creating a potential conflict of interest. Thus, although not of itself a disqualifying condition, a psychiatric disorder and mental health treatment, where relevant to the adjudication of access to classified information, may result in further inquiry and investigation.

When applicants for security clearance or undergoing a security clearance review respond "yes" to the standard "Mental and Emotional Health" question, they can expect that their treating clinician will be contacted for additional information. A "yes" answer also directs applicants to complete an "Authorization

for the Release of Medical Information." This form authorizes a mental health practitioner to answer three questions:

1. Does the person under investigation have a condition that could impair his or her judgment, reliability or ability to properly safeguard classified national security information?
2. If so, describe the nature of the condition and the extent and duration of the impairment or treatment.
3. What is the prognosis?

Treating clinicians should note that they are not expected to perform an evaluation to assess security risk. Their responses to these questions should be based on diagnoses and judgments formed in the course of the treatment relationship (American Psychiatric Association 2006). When the mental health practitioner answers "no" to the first question, there is usually no further investigation of this issue. When the answer to the first question is "yes," investigators require and obtain additional authorization to gather more detailed information regarding medication, other treatment, test results, and medical opinions regarding health, recovery, and/or rehabilitation. If treating mental health clinicians indicate that they do not have an opinion on this issue, the patient is typically required to undergo an independent security risk evaluation.

Clinicians should review this information with their patients when the issue of security clearance investigations arises. A person with a security classification may view signing release forms for mental health and other information as a perfunctory job requirement and have little anxiety about the disclosure. Many disclosures for security clearance purposes are indeed minimal, as indicated above, and will not affect security clearance status or employment status. However, in more complex situations, the patient may not be aware that the treating clinician is required to report information that may adversely affect the clearance investigation.

Ultimately, almost all cases where a final clearance is denied due to psychological conditions involve one of the four following situations (Henderson 2010):

- The applicant has displayed dysfunctional or abnormal behavior, and the applicant refuses to seek treatment or refuses to undergo medical evaluation.
- A qualified medical practitioner has determined that the applicant's condition could impair his or her judgment or reliability, and the applicant has failed to take medication or participate in other treatment as prescribed.
- A qualified medical practitioner has determined that the applicant's condition could impair his or her judgment or reliability and the condition cannot be adequately treated.
- A qualified medical practitioner has determined that the applicant's condition could impair his or her judgment or reliability and there is a lack of persuasive evidence that the condition is under control and will remain so for the foreseeable future.

Clinical situations where these circumstances arise, or where the patient is not sufficiently stable to appreciate the potential consequences of disclosure, will

require extensive discussion with the patient. Clinicians who find themselves in these complicated situations with conflicting obligations should proceed with extreme caution, as such disclosures may compromise the patient's employment and may also disrupt the treatment relationship.

For example, a person with Bipolar Disorder who refuses to adhere to treatment due to denial of illness may become angry if the clinician reports this to the investigator. The clinician should review the specific information that is being requested with the patient. When the patient learns that the information the employer is requesting may adversely affect the patient's security classification and future employment, he or she may consider restricting the limits of the consent or rescinding it. However, this course of action also may result in loss of security clearance. Under these circumstances, the clinician should review with the patient how disclosure may affect the security clearance and may result in discussion regarding the patient's employability in the chosen field.

Again, the clinician should be certain to inform the patient whenever a request for clinical information is received. The clinician should discuss with the patient how the inquiry will be addressed, especially when the request includes questions about the patient's adherence to treatment, prognosis, their ability to make sound judgments, reliability, potential for violence, and whether the treatment was involuntary. Clinicians should assure patients that information will not be released without the patient's consent and knowledge. Clinicians should also explain to patients that they do not control the final decision regarding security clearance, and will not provide an opinion outside their training and expertise, including whether a security clearance should be given (American Psychiatric Association 2006).

Return-to-Work Plans

Both patients and their employers benefit when patients resume working as soon as they are able to do so. Employees join the workforce for many reasons, including compensation, career, benefits, training, autonomy, interpersonal contact, a sense of purpose and identity, and an improved quality of life. Employees who withdraw from the workplace may lose any or all of the benefits that working provides. Employers invest resources to recruit and retain skilled, conscientious employees. When an employee is away from work, the employer loses the productivity of a skilled worker. Replacing the employee is costly to the employer who must invest time and resources to recruit, train, and compensate the new worker while, in many cases, compensating the disabled employee.

Clinicians therefore should seek to support patients who have taken a leave of absence due to impairments in attempts to return to the workplace. Clinicians also should be familiar with how to craft and discuss transitional work or return-to-work plans. As noted above, this discussion should begin at the same time as discussions about withdrawing from the workplace.

In the United States, the first return-to-work or transitional work programs were developed to decrease costs for employers and lost work time for employees while their workers' compensation claims were being processed. In recent years, many corporations have used these cost-effective plans to help employees with various work and non work-related impairments, including mental disabilities, resume working. Effective return-to-work programs are structured to help disabled employees resume working at a safe pace that is informed by each employee's evolving health status and work ability (Randolph and Ranavaya 2000).

Transitional work plans may be guided by and may include ADA provisions, although the ADA does not require employers to have structured return-to-work programs in place for employees. If an employer does not have a return-to-work plan, clinicians may serve an important role in assisting patients in determining the type of work accommodation(s) they will need if unable to resume working at full capacity without some job modifications. Mental health professionals should discuss with their patients what kind of workplace accommodations might be effective and beneficial in the workplace. Examples of reasonable work-related modifications include (but are not limited to) a graduated or part-time work schedule, a less stressful "light duty" work assignment, or flexible scheduling. Physical changes to the workplace, such as a quieter workspace, may also be a reasonable work accommodation for an employee who has a mental disability. At times, changing workplace policies or practices for that individual or a temporary job coach may be available and may be considered reasonable accommodations.

The clinician and patient should consider patient's diagnosis, the symptoms of the patient's mental disorder, and at times effects of treatment and related impairments to select or design accommodations. For example:

- A person with Attention Deficit/Hyperactivity Disorder may be more productive in a quieter, less distracting work environment that is more conducive to concentration and task completion. Limiting the amount of multitasking that is required may also enhance the patient's/employee's productivity. Reminding patients with ADHD to take breaks that are already structured into the workday may help them to refocus.
- A person who has Social Anxiety Disorder may perform better if the employer limits the amount of time that the employee has to spend with the public, or working with large groups of coworkers.
- A patient/employee who has Bipolar Disorder may be better served by not working rotating shifts.
- A person who hears voices that are diminished by the sounds of humming machinery may be more productive in a location near machinery or where there are distracting sounds.
- A patient/employee who has offensive vocal tics due to Tourette's Disorder may be effective working night shift in a workplace that has low occupancy overnight.
- The patient/employee who has a phobic reaction to heights may benefit from a ground level parking space.

- A depressed, irritable person who has impaired concentration may function better if he or she is permitted to work near fewer people.
- A person who has Posttraumatic Stress Disorder due to a motor vehicle accident and whose flashbacks and hypervigilance are triggered by sirens and flashing lights may work better in a setting away from those types of triggers.
- A patient/employee who is prescribed psychotropic medication that reduces their ability to tolerate sun or regulate body temperature or bodily fluids should be assigned to a work setting that does not require extended exposure to sun or excessive heat. In some cases, permitting the employee to wear sunglasses or a cap to shield them from the sun, even if not part of the company uniform, may be a sufficient accommodation.
- A patient/employee whose medication causes frequent urination should be given extra breaks and additional time to rehydrate, especially in warmer climates or work settings.
- A depressed person who is able to work for part of the day but lacks sufficient stamina to complete the entire shift could benefit from a reduced workday until his or her energy improves.
- Supervisors who are reintegrating to the workforce after time off due to a mental disorder may benefit from being responsible for fewer supervisees until they have acclimated to the work environment.

At times, an employer and employee may mutually agree that a temporary work duty assignment would be a reasonable intervention until the employee's work skills improve. This, too, would be a reasonable accommodation.

Flexibility to attend mental health sessions should also be factored into the patient's accommodations. Clinicians may be in a better position to support patients who are trying to identify accommodations if they review the patient's work routine and related impairments with the patient. Crafting workplace accommodations may be facilitated when the clinician has access to the job description. When this is not possible, the clinician should ask the patient to describe the types of work tasks, safety precautions, productivity expectations, and interpersonal skills that are required for the job.

Clinicians should also discuss with patients seeking or receiving workplace modifications under the ADA that they are required to follow through with treatment recommendations to maintain their eligibility for current and future accommodations. Patients whose lack of treatment compliance results in recurrent or exacerbated symptoms may lose their jobs due to poor work performance. For example, patients are responsible for complying with medication or other recommended mental health interventions; employers cannot be required to provide medication monitoring services or mental health monitoring as workplace accommodations.

Clinicians should not feel obligated to modify treatment recommendations to accommodate a patient if the clinician is not comfortable with the alternatives or if the desired treatment requests fall below the standard of care. If the clinician and patient cannot agree on an acceptable treatment plan, then the patient should be

advised to consider seeking consultation or a second opinion, and possibly even treatment from a different clinician.

Types of Return-to-Work Evaluations

In the case example, Larry has not worked in 6 weeks, has responded well to treatment, and believes that his mental health status is sufficiently stable for him to return to work. In view of the duration and severity of his illness, Larry's employer requires a return-to-work assessment.

Informal Evaluation for Return to Work

Return-to-work assessments are an important part of mental health care for patients who may need to withdraw from the workplace due to mental illness. Clinicians should consider the mental health implications for patients who return to work before their symptoms are sufficiently stable, who resist returning to work after they are able to do so, or who need to explore what support they may need to maintain improved functioning. Some workers lack insight into the severity of their impairments or may experience financial, familial, or social pressure to return to the workplace before they are stable or resilient enough to tolerate its demands and stresses without a recurrence of symptoms. In contrast, others who are sufficiently stable to resume working may resist returning to work. In either case, a mental health work readiness evaluation is needed, especially when the patient has been away from work for an extended period.

In addition, employers typically require employees who have taken medical leave or applied for disability benefits to obtain documentation of readiness to return to work. Often, employers will accept a brief note that simply states something like, "Mr. Jones may return to work as of today." However, in more complicated mental health situations, a more thorough evaluation of the patient's readiness to return to the workplace is required or requested.

Two types of return-to-work determinations are performed by treating mental health professionals: informal and formal. Treating clinicians more commonly provide "informal" evaluations. These often arise as a routine part of clinical work and are not performed at the request of an employer, attorney, or insurance company. The informal evaluation is conducted to determine, in conjunction with the patient, whether he or she is sufficiently stable to resume working with or without work-related modifications.

The informal return-to-work evaluation has several advantages. Patients have a therapeutic relationship with their treating clinicians and may feel more comfortable sharing critical information relevant to their ability to work. Also, the treating clinician knows the patient's history and may comfortably be able to adopt

an advocacy role on the patient's behalf. The clinical relationship facilitates ongoing assessment and collaborative revisions of recommended work accommodations as the impaired patient work capacity evolves.

When the informal process of evaluating the patient's readiness to return to work reaches a point where decisions need to be made or documentation needs to be provided to employers, clinicians should review their opinions with the patient. When the clinician and patient agree with the clinical opinion, the discussion likely will go well. However, when there is a significant gap between the clinician's findings and the patient's expectations, the results of the examination may damage the therapeutic alliance, affect future treatment, and place stress upon the patient. The patient may decide to withdraw from treatment or modify treatment without consultation with the clinician; either action can have adverse effects on the patient's disorder.

The mental health professional who anticipates an unfavorable reaction from the patient or who feels that providing documentation regarding return to work creates an ethical conflict may advise the patient to consider requesting an independent FFD evaluation (see Chap. 3) in an effort to preserve the therapeutic alliance and to help the patient make continued progress toward improved mental health and functioning. Return-to-work evaluations differ from FFDs in important respects (see discussion below), but there may be considerable overlap between the two types of evaluations. Of course, patients are always free to seek mental health treatment from another professional, hoping to find someone who will agree with their position, and if the assessment is not handled sensitively, patients will often do so.

Patients who do not agree with their treatment providers should be encouraged to discuss their concerns about returning to the workplace. If the clinician believes the patient is ready to resume work and the patient is reluctant to do so, the patient's threshold for returning to work should be explored. In some cases, the patient may be aware of issues or impairments that have not been adequately addressed. In other cases, patients may have unrealistic expectations about when they are sufficiently stable to resume working. For example, some patients may believe that they cannot return to the workplace until they are functioning at 100 % of their previous baseline. In these cases, clinicians may be able to work with patients to help them understand how they might be able to return to the workplace, with or without job modifications, even if they are still experiencing some symptoms.

There may be secondary gains for patients to avoid the workplace, such as avoiding an unpleasant or unstable work environment, a pending adverse job action or a pending lawsuit, a desire to have more time for family and/or recreational activities, or to obtain long-term disability benefits. Although it may be uncomfortable, the mental health professional should examine these concerns with the patient. Again, these difficult discussions should be framed within the context of concerns for the best interests of the patient's mental health and quality of life. The conversation should include a review of the clinician's assessment of the patient's readiness to return to work. The mental health professional and the

patient should discuss the patient's suitability for their particular job, job satisfaction/dissatisfaction, including pending disciplinary actions, and long-term goals. Additionally, the clinician and patient should examine the possible negative effects of long-term disability and unemployment on the patient's mental health.

This discussion may be facilitated when clinicians appreciate the external pressures not to resume working. This involves discussing the patient's lifestyle, support system, non-psychiatric medical health concerns, and other salient matters. In some cases, a patient may choose to seek employment elsewhere; the clinician can be supportive as the patient works through this process. However, mental health professionals should not feel pressured by fear of conflict or loss of the therapeutic alliance into documenting either disability or ability to return to work if they do not agree that this is the case.

The situation regarding patients who believe they are ready to resume work when the clinician has reservations is more complex as such patients may put themselves, others, their job, and/or their employers at risk. Clinicians should ask these patients about their motivation for resuming work. There could be financial or marital stressors, or the employer may be pressuring the patient to return to work. Patients may lack insight into the severity of their impairments; the clinician and patient should review what is needed for the patient to achieve work readiness from a clinical standpoint.

In some cases, patients may be willing to invite a family member or friend to attend a clinical session to support them as they strive to achieve wellness. The presence of a support person and the corroborative information that he or she may provide can enhance the patient's treatment if the support person has the capacity to understand the patient's clinical and employment situation and wants the patient to succeed in the workplace. Clinicians should be aware, however, that individuals identified as supportive may not be objective or may have a different agenda than returning the patient to health and workplace functioning, so decisions to invite support persons into the treatment process should be carefully considered.

The treating clinician may believe that the patient's desire to return to work is premature because returning to work will cause exacerbation or relapse of illness, or that the patient's prognosis precludes successful return to competitive employment. In these cases, clinicians may want to initiate a discussion regarding other options with which patients may be unaware or unfamiliar. Patients can be advised to consider consulting a human resources representative regarding options, such as applying for short- or long-term disability leave, early retirement, disability retirement, or Supplemental Security Disability Insurance benefits in more extreme cases. Mental health professionals should not advise the patient to pursue any specific course of action, although they may choose not to provide documentation supporting a patient's choice. Advising or directing patients' actions can be considered a violation of the ethical obligation to respect patient autonomy and can create potential liability for clinicians. Clinicians should however make sure that the patient understands that these options may exist and can be explored.

If the patient asks the clinician to prepare a letter regarding readiness to return to work, the clinician and patient should review the intended contents of the

document before it is prepared. The clinician may describe the patient's status, along with any recommended accommodations. The letter should contain the minimum amount of information necessary for the situation and should be issued to the patient who may decide with whom to share the information. Also, the clinician should document the request for the letter and any salient discussion, including how the patient plans to use the letter, in the medical record where a copy of the letter should be filed.

As noted above, at times employers will request information directly from the clinician. Mental health professionals should not respond to such requests before reviewing the inquiry with the patient. If the patient gives consent in writing for the clinician to respond to the request, then the patient should be permitted to review the clinician's intended response. Again, the correspondence should contain the minimum amount of information that is appropriate for the situation. The clinician should bear in mind that, in some cases, releasing information to the employer, even with the patient's consent, may affect the therapeutic relationship and/or hinder the patient's rehabilitation. Such concerns ideally should be discussed with the patient before health information is provided to the employer.

Formal Evaluation for Return to Work

"Formal" evaluations are requested by an agent or "third party," i.e., employers, insurers, attorneys, or their designee(s). The formal examination or FFD evaluation may require the treating mental health professional to respond to a series of questions, or to prepare a report that includes specific information (see Chap. 12). The treating clinician should not proceed with a formal evaluation unless the patient consents to the evaluation and to submission of the results to the agent/third party.

Although similar in intent and recommendations, there are significant differences between a return-to-work assessment and a FFD assessment. A FFD assessment is performed by a mental health professional who is retained by a third party, such as an employer or an insurance company, who does not have a therapeutic relationship with the examinee. The less formal return-to-work assessment is typically performed by a treating clinician who is familiar with the patient and his or her history and hopefully has on ongoing therapeutic alliance. The treating clinician in some cases may have the advantage of having had several meetings with the patient and therefore potentially a better appreciation for the patient's current situation, past history, and changes in mental status and functional capacities. The treating clinician will also be more familiar with the patient's resilience, flexibility, and compliance and course of illness than the independent evaluator who meets with the patient/employee once or twice before preparing a report.

Treating clinicians should carefully consider whether they want to assume the responsibility of providing a formal return to work evaluation for their patients rather than suggesting an independent FFD evaluation. If treating mental health professionals decide to provide a formal return to work evaluation for their own

patients, they should recognize that they are serving in a dual role that may create practical and ethical conflicts. Inevitably, the third party wants specific confidential information about the patient, who depends on the clinician as an advocate. The clinician is ethically and legally obligated to release only what the patient agrees may be submitted (see Gold and Metzner 2006). The clinician may feel pressured to provide information in a manner that is most likely to serve the patient's wishes. Although the clinician's primary role is to support the patient's mental health and best mental health interests, in agreeing to provide a formal FFD evaluation, clinicians become obligated to provide what would otherwise be confidential information and to adopt an objective perspective that may not serve the patient's best interests.

Independent FFD examinations can be useful even when a clinician and patient agree on a plan regarding returning to work. The independent mental health evaluator may be aware of the third party's concerns about the employee's work capacity that are not readily available to the treating mental health professional. The patient who does not disclose this information to the treating clinician may not be aware of the employer's concerns, may not appreciate their importance, or may be choosing not to disclose this information. Such concerns may include previous disciplinary actions, safety concerns, reliability problems, interpersonal conflicts, and/or productivity problems. Since the independent evaluator is ethically obligated to consider all this information, and doing so does not violate patient confidentiality (see Chap. 2), the evaluator's findings and recommendations may carry greater weight with an employer.

The third party's questions may require the clinician to assess the patient's capacity to engage in work-related tasks that are specific to the patient's job description. These questions may be useful for the clinician to consider and should be discussed with the patient, especially if the clinician does not have access to the patient's formal, written job description. The clinician otherwise may not be aware of specific safety or interpersonal requirements that are unique to the patient's job.

Regardless of whether the evaluation is being conducted by a treating clinician or an independent clinical evaluator, mental health professionals should limit their opinions to those requested by the third party and related to the patient's functioning. Even so, treating clinicians who go forward with providing a formal report may find that they cannot comfortably answer certain questions. Prior to submitting the report, treating clinicians undertaking a FFD for their own patients should discuss the decision not to respond to particular questions with patients so that patients will remain informed of potential conflicts and consider alternatives. When the clinician and patient concur about what needs to be communicated, the provision of the FFD evaluation is relatively straightforward. However, when there is a difference of opinion, the clinician should proceed cautiously because of potential damage to the therapeutic alliance, as well as ethical obligations and liability issues (see Chaps. 2 and 3).

When formulating a return-to-work plan, clinicians should bear in mind that workplace modifications should not be aspirational or excessive. While the patient

may require work modifications to perform his or her job more effectively or to return to the workforce, the accommodations recommended by the clinician should not exceed what is minimally required for the patient to succeed. This limitation may contribute to tension in the clinician/patient relationship if the patient wants more workplace modifications than the clinician believes are necessary. The clinician should not feel an obligation to yield to the patient's wishes if the clinician does not support them, but should address the patient's concerns. At times, the clinician and patient will be able to reach a consensus opinion that is clinically accurate and ethical. If not, then mental health professionals should not exceed the scope of their professional boundaries. If the treating clinician and patient reach this impasse, the treating clinician still has the option of suggesting that the patient consider obtaining an independent FFD evaluation, which may serve to protect the therapeutic alliance and certain important aspects of the patient's confidentiality.

Despite owing certain duties to the employee being evaluated (see Chap. 2), the independent medical examiner's primary obligation is to the referring agency. For example, unlike a treating clinician, a mental health evaluator who conducts an independent return-to-work or fitness for duty assessment does not have to, and in fact should not review the findings directly with the evaluee. It is important for the independent evaluator to maintain objectivity by not responding to perceived or actual pressure from the referring agency to give an opinion that a mentally disabled employee is fit to return to work, or does not need workplace accommodations, just as it is important for the treatment provider not to respond to undue pressure from patient to provide favorable opinions (American Academy of Psychiatry and the Law 2005).

Releasing Information to the Employer

Treating clinicians and independent medical examiners are obligated to preserve confidentiality regarding non-relevant material. For example, when sexual issues or family issues are not related to the mental disability, they should not be reported to the employer or retaining party. Treating clinicians are more tightly bound by ethical obligations of confidentiality than are independent medical examiners (see Chap. 2). At times, the mental health professional, whether treating or non-treating, may not feel comfortable releasing certain information that is relevant to the employer, as the professional has no control over how the information will be used, even though the ADA clearly limits the use of this information by employers. The independent medical examiner should review these concerns with a colleague or consult the appropriate professional agency for guidance. Treating clinicians may share specific concerns with patients so that they will remain informed and proactive.

When consenting patients are dissatisfied with the findings of, or even the interaction with, the evaluating mental health professional, patients may revoke their consent to release the results to the third party. This may place the patient in a

precarious situation with the employer, especially if the patient previously identified the mental health professional as the person who would be conducting the evaluation. If evaluating clinicians are also the treating clinicians, they should review the pros and cons of rescinding the release with the patient so that patients can make an informed decision regarding the release of information. Clinicians should bear in mind that the decision-making process in these situations may increase the patient's emotional distress and introduce tension into the therapeutic relationship.

The ABCs of the Return-to-Work Examination

In the case example, Dr. Gee is prepared to formalize the assessment and determination of whether Larry may resume working and the types of accommodation from which he would benefit. Dr. Gee will use a systematic approach to complete the analysis.

A mental health return-to-work evaluation should assess the subject's emotional readiness to resume work in a productive, collaborative, and safe manner. This examination contains three key components: Assessment, Barriers, and Compromises (ABCs).

Assessment

When a person who has withdrawn from the workplace due to impairment from a mental disorder seeks to return to work, the most important question is "What has changed?" In the case example, Dr. Gee knows that Larry has followed through with treatment recommendations. She has observed that Larry's mood, attention, concentration, sleep, and energy have improved, and that Larry no longer feels fatigued after fulfilling his obligations at home. Larry agrees that these observations are valid. These are changes that weigh in favor of Larry returning to the workplace.

The treating clinician should ascertain how the patient's status has changed and whether these changes improve the patient's capacity to resume work duties with adequate safety, perspective, responsibility, productivity, and interpersonal acumen. The most important part of this evaluation is the history. The clinician that performs the return-to-work assessment should be or should become familiar with the patient's background, work history, and interpersonal conflicts. When possible, a review of the patient's job description may provide clinicians with a snapshot of what will be expected when the patient returns to work.

The clinician should have a sense of the patient's pre-disability work performance in terms of professionalism, productivity, and safety. It is helpful to obtain details about required work shifts, including the frequency at which the shifts rotate or change. The clinician should determine if the patient has a realistic

understanding of the expectations of the job, including required tasks and productivity expectations, reliability, safety, and when applicable, relationships with co-workers and clients. The mental health professional should attempt to learn about the patient's satisfaction with the job, as well as how patients rated their baseline job performance before they began to have work-related impairment.

Additionally, the clinician evaluator should explore how patients' current emotional and mental status will affect their capacity to meet the job requirements. This discussion should include a review of what the patient believes is needed to sustain emotional stability, including medication, counseling, medical consultation for physical health problems, or other issues that may affect degree of impairment associated with psychiatric illness. Evaluating clinicians should ask the patient about the logistics associated with scheduling follow-up consultations with mental health professionals, as the patient may need a formal or informal workplace accommodation to accomplish this. This series of inquiries will help the clinician assess the patient's level of insight into the situation and motivation to do what is necessary to achieve and maintain wellness.

Patients whose work responsibilities require supervision of others or require them to work with the public must routinely utilize different skill sets than those who work by themselves or where there are few workers. A person who works with or near dangerous machinery or in traffic requires a higher level of alertness and responsiveness than a worker whose job does not require intense concentration or is less physically demanding. Consequently, the assessment of a patient's ability to return to work should examine the patient's mental impairment in the context of the job requirements.

Barriers

If patients are not emotionally prepared to do their jobs professionally, productively, reliably, and safely, then the clinical evaluator should identify barriers that prevent return to work. Non-psychiatric health barriers to returning to work should be managed by a suitably trained health care professional. Although a disabling mental disorder by itself may impede a patient's transition back to work, other factors may complicate the process. These barriers may be associated with either employers or employees. External matters that are not under the control of the employer or employee may become barriers for either or both parties.

Employer Barriers

An employer who believes that the employee has caused disruption in the work environment or that the recommended workplace accommodation might be too costly to the company may be a barrier to the employee returning to work. An

employer may only want an employee to return to work if he or she is able to work at 100 % capacity. Employers may not be aware of their obligations, under the ADA, to offer an otherwise qualified employee who has a mental disability a reasonable workplace accommodation so that the employee may work. The fact that an employer is uncooperative should not preclude the mental health professional from recommending workplace accommodations if the patient asks the clinician to do so. If the employer fails to offer reasonable accommodations, then the patient/employee may have to seek guidance or advocacy from an expert in workplace accommodation assessment, mediation, and/or litigation.

Employers may be required to offer additional accommodations if an employee's work capacity diminishes after he or she returns to work. When employers believe that all reasonable accommodations have been exhausted, they may request a FFD examination, or ask the employee to leave the work site. The employee may have to seek expert consultation under these circumstances as they may be eligible for long-term disability benefits. Patients who receive workplace accommodations and who do not meet job expectations for reasons unrelated to the identified mental disability will be at risk for losing their jobs.

Patient/Employee Barriers

Patients also may have barriers to returning to work. A patient who had an embarrassing situation occur prior to leaving work may fear shame or stigmatization upon returning to work. A change in appearance or physical functioning due to a health condition may result in the patient being fearful in anticipation of the reactions of coworkers. Also, psychotropic medication may slow the patient's cognition or reaction time, making it unsafe for the patient to return to certain work settings, to operate machinery, or to drive a vehicle to work. A patient's motivation to resume working may be diminished if there has been conflict between co-workers, subordinates, or supervisors.

Additionally, patients who do not consistently follow through with recommended mental health interventions or who habitually disregard workplace rules and policies create a barrier to their rehabilitation. Patients who fail to meet deadlines for submitting required documents also create a barrier to returning to work; their actions may legitimately give the employer a reason to replace them, and under these circumstances, these individuals may not have legal protection or recourse.

Although returning to work may improve the financial profile of a patient, financial matters may also impede a patient's efforts to return to work. For example, a patient who is unable to afford co-payments for mental health appointments or prescription medication, or who has uncomfortable medication side effects, may not be able to comply with a treatment plan designed to improve the patient's ability to resume working. The clinician should work with the patient to reduce any barriers that may prevent or delay the return to work.

Desensitization or "deconditioning" also may be a barrier for patients who want to resume working. If the hiatus from work has been lengthy, then it will be more challenging for patients to resume their former baseline level of productivity and social engagement in the workplace. Patients may have developed different routines for sleeping, awakening, dining, socializing, and engaging in physical activity. The patient who has become desensitized to the workplace routine, which may include productivity expectations, meeting deadlines, reflex reactions, safety precautions, attending meetings, and taking breaks at designated times, may be less productive and have diminished work acuity.

Clinicians who anticipate this type of problem should talk with patients about a gradual return to work, rather than prematurely returning to a full-time work schedule. Patients will need to negotiate this with their employers, but gradually increasing work hours avoids the disastrous outcome of a good faith attempt to return to work ending in failure. Such adverse work experiences may result in patients believing they are permanently disabled and discourage them from further attempts to return to work.

A patient's lack of insight into the mental disorder and failure to adhere to treatment also may create barriers to resuming employment. For example, a patient who is paranoid, hears voices, and stops taking the medication that alleviates the symptoms may not be able to focus well enough to work safely and productively. The clinician should examine the patient's understanding of the diagnosis and cause(s) of the mental disorder, as well as treatment and steps to prevent of relapse. A patient who adheres to the recommended treatment protocol in an effort to achieve wellness has insight and motivation that are conducive to the development of a transitional return-to-work plan.

External Barriers

External barriers to returning to work include restrictive health insurance plans that prevent the patient from receiving necessary treatment; mental health professionals who do not refer the client to a clinician who is better suited to treat the patient; and mental health professionals who are unable to arrange timely follow-up appointments with the patient. Although external barriers to returning to work may exist, the patient who is motivated to address and overcome them is in a better position to have a successful transition to the workplace.

In the case example, Larry's identified barriers to resuming work are insomnia and daytime drowsiness. It is unsafe for him to drive to work or to industrial sites to supervise his team. He will likely be unable to work 12 hour shifts effectively or to be on call from home due to decreased mental acuity that may result in poor decision making. Larry always has taken "power naps" during breaks to replenish his energy and concentration, but these are no longer effective. He and Dr. Gee will discuss compromise and recommended accommodations during their next meeting.

Concessions/Compromise

A well-designed return-to-work plan fosters gradual reintegration of a patient into the work setting. The plan is dynamic because the patient's work capacity may change as their health improves. Clinicians should have an understanding of patients' barriers to working at 100 % of their previous capacity. If no barriers exist, then no work restrictions are needed. If the patient is unable to resume working at a 100 % benchmark, then a return-to-work plan that contains concessions or work modifications/reasonable accommodations should be crafted to address the identified barriers to working at full capacity, including work "deconditioning" or desensitization. These recommendations should be informed by the patient's impairments and should be designed with the goal of eventually reaching 100 % work capacity. Even if patients ultimately fall short of that goal, attempts should be made to reach full prior work capacity before clinicians, patients, or employers assume that it is not possible.

When an accommodation that seems reasonable from the mental health professional's perspective is not available, then the clinician should attempt to restate or reframe the recommended intervention so that the employer may identify an alternative work modification. In some cases, the clinician, with the patient's consent, may be able to work directly with the employer to achieve this goal.

In the case example, Larry and Dr. Gee have decided that Larry will be able to return to work if he has a modified work schedule. He will need to work reduced hours with no on-call commitments. This will permit Dr. Gee to work with Larry to improve his sleep hygiene and will afford him sufficient time to obtain rest so that he may be safe and focused when he is at work. The modified work schedule will afford Larry time to meet with Dr. Gee twice weekly for medication monitoring and therapy. Larry will meet with his supervisor every other week to review Larry's progress and barriers to achieving his goals and advancing his work schedule.

Formulating the Return-to-Work Plan

When the assessment of workplace expectations, barriers to working, and potential reasonable accommodations (modified schedule, light duty, transitional work) have been identified, the clinician is ready to collaborate with the patient to formulate a return-to-work proposal for the patient to implement or to be submitted to the referral source or employer. Informal return-to-work evaluations conducted by the treating clinician should include a discussion of the assessment and recommendations with the patient who wants to resume working. Treating clinicians who conduct formal return-to-work assessments, that is FFD evaluations, should consider reviewing findings with the patient, although this again raises potential "dual role" ethical conflicts. As noted above, when such conflicts arise, a referral for a FFD evaluation by an independent mental health evaluator may be indicated.

A non-treating clinician who conducts an independent return-to-work or FFD evaluation does not have to review the findings with the evaluee (see Chap. 12).

Also, as discussed above, at times the opinions of clinicians and their patients regarding their readiness to return to work may differ. Informal return-to-work evaluations conducted by the treating clinician should include a discussion of the assessment and recommendations with the patient who wants to resume working. Patients may believe that the clinician has proposed too many or too few accommodations. Or, patients may believe that they are not capable of returning to work when clinicians feel that patients may resume working.

Clinicians may wish to review the conclusions and recommendations and make adjustments if they are clinically warranted and appropriate. However, clinicians should not modify the recommendations simply to acquiesce to the patient's wishes, especially if the clinician believes the desired changes are not in the best interests of the patient's mental health. In addition, there may be adverse short- and/or long-term professional consequences for the clinician who engages in behavior that does not meet the standard of care (see Chap. 2).

Patients may also be at risk for undesirable penalties if they or their clinicians misrepresent capacities to return to work. This is especially true if the clinician knows that a patient is not sufficiently stable to return to work due to a serious mental disorder, but certifies work readiness to the employer. In the most serious cases, patients may present a danger to themselves and others. Employment consequences can ultimately include loss of the job.

In these cases, the treating clinician's best course of action is to review the materials and supporting documents when available to assure a sound conclusion has been rendered. If the patient still disagrees with the clinician's assessment, then he or she may request a second opinion from a different mental health professional or can be referred for a FFD evaluation. If patients request a copy of their records, the documents should be provided in a timely manner, in accordance with the provisions of the HIPAA (Gold and Metzner 2006).

Documentation

When patients are ready to return to work, employers may request documentation about the patient's preparedness to resume working. The clinician should work with the patient to develop a return-to-work report that contains the minimal necessary information. The documentation should be sufficiently detailed to satisfy the employer's legitimate concerns, but should not include excessive or unnecessary information, such as personal issues reviewed in therapy, embarrassing symptoms, the fact that the patient dislikes his or her supervisor, and/or a copy of the medical record.

The written communication from clinicians to the employers should provide information that is related to the job and is a business necessity, according to the Equal Employment Opportunity Commission (EEOC), so that the employer will

know what is needed to help the patient safely return to the workplace. The report should provide concise information about impairments and/or diagnosis, and the type of modifications or accommodations that may assist the transition or return to work (EEOC Reasonable Accommodation and Undue Hardship 2002).

A patient whose return-to-work report consists of a one-sentence statement on a prescription pad, such as, "Mr. Jones may return to work on March 15, 2013," typically has not provided sufficient information to the employer, especially when the employer is aware of the patient/employee's history of mental health issues. The patient may have engaged in aggressive or inappropriate behavior in the workplace, or expressed suicidal ideation to coworkers or supervisors. The employer may have legitimate concerns regarding the patient's ability to return to work safely and without disrupting the workplace. Inadequate documentation does not serve the patient's best interests. Employers will almost certainly request additional information or an independent FFD evaluation, and are entitled to such information prior to offering accommodations (EEOC Reasonable Accommodation and Undue Hardship 2002). This can delay the return to work and potentially subject patients to additional emotional and/or financial stress.

The return-to-work report submitted by the treating clinician to the employer or insurance company may recommend periodic re-evaluation of the need for accommodations so that, when possible, patients may work toward resuming their previous work duties at full capacity. Ideally, reviews should be conducted by the patient's supervisor and human resources personnel as well as by a mental health professional to assure that advancements in duties are appropriate and conducive to a safe and productive work environment for the patient and others.

In the case example, Larry's employer reviews and accepts the recommended workplace accommodations, but adds one additional modification: Larry must attend a briefing session each morning to make sure he remains on track with reporting and documentation and that he understands the daily agenda for his department.

Next Steps

When the employer and patient agree on accommodations, they should determine when the patient will return to work. The return-to-work report submitted by the treating clinician to the employer or insurance company may recommend periodic re-evaluation of the need for accommodations. When possible, the clinician and patient should establish a monitoring plan to assure that the patient's progress is tracked. The plan should outline parameters for monitoring the patient's functioning on the job and should help the patient determine when it is appropriate for them to negotiate increased or decreased accommodations in the workplace. Mental disorders are often dynamic and may improve or worsen over time. The patient and clinician should be proactive rather than reactive when crafting work-related interventions for the patient.

In the case example, Larry has returned to work with the agreed upon modifications. He continues to meet with Dr. Gee and is compliant with medication. He has been making steady progress toward returning to full-time employment.

Conclusion

When a clinician uses a systematic approach to assess a patient's capacity to work or to continue working, the task becomes less onerous and increases the potential for the patient to be successful in remaining or returning to the workplace. The ABCs of assessing return to work include: Assessment, a detailed examination of changes in status that are conducive to the patient returning to work; an analysis of Barriers to employment, and a Compromise approach to formulating a return-to-work plan that fosters crafting formal or informal workplace modifications or accommodations that can preserve or support workplace functioning.

Key Points

1. When a mental disorder causes a patient to have impaired work functioning, a modified work schedule, or withdrawal from the workplace should be explored with the patient.
2. A return-to-work plan should be implemented, as soon as the topic of withdrawing from the workplace is presented, to facilitate the patient's return to work, and to avoid the consequences of prolonged or permanent disability.
3. There are informal and formal approaches to implementing work modifications. Informal methods may afford the patient greater privacy. Formal approaches afford patients greater protection.
4. A work readiness determination involves three steps: Assessment including changes that are conducive to resuming work, identification of Barriers, and Compromise.
5. Work readiness documentation should contain the minimum amount of information that is necessary for the situation.

Appendix I

The Family Medical Leave Act Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act) [edited to indicate instructions and requested information and current as of 5/1/12]

Section I: For Completion by the EMPLOYER
INSTRUCTIONS to the EMPLOYER:

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

Section II: For Completion by the EMPLOYEE
INSTRUCTIONS to the EMPLOYEE

Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

Section III: For Completion by the HEALTH CARE PROVIDER INSTRUCTIONS to the HEALTH CARE PROVIDER

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address:
_____

Type of practice / Medical specialty:
_____

Telephone: (_____)_____
Fax:(_____)_____

Part A: Medical Facts

1. Approximate date condition commenced: _____

Probable duration of condition _____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No Yes. ___If so, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No Yes____. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. Is the employee unable to perform any of his/her job functions due to the condition:
____ No ____ Yes. If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Part B: Amount of Leave Needed

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No Yes. ___If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.
If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No Yes____.

Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No Yes____ . If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days): Frequency: ____ times per ____ week(s) month(s) ____

Duration: _____ hours or ___ day(s) per episode

Signature of Health Care Provider Date

References

American Academy of Psychiatry and the Law. Ethics Guidelines for the Practice of Forensic Psychiatry. http://www.aapl.org/ethics.htm (2005). Accessed 15 Oct 2011

American Psychiatric Association: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (Text Revision). American Psychiatric Association, Washington, DC (2000)

American Psychiatric Association: Psychiatrists' responses to requests for psychiatric information in federal personnel investigations: Resource document. http://www.psych.org/rd2006federal (2006). Accessed 23 Nov 2011

Equal Opportunity Employment Commission. Appendix to Part 1630—Interpretive Guidance on Title I of the Americans with Disabilities Act: 29 C.F.R. App. § 1630.3(o). http://www.eeoc.gov/policy/docs/902cm.html (2000). Accessed 15 Nov 2011

Equal Employment Opportunity Commission. Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities (2002). http://www.eeoc/gov/policy/docs/psych.html (2000). Accessed 31 Oct 2011

Equal Employment Opportunity Commission. Enforcement Guidance: Reasonable Accommodation and Undue Hardship under the Americans with Disabilities Act: http://www.eeoc.gov/policy/docs/accommodation.html (2002). Accessed 29 Oct 2012

Family Medical Leave Act: 29 U.S.C. § 825. http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=f821330e628d662ec14048d565d14cf6&rgn=div5&view=text&node=29:3.1.1.3.53&idno=29#29:3.1.1.3.53.1.477.1. Accessed 31 Dec 2011

Gold, L.H., Metzner, J.L.: Psychiatric employment evaluations and the Health Insurance Portability and Accountability Act. Am. J. Psychiatry **163**(11), 1878–1882 (2006)

Haire, T.: Financial problems or PTSD need not affect security clearance. http://www.army.mil/article/24053/financial-problems-or-ptsd-need-not-affect-security-clearance/. Accessed 4 Nov 2009, 8 July 2009

Henderson, W.: DOHA: Top reasons for security clearance denial in 2008. Clearancejobs.com, 1 Oct 2009. http://www.clearancejobs.com/cleared-news/65/doha-top-reasons-for-security-clearance-denial-in-2008. Accessed 4 Nov 2012

Henderson, W.: Mental health and final security clearances, 3/19/10, Clearancejobs.com. http://www.clearancejobs.com/cleared-news/126/mental-health-and-final-security-clearances. Accessed 4 Nov 2012

Mattaliano, R.: Beyond the ad hoc approach: Putting a return to work program "on the books". Prof. Case Manag. **13**, 290–292 (2008)

Randolph, D.C., Ranavaya, M.I. (eds.): Risk and disability evaluations in the work place. In: Occupational Medicine: State of the Art Reviews, vol. 15(4). Hanley and Belfus, Philadelphia (2000)

United States Department of State: Adjudicative Guidelines for Determining Eligibility for Access to Classified Information. http://www.state.gov/m/ds/clearances/60321.htm#i. Accessed 4 Nov 2012

Chapter 5
Psychological Testing in Workplace Disability Evaluations

William J. Stejskal

Introduction

In conducting workplace disability evaluations, the mental health evaluator is asked to determine the nature, severity, and functional consequences of the claimed disorder and its functional *impairments*, and to evaluate the manner in which these impairments affect the evaluee's capacity to work. Capacity to work can be understood as the balance between work supply (an individual's functional capacities) and work demand (the demands or requirements of the job). When an individual's functional capacities are impaired such that they no longer meet or exceed work demand, the individual is *disabled* (Gold and Shuman 2009). Psychological testing has the potential to contribute to the disability evaluation process by providing the evaluating psychologist or psychiatrist an additional domain of incremental and objective information about an evaluee's functional capacities. This chapter will address the relevance, applications, and limitations of psychological testing in workplace disability evaluations.

Case Example

Recognizing that many types of forensic mental health assessments are conducted collaboratively by psychiatrists and psychologists, the following case example is offered both to illustrate the relevance of psychological testing in workplace disability evaluations, and to provide a model for effective professional collaboration.

W. J. Stejskal (✉)
Curry Programs in Clinical and School Psychology, University of Virginia,
Woodbridge Psychological Associates, PC, 4320 Pr. Williams Parkway, Suite 109,
Woodbridge, VA 22192, USA
e-mail: wstejskal@mac.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_5,

Veronica, a divorced 46-year-old woman has worked for 27 years in the Human Resources department of a large energy and petrochemicals company. She was consistently promoted over the course of her employment, and 18 months previously, had been promoted to a management position. Her new work duties included higher level planning, directing, training, and supervision. Veronica's first several weeks went smoothly until Veronica learned that she would have to take 2 weeks of sick leave to undergo podiatric surgery.

Veronica's mobility was severely restricted for several weeks as she recovered. Persistent post-surgical pain necessitated the initiation of narcotic analgesic medication on an almost daily basis. Veronica became less active, more isolated, and was in constant pain. She took additional sick leave from her job, often on short notice if she was "having a bad pain day."

Veronica became increasingly depressed as her mobility and pain issues persisted. Her attention and her ability to integrate information were inconsistent. She lost track of deadlines and projects, and became confused and unfocused in meetings. Veronica began to have "spells" at home and at work when her heart suddenly began racing and she felt like she could not get enough air. She began to "hide" in her office, isolating herself from coworkers, subordinates, and her clients (the managers/supervisors) in the organization. Veronica felt unfairly criticized when managers began to complain about her performance.

Worsening insomnia prompted Veronica to consult her primary care provider, who diagnosed depression. Veronica reluctantly initiated treatment with antidepressant medication and cognitive behavioral therapy. Because she had exhausted all of her accumulated sick leave in the months following her foot surgeries, Veronica filed a disability claim at her workplace.

After reviewing Veronica's claim, the disability insurance carrier engaged a psychiatrist to conduct an Independent Medical Examination (IME) to evaluate her condition. After conducting a clinical interview with the evaluee, and reviewing relevant employment and treatment records, the psychiatrist consulted with a psychologist colleague to determine whether psychological testing could assist in her analysis of the clinical findings, and in the development of a clearer case formulation.

Workplace Disability Evaluations

Gold and Shuman (2009) and others (Piechowski 2011; Vore 2007) provide detailed information about disability determination processes, and review the extensive case law and regulatory history pertaining to disability determinations under the Social Security Disability Insurance (SSDI) program, and under disability insurance policies that are privately purchased or obtained through one's employment. In general, individuals submitting a disability claim are determined to be *disabled* and therefore eligible to receive disability benefits only if they can demonstrate to the responsible agency or insurance carrier (1) that they have a

sickness, injury, or condition that causes functional *impairments*, and (2) that these impairments limit their work capacity to such an extent that they are unable to perform their work duties/functions.

The scope of the IME in cases of claimed mental illness-related workplace disability requires more than simply conducting a diagnostic evaluation of the claimant evaluee. The mere presence of a mental disorder identified in the *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition*, *Text Revision* (DSM-IV) (American Psychiatric Association 2000) is not sufficient to conclude that the evaluee's work capacity is so diminished that they are disabled (Foote and Jackson 2008; Piechowski 2011). The mental health professional must additionally determine the nature, extent, and severity of the evaluee's functional impairments, determine whether they are due to the claimed disorder, and evaluate the impact of these impairments on the evaluee's capacity to meet the demands of the job. Psychological and neuropsychological testing can provide an additional source of objective data regarding an evaluee's psychological status and cognitive abilities as they pertain to claimed impairments and disability.

Psychological Testing in Disability Evaluations

In conducting workplace disability evaluations, the mental health professional seeks to contribute to the claim adjudication process by providing relevant and objective information regarding the evaluee's *current* work capacity (Piechowski 2011). Evaluations of workplace disability, therefore, pertain primarily to an evaluee's present condition and circumstances. The objectivity, accuracy, and validity of these mental health assessments are enhanced when evaluation procedures are multimodal, and when they involve the evaluation of data from multiple sources (Greenberg et al. 2003; Heilbrun et al. 2002, 2003; Melton et al. 2007). Typical sources include direct interview/observation of the subject, evaluation of records, interview of collateral sources, and, in some instances, the administration of psychological testing.

Whether in evaluations undertaken in treatment or non-treatment (e.g., forensic evaluations) settings, evaluators exercise discretion and judgment in their selection of assessment procedures on a case-by-case basis, even at the level of deciding whether it is necessary and appropriate to use psychological testing at all. Some diagnostic questions, and some psycholegal issues that might be in dispute, are not amenable to the use of testing. In determining whether psychological testing should be included as potential data source in any type of mental health assessment, including workplace disability evaluations, mental health professionals must consider a number of factors, for example:

- *What are the psychological factors that are relevant to the diagnostic and/or psycholegal questions, and are they amenable to being evaluated by testing*?
- *How directly can the relevant psychological factor be assessed by testing*?

- *Are relevant tests available, and are they sufficiently robust to justify their use in an evaluation that might become adversarial and require their use as evidence in a legal proceeding*?
- *Do the risks/costs of testing outweigh their potential incremental value*?
- *Are there alternative assessment procedures that would provide a more direct way of evaluating the factors in question*?

There are no specialized psychological assessment instruments (Heilbrun et al. 2002) that directly assess work capacity. Even if such instruments existed, it would remain the case that no psychological test score, or profile of scores could ever be dispositive on any psycholegal issue, including the issues that need to be evaluated in workplace disability cases. Instead, psychologists have available to them a number of clinical assessment instruments and forensically relevant instruments (Heilbrun et al. 2002) that are well suited to such cases. These instruments can provide mental health evaluators with incremental data that allows them to efficiently generate and evaluate competing hypotheses regarding the evaluee's current psychological "condition and functional capacities, and the nexus between these and the demands of the evaluee's job" (Piechowski 2011).

Ethical Considerations and Standards of Practice

With respect to the selection and use of assessment techniques, the revised *Specialty Guidelines for Forensic Psychology* (*SGFP*; *Specialty Guidelines*), recently adopted by the American Psychological Association (APA) (American Psychological Association 2011), incorporate the standards of professional practice articulated in the American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* (2002). Forensic psychologists, like their colleagues in other specialty areas of psychology, use assessment procedures in a manner and for the purposes that are appropriate in light of the research on or evidence of their usefulness and proper application. Recognizing that the use of non-standardized, invalidated, or idiosyncratic tests can spawn spurious results and inaccurate inferences, psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation. Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues (*SGFP* Guideline 10.02; *EPPCC* Standard 9.02).

Psychologists should only administer and interpret tests that are within the boundaries of their competence (Standard 2.01, American Psychological Association, 2002). The *Specialty Guidelines* advise psychologists to consider, among other things, whether they have the competence, the relevant training, and the experience necessary to provide services in a particular matter (Guideline 2.01, American Psychological

Association 2011). Psychologists do not promote the use of psychological assessment techniques by individuals who have not had sufficient appropriate training and supervised experienced in the development, administration, scoring, and interpretation of psychological tests (*EPPCC* Standard 9.07).

In conducting workplace disability evaluations, psychologists should select only those psychological tests that have demonstrated their relevance to the issue, or to a psychological construct underlying the issue, in research published in peer-reviewed journals (Heilbrun 1992). When selecting, administering, and interpreting psychological testing, psychologists recognize that the applicability of a test's results will vary according to the degree of correspondence between the characteristics of the examinee and those of the population that was used in the validation research. It would be inappropriate, for example, to administer the English language version of an intelligence test that was normed on an adult sample from the United States (such as the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV)) to a minimally educated recent immigrant from a non-English speaking South Asian nation, since the test results would offer a misleading impression of their abilities. Similarly, it would be inappropriate to administer a personality test that was normed on a sample of personality disordered and mentally ill adults (such as the Millon Clinical Multiaxial Inventory, 3rd edition (MCMI-III)) to an individual who is not in mental health treatment, or demonstrably in need of such treatment, since the results of such testing could tend to create an inaccurate impression regarding the presence of mental illness or personality disorder.

The results of a test should not be applied toward a purpose for which the test was not developed. Following the publication of any psychological test, subsequent research will often describe clinical correlates associated with specific populations that may not have been contemplated or described by the test's original developers. For example, certain patterns of performance on tests such as the *WAIS* may be shown to differentiate adults with High Functioning Autism from adults with Asperger's Syndrome (Kanai et al. 2012). Patterns of responding on the *RIM* (Rorschach Inkblot Method) may be shown to differentiate adults with Borderline Personality Disorder from adults with various Axis I disorders (Zodan et al. 2009). While evolving scientific research such as this certainly broadens our understanding and our theories respecting the nature of psychopathology, findings from such research do not justify the use of specific test results to supplant established diagnostic criteria (e.g., the DSM-IV 2000). Considering the above examples, patterns of performance on the *WAIS* should not be relied upon as the basis for diagnosing Asperger's Syndrome, and patterns of performance on the *RIM* should not be the basis for diagnosing Borderline Personality Disorder.

The individualized selection and interpretation of psychological testing requires a level of specialized expertise sufficient to permit the exercise of informed judgment about the applicability of the broad range of possible clinical correlates to the case at hand. Any test score, and any profile of multiple scores, can be associated with and influenced by a broad array of potential factors, some of which have valid clinical relevance, and others that are merely spurious. Among the higher order skills in the process of psychological assessment is the ability of the

psychologist to evaluate this "signal versus noise" aspect of psychological testing, in other words, the ability to recognize when a test result is inaccurate, or when a proposed interpretive hypothesis is not applicable. Because of this, the uncritical or uninformed adoption of generic "cookbook" interpretations of test results is never an appropriate use of psychological testing.

When interpreting the results of personality testing, evaluators appropriately make use of resources such as automated, computer-based interpretative narratives in combination with other data sources when they generate and evaluate hypotheses about a subject's psychological disorder or personality (Melton et al. 2007; Weiner and Greene 2008). However, psychologists and psychiatrists should bear in mind that computer-based test interpretations (CBTI) do not represent an individualized description of the subject, but instead represent a broadly inclusive and rather generic aggregation of clinical correlates that have been associated (sometimes empirically, and sometimes not) with similar scores or profiles in various normative or reference groups (Rogers 2003). Some of these correlates may apply to the evaluee, and others may not.

Psychologists and psychiatrists conducting workplace disability evaluations should never assume that computer-based interpretive narratives, or the diagnoses that these narrative often propose, are fully accurate characterizations of an evaluee's psychological status or personality. Instead, evaluators should always exercise discernment about which test results, and which portions of CBTI narratives, are accurate, partially accurate, or erroneous as they pertain to a particular evaluee (EPPCC Standard 9.06; American Psychological Association 2002; Lichtenberger 2006). (Psychologists familiar with processes of test development and validation have a clear advantage in this regard compared with most other mental health professionals.) The narratives generated by CBTI should never be adopted as the basis for an evaluator's formulation or opinion in an uncritical or psychometrically uninformed manner. Such narratives should never be incorporated into an evaluator's written report (Butcher et al. 2004; Garb 2000) without attribution.

The Relevance of Response Style

Response style refers to the manner in which individuals are inclined to represent their symptoms and/or demonstrate their functional capabilities during a clinical or evaluative encounter. Subject's response styles can influence their presentation during interviews, their accounts of past and present functioning, their attribution of causation for past and present difficulties, and their performance on psychological tests. While some subjects' response styles are largely honest and relatively unbiased, other subjects can consciously or unconsciously adopt response styles that tend to convey a distorted picture of their actual condition or psychological status.

Response styles relevant to mental health assessments of workplace disability can be broadly categorized as reflecting degrees of either *symptom/impairment*

exaggeration or *simulated adjustment* (Rogers 2008a). In their self-report, their non-verbal behavior, and their responses on psychological tests that assess psychopathology, subjects can variously minimize, emphasize, deny, exaggerate, suppress, or feign symptoms and other factors relevant to *psychopathology*. Occasionally, there will be evidence of both symptom exaggeration and defensiveness during the same encounter.

On tests of cognitive or neuropsychological functioning, subjects can modulate their effort, as well as the accuracy of their responses, to create unrealistic and misleading impressions regarding the presence and severity of *cognitive deficits*. While the interpersonal prompting, task structure, and optimal environmental conditions inherent in most cognitive testing situations can sometimes produce test results that fail to reflect the presence of genuine impairments (Bennett and Raymond 2010), subjects cannot "fake good" on cognitive or neuropsychological testing.

Response Styles in Workplace Disability Evaluations

In workplace disability evaluations, the preponderance of potential incentives, whether extrinsic (e.g., disability benefits, avoiding responsibilities, avoiding a stressful or toxic workplace) or intrinsic (e.g., justifying feelings of anger and entitlement, maintaining one's identification as "sick" or a "victim"), are such that evaluators should be proactive in evaluating *symptom validity*, that is, the degree to which an evaluee's self-report and test performance have been distorted by *symptom/deficit exaggeration* (Bush et al. 2005; Foote and Jackson 2008; Samuel and Mittenberg 2005). When psychological testing is administered as part of a workplace disability evaluation, the interpretation of an evaluee's test performance, including the psychologist's decisions to credit, qualify, or discount the validity of any portion of the test results, should be guided by an explicit assessment of response style (Melton et al. 2007).

Rogers and Payne (2006) have pointed out that evaluees can feign a mental disorder by amplifying their reports or depictions of genuine but subsyndromal symptoms that they are currently experiencing. They can marshal their recollections of past episodes of illness to misrepresent their current experience. Alternately, evaluees will sometimes manufacture and endorse utterly false symptoms of psychopathology, misrepresenting their course, intensity, and effects on their daily life, all while relying on their own idiosyncratic conceptions of mental illness, or on widely available information about mental illness. They can feign cognitive deficits simply by slowing their responses, or "while appearing invested in succeeding … merely report incorrect responses on test items that measure cognitive abilities" (Rogers and Payne 2006, p. 650).

It is essential to bear in mind that responses styles, including tendencies to overstate psychopathology or underperform on cognitive measures, are neither traits nor binary, all-or-nothing phenomena (Otto 2008; Tellegen and Ben-Porath 2008). Instead, response styles typically operate inconsistently along a continuum

of intensity, influencing test results, self-report, and other behaviors to varying degrees, from one encounter to the next, and even across different tests/measures within the same encounter.

While evaluees' presentations can sometimes reflect the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" (American Psychiatric Association 2000, p. 739), *malingering* (see Chap. 6) does not occur with a majority of workplace disability evaluees (Mittenberg et al. 2002; Rogers 2008a). While atypical findings suggestive of exaggeration are commonplace in forensic mental health assessments generally, and in workplace disability evaluations specifically (Mittenberg et al. 2002), it would be simplistic and naive for evaluators to conclude that any evidence of exaggeration is necessarily evidence of malingering (Rogers 2008b). Evaluees may, because of personality factors, situational dynamics, factors related to a transient mental state, or the consequences of social learning, present themselves in ways that dramatize, emphasize, or make selectively salient, aspects of their subjective experience that others would perceive as overly negative, or exaggerated (Iverson 2010; Morey and Hopwood 2006; Otto 2008). In these instances, the exaggeration, while goal directed, is not motivated by external incentives *per se*, and may not be intentionally (that is, consciously and deliberately) produced. Ascribing a diagnosis of malingering in such instances is inappropriate and inaccurate, and has the potential to deny benefits and relief to evaluees with legitimate disabilities.

Incorporating Testing in a Disability Evaluation

In the case example provided above, the evaluating psychiatrist consulted a psychologist colleague because she felt that psychological testing could provide data that would be helpful in the disability assessment. The most effective approach in such a collaboration is to identify and discuss the questions that the referring mental health professional hopes can be addressed by testing.

In the case of Veronica, the evaluating psychiatrist felt that some aspects of her presentation and history were consistent with depression, but wondered about the possibility of a personality disorder, exaggeration of complaints, possible paranoia, and cognitive changes due to factors other than mood disorder. She therefore posed the following questions to the psychologist:

1. Could testing clarify the presence and severity of Veronica's depression, and the degree to which exaggeration might be coloring her report/presentation?
2. Can testing shed light on whether "Cluster B" traits or characteristics are present?
3. Are the Minnesota Multiphasic Personality Inventory (MMPI) and the *MCMI* (Millon Clinical Multiaxial Inventory) good tests to obtain in a case like this?

4. Can testing provide a better understanding of the authenticity, severity, and likely cause of the cognitive changes that Veronica reports? What test would best assess cognitive functioning in this case?
5. Is there a standard battery of psychological testing that should be obtained?

In the discussion that ensued, the psychologist indicated that psychological testing could indeed provide potentially useful incremental data about the areas of concern to the psychiatrist, but that there really was no such thing as a "standard battery." He explained that psychologists typically administered individualized batteries of tests, with test selection determined by the psychologist based on case-specific factors.

The psychologist went on to elicit additional information from the psychiatrist about the evaluee's trauma history, medical status, history of neurological insult, substance abuse, etc., explaining that this information, along with other information about the evaluee and her presenting complaints, would enable him to select an appropriate set of tests that could assess the domains of psychopathology and cognitive functioning that were relevant to the psychiatrist's concerns. By the conclusion of the discussion, having clarified the referral questions and the appropriateness of testing, the psychiatrist decided to recommend to the insurance carrier that the psychologist be engaged to conduct psychological testing to assist her evaluation.

Assessing Psychopathology

To develop accurate formulations regarding an evaluee's condition and impairments, mental health clinicians should rely on multiple sources of information, including observation and self-report obtained during interview, medical, and mental health treatment records, employment records, and interviews with collateral sources (Gold and Shuman 2009). Psychological testing can assist the evaluator by providing additional objective information about the presence of psychopathology. In addition, testing can provide a means of determining what weight to assign to the information obtained during the course of the evaluation, based on a proactive consideration of response style.

Serious and persistent mental illnesses, such as schizophrenia, are typically quite disabling across multiple domains of functioning. However, because early onset, chronic psychotic disorders, and severe developmental disorders tend to be a barrier to competitive employment (Bonnie 1997), workplace disability evaluations do not typically involve considerations of impairments due to these conditions. Instead, as Veronica's case illustrates, IMEs are more likely to be requested to evaluate claimed impairments associated with mood disorders, such as major depression, and anxiety disorders, such as post-traumatic stress disorder (PTSD), either in isolation, and in comorbid presentations that may include substance use disorders.

Like other mental disorders, mood disorders and anxiety disorders encompass a broad range of potential presentations, with admixtures of both highly obvious (e.g., frequent tearfulness, irritability, panic attacks, insomnia, hypomania, suicidality) and subtle (e.g., poor concentration, diminished cognitive flexibility, diminished working memory) features. Psychological testing provides a means of evaluating many of these features, as well as the personality factors and response styles that can mediate their expression.

Multiscale Inventories

Multiscale inventories such as the *Minnesota Multiphasic Personality Inventory, Second Edition* (MMPI-2; Butcher et al. 2001) and the *Personality Assessment Inventory* (PAI, Morey 1991) can provide useful information about the evaluee's current psychological status and personality, as well as their response style, and would be appropriate to use in cases such as Veronica's. Originally developed for use in clinical treatment settings, both tests have been subjected to considerable research in non-treatment contexts (Ackerman 2010; Morey et al. 2007; Pope et al. 2006), and are in wide use among forensic psychologists (Archer et al. 2006; Edens et al. 2001; Lally 2003).

The *MMPI*-2 and *PAI* yield scores on multiple clinical scales that pertain to domains of symptomatology, psychopathology, and internal experience that are likely to be relevant to evaluees' reported symptoms. Both tests also have the potential to provide information about the presence of syndromal features or comorbidity that evaluees may not recognize or wish to acknowledge. Both instruments also include several validity scales that allow the psychologist to evaluate whether or not the evaluee was exaggerating, defensive, or inconsistent in their presentations (Greene 2000; Rogers 2003).

The *MMPI*-2 consists of 567 true–false questions that comprise multiple scales of clinical and interpretive relevance. The scales of the *MMPI*-2 are considered *overlapping* scales, in that they share many test items in common. It is written at a sixth-grade reading level, and can be administered in one of several standardized forms, including an audio recorded version. The ten primary clinical scales bear anachronistic names that harken to the middle of the last century when the *MMPI* was first developed (e.g., the Hysteria scale). (These scale names can be misleading to those not familiar with the manner in which the *MMPI*-2 is used and interpreted in the modern era.) Elevations on each scale reflect the degree to which the evaluee has endorsed items that pertain to that scale's domain, relative to each test's normative reference sample.

The *MMPI*-2 also yields over two dozen Content and Supplementary scales that pertain to a variety of clinical issues that might be endorsed (e.g., Somatic Complaints, Hypomanic Activation, and Bizarre Mentation). Recently developed refinements of the *MMPI*-2 include the *Personality Psychopathology Five Scales* (PSY-5; Harkness et al. 1995) and measure five-dimensional personality constructs

(e.g., Psychoticism and Positive Emotionality). Other refinements include the nine non-overlapping *Restructured Clinical Scales* that provide a more focused assessment of dimensions of psychopathology associated with the original clinical scales (Tellegen et al. 2003). Importantly, the *MMPI*-2 also includes over a dozen validity scales that provide the psychologist with a means of evaluating the degree to which evaluees may have been exaggerating, minimizing/defensive, uncomprehending, or inconsistent when they completed the *MMPI*-2.

Like the *MMPI*-2, the *PAI* consists of items that comprise multiple scales that pertain to dimensions of psychopathology and test validity. Because it is shorter than the *MMPI*-2 (344 vs. 567) and its items are written at a fourth-grade reading level, the *PAI* is a somewhat more practicable measure across the ranges of assessment settings and test-taking populations (Edens et al. 2001; Rogers 2003). The *PAI* offers four response options, *False*, *Slightly True*, *Mainly True*, and *Very True*; test takers are less constrained in conveying their nuanced responses to the items, compared to tests such as the *MMPI*-2 that use a *True–False* format. Most importantly, the *PAI* comprises non-overlapping scales with strong internal consistency, and, compared to the *MMPI*-2, provides a clearer association with the domains of clinical and functional impairment associated with many mental disorders in the DSM-IV (Morey 1991).

The *Millon Clinical Multiaxial Inventory*, *Third Edition* (MCMI-III; Millon 1994) is another multiscale inventory in wide use among psychologists in treatment settings but in relatively limited use among psychologists conducting testing for non-treatment purposes (Archer 2006; Lally 2003). The *MCMI-III* consists of 175 items that yield heavily overlapping scales that pertain to aspects of personality functioning and clinical status. The *MCMI-III* has been criticized as a measure unsuitable for use in non-treatment evaluations because of limited construct validity (i.e., limited diagnostic accuracy; Rogers 2003; Rogers et al. 1999, 2000). Psychologists considering using the *MCMI-III* have also been cautioned about problems differentiating among patterns of personality pathology (Rossi et al. 2003), a tendency to overdiagnose psychopathology (Widiger 2001) and an inability to detect threats to test validity such as random responding (Charter and Lopez 2002) and exaggeration (Morgan et al. 2002).

Even among those who support the use of the *MCMI-III* in non-treatment settings such as disability evaluations, there is an acknowledgment of the test's limited research base with forensic populations, its limited applicability with civilian trauma victims, and lingering questions about the tendency of the *MCMI-III* to overpathologize personality functioning (Craig 2006). Considered in the aggregate, these issues suggest that psychologists should be cautious in using the *MCMI-III* in workplace disability evaluations. In cases where there are diagnostic concerns about personality dysfunction/disorder, other sources of data, such as interviews with collateral sources, and other tests, such as the *MMPI*-2 and the *PAI* have greater utility than the *MCMI-III* in evaluating alternative hypotheses regarding diagnosis and patterns of impairment.

The *Trauma Symptom Inventory* (TSI; Briere 1995) is a 100-item specialized measure in wide use among clinicians evaluating trauma victims in treatment

settings. Its overlapping scales provide information about domains of impairment associated with acute, chronic, and complex forms of PTSD. Because the *TSI's Atypical Response* scale (ATR) was developed to serve as a general validity screen, and not as an exaggeration/malingering screen, research has failed to demonstrate the TSI's ability to detect response styles most relevant to workplace disability evaluations (Arbisi et al. 2010; Rosen et al. 2006). In workplace disability evaluations that require consideration of trauma-related symptoms, use of the *TSI* should be combined with more robust measures of response style.

Other Measures of Psychopathology

Other clinical measures, such as the *Beck Depression Inventory* (Beck 1996) and the *Symptom Checklist*-90-*Revised* (Derogatis 1994) have utility in their capacity to elicit self-reported symptoms in a concise and structured format, even in the context of workplace disability evaluations. However, because the items on measures such as these explicitly and transparently correspond with relevant symptoms (i.e., high face validity), and because they do not incorporate any means of assessing the effects of response style on the validity of results, the value that they can bring to the process of opinion formation in workplace disability evaluations is limited.

While psychologists continue to utilize projective measures such as the *Rorschach Inkblot Method* (*RIM*) in treatment settings (Musewicz et al. 2009), the use of the *RIM* in non-treatment or forensic settings has been less robust (Archer et al. 2006; Lally 2003). In addition, use of the *RIM* in non-treatment or forensic settings has been controversial, with critics raising concerns ranging from the inconsistent application of prevailing scoring system (i.e., The Comprehensive System; Exner Jr 2003) to insufficient test validation (e.g., Wood et al. 2001). Proponents support its limited use to elucidate personality characteristics that may be pertinent to the legal issues that are in dispute (Weiner 2006).

Recent suggestions that the *RIM*, described as a performance-based personality test (Weiner and Hess 2006), may have some utility in workplace forensic evaluations are intriguing (Smith et al. 2008). There is some support for suggestions that the *RIM* can provide useful data regarding aspects of self-regulation, reality testing, and information processing that are relevant to workplace functioning (e.g., Hartmann and Grønnerød 2009). However, the inability of projective measures to detect the influence of relevant response styles limits their utility in non-treatment contexts (Piechowski 2011; Rogers 2008b; Sewell and Rogers 2008). Psychologists who feel that administering the *RIM* in workplace disability evaluations would yield some relevant and useful information should always apply the Comprehensive System of scoring (Exner Jr 2003), and should incorporate robust measures of response style to augment the deficiencies of the *RIM* in this regard.

Assessing Cognitive Deficits

Workplace disability evaluations are rarely requested in cases involving moderate to severe central nervous system (CNS) insults or dysfunction. When individuals survive episodes of prolonged anoxia, moderate to severe traumatic brain injury (TBI), or hemorrhagic stroke, the resulting cognitive deficits in working memory, executive functions, attention, and concentration can be devastating to the individual's capacity to carry out instrumental activities of daily living (IADL), not to mention their capacity to perform adequately in the workplace. Where significant deficits are obvious and pervasive, and their underlying neuropathology is well documented, there will likely be little dispute about the merits of a disability claim.

However, cognitive deficits can occur in contexts where a moderate to severe CNS insult has not occurred, and where neuropathology cannot be confirmed using neuroimaging or other diagnostic procedures. In post-concussive syndrome, for example, persistent attention problems, reduced working memory, slowed information processing, and impaired executive functions can occur after a mild traumatic brain injury (mTBI) with little or no loss of consciousness (Binder 1986; Konrad et al. 2011). Often, personality changes, as well as symptoms of depression and PTSD can follow mTBI, and may exacerbate cognitive, functional, and social deficits (Ashman et al. 2004). Even in the absence of any discernible CNS insult, cognitive deficits associated with depression can cause significant deficits in working memory, attention and concentration, and executive functions, especially during and beyond mid-life (Lavretsky and Small 2004; Loveston 2009), as suggested in Veronica's case illustration.

Standard Tests of Cognitive and Neuropsychological Functioning

The assessment of cognitive deficits in workplace disability evaluations can range from administering brief multiscale screening measures such as the *Repeatable Battery for the Assessment of Neuropsychological Status* (RBANS; Randolph 1998), to administering more complex multiscale screening measures such at the *Wechsler Adult Intelligence Scale—Fourth Edition* (WAIS-IV; Wechsler 2008) in combination with measures such as the *Wechsler Memory Scale—Fourth Edition* (WMS-IV; Wechsler 2009), to administering an expanded *Halstead–Reitan* battery that incorporates well over a dozen discrete measures (eHRB; Heaton et al. 2004). A comprehensive battery of neuropsychological tests, such as the eHRB, will include measures to assess sensory-motor functioning, motor skills, language abilities, visual/spatial skills, executive functioning, attention and memory, emotional status, personality functioning, and effort (Horton 2010).

In workplace disability evaluations, the scope of the assessment of cognitive deficits, including the selection of specific tests, will be determined by the nature

of the referral question, the nature and extent of suspected/claimed deficits and conditions, and qualifications of the evaluating psychologist. When evaluees, as in Veronica's case, complain of forgetfulness or diminished ability to concentrate in the context of a disability claim alleging depression or an anxiety disorder such as PTSD, screening measures such as the *RBANS* or the *WAIS-IV*, accompanied by measures that assess effort (see below), are likely to be sufficient, and may not require the involvement of a fully qualified clinical neuropsychologist. Screening for cognitive deficits associated with psychopathology or CNS dysfunction is within the scope of competencies of most clinical psychologists whose practice routinely includes psychological testing.

When the evaluation context is more complex and involves claims of extensively compromised cognitive functions, such as occurs in cases of alleged mTBI, or where there are complex differential diagnostic questions (e.g., dementia versus depressive pseudo-dementia), screening measures cannot provide data of sufficient depth and detail to address the question. In these instances, a comprehensive neuropsychological evaluation, administered by a qualified clinical neuropsychologist, will be necessary (Bush 2005; Sbordone 2010).

Self-Report Measures of Cognitive Status

In addition to traditional, performance-based neuropsychological tests, the breadth of the evaluator's dataset (and by extension, the validity of the evaluator's conclusions) can be enhanced by the inclusion of instruments that gather information on the evaluee's perspective and experience. The *Ruff Neurobehavioral Inventory* (RNBI; Ruff and Hibbard 2003) and the *Brief Rating Inventory of Executive Function—Adult Version* (BRIEF-A; Roth et al. 2005) are multiscale measures that elicit responses regarding the evaluee's cognitive and functional changes in relation to their claimed condition. Both tests also yield multiple validity scales that provide information regarding the evaluee's response style.

The *RNBI* is a 243-item questionnaire that was developed to assess several domains (i.e., Cognitive, Emotional, Physical, and Quality of Life) of pre-morbid and post-morbid daily functioning in cases involving traumatic brain injury. The *RNBI's* 18 basic scales (e.g., learning and memory, executive functions, anger, depression, pain, somatic complaints, activities of daily living, vocation, and finance) are almost equally divided in their temporal focus, with about half of the items assessing pre-injury functioning, and others addressing the evaluee's current status.

Like all self-report measures, the *RNBI* is subject to the distorting effects of response style (e.g., exaggeration, minimization due to limited self-awareness), and the validity scales have yet to demonstrate their capacity to detect response style accurately with mTBI populations in non-treatment settings (Iverson 2010; Young et al. 2009). Because of this, *RNBI* should not be used and interpreted in isolation in workplace disability evaluations. But, when used in combination with

other measures that detect response style, the *RNBI* can provide useful and fairly comprehensive information about how the claimant evaluee perceives their deficits in relation to their pre-morbid functioning (Jamoraet al. 2012).

The *BRIEF-A* is a 75-item questionnaire that assesses an evaluee's perceived executive functions and self-regulation in everyday life. It yields nine non-overlapping scales (e.g., Inhibit, Self-monitor, Plan/Organize, Initiate, Working Memory, Organization of materials), that in turn form a Behavioral Regulation Index (BRI), a Metacognition Index (MI), and an overall summary score, the Global Executive Composite. The *BRIEF-A* includes three validity scales that assess extreme, atypical, and inconsistent responding.

The *BRIEF-A* is available in two formats, a self-report form that is completed by the evaluee, and a collateral informant form that is completed by an adult who is familiar with the daily functioning of the evaluee. Clearly, there is considerable potential value in being able to consider information from multiple perspectives concerning functional domains that may be relevant to an evaluee's work capacity. The *BRIEF-A's* potential in this regard, like the *RNBI*, is counterbalanced by its vulnerability to distortion due to response style, and validity scales that have yet to demonstrate their utility in forensic settings (Iverson 2010). The *BRIEF-A*, like the *RNBI*, should only be used in conjunction with robust methods of detecting response style.

Assessing Response Style

As described earlier, the response styles that are most relevant to workplace disability evaluations encompass the exaggeration of symptoms (via self-report) and deficits (via interview behavior and on psychological testing). The presence of external incentives, and the evaluee's likely (and often understandable) investment in the outcome of the evaluation, establish an over-determined context that is likely to influence the response style of the evaluee, whether (at best) by mobilizing them to offer a selective but accurate presentation of genuine symptoms/deficits, or (at worst) by motivating them to offer a malingered presentation of meritless claimed impairments (Rogers and Payne 2006).

As stated earlier, response styles are rarely unitary or static. The mental health evaluation process is multifaceted and dynamic, and subjects of any non-treatment oriented mental health assessment, including evaluees in workplace disability cases, experience complex and sometimes competing motivational states. Therefore, mental health evaluators conducting such evaluations should not assume that only one response style will be operative throughout the evaluation or across measures. Instead, evaluators should remain alert throughout the evaluation process for evidence suggesting the operation of alternative or additional response styles (e.g., honest and effortful performance, defensiveness, random responding, languid disengagement). Additionally, evaluators should always be mindful that exaggeration and even malingering often co-occur with mental disorders; it is

commonplace in all mental health practice settings for evaluators to encounter presentations that encompass aspects of exaggeration/malingering as well as genuine and significant psychopathology or CNS dysfunction.

Evaluators of workplace disability claims should consider multiple sources of data when they attempt to determine the degree to which a subject's response style might have distorted the findings of the evaluation (Rogers 2008b; Slick et al. 1999). Mental health evaluators can hope to accurately discern the influence that a subject's response style had on the validity of the findings only by considering discrepancies between and among multiple domains of data. These include self-reported history, self-reported symptoms, behavioral observations, interviews with collateral sources, treatment records, and documented history.

Psychological testing can contribute additional objective data to this analysis of the authenticity of claimed psychopathology and cognitive deficits, including those suggested in Veronica's case. However, no single psychological test, score, or finding should ever be relied upon as a dispositive "gold-standard" in detecting malingering. Instead, converging data from multiple measures and multiple sources of information are required to support a conclusion that an evaluee is malingering (Rogers 2008b).

Assessing Exaggerated Symptoms of Psychopathology

Psychometric approaches to assessing the authenticity of psychopathology involve comparing the subject's pattern of symptom endorsement with what is known about patterns of symptom endorsement in actual clinical populations. Psychologists make these comparisons using embedded validity scales on standard multiscale personality tests, and by administering specialized tests of symptom validity. When a subject's pattern of responding on these scales and tests is atypical of the range of response patterns obtained from clinical samples, and when this difference is due to the subject endorsing symptoms in a relatively more extreme, indiscriminate, or incongruous manner, then the authenticity or validity of the reported symptoms comes into question (Greene 2000; Piechowski 2011; Rogers 2008a).

Embedded Validity Indicators

The *MMPI*-2 yields several scales that measure extreme or atypical endorsement of psychopathology. The *F* (infrequency) and *Fb* (infrequency–back) scales consist of items that were rarely endorsed in the normative sample. The *Fp* (infrequency–psychopathology) scale consists of items that are rarely endorsed by genuine patients. The *O-S* (obvious–subtle) scale capitalizes on feigners' tendency to endorse items that pertain to obvious features of mental disorders, while neglecting to endorse items that pertain to subtle features. The *Ds* and *Ds-revised*

(Gough's Dissimulation Scale) and the *FBS* (Fake Bad Scale; Lees-Haley et al. 1991; Wygant et al. 2010) exploit feigners' tendency to endorse items that pertain to inaccurate stereotypes of mental illness. The *MMDS* (Malingered Mood Disorder Scale; Henry et al. 2008), the *HHI* (Henry–Heilbronner Index; Henry et al. 2006), and the recently described *PDS* (Psychosocial Distress Scale; Henry et al. 2011) attempt to discriminate feigners from individuals experiencing genuine emotional disturbance.

The *PAI* (Morey 2007) also yields multiple measures of extreme or atypical endorsement of psychopathology. The negative impression management (*NIM*) scale consists of items that are rarely endorsed by the general population. The *Malingering Index* (*MAL*) is calculated based on the presence or absence of characteristics on the *NIM* scale and the clinical scales that differentiated individuals simulating mental disorders from actual clinical patients. The *Rogers Discriminant Function* (*RDF*) is calculated from 20 weighted *PAI* scales and subscales that distinguish the profiles of patients with mental disorders from those of coached and naive simulators.

While these *MMPI*-2 and *PAI* scales can be useful in differentiating feigned psychopathology from valid mental disorder, none of these scales is perfect in its sensitivity (i.e., ability to identify true cases of feigning) and specificity (i.e., ability to identify true cases of valid psychopathology). Additionally, none of these scales can reveal the evaluee's motivation for responding to the test items as they did, only the degree to which extreme or atypical responding did or did not occur (Greene 2000; Morey et al. 2007). When considering the implications of elevations on these scales in the context of workplace disability evaluations, the evaluating or consulting psychologist should be familiar not only with the psychometric properties that are described in the tests' manuals (Butcher et al. 2001; Morey 2007), but also with the extensive and ongoing research that has evaluated the validity of these scales in their application across settings and populations (Bagby et al. 2002; Hawes and Boccaccini 2009; Lees-Haley et al. 2002; Rogers et al. 2011, 2003; Wygant et al. 2010).

Specialized Measures

Several specialized measures have been developed to identify patterns of symptom reporting that are atypical or extreme when compared to those of patients with bona fide mental disorders. The *Miller Forensic Assessment of Symptoms Test* (M-FAST; Miller 2001) and the *Structured Inventory of Malingered Symptomatology* (SIMS; Widows and Smith 2005) are time-efficient screening measures that are easily incorporated into a broader battery of procedures in a workplace disability evaluation. Either test would be appropriate to administer in evaluation contexts illustrated by the case of Veronica.

The *M-FAST* is a structured interview that elicits responses to 25 questions about a variety of symptoms, and yields scale scores that are organized according

to detection strategy (e.g., Extreme Symptomatology, Rare Combinations, Unusual Symptom Course). The *SIMS* uses a 75-item self-administered true–false format to generate five non-overlapping scales that pertain to both malingered psychopathology and malingered neurocognitive deficits (i.e., Low Intelligence, Affective Disorders, Neurologic Impairment, Psychosis, and Amnesia). Instruments such as these can provide an additional means of determining what credence and weight to assign to the presentation and self-reported symptoms in cases such as Veronica's.

The *Structured Interview of Reported Symptoms*, *Second Edition* (SIRS-2; Rogers et al. 2010) is a more extensive structured interview that uses a broader range of detection strategies (e.g., symptom severity, indiscriminate symptom endorsement, erroneous subtypes, improbable symptoms) than the much briefer *M-FAST*. The *SIRS*-2'*s* 172 items require about 1 hour of administration time. Although the *SIRS* was originally developed to detect suspected malingering in cases involving presentations of serious and persistent mental disorders in clinical, forensic, and correctional settings, its use with potentially less severely symptomatic or impaired populations in compensation and disability contexts has received recent support (Rogers et al. 2009).

Each of these specialized measures of extreme or atypical symptom reporting, like the validity scales and indices associated with the *MMPI*-2 and the *PAI*, have imperfect sensitivity and specificity and do not provide a window into the motivations underlying an evaluee's test performance. The evaluating or consulting psychologist must be familiar with each instrument's capacities both to fail to detect feigning, and to misclassify genuinely impaired evaluees as probable malingerers. Psychologists should not rely solely on information available in the tests' manuals, but should remain abreast of research about the applications of these scales across populations and settings (Alwes et al. 2008; Green and Rosenfeld 2011; Jelicic et al. 2011; Vitacco et al. 2007, 2008; Weiss et al. 2011).

Assessing Exaggerated Cognitive Deficits

When performance on cognitive or neuropsychological testing is suppressed because of poor effort or effortful failure (i.e., feigning) on all or part of the testing, it can contribute to inaccurate impressions about the presence of CNS dysfunction (Fox 2011). For this reason, psychologists and neuropsychologists should proactively assess effort and symptom validity whenever they evaluate subjects' cognitive abilities in contexts that hold potential incentives for findings of impairment (Bush et al. 2005).

Psychometric approaches to assessing the authenticity or validity of poor performance on cognitive measures involve considerations of whether a subject exerted sufficient honest effort during testing to allow the psychologist to conclude that their level of performance reflects their true capabilities. Psychologists and neuropsychologists evaluate symptom validity using measures adapted from traditional cognitive or neuropsychological tests, as well as specialized tests of poor

effort. The detection strategies of these measures can include considerations of the degree to which a subject's test performance violates basic learning principles, is incompatible with known patterns of impairment in genuine disorders, or falls significantly below the typical performance of significantly impaired populations (or even below chance probability).

Measures Adapted from Traditional Tests

Performance patterns on standardized tests of cognitive ability can be examined for evidence of poor effort. This approach has several advantages, including time efficiency, retrospective application to results of previous testing, and potential for more continuous and less salient assessment of effort than is possible with specialized measures of effort (Sweet et al. 2008). Many traditional cognitive and neuropsychological tests have been marshaled for this purpose, including the *California Verbal Learning Test—Second Edition* (CVLT-II; e.g., Demakis 2004; Slick et al. 2000), the *Wechsler Memory Scale* (e.g., Ord et al. 2008), the *RBANS* (Barkeret al. 2010), and the *Wisconsin Card Sorting Test* (e.g., King et al. 2002). Hundreds of studies have been published that evaluate the viability of various effort-relevant embedded measures and performance patterns derived from traditional tests (Berry 2008; Iverson 2010; Larrabee 2003; Sweet et al. 2008).

Although there are practical and strategic advantages to using symptom validity indicators adapted from traditional tests, these measures tend to have only moderate sensitivity and specificity, at best (Berry 2008; Ord et al. 2008; Slick et al. 2000). For this reason, these indicators should never be interpreted in isolation, but should be considered in combination with specialized measures of effort and symptom validity and other sources of data.

Specialized Measures

Whenever psychologists and neuropsychologists assess claimed impairments of memory, attention and concentration, or other cognitive functions in contexts where there are clear external incentives for poor performance, including workplace disability evaluations, tests that specifically assess poor effort and symptom validity should be included among the tests administered (Bender 2008; Bush et al. 2005; Iverson 2010).

There are dozens of specialized instruments available to assess feigned cognitive deficits. Many have been extensively cross-validated for use in non-treatment settings, including disability evaluations, and have demonstrated strong sensitivity and specificity (e.g., Test of Memory Malingering, Word Memory Test, Validity Indicator Profile, Computerized Assessment of Response Bias, Portland Digit Recognition Test; Lynch 2004; Rogers 2008b; Sweet et al. 2008). Including

one or two of these specialized instruments as part of an assessment of claimed cognitive deficits can provide an objective basis for evaluating the validity of other findings (Constantinou et al. 2005; Iverson and Franzen 1996; Larrabee 2008).

The *Test of Memory Malingering* (TOMM; Tombaugh 1996) is one example of a well-validated specialized measure of poor effort or feigning. The *TOMM* is a 50-item visual recognition test that relies on the floor effect to detect feigning. In each of two trials, subjects are shown 50 simple line drawings of items from daily life, one at a time for 3 seconds each. Each trial is followed by a forced recognition trial where the subject is provided with feedback about their accuracy after each attempt to differentiate previously viewed items from foils. A third recognition trial is administered following a delay.

Subjects motivated to appear impaired can misjudge the nature and the difficulty of the task on the *TOMM*, and will perform at levels that fall below the levels of genuinely impaired groups (Teichner and Wagner 2004), and sometimes below chance probability (i.e., less than 50 % accuracy). The manual provides cut scores to distinguish levels of performance suggestive of poor effort or feigning. Several studies have found that the *TOMM* accurately classifies subjects feigning cognitive impairment in litigating populations and among workplace disability evaluees (Green 2011; Jelicic et al. 2011), while misclassifying only a small percentage of severely impaired patients (Greveet al. 2006).

Specialized measures of effort and symptom validity, such as the *TOMM*, are the most robust measures available to psychologists in making judgments about the validity of an evaluee's neuropsychological test performance (Bender 2008; Slick et al. 1999). However, these measures, like other measures of effort, symptom validity, and response style have imperfect sensitivity and specificity. Sophisticated malingers might not be detected, and genuinely impaired individuals can be misclassified as feigning. As with other testing instruments, psychologists should not rely solely on information available in the tests' manuals, but should remain abreast of research about the applications of these scales across populations and settings (Green 2011; Iverson 2010).

Integrating the Results of Psychological Testing

In the case of Veronica, having clarified the referral questions with the psychiatrist, the psychologist administered a *PAI* and a *WAIS-IV* to assess Veronica's reported depression and cognitive changes. These tests were augmented with a *SIMS* and a *TOMM* to further assess response style and symptom validity. Veronica's profile on the *PAI* was consistent with a moderate degree of depressive distress, with a pattern of elevations on several subscales that reflected diminished confidence, low hedonic tone, somatic preoccupation, indecisiveness, ruminative worry, and a perception of non-support within a difficult situation. These scores, considered in light of Veronica's lack of significant elevations on scales pertaining to affective instability, identity problems, negative relationships, or substance abuse, are

consistent with a picture of depression, anxiety, and somatic preoccupation in a non-personality disordered individual with a low addiction potential.

Veronica's inconsistent performance on the *WAIS-IV* subscales that comprise this test's Processing Speed and Working Memory indices resulted in Low Average scores on these indices, well below her Above Average performance on the test's Verbal Comprehension and Perceptual Reasoning indices. This pattern of performance is consistent with disrupted cognitive efficiency due to a distressed psychological state, as opposed to some form of pervasive central nervous system dysfunction.

Regarding Veronica's response style, the validity scales on the *PAI* reflected an overall orientation to downplay or underreport personal problems, with only a mild elevation on a scale pertaining to the selective emphasizing of symptoms. There was no elevation on a scale pertaining to malingering. Veronica did not elevate any of the subscales of the *SIMS*, whether they pertained to psychological or cognitive/neurologic symptom domains. During the administration the *WAIS-IV*, Veronica's level of engagement and motivation had appeared adequate, with no unusual inconsistencies between or within the various subtests. The results of the *TOMM*, administered as an additional screen for poor effort or cognitive feigning, bore out the psychologist's impressions from Veronica's *WAIS-IV* performance; she scored well above the threshold for valid performance on all three trials of the TOMM.

In discussing these test results with the referring psychiatrist, the psychologist emphasized that Veronica's test-taking behavior and her test performance were consistent with essentially honest responding and good effort. She appeared to be an individual who ordinarily functioned in a rather stoic or understated manner with respect to her experience and expression of distress. She did not in the present instance appear to be deviating significantly from this style of functioning, other than to be making use of the opportunity presented by the evaluation to convey her current distress/symptoms. Her test performance on personality testing was consistent with her reports of a low mood, an anxious and preoccupied internal process, and decreased confidence and self-worth. The psychologist explained that Veronica's performance on cognitive testing credibly captured the attentional, focusing, and processing efficiency issues that she (and her workplace) had described, and he contextualized these deficits as being attributable to psychological (as opposed to neuropathological) factors.

The psychologist's explanation of the results of the psychological testing (and his eventual written report) assisted the psychiatrist to form a clearer and more nuanced understanding of Veronica's case. This did not occur because the testing, or the psychologist, had answered the ultimate issue (i.e., does she have diminished work capacity?), but because the collaborative and consultative input of the psychologist and the psychological testing enabled the psychiatrist to more clearly determine the priority, relevance, and weight to assign to her own observations and findings, thereby enabling her to reach a more robust formulation and opinion.

Conclusion

In conducting workplace disability evaluations, evaluators can enhance the accuracy and objectivity of their formulations by including psychological testing among their assessment procedures. Whether administered and interpreted by an the evaluating psychologist, or by a psychologist acting as a consultative resource to the evaluating psychiatrist, psychological testing can provide the evaluator with additional incremental objective data about the types of psychopathology and cognitive deficits that often underlie claims of compromised work capacity. Psychological testing also provides an objective means of evaluating the manner in which an evaluee's response style and test-taking effort may have distorted their test performance, their self-report, and their behavioral presentation during the evaluation.

Multiscale personality inventories such as the *MMPI*-2 or the *PAI*, can provide useful information about claimed symptoms of psychopathology, and about personality factors and response styles that mediate their expression. Because these tests assess symptoms of varying saliency across a broad array of conditions, they can also provide information about the presence of syndromal features or comorbidity that may not be recognized or acknowledged by the evaluee.

Psychometric assessment of cognitive deficits and neuropsychological status can range from the administration of multiscale screening tests such as the *WAIS-IV* or the *RBANS*, to the administration of comprehensive batteries that include over a dozen measures to assess sensory-motor functioning, motor skills, language abilities, visual/spatial skills, executive functioning, attention and memory. The scope of the assessment is determined by the nature of the referral question, the nature and extent of suspected/claimed deficits and conditions, and qualifications of the evaluating psychologist. Evaluations of claims of disability due to cognitive deficits should include a measure such as the *MMPI*-2 or the *PAI* to assess emotional status and personality functioning. Self-report instruments such as the *RNBI* or the *BRIEF-A* can provide useful information about the evaluee's experience of claimed cognitive deficits.

Psychological testing also provides an objective means of evaluating the manner in which an evaluee's response style and test-taking effort may have distorted their test performance, their self-report, and their behavioral presentation during the evaluation. The validity scales on the *MMPI*-2 and *PAI* provide useful information about the response style of the evaluee. These embedded scales can be augmented by the use of specialized measures of responses style, such as the *SIMS* and the *M-FAST*, and by other sources of data in evaluating the validity of an evaluee's overall clinical presentation. In assessing the validity of reported cognitive deficits, psychologists have available to them a variety of embedded scales and specialized tests of symptom validity and effort, such as the *TOMM*. In considering the possibility of feigned or malingered cognitive deficits, the results of specialized measures of symptom validity and effort should not be evaluated in isolation, but in combination with other information from and about the evaluee, from collateral sources, and from other test results.

Key Points

1. Psychologists should only use tests that have demonstrated sufficient validity and reliability with the population represented by the evaluee, and with the relevant issues in a particular case. Multiple measures should be utilized.
2. Psychologists should always conduct a focused assessment of response style to evaluate the validity of an evaluee's test performance. Tests that do not incorporate validity checks should be avoided, or used conservatively in conjunction with specialized measures of response style.
3. Mental health professionals considering the use of psychological testing should collaborate with psychologists qualified to administer and evaluate psychological testing to determine the utility/appropriateness of testing, to clarify the referral question(s), and to select the appropriate combination of testing instruments
4. Computer-based interpretations of personality tests can be used to generate and evaluate clinical hypotheses about an evaluee, but should never be uncritically adopted as valid characterizations of an evaluee's status, diagnosis, or motivational state.
5. Evidence of exaggerated or selective symptom endorsement on psychological testing, while problematic, should not be characterized as representing malingering unless the confluence of data from multiple sources supports such a characterization.

References

Ackerman, M.J.: Essentials of Forensic Psychological Assessment, 2nd edn. Hoboken, Wiley (2010)

Alwes, Y.R., Clark, J.A., Berry, D.T., et al.: Screening for feigning in a civil forensic setting. J. Clin. Exp. Neuropsychol. **30**(2), 133–140 (2008)

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (Text Revision). American Psychiatric Association, Washington, DC (2000)

American Psychological Association: Ethical principles of psychologists and code of conduct. Am. Psychol. **57**(12), 1060–1073 (2002)

American Psychological Association: Specialty guidelines for forensic psychology. http://www.apa.org/practice/guidelines/forensic-psychology.aspx (2011). Accessed 4 Jan 2012

Arbisi, P.A., Erbes, C.R., Polusny, M.A., et al.: The concurrent and incremental validity of the trauma symptom inventory in women reporting histories of sexual maltreatment. Assessment **17**(3), 406–418 (2010)

Archer, R.P.: Forensic Uses of Clinical Assessment Instruments. Lawrence Erlbaum Associates Publishers, Mahwah (2006)

Archer, R.P., Buffington-Vollum, J.K., Stredny, R.V., et al.: A survey of psychological test use patterns among forensic psychologists. J. Pers. Assess. **87**(1), 84–94 (2006)

Ashman, T., Spielman, L.A., Hibbard, M.R., et al.: Psychiatric challenges in the first 6 years after traumatic brain injury: Cross sequential analysis of Axis I disorders. Arch. Phys. Med. Rehabil. **85**(2), 36–42 (2004)

Bagby, R.M., Nicholson, R.A., Bacchiochi, J.R., et al.: The predictive capacity of the MMPI-2 and PAI validity scales and indexes to detect coached and uncoached feigning. J. Pers. Assess. **78**(1), 69–86 (2002)

Barker, M.D., Horner, M.D., Bachman, D.L.: Embedded indices of effort in the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) in a geriatric sample. Clin. Neuropsychol **24**(6), 1064–1077 (2010)

Beck, A.: Beck Depression Inventory Manual. Psychological Corporation, San Antonio (1996)

Bender, S.D.: Malingered Traumatic Brain Injury. In Rogers, R. (ed.) Clinical Assessment of Malingering and Deception, 3rd edn., pp. 69–86. Guilford Press, New York (2008)

Bennett, T.L., Raymond, M.J.: Neuropsychological Assessment in Disability Determination, Fitness-for-Duty Evaluations, and Rehabilitation Planning. In: Horton, A.M., Hartlage L.C. (eds.) Handbook of Forensic Neuropsychology, 2nd edn., pp. 431–451. Springer, New York (2010)

Berry, D.T.R.: Assessment of Feigned Cognitive Impairment Using Standard Neuropsychological Tests. In Rogers, R. (ed.) Clinical Assessment of Malingering and Deception, 3rd edn., pp. 237–252. Guilford Press, New York (2008)

Binder, L.M.: Persisting symptoms after mild head injury: A review of the postconcussive syndrome. J. Clin. Exp. Neuropsychol. **8**, 323–346 (1986)

Bonnie, R.J.: Mental disorder and workforce participation: An epidemiological perspective. In: Bonnie, R.J., Monahan, J. (eds.) Mental Disorder, Work Disability, and the Law, pp. viii, 308. University of Chicago Press, Chicago (1997)

Briere, J.: Trauma Symptom Inventory Professional Manual. Psychological Assessment Resources, Odessa (1995)

Bush, S.S.: Independent and court-ordered forensic neuropsychological examinations: Official statement of the National Academy of Neuropsychology. Arch. Clin. Neuropsychol. **20**(8), 997–1007 (2005)

Bush, S.S., Ruff, R.M., Tröster, A.I., et al.: Symptom validity assessment: Practice issues and medical necessity: NAN policy and planning committee. Arch. Clin. Neuropsychol. **20**(4), 419–426 (2005)

Butcher, J.N., Graham, J.R., Ben-Porath, Y.S., et al.: MMPI-2: Manual for Administration and Scoring (Revised Edition). University of Minnesota Press, Minneapolis (2001)

Butcher, J.N., Perry, J., Hahn, J.: Computers in clinical assessment: Historical developments, present status, and future challenges. J. Clin. Psychol. **60**(3), 331–345 (2004)

Charter, R.A., Lopez, M.N.: Millon Clinical Multiaxial Inventory (MCMI-III): The inability of the validity conditions to detect random responders. J. Clin. Psychol. **58**(12), 1615–1617 (2002)

Constantinou, M., Bauer, L., Ashendorf, L., et al.: Is poor performance on recognition memory effort measures indicative of generalized poor performance on neuropsychological tests? Arch. Clin. Neuropsychol. **20**(2), 191–198 (2005)

Craig, R.J.: The Millon Clinical Multiaxial Inventory-III. In: Archer, R.P. (ed.) Forensic Uses of Clinical Assessment Instruments, pp. 121–145. Lawrence Erlbaum Associates Publishers, Mahwah (2006)

Demakis, G.J.: Application of clinically-derived malingering cutoffs on the California Verbal Learning Test and the Wechsler Adult Intelligence Test-Revised to an analog malingering study. Appl. Neuropsychol. **11**(4), 222–228 (2004)

Derogatis, L.R.: SCL–90-R: Administration, Scoring and Procedures Manual. National Computer Systems, Minneapolis (1994)

Edens, J.F., Cruise, K.R., Buffington-Vollum, J.K.: Forensic and correctional applications of the Personality Assessment Inventory. Behav. Sci. Law **19**(4), 519–543 (2001)

Exner Jr, J.E.: The Rorschach: A Comprehensive System, 4th edn. Wiley, Hoboken (2003)

Foote, W.E.: Evaluations of individuals for disability in insurance and Social Security contexts. In Jackson, R. (ed.) Learning Forensic Assessment, pp. 449–479. Routledge/Taylor & Francis Group, New York (2008)

Fox, D.D.: Symptom validity test failure indicates invalidity of neuropsychological tests. Clin. Neuropsychol. **25**(3), 488–495 (2011)

Garb, H.N.: Computers will become increasingly important for psychological assessment: Not that there's anything wrong with that. Psychol. Assess. **12**(1), 31–39 (2000)
Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Model, Process, Analysis. Springer, New York (2009)
Green, D., Rosenfeld, B.: Evaluating the gold standard: A review and meta-analysis of the Structured Interview of Reported Symptoms. Psychol. Assess. **23**(1), 95–107 (2011)
Green, P.: Comparison between the Test of Memory Malingering (TOMM) and the Nonverbal Medical Symptom Validity Test (NV-MSVT) in adults with disability claims. Appl. Neuropsychol. **18**(1), 18–26 (2011)
Greenberg, S.A., Otto, R.K., Long, A.C.: The utility of psychological testing in assessing emotional damages in personal injury litigation. Assessment **10**(4), 411–419 (2003)
Greene, R.L.: The MMPI-2: An Interpretive Manual, 2nd edn. Allyn & Bacon, Needham Heights (2000)
Greve, K.W., Bianchini, K.J., Doane, B.M.: Classification accuracy of the Test of Memory Malingering in traumatic brain injury: Results of a known-groups analysis. J. Clin. Exp. Neuropsychol. **28**(7), 1176–1190 (2006)
Harkness, A.R., McNulty, J.L., Ben-Porath, Y.S.: The Personality Psychopathology Five (PSY-5): Constructs and MMPI-2 scales. Psychol. Assess. **7**(1), 104–114 (1995)
Hartmann, E., Grønnerød, C.: Rorschach variables and big five scales as predictors of military training completion: A replication study of the selection of candidates to the naval special forces in Norway. J. Pers. Assess. **91**(3), 254–264 (2009)
Hawes, S.W., Boccaccini, M.T.: Detection of overreporting of psychopathology on the Personality Assessment Inventory: A meta-analytic review. Psychol. Assess. **21**(1), 112–124 (2009)
Heaton, R.K., Miller, S.W., Taylor, M.J., et al.: Revised Comprehensive Norms for an Expanded Halstead-Reitan Battery. Psychological Assessment Resources, Odessa (2004)
Heilbrun, K.: The role of psychological testing in forensic assessment. Law Hum. Behav. **16**(3), 257–272 (1992)
Heilbrun, K., Rogers, R., Otto, R.: Forensic assessment: Current status and future directions. In Ogloff, J.R.P. (ed.) Taking Psychology and Law into the Twenty-First Century, pp. 119–146. Kluwer Academic, New York (2002)
Heilbrun, K., Warren, J., Picarello, K., et al.: Third party information in forensic assessment. In: Goldstein, A.M., Weiner, I.B. (eds.) Handbook of Psychology: Forensic Psychology, vol. 11, pp. 69–86. Wiley, Hoboken (2003)
Henry, G.K., Heilbronner, R.L., Mittenberg, W., et al.: The Henry-Heilbronner Index: A 15-item empirically derived MMPI-2 subscale for identifying probable malingering in personal injury litigants and disability claimants. Clin. Neuropsychol. **20**(4), 786–797 (2006)
Henry, G.K., Heilbronner, R.L., Mittenberg, W., et al.: Empirical derivation of a new MMPI-2 scale for identifying probable malingering in personal injury litigants and disability claimants: The 15-item Malingered Mood Disorder Scale (MMDS). Clin. Neuropsychol. **22**(1), 158–168 (2008)
Henry, G.K., Heilbronner, R.L., Mittenberg, W., et al.: Noncredible performance in individuals with external incentives: Empirical derivation and cross-validation of the Psychosocial Distress Scale (PDS). Appl. Neuropsychol. **18**(1), 47–53 (2011)
Horton, A.M.: Overview of forensic neuropsychology. In: Horton, A.M., Hartlage, L.C. (eds.) Handbook of Forensic Neuropsychology, 2nd edn., pp. 3–9. Springer, New York (2010)
Iverson, G.L.: Detecting exaggeration, poor effort, and malingering in neuropsychology. In: Horton, A., Hartlage, L.C. (eds.) Handbook of Forensic Neuropsychology, 2nd edn., pp. 91–135. Springer, New York (2010)
Iverson, G.L., Franzen, M.D.: Using multiple objective memory procedures to detect simulated malingering. J. Clin. Exp. Neuropsychol. **18**(1), 38–51 (1996)
Jamora, C.W., Young, A., Ruff, R.M.: Comparison of subjective cognitive complaints with neuropsychological tests in individuals with mild vs more severe traumatic brain injuries. Brain Inj. **26**(1), 36–47 (2012)

Jelicic, M., Ceunen, E., Peters, M.J.V., et al.: Detecting coached feigning using the Test of Memory Malingering (TOMM) and the Structured Inventory of Malingered Symptomatology (SIMS). J. Clin. Psychol. **67**(9), 850–855 (2011)
Kanai, C., Tani, M., Hashimoto, R., et al.: Cognitive profiles of adults with Asperger's disorder, high-functioning autism, and pervasive developmental disorder not otherwise specified based on the WAIS-III. Res. Autism Spectr. Disord. **6**(1), 58–64 (2012)
King, J.H., Sweet, J.J., Sherer, M., et al.: Validity indicators within the Wisconsin Card Sorting Test: Application of new and previously researched multivariate procedures in multiple traumatic brain injury samples. Clin. Neuropsychol. **16**(4), 506–523 (2002)
Konrad, C., Geburek, A.J., Rist, F., et al.: Long-term cognitive and emotional consequences of mild traumatic brain injury. Psychological Medicine. Psychol. Med. J. Res. Psychiatry Allied Sci. **41**(6), 1197–1211 (2011)
Lally, S.J.: What tests are acceptable for use in forensic evaluations? A survey of experts. Prof. Psychol. Res. Pract. **34**(5), 491–498 (2003)
Larrabee, G.J.: Detection of malingering using atypical performance patterns on standard neuropsychological tests. Clin. Neuropsychol. **17**(3), 410–425 (2003)
Larrabee, G.J.: Aggregation across multiple indicators improves the detection of malingering: Relationship to likelihood ratios. Clin. Neuropsychol. **22**(4), 666–679 (2008)
Lavretsky, H., Small, G.W.: Mixed cognitive and depressive syndromes. In Roose, S.P., Sackehim, H.A. (eds.) Late-life Depression, pp. 81–94. Oxford University Press, New York (2004)
Lees-Haley, P.R., English, L.T., Glenn, W.J.: A fake bad scale on the MMPI-2 for personal injury claimants. Psychol. Rep. **68**(1), 203–210 (1991)
Lees-Haley, P.R., Iverson, G.L., Lange, R.T., et al.: Malingering in forensic neuropsychology: Daubert and the MMPI-2. J. Forensic Neuropsychol. **3**(1–2), 167–203 (2002)
Lichtenberger, E.O.: Computer utilization and clinical judgment in psychological assessment reports. J. Clin. Psychol. **62**(1), 19–32 (2006)
Loveston, S.: Alzheimer's disease and other dementias (including pseudodementias). In: David, A., Fleminger, S., Kopelman, M., Lovestone, S., Mellers, J. (eds.) Lishman's Organic Psychiatry: A Textbook of Neuropsychiatry, 4th edn, pp. 543–616. Wiley, Chichester (2009)
Lynch, W.J.: Determination of effort level, exaggeration, and malingering in neurocognitive assessment. J. Head Trauma Rehabil. **19**(3), 277–283 (2004)
Melton, G.B., Petrila, J., Poythress, N.G., et al.: Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers, 3rd edn. Guilford Press, New York (2007)
Miller, H.A.: Miller-Forensic Assessment of Symptoms Test (M-FAST): Professional Manual (2001)
Millon, T.: Manual for the MCMI-III. National Computer Systems, Minneapolis (1994)
Mittenberg, W., Patton, C., Canyock, E.M., et al.: Base rates of malingering and symptom exaggeration. J. Clin. Exp. Neuropsychol. **24**(8), 1094–1102 (2002)
Morey, L.C.: The Personality Assessment Inventory: Professional Manual. Psychological Assessment Resources, Odessa (1991)
Morey, L.C.: Personality Assessment Inventory: Professional Manual, 2nd edn. Psychological Assessment Resources, Inc., Lutz (2007)
Morey, L.C., Hopwood, C.J.: The Personality Assessment Inventory. In: Archer, R.P. (ed.) Forensic Uses of Clinical Assessment Instruments, pp. 167–211. Lawrence Erlbaum Associates, Mahwah (2006)
Morey, L.C., Warner, M.B., Hopwood, C.J.: The Personality Assessment Inventory: Issues in legal and forensic settings. In Goldstein, A.M. (ed.) Forensic Psychology: Emerging Topics and Expanding Roles, pp. 97–126. Wiley, Hoboken (2007)
Morgan, C.D., Schoenberg, M.R., Dorr, D., et al.: Over report on the MCMI-III: Concurrent validation with the MMPI-2 using a psychiatric inpatient sample. J. Pers. Assess. **78**(2), 288–300 (2002)

Musewicz, J., Marczyk, G., Knauss, L., et al.: Current assessment practice, personality measurement, and Rorschach usage by psychologists. J. Pers. Assess. **91**(5), 453–461 (2009)
Ord, J.S., Greve, K.W., Bianchini, K.J.: Using the Wechsler Memory Scale-III to detect malingering in mild traumatic brain injury. Clin. Neuropsychol. **22**(4), 689–704 (2008)
Otto, R.K.: Challenges and advances in assessment of response style in forensic examination contexts. In: Rogers, R. (ed.) Clinical Assessment of Malingering and Deception, 3rd edn., pp. 365–375. Guilford Press, New York (2008)
Piechowski, L.D.: Evaluation of Workplace Disability. Oxford University Press, New York (2011)
Pope, K.S., Butcher, J.N., Seelen, J.: The MMPI, MMPI-2, and MMPI-A in Court: A Practical Guide for Expert Witnesses and Attorneys, 3rd edn. American Psychological Association, Washington (2006)
Randolph, C.: The Repeatable Battery for the Assessment of Neuropsychological Status: Manual. The Psychological Corporation, San Antonio (1998)
Rogers, R.: Forensic use and abuse of psychological tests: Multiscale inventories. J. Psychiatr. Pract. **9**(4), 316–320 (2003)
Rogers, R. (ed.): Clinical Assessment of Malingering and Deception, 3rd edn. Guilford Press, New York (2008a)
Rogers, R.: Current Status of Clinical Methods. In: Rogers, R. (ed.) Clinical Assessment of Malingering and Deception, 3rd edn., pp. 391–410. Guilford Press, New York (2008b)
Rogers, R., Gillard, N.D., Berry, D.T.R., et al.: Effectiveness of the MMPI-2-RF validity scales for feigned mental disorders and cognitive impairment: A known-groups study. J. Psychopathol. Behav. Assess. **33**(3), 355–367 (2011)
Rogers, R., Payne, J.W.: Damages and rewards: Assessment of malingered disorders in compensation cases. Behav. Sci. Law **24**(5), 645–658 (2006)
Rogers, R., Payne, J.W., Berry, D.T.R., et al.: Use of the SIRS in compensation cases: An examination of its validity and generalizability. Law Hum. Behav. **33**(3), 213–224 (2009)
Rogers, R., Salekin, R.T., Sewell, K.W.: Validation of the Millon Clinical Multiaxial Inventory for Axis II disorders: Does it meet the Daubert standard? Law Hum. Behav. **23**(4), 425–443 (1999)
Rogers, R., Salekin, R.T., Sewell, K.W.: The MCMI-III and the Daubert standard: Separating rhetoric from reality. Law Hum. Behav. **24**(4), 501–506 (2000)
Rogers, R., Sewell, K.W., Gillard, N.D.: Structured Interview of Reported Symptoms Professional Manual, 2nd edn. Psychological Assessment Resources, Odessa (2010)
Rogers, R., Sewell, K.W., Martin, M.A., et al.: Detection of feigned mental disorders: A meta-analysis of the MMPI-2 and malingering. Assessment **10**(2), 160–177 (2003)
Rosen, G.M., Sawchuk, C.N., Atkins, D.C., et al.: Risk of false positives when identifying malingered profiles using the Trauma Symptom Inventory. J. Pers. Assess. **86**(3), 329–333 (2006)
Rossi, G., Hauben, C., Van den Brande, I., et al.: Empirical evaluation of the MCMI-III personality disorder scales. Psychol. Rep. **92**(2), 627–642 (2003)
Roth, R.M., Isquith, P.K.: DGioia GA: Brief Rating Inventory of Executive Functions—Adult Version. Psychological Assessment Resources, Lutz (2005)
Ruff, R.M., Hibbard, K.: Ruff Neurobehavioral Inventory. Psychological Assessment Resources, Odessa (2003)
Samuel, R.Z., Mittenberg, W.: Determination of malingering in disability evaluations. Prim. Psychiatry **12**(12), 60–68 (2005)
Sbordone, R.J.: Ecological validity issues that arise in medi-legal cases when neuropsychologists are asked to assess patients with traumatic brain injuries. In: Horton, A., Hartlage, L.C. (eds.) Handbook of Forensic Neuropsychology, 2nd edn., pp. 381–408. Springer, New York (2010)
Sewell, K.W., Rogers, R.: Dissimulation on projective measures. In: Rogers, R. (ed.) Clinical Assessment of Malingering and Deception, 3rd edn., pp. 207–217. Guilford Press, New York (2008)
Slick, D.J., Iverson, G.L., Green, P.: California Verbal Learning Test indicators of suboptimal performance in a sample of head-injury litigants. J. Clin. Exp. Neuropsychol. **22**(5), 569–579 (2000)

Slick, D.J., Sherman, E.M., Iverson, G.L.: Diagnostic criteria for malingered neurocognitive dysfunction: Proposed standards for clinical practice and research. Clin. Neuropsychol. **13**(4), 545–561 (1999)

Smith, B.L., Gacono, C.B., Evans, F.B., et al.: Rorschach assessment in tort and employment litigation. In Gacono, C.B., Evans, F.B. (eds.) The Handbook of Forensic Rorschach Assessment, pp. 279–299. Routledge/Taylor & Francis Group, New York (2008)

Sweet, J.J., Condit, D.C., Nelson, N.W.: Feigned amnesia and memory loss. In: Rogers, R. (ed.) Clinical Assessment of Malingering and Deception, 3rd edn., pp. 218–236. Guilford Press, New York (2008)

Teichner, G., Wagner, M.T.: The Test of Memory Malingering (TOMM): Normative data from cognitively intact, cognitively impaired, and elderly patients with dementia. Arch. Clin. Neuropsychol. **19**(3), 455–464 (2004)

Tellegen, A., Ben-Porath, Y.S.: Minnesota Multiphasic Personality Inventory-2 Restructured form (MMPI-2-RF): Technical Manual. University of Minnesota Press, Minneapolis (2008)

Tellegen, A., Ben-Porath, Y.S., McNulty, J.L., et al.: The MMPI-2 Restructured Clinical Scales: Development, Validation, and Interpretation. University of Minnesota Press, Minneapolis (2003)

Tombaugh, T.N.: Test of Memory Malingering. MultiHealth Systems, Toronto (1996)

Vitacco, M.J., Jackson, R.L., Rogers, R., et al.: Detection strategies for malingering with the miller forensic assessment of symptoms test: A confirmatory factor analysis of its underlying dimensions. Assessment **15**(1), 97–103 (2008)

Vitacco, M.J., Rogers, R., Gabel, J., et al.: An evaluation of malingering screens with competency to stand trial patients: A known-groups comparison. Law Hum. Behav. **31**(3), 249–260 (2007)

Vore, D.A.: The Disability Psychological Independent Medical Evaluation: Case law, ethical issues, and procedures. In Goldstein A.M. (ed.) Forensic Psychology: Emerging Topics and Expanding Roles, pp. 489–510. Wiley, Hoboken (2007)

Wechsler, D.: Wechsler Adult Intelligence Scale, 4th edn. Pearson, San Antonio (2008)

Wechsler, D.: Wechsler Memory Scale, 4th edn. Pearson, San Antonio (2009)

Weiner, I.B.: The Rorschach inkblot method. In: Archer, R.P. (ed.) Forensic Uses of Clinical Assessment Instruments, pp. 181–207. Lawrence Erlbaum Associates, Mahwah (2006)

Weiner, I.B., Greene, R.L.: Handbook of Personality Assessment. Wiley, Hoboken (2008)

Weiner, I.B., Hess, A.K.: The Handbook of Forensic Psychology, 3rd edn. Wiley, Hoboken (2006)

Weiss, R.A., Rosenfeld, B., Farkas, M.R.: The utility of the Structured Interview of Reported Symptoms in a sample of individuals with intellectual disabilities. Assessment **18**(3), 284–290 (2011)

Widiger, T.: Review of the Millon Clinical Multiaxial Inventory. In: Mitchell, J.J.V. (ed.) The Ninth Mental Measurements Yearbook, vol. 1, pp. 986–988. University of Nebraska Press, Lincoln (2001)

Widows, M.R., Smith, G.P.: Structured Inventory of Malingered Symptomatology: Professional Manual (2005). Psychological Assessment Resources, Lutz

Wood, J.M., Nezworski, M.T., Stejskal, W.J., et al.: Problems of the comprehensive system for the Rorschach in forensic settings: Recent developments. J. Forensic Psychol. Pract. **1**(3), 89–103 (2001)

Wygant, D.B., Sellbom, M., Gervais, R.O., et al.: Further validation of the MMPI-2 and MMPI-2-RF response bias scale: Findings from disability and criminal forensic settings. Psychol. Assess. **22**(4), 745–756 (2010)

Young, G., Merali, N.L., Ruff, R.M.: The Ruff Neurobehavioral Inventory: Validity indicators and validity. Psychol. Inj. Law **2**(1), 53–60 (2009)

Zodan, J., Charnas, J., Hilsenroth, M.J.: Rorschach assessment of reality testing, affect and object representation of borderline pathology: A comparison of clinical samples. Bull. Menninger Clin. **73**(2), 121–142 (2009)

Chapter 6
Malingering and Mental Health Disability Evaluations

Charles L. Scott and Barbara McDermott

Introduction

Disability assessments are the most common non-treatment evaluations requested of mental health professionals (Anfang and Wall 2006; Gold and Metzner 2006). Malingering of psychiatric symptoms during a disability evaluation is not rare and diagnosing malingered psychiatric symptoms is not easy. Green et al. (2001) noted that between 25 and 30 % of individuals presenting for workers' compensation or disability claims demonstrated probable symptom exaggeration. Likewise, in their survey of the American Board of Clinical Neuropsychology membership, Mittenberg et al. (2002) determined that 30 % of 3,688 disability cases involved probable malingering.

Patients seeking disability often ask their treating clinicians to complete standard forms that generally require a diagnosis and describe level of functioning. In turn, these forms are submitted to the responsible agency as part of the process to determine disability benefits eligibility. Clinicians may find it particularly problematic to evaluate potential malingering in a treatment setting where they often have limited access to collateral information and only the patient's self-report on which to rely. Providers who believe that a patient is probably feigning are faced with a dilemma represented by two obvious questions that result from this dual agency role:

C. L. Scott (✉)
Department of Psychiatry and Behavioral Sciences, UC Davis Medical Center, Sacramento, Stockton Blvd 2230, Sacramento, CA 95817, USA
e-mail: charles.scott@ucdmc.ucdavis.edu

B. McDermott
Department of Psychiatry and Behavioral Sciences, UC Davis Medical Center, UC Davis and Napa State Hospital Clinical Demonstration Unit, Stockton Blvd 2230, Sacramento, CA 95817, USA
e-mail: bemcdermott@usdavis.edu

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_6,

1. Do I report that my patient is likely faking his/her symptoms and/or poor functioning and risk rupturing our therapeutic relationship? or;
2. Do I report that my patient has a qualifying mental disorder and poor functioning when I do not have enough evidence and/or I think he or she is not really disabled?

The treating mental health professional's opinion can have substantial influence regarding the outcome of the disability determination. For example, Social Security Administration policy emphasizes that greater weight should be given to the treating clinician's opinion as opposed to the opinion of an outside evaluator. The patient may be unaware that the information reported on the disability form may have consequences contrary to their desired outcome, particularly if the evaluator reports that the patient is malingering. A survey of general and forensically trained psychiatrists revealed that both groups frequently failed to obtain informed consent from their patient regarding the disability evaluation process. In this same study, both groups also acknowledged that they often feel pressured to complete the requested form and identified themselves as their patient's advocate in the disability evaluation process (Christopher et al. 2011).

This chapter provides a general of overview of malingering, discusses methods for evaluating malingering, and highlights the presentation of various malingered psychiatric symptoms during disability evaluations.

Case Example

Mr. Grove initiates a psychiatric evaluation, in part to have a required disability evaluation form completed as required by his primary disability insurer. Mr. Grove is a 59-year-old tax attorney who typically works 60 hours a week. He told many people in his life that he no longer enjoys his work, the long work hours, and would like to quit. He was driving his car on the way to his office when another car ran a red light and hit Mr. Grove's car at a speed of 15 miles per hour. Mr. Grove's air bag deployed immediately and he sustained minimal damage to the passenger side of his car. When the ambulance arrived at the scene, Mr. Grove was observed as fully alert and oriented and his Glasgow Coma Score was 15. There was no evidence of head injury, loss of consciousness, or any other medical complaints at the time of the accident. Mr. Grove did not receive any further medical treatment that day and returned to his office the following day.

Two weeks later, Mr. Grove complained to his primary care physician that he was having difficulty concentrating, was unable to sleep, and was experiencing an increase in appetite. He also reported that he was feeling markedly depressed, was experiencing nightmares that involved his car being destroyed in an accident, and was having difficulty with his memory. Mr. Grove reported that he was filing for disability benefits after his primary care physician provided a report stating that Mr. Grove was unable to work due to a "traumatic head injury." Mr. Grove's primary care provider referred Mr. Grove to a psychiatrist.

At his initial appointment, Mr. Grove tells the psychiatrist that he thinks he has Posttraumatic Stress Disorder (PTSD) and does not believe he can ever return to work. Over the next 6 months, Mr. Grove reports that his memory problems, depression, and nightmares are worsening. He also describes that he has paralyzing flashbacks where he thinks he is reliving the car accident and becomes emotionally frozen. He eventually files for permanent disability, claiming that he can never return to work and if he does, he will experience a worsening of his depression and anxiety and "will die."

During the course of his treatment, Mr. Grove claims that he cannot remember his birthday, his address, and at times he suddenly behaves in a markedly confused manner. He reports that he is profoundly depressed though he is also noted to laugh when he tells a number of lawyer jokes. He also repeatedly points out to his clinician when similar questions have already been asked and at times humorously exclaims, "Asked and answered!" Before and after appointments, he is noted to initiate and enjoy social interaction with the office staff. Mr. Grove tells the treating psychiatrist that he has never been depressed prior to this accident, though medical records indicate that he was prescribed an antidepressant for nearly 2 years during his early 50s. Under Mr. Grove's private insurance policy, he is eligible for full disability payments if it is determined that he is unable to accomplish the tasks specific to his job as a tax attorney. When Mr. Grove asks the treating psychiatrist to complete the disability form indicating that he is depressed and suffers from PTSD, the psychiatrist hesitates and wonders how she should handle the request.

The psychiatrist's reluctance is understandable considering the circumstances of her provider-patient relationship. In this situation, the treating psychiatrist's alliance is to the patient and the clinical diagnosis and disability opinion relies heavily on the patient's self-report. Nevertheless, the treating psychiatrist does not believe Mr. Grove's entire report nor does she believe he is so impaired that he could not function as a tax attorney, increasing her discomfort; few treating providers relish the idea of identifying their patient as a "malingerer."

Furthermore, a busy treatment setting does not lend itself to a detailed review of collateral records, independent confirmation of functional abilities, or objective psychological testing. All of these activities are important when assessing malingering. Even forensically trained mental health professionals may overlook the possibility of malingering when considering all of the inherent challenges in conducting a more thorough assessment. With only a few precious moments to complete a seemingly simple form presented at the conclusion of a routine appointment, the clinician may feel the pressure to comply. With a cursory "checking the boxes" on the official disability form, the provider momentarily manages the patient's request. However, the following reality may be overlooked: whenever there is potential for monetary or other concrete benefits, malingering must be considered.

Malingering Definitions

The American Heritage Dictionary of the English Language defines malingering as "to feign illness or other incapacity in order to avoid duty or work" (Malingering n.d.). The American Psychiatric Association provides a more specific definition: malingering is "the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives." Although malingering is listed in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000), malingering is not considered a mental disorder and instead is designated under the section titled "V code." V codes are assigned when the presenting condition is a focus of clinical attention and the person's presenting symptoms are not accounted for by a DSM mental disorder (American Psychiatric Association 2000, p. 739).

The Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition, Text Revision (DSM-IV) guidelines for when to suspect malingering include (1) medico-legal evaluations (2) when there is a marked discrepancy between an evaluee's claimed stress or disability and objective findings (3) when there is a lack of cooperation with diagnostic interview, and (4) the presence of Antisocial Personality Disorder (American Psychiatric Association 2000, p. 739).

Resnick (1997, p. 131) has described the following three subcategories of malingering:

1. *Pure malingering*: A person feigns a disorder that does not exist at all.
2. *Partial malingering*: A person exaggerates existing symptoms or fraudulently alleges that prior symptoms are still present.
3. *False imputation:* A person attributes actual symptoms to a cause that they know has no relationship to the reported symptoms.

In the context of a medical or psychiatric illness, "gain" has been defined as "the advantages of an illness experienced by the patient and that hinder recovery" (van Egmond 2003, p. 137). Disability evaluations often request that the examiner comment on whether or not *primary* or *secondary gain* is involved in the presentation of the claimant's symptoms and alleged disability. Clinicians, evaluators, and insurers often share the common misconception that primary gain refers to an attempt by the patient to obtain something concrete as a result of their feigned symptoms, such as money or insurance benefits and that secondary gain refers to an unconscious motivation to obtain less tangible benefits. In reality, the correct meaning of primary and secondary gain is virtually the opposite.

The concept of primary gain developed largely from Sigmund Freud's psychoanalytic theory and associated psychoanalysis during the early 1900s. According to analytic theory, the development of an external symptom serves to relieve the individual's internal intrapsychic and unconscious conflict. The following example represents a classic example of primary gain and symptom development. A soldier is at attention and holding his firearm. His arm suddenly becomes paralyzed when he has the unconscious and unacceptable impulse to

shoot his drill sergeant. His newly paralyzed arm results in a loss of motor control, the release of the weapon from his hand, thereby preventing him from acting on his unconscious wish to kill.

Freud also recognized that there are clear motivators for symptoms to persist independent of an unconscious intrapsychic conflict. The term "secondary gain" refers to incentives that reinforce behavior. However, subtle distinctions are made between different types of secondary gain. In behavioral medicine, secondary gain is used to describe situations when a treating provider unintentionally reinforces the patient's illness behavior through provision of attention or comfort. In the context of disability evaluations, "secondary gain" means that the person is intentionally fabricating symptoms for a concrete goal, such as a financial benefit (Rogers and Payne 2006). When evaluating disability claims, the examiner should clarify which definition of secondary gain is being used.

In addition to secondary gain, individuals with genuine illness may also face *secondary losses,* including loss of power; loss of respect; loss of authority; and/or loss of function (Wiley 1998). Because many people are not familiar with the concept of secondary loss, malingerers may fail to understand and report these important secondary loss factors. Evaluators should also address whether the claimant volunteers any secondary losses related to their reported illness, as these may help discriminate between legitimate dysfunction and feigned impairment (Hall and Hall 2006).

Malingering and Disability Evaluations

Clearly, the evaluation of malingering in disability evaluations is important. Disability evaluations are wide ranging and include Social Security evaluations, workers' compensation evaluations, disability for US veterans, disability evaluations under the Americans with Disabilities Act (ADA), and private disability claims under an individual insurance policy. Each system has its own unique definition of disability, and its own terms for benefits, such as the amount paid for the disability and the length of time for disability compensation.

Although disability compensation systems vary, they have one common factor: malingering occurs frequently and results in unwarranted compensation. For example, the financial costs of Social Security Disability Insurance (SSDI) benefits are staggering and escalating (see Chap. 7). The number of people receiving SSDI benefits between 1970 and 2009 more than tripled, from 2.7 to 9.7 million. By 2015, a projected 11.4 million individuals will receive SSDI benefits with total expenditures climbing to $147 billion dollars (Dahl and Meyerson 2010). The potential cost savings for correctly identifying individuals malingering during Social Security evaluations is impressive. For example, in a review of 100 disability income applications, Griffin et al. (1996) determined that nearly one in five disability claimants was malingering.

Workers' compensation claims are also fraught with fraud. To obtain workers' compensation benefits, workers must show that they have suffered an injury or disability that affects earning power. Mental stress claims are generally compensable under the workers' compensation system (see Chap. 8). According to the National Insurance Crime Bureau, workers' compensation fraud is the fastest growing segment of insurance fraud with estimated annual costs of $7.2 billion dollars a year. From 2010 to 2011, there was a reported 60 % increase in questionable claims related to a prior injury unrelated to work and a 6 % increase in questionable claims related to the reported disability (Florian 2011).

The US Department of Veterans Affairs (VA) provides disability benefits to service members determined to have service-connected medical or mental conditions. A significant number of service members clearly have a legitimate service connected disability; however, there is also evidence that a significant number may malinger their symptoms. For example, Gold and Frueh (1999) found that either 14 or 22 % of veterans referred for an evaluation for Posttraumatic Stress Disorder (PTSD) were classified as "extreme exaggerators" on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), depending on the criteria used.

Finally, individuals determined to have a disability under the ADA can receive special accommodations, which may serve as a source of secondary gain thereby increasing the risk of malingering. Particular research attention has been given to students claiming an ADA disability in pursuit of special accommodation requests within the academic or testing environment. For example, Wierzbicki and Tyson (2007) determined that 43.5 % of college students seeking a diagnosis of Attention Deficit-Hyperactivity Disorder (ADHD), learning disability (LD), or both did not meet criteria for either diagnosis. The prevalence of malingering for individuals claiming disability under the ADA has not yet been well established but is becoming a focus of increasing interest.

Malingering and Differential Diagnoses

There are several DSM-IV disorders from which malingering should be differentiated. Table 6.1 summarizes key disorders that are differentiated from malingering. Although malingering does involve the intentional exaggeration or feigning of symptoms, the clinician should also be aware that individuals with actual psychiatric symptoms may also malinger additional symptoms during a disability evaluation. In other words, even if an evaluee is malingering some psychiatric symptoms, this does not mean that all reported symptoms are feigned.

Several disorders listed in the DSM are often confused with malingering, particularly Factitious Disorder. Like malingering, Factitious Disorder involves the deliberate production of psychiatric or medical symptoms. In contrast to malingering, however, the Factitious disordered patient is motivated by a desire for sympathy or medical attention as opposed to the malingering patient who is motivated by a more concrete external incentive (such as a disability payment).

Table 6.1 DSM Differential Diagnosis of Malingering

DSM category	DSM diagnosis	DSM code	Intentional symptom production	Motivation
Additional conditions that may be a focus of clinical attention	Malingering	V65.2	Yes	External incentive (such as money or work avoidance)
Factitious disorders	With predominantly psychological symptoms	300.16	Yes	Provider attention
	With predominantly physical symptoms	300.19	Yes	Provider attention
	With combined psychological and physical symptoms	300.19	Yes	Provider attention
	Not otherwise specified (NOS)	300.19	Yes	Provider attention
Somatoform disorders	Somatization disorder	300.81	No	No conscious motivation
	Undifferentiated somatoform disorder	300.82	No	No conscious motivation
	Conversion disorder	300.11	No	No conscious motivation
	Pain disorder	307.80	No	No conscious motivation

The identification of Factitious Disorder can be traced to Asher's (1951) original description of Munchausen syndrome. He attributed several possible motives to Munchausen syndrome, including "a desire to escape from the police" and "a desire to get free board and lodgings for the night" (p. 339), motives that would now clearly classify feigned illness behavior as malingering.

The tendency to include malingering within the Factitious Disorder spectrum was further reinforced by Spiro (1968), who recommended that in individuals with Munchausen syndrome, "malingering should only be diagnosed in the absence of psychiatric illness and the presence of behavior appropriately adaptive to a clear-cut long-term goal" (p. 569). As such, any individual with a psychiatric illness could not be considered a malingerer. There are, however, many examples of patients with factitious disorder who also malinger (Feldman 1995). Eisendrath (1996) described three such individuals, all of whom entered into civil litigation as a result of their feigned physical illnesses. In each case, it appeared that the feigned illness was intended to assume the sick role and only later was used to pursue financial incentives.

The clinician should also consider Somatoform Disorders in the differential diagnosis of malingering. In general, Somatoform Disorders involve the presentation of physical symptoms that cannot be fully explained by a general medical

condition, substance use, or another mental disorder. In the DSM-IV, Somatoform Disorders include the following diagnoses: Conversion Disorder; Somatization Disorder; Hypochondriasis; Body Dysmorphic Disorder; and Pain Disorder. Although a Somatoform Disorder may involve physical symptoms, Somatoform Disorders do not involve the production of symptoms for external incentives. Somatoform Disorders are often connected to psychological issues, of which the person often is unaware.

Persons with Conversion Disorder present with one or more symptoms that affect voluntary motor or sensory function suggestive of a neurological or other medical condition. In contrast to malingering, the symptom is not intentionally produced and is judged to be a result of psychological factors associated with a preceding stressor (McDermott and Feldman 2007). Cases of Pain Disorder involve persistent complaints of pain that are not accounted for by tissue damage.

Somatization Disorder cases involve chronic, unpleasant symptoms (often including pain), which appear to implicate multiple organ symptoms. In both Pain and Somatization Disorders, it is presumed that patients actually experience the pain they are reporting. The pain complaints may covary with psychological stressors. Unlike malingering, the pain reported in both disorders is not under conscious control, nor is it motivated by external incentives. However, there are no reliable methods for affirmatively establishing that pain and other complaints are unconscious and involuntarily produced. When opining that pain and/or physical complaints are *voluntarily* produced, evaluators should explain how this determination was made. Such determinations usually involve objective evidence that symptoms have been feigned as well as clear-cut secondary gain (McDermott and Feldman 2007).

Hypochondriasis is diagnosed in patients who unconsciously interpret physical sensations as indicative of serious disease. These patients may present with minor pains that they fear indicates some unrecognized, potentially life-threatening illness. When hypochondriac patients do simulate or self-induce illnesses, these deceptions often reflect a desire to convince physicians to perform further tests (Hamilton and Feldman 2001). These patients are eager to undergo diagnostic evaluations of all kinds. In contrast, the malingerer is often uncooperative with the diagnostic process and, unlike those with hypochondriasis, is unlikely to show any relief or pleasure in response to negative test results (McDermott and Feldman 2007).

Patients may have an underlying psychiatric illness that accounts for the feigning of symptoms. Consider the example provided by Drob et al. (2009) of a schizophrenic patient who has the delusional belief that the psychiatrist is actually an FBI agent sent by the government to interrogate him. In order to avoid questioning by this perceived persecutor, this patient fakes amnesia, which is detected on both the clinical interview and psychological testing. In this instance, the malingering of memory deficits is not the most relevant factor for treatment.

The same issue is cogent in the feigning of physical illness. The examiner should assess whether or not those patients who present with unexplained somatic complaints actually have an illness that is not detected during an initial evaluation or with subsequent testing. Physicians and other providers may be inclined to

presume that the patient is malingering physical symptoms, but should use caution in making this assumption. Finally, individuals who confabulate should be distinguished from malingerers, because they are unintentionally filling in information that they believed to have happened, when, in fact, it did not happen at all (Newmark et al. 1999; Resnick 2000).

Malingering and Informed Consent Assessment

What the examinee should be told prior to the initiation of the evaluation is of critical importance. As part of the disclosure process, evaluators should disclose their names, the purpose of the evaluation, limits of confidentiality, the purpose for which the information will be used, the absence of current or future treatment relationship, and a warning that once the information is released to a third party, the evaluator does not have control over the information (Gold and Shuman 2009). Opinions vary regarding whether or not an examinee should be specifically warned that the evaluation will also assess possible malingering. Such warnings are generally not recommended *immediately* prior to giving a test of malingering due to the risk of decreasing the effectiveness of the assessment (Gervais et al. 2001; Iverson 2006).

Are such warnings ever appropriate at *any* point in the examination? Youngjohn et al. (1995) suggested that cautioning examinees of special techniques to detect malingering will likely reduce the sensitivity of these techniques. In contrast, Slick and Iverson (2003) recommend that it is ethically appropriate to provide a general warning *at the beginning* of the evaluation that malingering may be detected. These divergent opinions were also reflected in a survey of 29 forensic neuropsychologists who were asked the following question: "Prior to commencing testing, do you give litigants any type of warning regarding the fact that psychological tests may be sensitive to poor effort, exaggeration or faking of deficits?" Fifty four percent answered that they "never" provided such a warning, 8.3 % reported that they "sometimes" gave this warning, and 37.5 % responded that they "always" gave this type of warning (Slick et al. 2004).

If the examiner elects to provide a caution regarding the assessment of malingering, written statements to be included in the informed consent section of the report might read as:

- I informed the examinee at the beginning of the interview that methods of detecting exaggeration and poor effort were part of the evaluation process; or
- I informed the examinee at the beginning of the interview that I was evaluating his/her diagnosis and it was important for him/her to answer my questions as accurately as possible.

Generally speaking, option two is preferred to avoid "priming" the examinee, and thus diminishing the chance of accurately detecting malingering. In addition, the second warning may actually enhance the evaluator's ability to detect

malingering. It hardly can be argued that examinees should NOT be warned to answer as honestly as they can. Finally, the second option is appropriate whether or not the referral question specifically requests an evaluation of malingering in addition to general assessment of a psychiatric disorder.

Malingering Assessment Methods

The optimal assessment of malingering is multimodal and generally involves a clinical interview, a review of relevant collateral information, and psychological testing when indicated. Comparing the examinee's report of symptoms to any prior reports and collateral records is particularly important. In a study surveying 105 board-certified orthopedic surgeons and neurosurgeons from six states, factors that surgeons most strongly considered in making their estimates of malingering were not in fact related to external incentive, but were more closely associated with inconsistencies in the medical examination (Leavitt and Sweet 1986). The two inconsistencies most frequently cited as suggestive of malingering were weakness in the exam not seen in other activities and reported impairment disproportionate to the objective findings. The survey results indicate that malingering should be considered when there is an inconsistency between reports and observations, or inconsistencies between various methods of assessment. The various data should converge in order to best explain the relationship of malingering to the presentation of particular symptoms.

Unless examinees confess that they have fabricated symptoms for some type of external gain, the assessment of malingering will require collateral information from a variety of potential sources. The examiner should incorporate multiple sources of information to support or refute malingering.

Interview Indicators of Malingering

When evaluating malingering, the evaluator should begin by asking open-ended questions about the reported symptoms. This initial approach allows the examinee an opportunity to describe symptoms without specific prompts. Such general questions might include the following:

- Describe any symptoms you are experiencing.
- Is there anything else you can report that would help me understand your situation more?
- When did your symptoms first start?
- Had you ever had any of these symptoms before?
- Have you noticed any change in your symptoms over time?
- Is there anything that you have learned that helps decrease (or worsen) your symptoms?

Because information regarding psychiatric symptoms is readily available through a variety of sources about diagnoses, the examiner may also wish to ask:

- Do you know any one else who has similar symptoms (or disorder)?
- Have you read or learned about this symptom (or disorder) from any source? If so, what?
- Were you given any specific instructions regarding how to describe your symptoms (or disorder) during this evaluation?

An evaluator should carefully record any inconsistencies that are noted during the course of the evaluation. Inconsistencies that may indicate malingering during the course of the interview are as follows (McDermott et al. 2008):

1. The individual presents an inconsistency in reporting an alleged symptom. For example, an evaluee may report an inability to organize thoughts while speaking eloquently and cogently throughout the interview. One common presentation of inconsistency in reporting is that of a claimant who reports difficulty recalling his or her age, birthday, or other obvious autobiographical material when told they are being "tested" with specific interview questions, yet demonstrates no other similar memory deficits during other portions of the interview.
2. The evaluator observes that the malingerer's exhibited behavior differs significantly from the reported symptoms. The person who describes active, continuous, disturbing hallucinations during the interview but shows no evidence of distraction illustrates this type of inconsistency.
3. The evaluee behaves in a dramatically different way depending on who is observing. This disparity in presentation is illustrated by a person who acts in a confused, disoriented manner in the clinician's office and shortly after leaving the evaluation room is observed to be chatting casually with office staff.
4. Malingerers often report symptoms that are inconsistent with how genuine symptoms normally manifest. For example, a person feigning PTSD may report their anxiety symptoms worsen over time when the more typical course of this disorder is a gradual fading of symptoms.
5. The evaluee's actual level of functioning is inconsistent with the severity of their reported symptoms. Evaluees who claim incapacitating depression while exercising daily, managing their finances, and organizing complicated community volunteer events represent an obvious illustration of this incongruence between self-report and actual ability.
6. The examinee's report of prior history significantly contradicts records and other collateral information. In particular, individuals who feign or exaggerate symptoms may underreport prior psychiatric treatment, minimize prior mental health symptoms, or misrepresent the presence or contribution of other important life stressors to their alleged mental disability.
7. Collateral informant's history is not consistent with the claimant's history. For this reason, it is important to conduct collateral interviews separately when

possible in order to compare and contrast the examinee's self-report with other individuals who are interviewed.

In applying the above principles to the case example of Mr. Grove, the examiner observes that Mr. Grove's reported complaints of depression are inconsistent with his excellent use of humor, normal range of motor movements, and proactive social engagement with the office staff when he thinks the evaluator is not observing him. His ability to accurately remember the exact questions posed to him during his 4-hour evaluation is highly inconsistent when contrasted to his report that he has no short-term memory capacity. In addition, Mr. Grove's minimization of any prior history of depression raises serious concerns regarding the accuracy of his reported symptoms.

The evaluator seeks further collateral information and the insurance company provides its private investigator's digital surveillance video. The submitted video shows Mr. Grove driving at multiple times during the day, including trips to the golf course where he wins his local tournament and to the local casino where he is observed gambling with friends. Mr. Grove's presentation is clearly suspicious for malingering, particularly with the secondary gain of not having to return to his exhausting job while continuing to collect full disability benefits.

Psychological Testing Indicators of Malingering

Psychological testing can serve as a useful adjunct when evaluating potential malingering during the course of a disability evaluation and is a valuable component in the multi-method assessment process (see Chap. 5 for general discussion of psychological testing in disability evaluations). The specific test or tests selected for the evaluation will likely vary depending on the individual case specifics and type of symptoms reported.

As discussed previously, the assessment of malingering requires the determination of intent. McGrath et al. (2010) provide an informative review of response biases, defined as the patient responding in a manner that is unrelated to the item content. One type of response bias most relevant for malingering is negative impression management, which he defines as "responding in an excessively aberrant manner" (p. 451). Response biases can include styles that are independent of intentional effort (e.g., inconsistent responding or acquiescence).

In fact, Bush et al. (2005) distinguish between symptom validity (accuracy of the examinees' behavioral presentation), response bias, effort, malingering, and dissimulation. They note that symptom validity tests (SVTs) are commonly employed as one of several strategies in the multi-method assessment of malingering. Rogers (1993) also emphasizes the importance of SVTs in assessing malingering when he writes, "One notable advantage of the SVT over all other strategies is the lack of other viable explanations for below-chance performances" (p. 262).

In general, symptom validity testing compares the evaluee's performance on a validated test designed to measure the feigning or exaggeration of symptoms.

Various testing strategies to assist evaluating symptom validity include the following:

1. "*Floor effect*": The concept known as the "floor effect" involves the incorporation of extremely easy questions or tasks in the testing methodology. Such items generally involve over-learned information or simple skills that are easily retained, even in those with limited intellectual functioning. Examples of such items include requests to perform simple arithmetic calculations (i.e., 2 + 2=?), questions about basic common information (i.e., Who is President of the United States?), queries regarding basic autographical information (such as one's age or birthday), requests to complete a simple sequence (i.e., a, b, _; 3, 4, __), or instructions to copy or recall simple diagrams or designs.
2. *Forced-choice memory paradigm*: In a forced-choice testing paradigm, individuals are shown a stimulus (such as a picture or a word) and after a brief delay are asked to select the correct response from one of usually two options. An evaluee is suspected of giving suboptimal effort during the test if he or she performs worse than chance (50 % with two options) or below established cut scores. There are numerous examples of these types of tests. One such test is the Validity Indicator Profile (VIP; Frederick and Crosby 2000), developed to assess feigned cognitive deficits. The VIP is one of the few SVTs that purports to directly measure effort of the evaluee.
3. *Unusual patterns or responses*: Many psychological tests evaluate if the examinee provides atypical responses to questions about mental health symptoms. Examples of such atypical responses include symptoms rarely presented by those with a genuine mental disorder, an unusual combination of symptoms, highly improbable or absurd symptoms, or an inconsistency in reported symptoms as compared to actual behavior observed during the evaluation or with prior reported symptoms on the test.

The Structured Interview of Reported Symptoms (SIRS: Rogers et al. 1992) is frequently described as the "gold standard" measure of feigning. The SIRS consists of 172 items that are verbally presented to the examinee. This instrument consists of eight primary scales and five supplementary scales designed to assess response styles such as defensiveness. The SIRS has been recently revised (SIRS-2), although the primary scales remain unchanged. A new supplementary scale was added (improbable failure (IF)) which was developed to assess feigned cognitive deficits. The SIRS-2 provides an algorithm for decision making that includes the use of composite scores as well as the primary scales. No information has yet been provided on the likelihood of feigning based on this algorithm.

4. *Validity indicator scales on psychological testing*: Self-report tests developed as broad-based assessments of psychopathology such as the Minnesota Multiphasic Personality Inventory Second Edition (MMPI-2) and the Personality Assessment Inventory (PAI) also include validity scales. These scales assess various response styles and biases as well as the degree to which the individual is over-reporting or under-reporting symptoms as compared to group norms. For

example, the MMPI-2 contains validity scales that assess inconsistent responding (VRIN), "yea or nay-saying" (TRIN), over reporting of psychopathology (F and Fp) and defensiveness (K) to name a few. The PAI also contains validity scales to assess exaggeration (NIM), defensiveness or underreporting (PIM) as well as inconsistent responding (INF and INC). These broad-based assessments can provide very useful information when combined with other assessments designed specifically to examine feigning and are a useful component in the multi-method model of assessment.

Psychological testing may be helpful in assessing the validity of the individual's reported mental health and/or cognitive symptoms. Poor performance on any one test may not be definitive for malingering, as there could be other reasons that explain the evaluee's suboptimal performance outside of a deliberate intent to mislead the examiner for secondary gain. However, poor performance on multiple SVTs increases the likelihood that the individual is deliberately feigning or exaggerating their reported symptoms (Chafetz 2008).

In Mr. Grove's case, the evaluator administered two forced-choice tests to evaluate Mr. Grove's claimed memory deficits. On both tests, Mr. Grove scored significantly below chance indicating that he was likely purposely misleading the examiner regarding his actual abilities. Mr. Grove's MMPI-2 results were interpreted as invalid due to his markedly elevated score on one of the validity scales that indicated he was over-reporting symptoms.

Malingering Assessment of Specific Disorders

Although it is beyond the scope of this chapter to summarize the literature regarding the assessment of all potentially malingered symptoms, key factors to evaluate malingering in psychotic disorders, PTSD, depression, neurocognitive impairment, and intellectual limitations are reviewed below. The general clinical and psychological assessment strategies to detect malingering highlighted above are relevant to evaluations of most psychiatric symptoms. The sections below primarily highlight the indicators of malingering gleaned from the clinical interview and history.

Malingered Psychosis

Individuals who present as potentially psychotic should be carefully observed to evaluate if their behavior and interactions are consistent with the type and severity of reported symptoms. Resnick (1997) has suggested a clinical decision model for the assessment of malingering psychosis outlined in Table 6.2 below that can be useful when organizing the malingering opinion in a forensic report.

Table 6.2 Clinical Decision Model for the Assessment of Malingered Psychosis

A.	Understandable motive to malinger
B.	Marked variability of presentation as observed in at least one of the following
	1. Marked discrepancies in interview and noninterview behavior
	2. Gross inconsistencies in reported psychotic symptoms
	3. Blatant contradictions between reported prior episodes and documented psychiatric history
C.	Improbable psychiatric symptoms as evidenced by one or more of the following
	1. Reporting elaborate psychotic symptoms that lack common paranoid, grandiose, or religious themes
	2. Sudden emergence of purported psychotic symptoms to explain antisocial behavior
	3. Atypical hallucinations or delusions
D.	Confirmation of malingered psychosis by either
	1. Admission of malingering following confirmation
	2. Presence of strong corroboration information, such as psychometric data or history of malingering

Reference Resnick (1997)

In regard to specific psychotic symptoms, Resnick (1997) has noted malingered hallucinations should be suspected if any of a combination of the following is observed:

- Continuous rather than intermittent hallucinations.
- Vague or inaudible hallucinations.
- Hallucinations not associated with delusions.
- Inability to state strategies to diminish auditory hallucinations.
- Self-report that all command hallucinations were obeyed.
- Visual hallucinations in black and white.

Some of the above symptoms are rarely reported (such as visual hallucinations in black and white), and therefore may not always serve as a useful indicator of malingering. However, when such atypical symptoms are described, the likelihood of malingering is increased and should prompt further investigation.

Resnick (1997) has also noted that malingered delusions should be considered if a combination of the following factors is present:

- Abrupt onset or termination of delusion.
- Eagerness to call attention to delusions.
- Conduct markedly inconsistent with delusions.
- Bizarre content without disordered thinking.

Using psychological testing as an adjunct to the clinical assessment can be extremely valuable when assessing feigned psychosis. Several instruments have been developed specifically to assess feigned psychiatric (including psychotic) symptoms (see Chap. 5). The SIRS, previously discussed in the section on psychological assessments, can be extremely valuable in this regard. Three of the

eight primary scales on the SIRS are most likely to be elevated in feigned psychotic symptoms: Rare Symptoms, Improbable/Absurd Symptoms, and Blatant Symptoms. Each of these scales includes symptoms many laypersons would associate with severe mental illness. Broad-based psychological assessments such as the MMPI-2 can also be a useful adjunct, primarily because of the inclusion of validity scales specifically designed to assess response bias.

Malingered Posttraumatic Stress Disorder

PTSD may be especially easy to malinger as the diagnosis is primarily based on self-report. Information about PTSD criteria is readily available: more than 2 million citations describing PTSD were noted in a recent Google search (Hall and Hall 2006). Furthermore, many of the standard assessment instruments to assess PTSD use a structured interview format with questions that are obviously directed toward possible PTSD symptoms. Questioning in this suggestive manner may actually teach specific PTSD symptoms to the examinee thereby enhancing the possibility of successful feigning.

Breslau (2009) noted that the lifetime cumulative exposure to any traumatic event in a national sample of the US population in 2000 was 82.8 %. Despite the vast majority of the population being exposed to one or more traumatic event, only a minority of trauma victims (<10 %) developed PTSD. Boals and Hathaway (2010) noted the importance of reviewing the E (duration of symptoms greater than a month) and F criteria (clinically significant distress or impairment) for PTSD in the DSM-IV in addition to the reported symptoms. In particular, when E and F criteria were included in individuals reporting PTSD symptoms, those meeting PTSD criteria dropped from 20 % to 3 %. Likewise, Rasco and North (2010) studied 261 survivors who were exposed to disaster to determine the extent to which the disaster affected their future employment. At the time of the disasters, 86 % were working; at follow-up, 84 % were working. Long-standing employment disability was virtually nonexistent in this highly exposed sample of trauma survivors.

Knowledge of genuine PTSD symptom presentation is important in addition to an understanding of the relationship of reported PTSD symptoms to the alleged stressor. The following approach may assist the evaluator in assessing potentially feigned PTSD symptoms:

1. Initially, use open-ended inquiries when asking about alleged PTSD symptoms. Likewise, avoid leading questions that include information as to how genuine PTSD symptoms present. An example of a leading question in this context is: "Do you have intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event?" Instead, consider initially asking a more general question such as, "Please describe all of the symptoms you have experienced."

2. Firmly request detailed illustration of symptoms. DSM criteria are readily available and therefore a malingerer may be able to report basic symptoms from easily obtained information. However, malingerers may have difficulty elaborating on criteria with personal life details and are more likely to report vague symptoms with an artificial quality (Pitman et al. 2006).
3. Inquire as to both duration of exposure to PTSD stressor and proximity to stressor. Increased exposure and closer proximity to stressor increases the risk of acquiring PTSD symptoms (Bokszczanin 2007). Individuals with minimal exposure and/or less proximity to the stressor are less likely to develop PTSD symptoms.
4. Inquire into rare or improbable symptoms not typically seen in PTSD. Consider asking about symptoms not associated with PTSD such as inflated self-esteem, a decreased need for sleep, increased talkativeness or impulsive spending. Malingerers are more likely to endorse symptoms that are inconsistent with PTSD.
5. Take a careful dream/nightmare history. Disturbed sleep is a hallmark of PTSD. Up to 75 % report nightmares whereas about 5 % of all adults report nightmares (Kilpatrick et al. 1994). Characteristics of genuine PTSD nightmares versus malingered nightmares include increased nocturnal awakenings, awakening earlier in the evening, increases in body movements, and increases in REM abnormalities. Genuine posttraumatic nightmares in those exposed to non-combat trauma typically diminish after several weeks or months, and psychotherapy is likely to hasten their resolution.

There is a mixed literature regarding whether or not reporting exact replications of the traumatic stressor in nightmares is consistent with genuine versus malingered nightmares. Wittmann et al. (2007) reviewed several studies and found that approximately 50 % of participants reported replicative post-trauma nightmares, while another study of treatment seeking individuals found that only 20 % of trauma-exposed individuals reported replicative nightmares (Davis and Wright 2007).

6. Investigate reported "flashbacks." Genuine flashbacks involve the individual reliving components of the event and behaving as though the traumatic event is occurring at that moment. Characteristics of malingered flashbacks include a Hollywood portrayal of events in an overly dramatic manner without behaviors consistent with the person's traumatic event exposure (Hall and Hall 2006).
7. Look for actual evidence of concentration deficits, irritability, hypervigilance, or an increased startle response during the interview (Resnick 1995).
8. Obtain details regarding daily activities before and after the trauma. Individuals who falsely claim PTSD may describe a much higher level of functioning and ability prior to the alleged trauma that is inconsistent with the actual contemporaneous record. Investigate if the person has an ability to enjoy recreation while reporting an inability to work. In addition, the evaluee may describe a limited involvement in activities (such as going to the gym or out to social events) that contradicts what they are actually doing (Resnick 1995).

Hall and Hall (2006) have suggested that malingered PTSD should be suspected when the examinee:

- Calls attention to symptoms early and frequently during the interview;
- Reports flashbacks where only visual images are experienced without additional components such as auditory, olfactory, or tactile sensations;
- Reports no problems prior to the alleged incident;
- Seeks treatment only in the context of litigation;
- Claims complete amnesia where no actions are recalled;
- Describes sleep difficulties not confirmed by partner;
- Exaggerates severity of symptoms with textbook rehearsed sounding answers;
- Enjoys recreational activities and justifies such activities as therapeutic;
- Reports chronic nonfluctuating symptoms that do not improve to some extent with time or treatment;
- Reports no survivor guilt in situations where others present and/or harmed;
- Has a history of multiple lawsuits and an unstable work history.

In addition to the general psychological testing strategies to evaluate malingering outlined above, the Morel Emotional Numbing Test (MENT) has been described as a SVT specific to PTSD. This instrument assesses affect recognition in a two-alternative forced-choice format. Many of the SVT's commonly used are primarily measures of memory malingering, whereas the MENT assesses primarily PTSD malingering. Using a two-alternative formats, the MENT is designed to give the test taker the impression that deficits in affect recognition are pathognomonic of PTSD. The evaluee is told, "Some individuals with PTSD may have difficulty recognizing facial expressions" and they are then asked to note the emotion associated with the facial expression they are shown. According to Morel (1998), any adult who puts forth a reasonable amount of effort (except for the visually impaired or those with less than a 3rd grade reading level) can complete the task with 90–100 % accuracy even if they have PTSD.

The Atypical Response (ATR) scale of the Trauma Symptom Inventory-Second Edition (TSI-2) has also been described as helpful in distinguishing genuine symptoms of PTSD from simulated PTSD (TSI-2, Briere 2010). In their study of 75 undergraduate students trained to simulate PTSD and 49 undergraduate students with genuine PTSD, Gray et al. (2010) determined that the ATR correctly classified 75 % of genuinely distressed individuals and 74 % of PTSD simulators.

Malingered Depression

In the case of Mr. Grove, his self-reported depressive symptoms did not match his treating psychiatrist's observation during the course of treatment. For example, Mr. Grove told jokes, had a normal range of facial expressions and motor movements, and his concentration and memory was excellent except when he was told that he was "being tested." At those moments, he suddenly presented with

marked memory impairments that were inconsistent with his unimpaired memory throughout other portions of the examination. Although Mr. Grove reported that he had no appetite and "wasn't eating," a review of his weight, documented in his outpatient medical records noted that Mr. Grove had actually gained two pounds. He also cancelled an appointment that had been arranged for more detailed psychological testing because he was "going on a scuba vacation."

As with PTSD symptoms, a diagnosis of depression relies significantly on an individual's self-report. Multiple interviews and more lengthy evaluations (greater than 1 hour) both provide opportunities to assess if observed symptoms and behavior are consistent with the report of depressive symptoms. The possibility of malingered depression should be considered if the examinee demonstrates one or more of the following:

- Excellent concentration during a lengthy interview despite claims that they are unable to concentrate or focus;
- Sense of humor (joking and laughing) in contrast to a depressed mood or restricted affect;
- A normal range of motor movements without evidence of psychomotor agitation or retardation;
- No loss or gain of weight noted in actual records in contrast to reported change in appetite or weight;
- Active exercise or physical activity in contrast to reports of extreme fatigue;
- Enjoyment of vacations or other social activities in contrast to reports of social isolation;
- Psychological testing strategies outlined above may be particularly useful in further assessing the degree, if any, of feigned or exaggerated depression.

Malingered Cognitive Impairment

Slick et al. (1999) coined the term "Malingering of Neurocognitive Dysfunction" (MND), which they note is characterized by the intentional exaggeration or fabrication of cognitive dysfunction for the purpose of obtaining some external incentive or avoiding responsibility. These authors developed four general criteria to consider when evaluating malingered impaired cognition and these criteria are summarized in Table 6.3 below.

These authors provided specific guidelines utilizing these four criteria to categorize MND into three categories: definite MND; probable MND; and possible MND.

The National Academy of Neuropsychology (NAN) issued similar guidelines regarding symptom validity assessment on neurocognitive tests as outlined below (Bush et al. 2005):

Table 6.3 Slick criteria for malingering neurocognitive dysfunction

Criteria	Definition	Examples
A: Presence of a substantial external incentive	At least one clearly identifiable and substantial external incentive present at the time of the examination	• Personal injury settlement • Avoidance of child support • Avoidance of public service
B: Evidence from neuropsychological testing	Fabrication or exaggeration on at least one neuropsychological test	• Scoring below chance on one or more forced-choice measures • Discrepancy between test data and known patterns of brain functioning • Discrepancy between test data and observed behavior
C: Evidence from self-report	Significant inconsistencies in the person's self-report that indicate possible malingering of cognitive deficits but not sufficient for diagnosis.	• Self-report is inconsistent with documented history • Self-report is inconsistent with known patterns of brain functioning • Self-report is discrepant with behavioral observations
D: Behaviors noted in criteria B and C are the product of an informed, rational, and volitional effort aimed to achieve an external incentive	Behaviors noted in criteria B and C are not fully accounted for by psychiatric, neurological, or developmental factors	• Person has a psychological need to play the "sick role" • Person has command hallucinations affecting test concentration and performance

Reference Slick et al. (1999)

- Performance consistent with feigning on empirically derived indices obtained from scores of ability measures.
- Invalid responding on ability measures.
- Test results are inconsistent with known patterns of brain functioning.
- Test results are inconsistent with observed behavior.
- Test results are inconsistent with reliable collateral reports.
- Test results are inconsistent with documented background information.

In addition to specific indicators of feigning as elicited through the use of neurocognitive testing, the evaluator should incorporate other standard strategies highlighted above. In particular, the evaluee's observed abilities during the interview and testing period should be carefully compared to his or her reported deficits and the historical record.

Evaluators should use caution in incorporating the same SVTs and neurocognitive test indicators for malingering utilized for reported cognitive dysfunction

when evaluating individuals with intellectual disabilities, such as mental retardation. The DSM (American Psychiatric Association 2000) criteria for mental retardation includes three basic components which are:

1. An IQ of approximately 70 or below on an individually administered IQ test;
2. Current impairment in at least two areas of adaptive functioning (such as communication, self-care, home living, social/interpersonal skills, and use of community resources); and
3. Onset prior to age 18.

Unfortunately, individuals can successfully feign deficits on tests designed to measure intelligence. For example, Graue et al. (2007) showed that community volunteers were able to feign a lowered I.Q. on the WAIS-III when instructed to do so and embedded tests of malingering (Digit Span Scaled Score and Reliable Digit Span) did not reliably identify such feigning. Likewise, measures of adaptive behavior, such as the Adaptive Behavior Assessment System (2nd ed.) (ABAS-II; Harrison and Oakland), are also susceptible to manipulation (Doane and Salekin 2009).

Unlike abundant studies examining characteristics of feigned cognitive impairment, there is limited research on appropriate testing methods for feigned intellectual disabilities and/or mental retardation. In their survey of 50 forensic psychology diplomats, Victor and Boone (2007), determined that 64 % reported using the TOMM, 50 % reported used the VIP, and 44 % reported using the Rey-15-Item test to assess malingered intellectual disabilities, despite limited data for the use of these measures with this population. Of particular concern, individuals with intellectual disabilities may be falsely identified as not providing adequate effort on many of the effort tests commonly used to assess feigned cognitive impairment (Salekin and Doane 2009).

In an effort to evaluate the utility of the SIRS-2 in this population, Weiss et al. (2011) administered the SIRS-2 to a sample of 43 persons diagnosed with intellectual disabilities with no incentive to feign psychiatric symptoms. She found that 23.3 % of the sample was misclassified as feigning psychiatric symptoms using the original SIRS scoring system. When the modified scoring algorithm described in the SIRS-2 manual was implemented, only 7.0 % of the sample was incorrectly identified as feigning. Although this represents a significant improvement, the relatively high percentage of potential false positives raises particular concern. Those individuals with a comorbid psychiatric diagnosis were at particular risk for being misclassified as malingering (Weiss et al. 2011).

In an attempt to address limitations of current effort tests and structured interviews administered to individuals claiming low cognitive functioning during their Social Security disability evaluations, Chafetz et al. (2007) developed the Symptom Validity Scale (SVS) for low-functioning individuals. The SVS utilizes 11 embedded indicators validated for use in low cognitive functioning individuals. The embedded indicators utilize a variety of strategies to assess effort, including missing simple arithmetic calculations, performing simple sequences, not knowing or being able to pick the US President from a list of names, missing personal information, providing "Ganser like" answers (i.e. near misses to easy questions),

performing poorly on a variety of target items from the Weschler scales, providing a highly improbable response to questions (i.e., What is the shape of a ball? "A triangle"), and claiming improbable pathology (such as seeing a ghost).

In light of limited research regarding the use of standard tests of effort in assessing feigned intellectual deficits along with limited utility of embedded malingered indices in intelligence tests, examiners must first carefully review the individual's developmental history prior to adulthood. In particular, absent a head injury or insult (such as a stroke), intellectual deficits do not have a sudden onset in late adolescence or early adulthood. In addition, important collateral information to obtain and review to provide additional assessment of potential malingering includes the following:

- All school records prior to age 18. The evaluator should review if the claimant was enrolled in special education classes, ever repeated a grade, ever failed a subject, or had any behavioral problems reasonably attributable to an identified intellectual disability;
- Any educational testing or individualized education plans;
- Interviews with parents, caretakers, or guardians familiar with the person's development and functioning;
- Pediatric and other medical records;
- Occupational, vocational, or other employment records.

Malingering and Disability Documentation

A clinician's documentation of a patient's mental status examination, diagnosis, and treatment is usually a critical component of the disability determination. The treating clinician may understandably feel uncomfortable when a patient requests that the treatment provider support a disability claim, and the clinician has insufficient information to render an opinion or believes that the patient is malingering psychiatric symptoms. In their survey of forensic and nonforensic psychiatrists' practice patterns regarding social security disability evaluations, Paul et al. (2011) posed the following question: "Have you ever indicated that a patient was disabled to help him/her when you thought that he/she really could work?" Fourteen percent of nonforensic psychiatrists and 20 % of forensic psychiatrists answered "yes" to this question, suggesting that a substantial minority of evaluators report that their patient is disabled when they do not really believe this to be true. An evaluator who reports a person is disabled when they know they are not may face serious consequences. For example, the Social Security Administration's (SSA) Office of the Inspector General has an enforcement program called the "Cooperative Disability Investigations" to prevent fraud in SSA disability programs. Disability fraud can involve malingering and exaggerating or lying about disabilities, and can result in criminal prosecution or monetary penalties (Office of the Inspector General, Social Security Administration 2012).

What are some appropriate approaches for the treating mental health provider in this situation? Thorough documentation of the steps taken and information provided is essential in all cases, and particularly when the clinician suspects malingering. Important aspects of the evaluation and treatment to document include the following:

- *Informed consent and limitations to confidentiality*. An example chart or report notation regarding this issue may read as:

  Mr. Grove requested that I complete a disability form for his private insurer, so that he could submit this form for his disability claim. I informed Mr. Grove that this request would limit the confidentiality of our treatment and I would be required to honestly report his diagnosis, my observations, his treatment progress, and level of functioning. I also told Mr. Grove that such disclosures may or may not assist his disability claim. Mr. Grove stated that he understood, requested that I submit the information to his insurance carrier, and signed the non-confidentiality disclosure form.

- *Clear identification of self-reported symptoms, especially when described symptoms are due to self-report alone*. In both the clinical chart and documentation submitted to the disability-reviewing agency, the provider should carefully note when symptoms represent the patient's communication. By writing in this manner, the provider is not suggesting that they have independently verified the symptoms or that the objective evidence supports the symptoms. The provider is appropriately recording what the patient has told them. An example documentation of a patient's self-report might read as,

  Mr. Grove reported that he has had difficulty sleeping and has experienced nightmares since his car accident. He also stated that he has experienced a decreased appetite and "hasn't been eating" in nearly 4 weeks.

- *Request for collateral information when appropriate*. When evaluating a patient's disability claim, the provider may find it useful to review collateral records (such as medical records or other therapy records) and to interview those who can provide additional information regarding the patient's symptoms and level of functioning. The provider should note all documents reviewed and collateral contacts interviewed. If the patient refuses to sign a release of information for collateral records or collateral interviews, the evaluator should consider documenting this refusal in the following manner:

  I asked Mr. Grove to sign a release of information form that authorized me to request his non-psychiatric treatment records, so that I could address his request that I submit a report related to his disability claim. In addition, I asked to interview his wife. Mr. Grove stated, "You have all the information you need" and refused to sign any releases for outside information or to allow me to interview his wife. I informed Mr. Grove that I would have to note this refusal in the letter I submitted to his disability carrier and that his restrictions may limit my opinions regarding his claimed disability.

- *Psychological testing results* (Scott and McDermott 2011): An examinee may interact with the examiner and respond to psychological test questions in a variety of ways that indicate their responses are not consistent with the objective evidence. As discussed above, such presentations are often referred to as the person's *response style.* The examiner should be familiar with definitions of these various response styles and appropriately incorporate them in the disability report or submitted form. Malingering represents only one of many possible response styles. Other terms used to describe interview behavior or responses on psychological testing include faking, simulating, dissimulating, magnifying, amplifying, and exaggerating. Numerous terms have been used to describe a person's *effort level* on psychological tests or neuropsychological testing. Such terms include non-optimal effort, submaximal effort, incomplete effort, negative response bias, and suboptimal effort and poor effort (Iverson 2006).

Iverson (2006) recommends that the term *poor effort* be used when a person underperforms on neuropsychological tests and the term *exaggerating* be used to describe symptom reporting during an interview, during psychological testing, or through behavioral observations. In contrast to these recommendations, Rogers and Payne (2006) caution against the use of terms such as suboptimal or poor effort because a person's ideal effort cannot be reliably measured. In Mr. Grove's case, the documentation addressing the discrepancies in his report as compared to psychological testing and interview observations could be written as follows:

Mr. Grove reported that he was extremely depressed since his accident and that his nightmares of the accident were becoming more frequent and more severe each day. He also stated that he had lost his appetite and had not been eating for several weeks. In contrast to his report, I observed him during my evaluations to frequently smile, to joke, to have a good degree of energy, and to have excellent concentration when not being formally tested.

I administered the Test of Memory Malingering (TOMM) to evaluate Mr. Grove's disability claim of memory loss. The TOMM is a symptom validity test that involves presenting the individual with 50 different picture drawings. The person is then asked to identify which drawing they were previously shown when presented two pictures (one picture they have seen and one they have not). The TOMM requires that the tested person have at least two trials to select the pictures that they were shown. By chance alone, a person should correctly identify at least 50 % (i.e., 25 of 50 pictures) and their recognition performance should improve on the second trial.

Mr. Grove correctly identified 20 of the 50 pictures on the first trial and 16 of 50 pictures on the second trial. His performance was below chance on both trials. He performed worse on the second trial than he did on the first trial. His performance is opposite the pattern typically seen in people who are genuinely reporting their symptoms. His performance on the TOMM indicates that he presented his memory ability in a manner to appear more impaired than he actually is.

In addition to appropriate documentation, the clinician should consider the following two approaches when addressing potential malingering with their client:

1. Openly discuss with the patient that the diagnosis and observations do not support their disability claim. A provider can attempt to make this a therapeutic intervention to work with the patient to better understand motivations for the disability claim and alternative solutions in their life. If the patient is not open to this discussion and ends the treatment relationship, the provider should consider referring the patient for a second opinion.
2. Recommend that the patient have an independent forensic mental health evaluation. Such referrals may be warranted in situations where treating clinicians do not have the appropriate training for conducting the necessary testing or they are unable to provide detailed evaluations, which are all the more important when malingering is likely.

Conclusion

There is a substantial risk of malingering during the course of a disability evaluation. Both treatment providers and forensic evaluators should use a multifaceted approach to the assessment of malingering. Evaluators should carefully consider the possibility of malingering when the patient's presentation is characterized by various inconsistencies, when objective testing does not support the reported symptoms, and when collateral information indicates a higher level of functioning than self-reported. Malingering assessments can be extremely challenging as malingering itself involves two opposite ends of the clinical and forensic spectrum: it is so easy to suspect, yet so difficult to prove.

Key Points

1. The threshold for suspecting malingering in disability claims should be high and mental health professionals should carefully consider the possibility of malingering when conducting disability evaluations.
2. The evaluator should focus on how the examinee presents symptoms during the interview and be familiar with characteristics of genuine versus malingered symptomatology.
3. The evaluator should utilize psychological testing relevant to the symptoms reported. Use of multiple symptom validity tests combined with the clinical assessment improves the examiner's ability to determine the likelihood of malingering.
4. The evaluator should acquire as many relevant records as possible and interview as many relevant contacts as feasible in order to compare the evaluee's reported symptoms with collateral evidence.
5. Mental health professionals should report malingering only when they have sufficient information to indicate that the person is intentionally feigning their symptoms for external gain. The most direct evidence for malingering involves the patient's admission that they were fabricating or exaggerating symptoms.

References

American Medical Association: Federal fraud and abuse laws. http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/regulatory-compliance-topics/health-care-fraud-abuse/federal-fraud-enforcement-physician-compliance/federal-fraud-abuse-laws.page. Accessed 15 Apr 2012

American Psychiatric Association: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (Text Revision). American Psychiatric Association, Washington, DC (2000)

Anfang, S.A., Wall, B.W.: Psychiatric fitness-for-duty evaluations. Psychiatr. Clin. N. Am. **29**, 675–693 (2006)

Asher, R.: Munchausen's syndrome. Lancet **1**, 339–341 (1951)

Boals, A., Hathaway, L.M.: The importance of the DSM IV E and F criteria in self report assessments of PTSD. J. Anxiety Disord. **24**, 161–166 (2010)

Bokszczanin, A.: PTSD symptoms in children and adolescents 28 months after a flood: Age and gender differences. J. Trauma. Stress **20**, 347–351 (2007)

Breslau, N.: The epidemiology of trauma, PTSD, and other posttrauma disorders. Trauma Violence Abuse **10**, 198–210 (2009)

Briere, J.: Trauma Symptom Inventory (TSI-2): Professional Manual, 2nd edn. Psychological Assessment Resources, Odessa (2010)

Bush, S.S., Ruff, R.M., Troster, A.I., et al.: Symptom validity assessment: Practice issues and medical necessity NAN policy and planning committee. Arch. Clin. Neuropsychol. **20**, 419–426 (2005)

Chafetz, M.D., Abrahams, J.P., Kohlmaier, J.: Malingering on the Social Security Disability Consultative Exam: A new rating scale. Arch. Clin. Neuropsychol. **22**, 1–14 (2007)

Chafetz, M.D.: Malingering on the Social Security Disability Consultative Exam: Predictors and base rates. Clin. Neuropsychol. **22**, 529–546 (2008)

Christopher, P.P., Arikan, R., Pinals, D.A., et al.: Evaluating psychiatric disability: Differences by forensic expertise. J. Am. Acad. Psychiatry Law **39**, 183–188 (2011)

Dahl, M., Myerson, N.: Social Security Disability Insurance: Participation trends and their fiscal implications. Congressional Budget Office (2010). http://www.cbo.gov/ftpdocs/116xx/doc11673/07-22-SSDisabilityIns_Brief.pdf. Accessed 6 Feb 2012

Davis, J.L., Wright, D.C.: Randomized clinical trial for treatment of chronic nightmares in trauma-exposed adults. J. Trauma. Stress **20**(2), 123–133 (2007)

Doane, B., Salekin, K.L.: Susceptibility of current adaptive behavior measures to feigned deficits. Law Hum. Behav. **33**, 329–343 (2009)

Drob, S.L., Meehan, K.B., Waxman, S.E.: Clinical and conceptual problems in the attribution of malingering in forensic evaluations. J. Am. Acad. Psychiatry Law **37**, 98–106 (2009)

Eisendrath, S.J.: When Munchausen becomes malingering: Factitious disorders that penetrate the legal system. Bull. Am. Acad. Psychiatry Law **24**, 471–481 (1996)

Feldman, M.D.: Illness or illusion? Distinguishing malingering and factitious disorder. Prim. Psychiatry **2**, 39–41 (1995)

Florian, A.: Data analytics forecast report. National Insurance Crime Bureau, 11 May 2011

Frederick, R.I., Crosby, R.D.: Development and validation of the Validity Indicator Profile. Law Hum. Behav. **24**, 59–82 (2000)

Gervais, R.O., Green, P., Allen, L.M., et al.: Effects of coaching on symptom validity testing in chronic pain patients presenting for disability assessments. J. Forensic Neuropsychol. **2**, 1–20 (2001)

Gold, L.H., Metzner, J.L.: Psychiatric employment evaluations and the Health Insurance Portability and Accountability Act. Am. J. Psychiatry **163**, 1878–1882 (2006)

Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. Springer, New York (2009)

Gold, P.B., Frueh, B.C.: Compensation-seeking and extreme exaggeration of psychopathology among combat veterans evaluated for PTSD. J. Nerv. Ment. Dis. **187**, 680–684 (1999)

Graue, L.O., Berry, D.T., Clark, J.A., et al.: Identification of feigned mental retardation using the new generation of malingering instruments: Preliminary findings. Clin. Neuropsychol. **21**, 929–942 (2007)

Gray, M.J., Elhai, J.D., Briere, J.: Evaluation of the Atypical Response scale of the Trauma Symptom Inventory-2 in detecting simulated posttraumatic stress disorder. J. Anxiety Disord. **24**, 447–451 (2010)

Green, P., Rohling, M.L., Lees-Haley, P.R., et al.: Effort has a greater effect on test scores than severe brain injury in compensation claimants. Brain Inj. **15**, 1045–1060 (2001)

Griffin, G.A., Normington, J., May, R., et al.: Assessing dissimilation among Social Security Disability Income claimants. J. Consult. Clin. Psychol. **64**, 1425–1430 (1996)

Hall, C.W., Hall, C.W.: Malingering of PTSD and diagnostic considerations, characteristics of malingerers and clinical presentations. Gen. Hosp. Psychiatry **28**, 525–535 (2006)

Hamilton, J.C., Feldman, M.D.: "Chest pain" in patients who are malingering. In: Hurst, J.W., Morris, D.C. (eds.) Chest Pain, pp. 443–456. Futura Publishing Co., Inc., Armonk (2001)

Iverson, G.L.: Ethical issues associated with the assessment of exaggeration, poor effort, and malingering. Appl. Neuropsychol. **13**, 77–90 (2006)

Kilpatrick, D.G., Resnick, H.S., Freedy, J.R. et al.: The posttraumatic stress disorder field trial: Evaluation of the PTSD construct: Criteria A through E. In: Widiger, T., Frances, A., Pincus, H., Ross, R., First, M., Davis, W., Kline, M. (eds.) DSM-IV Sourcebook, pp. 803–844. American Psychiatric Press, Washington, DC (1994)

Leavitt, F., Sweet, J.J.: Characteristics and frequency of malingering among patients with low back pain. Pain **25**, 357–364 (1986)

Malingering. (n.d.). American Heritage Dictionary of the English Language, 4th edn. Dictionary.com website: http://dictionary.reference.com/browse/malingering. Accessed 6 July 2009

McDermott, B.E., Feldman, M.D.: Malingering in the medical setting. Psychiatr. Clin. N. Am. **30**, 645–662 (2007)

McDermott, B.E., Leamon, M.H., Feldman, et al.: Factitious disorder and malingering. In: Hales, Yudofsky, S.C., Gabbard, G.O. (eds.) The American Psychiatric Publishing Textbook of Psychiatry, 5th edn., pp. 643–664. American Psychiatric Publishing, Inc, Washington, DC (2008)

McGrath, R.E., Mitchell, M., Kim, B.H., et al.: Evidence for response bias as a source of error variance in applied assessment. Psychol. Bull. **136**, 450–470 (2010)

Mittenberg, W., Patton, C., Canyock, E.M., et al.: Base rates of malingering and symptom exaggeration. J. Clin. Exp. Neuropsychol. **24**, 1094–1102 (2002)

Morel, K.R.: Development and preliminary validation of a forced-choice test of response bias for Posttraumatic Stress Disorder. J. Pers. Assess. **70**, 299–314 (1998)

Newmark, N., Adityanjee, K.J.: Pseudologia fantastica and factitious disorder: Review of the literature and a case report. Compr. Psychiatry **40**, 89–95 (1999)

Office of the Inspector General, Social Security Administration: Cooperative Disability Investigations (2012). http://oig.ssa.gov/cooperative-disability-investigations-cdi. Accessed 5 Apr 2012

Pitman, R.K., Sparr, L.F., Saunders, L.S. et al.: Legal issues in post-traumatic stress disorder. In: van der Kolk, B.A., McFarlane, A.C., Weisaeth, L. (eds.) Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and the Society, pp. 378–397. Guilford, New York (2006)

Rasco, S.S., North, C.S.: An empirical study of employment and disability over three years among survivors of major disasters. J. Am. Acad. Psychiatry Law **38**, 80–86 (2010)

Resnick, P.J.: Malingered psychosis. In: Rogers, R. (ed.) Clinical Assessment of Malingering and Deception, 2nd edn., pp. 47–67. Guilford, New York (1997)

Resnick, P.J.: The Clinical Assessment of Malingered Mental Illness, In Annual Board Review Course Syllabus, pp. 842–866. American Academy of Psychiatry and the Law, Bloomfield (2000)

Resnick, P.J.: Guidelines for the evaluation of malingering in posttraumatic stress disorder. In: Simon, R. (ed.) Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment, pp. 187–238. American Psychiatric Association, Washington, DC (1995)
Rogers, R., Harrell, E.H., Liff, C.D.: Feigning neuropsychological impairment: A critical review of methodological and clinical considerations. Clin. Psychol. Rev. **13**, 255–274 (1993)
Rogers, R., Bagby, R.M., Dickens, S.E.: Structured Interview of Reported Symptoms: Professional Manual. Psychological Assessment Resources, Odessa (1992)
Rogers, R., Payne, J.W.: Damages and rewards: Assessment of malingered disorders in compensation cases. Behav. Sci. Law **24**, 645–658 (2006)
Salekin, K.L., Doane, B.: Malingering intellectual disability: The value of available measures and methods. Appl. Neuropsychol. **16**, 105–113 (2009)
Sayer, N.A., Spoont, M., Murdoch, M., et al.: A qualitative study of U.S. veterans' reasons for seeking Department of Veterans Affairs disability benefits for Posttraumatic stress disorder. J. Trauma. Stress **00**, 1–9 (2011)
Scott, C.L., McDermott, B.: Malingering. In: Buchanan, A. Norko, M. (eds.) The Psychiatric Report, Principles and Practice of Forensic Report Writing, pp. 240–253. Cambridge University Press, New York (2011)
Slick, D.J., Iverson, G.L.: Ethical issues arising in forensic neuropsychological assessment. In: Schultz, I.Z., Brady, D.O. (eds.) Handbook of Psychological Injuries, pp. 2014–2034. American Bar Association, Chicago (2003)
Slick, D.J., Tan, J.E., Strauss, E.H., et al.: Detecting malingering: A survey of experts' practices. Arch. Clin. Neuropsychol. **19**, 465–473 (2004)
Slick, D.J., Sherman, E.M., Iverson, G.L.: Diagnostic criteria for malingered neurocognitive dysfunction: Proposed standards for clinical practice and research. Clin. Neuropsychol. **13**, 545–561 (1999)
Spiro, H.R.: Chronic factitious illness: Munchausen's syndrome. Arch. Gen. Psychiatry **18**, 569–579 (1968)
Van Egmond, J.J.: The multiple meanings of secondary gain. Am. J. Psychoanal. **63**, 137–147 (2003)
Victo, T.L., Boone, K.B.: Identification of feigned mental retardation. In: Boone, K.B. (ed.) Assessment of Feigned Cognitive Impairment: A Neuropsychological Perspective, pp. 310–345. Guilford Press, New York (2007)
Wiley, S.: Deception and detection in psychiatric diagnosis. Psychiatr. Clin. N. Am. **21**, 869–893 (1998)
Weiss, R.A., Rosenfeld, B., Farkas, M.R.: The utility of the Structured Interview of Reported Symptoms in a sample of individuals with intellectual disabilities. Assessment **18**, 284–290 (2011)
Wierzbicki, M.J., Tyson, C.M.: A summary of evaluations for learning and attention problems at a university training clinic. J. Postsecond. Educ. Disabil. **20**, 16–27 (2007)
Wittman, L., Schredl, M., Kramer, M.: Dreaming in posttraumatic stress disorder: A critical review of phenomenology, psychophysiology and treatment. Psychother. Psychosom. **76**, 25–39 (2007)
Youngjohn, J.R.: Confirmed attorney coaching prior to a neuropsychology evaluation. Assessment **2**, 279–283 (1995)

Part II
Specific Types of Mental Health Disability Evaluations

Chapter 7
Social Security Disability Income Claims: Treating Mental Health Clinicians and Consultative Mental Health Examiners

C. Donald Williams

Introduction

When a patient applies for federal Social Security Disability Insurance (SSDI) benefits on the basis of psychiatric illness, the Social Security Administration (SSA) requests that the patient's treating mental health professional provide certain information so that the claim can be reviewed and a decision regarding eligibility for benefits can be made. More people receive SSDI benefits than any other type of disability income. The SSA provides federal benefits for approximately 3.4 million adult Americans disabled by mental illnesses. SSDI claims approved on the basis of mental illness constitute nearly one-third of all SSA beneficiaries, the largest of any diagnostic category (Social Security Administration 2010).

Therefore, clinicians with active practices often are asked by their patients to fill out SSDI forms, and so have some familiarity with this federally administered public disability insurance program. Determinations of eligibility for SSDI benefits rely primarily on documentation provided by treating clinicians. If additional information is needed, the SSA may request a consultative examination (CE) from either the treating clinician or a non-treating mental health professional. A CE more closely resembles a disability independent medical examination (IME) in its structure, goals, and relationship with the evaluee.

Most mental health clinicians receive little or no training in conducting disability evaluations generally, much less the specific documentary requirements of an SSDI application or a CE (Gold and Shuman 2009). This results in a certain amount of misunderstanding of the federal disability application process and requirements. For example, many psychiatrists mistakenly believe that the SSA gives more weight to information provided by independent evaluators than

C. Donald Williams (✉)
402 E Yakima Ave #1080, Yakima, WA 98901, USA
e-mail: cdonald@aol.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_7,

information provided by treating clinicians (Christopher et al. 2011). The SSA's emphasis on information provided by the treatment provider indicates that the treating mental health professional's documentation of disability is more heavily weighted; CEs are obtained only if there is some deficiency or ambiguity in the treating clinician's documentation.

The SSA's disability determination process, definition of disability, and criteria for determining disability are highly specific, statutorily defined, and unique to SSA. This chapter will review the definitions, process, and requirements associated with providing SSDI documentation needed by general clinicians to meet their patients' needs. For those mental health clinicians interested in or already providing CEs, this chapter will also review the role of Consultative Examiners in these SSA evaluations.

Case Example

Mr. Smith is a 34-year-old blue-collar worker who has held a variety of jobs over the past 18 years. Since the age of 16 he has had episodes of mood swings, alternating between periods of euphoria and manic activity, and periods of depression with suicidal ideation. Manic periods have been associated with excessive alcohol use, on more than one occasion leading to police arrests. In the past, Mr. Smith was typically euthymic in between episodes and was employed in various types of construction work. Mr. Smith entered psychiatric treatment 2 years previously, after his last arrest. He was diagnosed with Bipolar I Disorder, entered a dual diagnosis outpatient day treatment program, and began living in a halfway house. In the past 12 months, Mr. Smith has not used alcohol, has had no arrests, but has had no periods of mood stability, and has been unable to maintain any employment. Mr. Smith applied for SSDI benefits, and a form requesting information was sent to his treating psychiatrist.

Public Disability Insurance in the United States

Throughout history, the uncertainty and insecurity connected with ill fortune including illness, disability, and death has caused societies to develop systems or practices designed to increase economic security. The economic hardship caused by the Great Depression resulted in public support for a national old-age insurance system. On August 15, 1935, President Roosevelt signed the Social Security Act into law, creating federally funded old-age pensions. Social Security "insurance" was supported by "contributions" in the form of taxes on individuals' wages and employers' payrolls rather than directly from government funds. The first Social Security taxes were collected in January 1937 and monthly benefits were first paid to eligible recipients in January 1940 (Social Security Administration 2012a).

SSDI and Supplemental Security Income (SSI), the federally funded public disability insurance programs, were grafted onto this federal retirement program for the elderly. Thus, the SSA is responsible for evaluating applications for both SSDI and SSI programs. The SSA contracts with state agencies called Disability Determination Services (DDS) in each state throughout the nation and Puerto Rico to perform these services. The SSA's headquarters, located in Baltimore, oversees operations through 10 regional offices.

Both SSDI and SSI require that individuals meet certain medical criteria to be eligible for disability benefits. These criteria include the anticipated length of the disability and a set of accepted medical conditions causing impairments that may result in disability. The SSA also provides a definition of the degree of functional impairment that sets the threshold that must be met in order for a person to be entitled to either type of disability benefits. The statutory definition of disability is the same in both programs. Compensability requires total disability, which the SSA defines as the inability to perform the functions of any job for a period of at least 12 continuous months. This is in contrast to other forms of disability insurance, where individuals may be eligible for benefits if only partially disabled.

Nevertheless, SSDI and SSI differ in important ways. SSDI is designed to provide replacement income for disabled workers. SSDI provides disability cash benefits to citizens and lawful aliens who have not reached 62 years of age (when other benefit programs such as Old Age Assistance apply). Under SSDI, medical benefits in the form of Medicare are added after 2 years of disability. Eligibility for SSDI benefits is not means tested, but is only available to those disabled workers (and their dependents) who have contributed to the Social Security trust fund through the Federal Insurance Contributions Act (FICA) tax on their earnings for at least 5 years over the 10-year period preceding the disability claim (Social Security Administration 2012b). For purposes of this discussion, Mr. Smith in the case example will be considered to have met this requirement.

In contrast, SSI is a needs-based social welfare program intended to provide a minimum income level for the needy, aged, blind, and disabled, regardless of work history. Benefits reflect a flat rate, subsistence payment that is lower than average SSDI payments. Also in contrast to SSDI, those considered eligible for benefits under SSI will most likely receive medical benefits in the form of Medicaid, although this is not guaranteed and depends on each state's provisions. SSI will not be discussed further, as eligibility for benefits under this program does not require any previous attachment to the workforce. However, mental health professionals should be aware that despite differences between the programs, an individual could be eligible for benefits under both programs.

Mental health professionals should also understand that SSDI differs in significant ways from workers' compensation programs, private disability programs, and other government disability programs. For example, a person considered disabled under another program, such as a workers' compensation program, or even under another federal statute, such as the Americans with Disabilities Act, will not necessarily be deemed disabled for purposes of a Social Security benefits

program. In addition, unlike some other programs, determination of causation of disability is not relevant. Moreover, as noted above, SSDI benefit eligibility requires "total disability" (Social Security Administration 2012c); most other types of disability programs recognize "partial disability."

A Clinician's "Guide" to SSDI

Medical evidence, preferably provided by treating clinicians, is the cornerstone in the determination of eligibility for SSDI benefits. Mental health providers and the information they provide are integral to the adjudication of an SSDI claim. However, the SSDI evaluation form sent to treating clinicians after a patient has filed a disability claim is filled with statutorily defined terms. The relationship of these terms to one another and to psychiatric diagnoses can be confusing and frustrating, and is in some ways often unfamiliar to mental health clinicians.

Mental health treating clinicians are not asked to determine whether their patients are disabled and if so, whether they are eligible for SSDI benefits. The SSA alone makes those determinations. However, psychiatrists and psychologists should provide enough information in an SSDI report to allow lay administrators to determine whether claimants meet the SSDI criteria.

Those interested in a more detailed description than space allows here of the SSDI process, the role of treating clinicians and Consultative Examiners, and the type of medical evidence the SSA seeks can refer to the SSA's publication, "Disability Evaluation under Social Security," also known as the "Blue Book" and available on the SSA's website (Social Security Administration 2008). State DDS's also maintain a Professional Relations Office, which mental health professionals may contact for additional training or clarification of their role in the disability process. The following discussion summarizes information relevant to SSDI claims and evaluations.

The SSDI Claim Process

Claimants typically begin the SSDI process by filing an application with an SSA district office. The claim is then referred to the DDS, a federally funded state agency responsible for gathering medical records, obtaining medical and vocational evaluations, and rendering the initial determination of disability. Claimants are responsible for providing medical evidence to support their disability claim including information from their health care providers, and a standard form is forwarded by the DDS to the identified treatment providers, including mental health clinicians. The SSA will help claimants get medical reports and medical records from their own medical sources when the claimants give SSA permission to do so.

SSA defines total disability as the inability "to engage in any *substantial gainful activity* by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" (Social Security Administration 2008). Notably, although the statute does not require "permanent" disability, clinicians should bear in mind that it is relatively uncommon for individuals who apply and receive SSDI benefits to reenter the workforce to a degree that would disqualify them from continuing to receive SSDI benefits. Thus, a decision to apply for SSDI benefits can represent a life-altering event.

Substantial gainful activity (SGA) is considered to be any productive work of a nature generally performed for remuneration or profit, involving the performance of significant physical or mental duties or a combination of physical and mental duties. The definition of SGA is intended to be more than a benchmark set by the claimant's previous employment or level of remuneration. It is not limited by geographic convenience to employment available in the same town or time zone, nor is it limited to fortuitous economics that assure that full employment at prime wages for all members of the trade or profession (Social Security Administration 2008). SSA considers SGA to include any kind of work the claimant is physically or mentally capable of performing for profit. If jobs exist in substantial quantity somewhere in the country that the claimant could do, considering the claimant's specific circumstances, then the claimant is not eligible for disability benefits (Social Security Administration 2008).

Each state's DDS determines whether a claimant meets the SSA's definition of disability by sequentially addressing five threshold questions (Social Security Administration 2008). The DDS asks:

1. If the claimant is working and earnings average over $1000 per month. If so, the claimant cannot be considered disabled.
2. If the claimant's condition interferes with basic work-related activities. If it does not, the claimant cannot be considered disabled.
3. If the claimant has one of a list of recognized medical conditions. This "Listing of Impairments" includes separate listings for each of 14 different body systems, and nine mental disorders are "listed" or recognized (see below for discussion). If the claimant has a "listed" disorder, then the adjudicator proceeds to question 4.
4. Can the claimant do the work done previously? If the condition is not sufficiently severe that it interferes with the claimant's ability to do the work done previously, the claim is denied. If it does, then the adjudicator proceeds to question 5.
5. If the claimant cannot do the work done in the past, a determination is made as to whether the claimant can adjust to other gainful work that is available in the national economy. If a claimant can perform other gainful work, the claim is denied. If not, the claim will be approved. In making this decision, age, education, and work experience are taken into consideration.

If claimants disagree with a denial of benefits on a first review, they can file for a reconsideration of their disability benefits application. It is not unusual for an application to be denied on first review. In 2009, only 25.3 % of all claims were

allowed on initial application (Social Security Administration 2010). In 2009, only an additional 6.5 % were allowed on subsequent DDS review of the denial (Social Security Administration 2010). The initial application review and the state DDS reconsideration, if the initial application is not approved, are paper reviews and rely primarily on information provided by treating clinicians and/or the consultative examiner.

The next levels of appeal involve adjudicative hearings and ultimately, litigation. If claims are denied on the DDS review and claimants are still dissatisfied, they can appeal to an administrative law judge (ALJ) and request a hearing. Direct involvement in a patient/claimant's SSDI claim beyond providing information as a treating clinician and/or as a Consultative Examiner is not common among either general or forensic mental health professionals. However, in the event that a clinician's patient is denied benefits, it is possible that a treating clinician or a Consultative Examiner may be called to provide testimony.

ALJs can administer oaths, rule on questions of evidence, hear testimony, and make rulings, very much like a trial judge. Therefore, if a claimant has not already done so, it is prudent for a claimant to retain a qualified Social Security disability lawyer at this point in the process. If denied again, the claim may be appealed to the Appeals Council. Once all avenues are exhausted, relief can be sought through the federal courts (Wunderlich et al. 2002). Of claims that went through any level of the hearing process in 2009, 69 % were successful and benefits were awarded (Social Security Administration 2010).

Attorneys may be involved at any stage in the application process, but claimants typically retain attorneys after their applications are denied initially. Attorneys are then often retained to assist with the reconsideration process, and if denied again, for the appeal hearing before an ALJ. Attorney fees are set by statute, and the SSA must specifically approve attorneys before they can represent clients.

The Treating Clinician and the SSDI Evaluation: Considerations

The SSA considers treating clinicians to be the medical professionals best able to provide a detailed, longitudinal picture of the claimant's impairments. SSA believes treating medical professionals bring a unique perspective to the medical evidence that is not obtainable either from medical findings alone, from reports of an individual examination, or from a brief hospitalization (Social Security Administration 2008). The SSA regards a mental status examination as objective medical evidence needed by disability adjudicators to establish the existence of a mental impairment and to determine the severity of the impairment. Treatment providers reporting history, symptoms, impairments, treatment, and a mental status examination are therefore the primary source of information upon which the SSA depends in making disability determination decisions based on claims of mental illness.

As with the determination of disability for purposes of SSDI, mental health care providers are not asked to address whether or not a claimant is capable of SGA. As per statute, if claimants are working and earning over the prescribed level, SSA considers them to be engaged in SGA, and therefore not disabled. SSA will deny such claims no matter how serious the claimant's medical condition. In contrast, the information provided by treating mental health clinicians and Consultative Examiners helps DDS address other threshold questions, including diagnosis, level of functional impairment, and prognosis.

Decisions on claims for disability benefits are based on the medical information provided on a relatively brief standardized form sent to treating professionals when claimants initiate the disability determination process. The SSA's administrative definitions and criteria for the determination of psychiatric disability translate in a relatively straightforward manner into three key mental health concepts. Treatment providers should be aware that all three must be demonstrated to be present for an award of benefits:

1. Whether the claimant has a medically determinable impairment, referred to as a "listed" mental disorder;
2. Whether the mental disorder has resulted in an inability to work; and
3. Whether the inability to work resulting from the mental disorder has lasted or is expected to last for at least 12 months.

The state's DDS form usually specifies the level of detail of the required medical information, which is based on explicit SSA medical eligibility criteria. Clinicians should therefore closely adhere to the DDS's format and provide the level of detail requested. A copy of the treatment records may also be requested. Clinicians' time for providing information about their patients is unreimbursed; a nominal fee for copying charges associated with copying the treatment file is allowed.

Requests for information, whether as a standardized form or copies of medical records, should be accompanied by a signed release from the patient/claimant. Even with receipt of a signed consent, clinicians should consider contacting the patient/claimant, verifying that he or she agrees to the release of information to the DDS, and documenting the conversation. Treating mental health professionals should at that time ensure that patients understand providing information regarding a disability claim means the mental health professional will be providing confidential information to the DDS.

In addition to the obligation to protect confidentiality, treating clinicians should be aware that the Privacy Act permits individuals or their authorized representative to examine records held by a federal agency pertaining to those individuals (Privacy Act 1974). For disability applicants, this means that individuals may request to see the medical or other evidence used to evaluate their applications for disability benefits under Social Security programs. This evidence, however, is not available to the general public. In addition, SSA screens all requests to access medical evidence in a claim file to determine if release of the evidence directly to the individual might have an adverse effect on that individual. If so, the report will

be released only to an authorized representative designated by the individual (Social Security Administration 2008). Nevertheless, mental health clinicians should bear in mind that their patients may review their own reports, and are likely to do so in the event of an adjudicative appeal or litigation regarding a denied claim.

For this and other reasons (see Chaps. 2 and 3) mental health treatment providers should consider whether agreeing to submit medical information to the DDS for their own patients, as opposed for example, to only submitting a copy of the chart, is in the patient's best interest. When filling out this form, mental health professionals should be aware that they are documenting both mental health status and a disability evaluation, in effect, occupying dual roles. The potential for a conflict of interest should be considered whenever a psychiatrist combines the roles of treatment provider and evaluator (Strasburger et al. 1997). Nevertheless, the structure of the SSA's public disability insurance program makes occupying the dual roles of treatment provider and disability evaluator difficult to avoid if a treating clinician's patient files an SSDI claim.

A disability evaluation could present findings that are in conflict with the patient's desire to be awarded disability benefits, and thus affect the patient's financial interests. In addition, although the SSDI statute does not require "permanent" disability, clinicians should bear in mind, as noted above, that it is relatively uncommon for individuals to reenter the workforce after being found eligible for SSDI benefits. The psychological, social, and financial implications of leaving the workforce as disabled ultimately may not be in the patient's best mental health interests.

Such conflicts can undermine or destroy the treatment relationship. This necessitates careful consideration and discussion with the patient/claimant and a conscious effort on the part of the clinician to be as objective in reporting findings as possible. The challenges of maintaining objectivity when documenting disability in ones' own patients can be significant. In a survey study of psychiatrists, a substantial minority of both forensically trained and non-forensically trained psychiatrists completing SSDI forms reported having identified a patient as disabled despite believing that the patient could work (Christopher et al. 2011).

The Treating Clinician: Medical Information and SSA Claim Analysis

Each DDS analyzes the medical information provided to determine whether the claimant meets the statutorily defined criteria for eligibility. Therefore, treatment providers should have a general concept of how the SSA analyzes the data they provide. The SSDI determination process for claims based on psychiatric disorders is the same for each recognized diagnostic category.

The SSA analyzes each recognized or "listed" mental health diagnosis in the same formatted manner with review of four sections (Social Security Administration 2008). First, there is a description of the specific disorder. Second, paragraph "A" lists a set of medical findings, referred to as Paragraph A criteria, which specify what symptoms are needed to qualify for that diagnosis or listing. Third, paragraph "B" lists related functional limitations, similarly referred to as Paragraph B criteria. Finally, for some diagnostic categories considered "chronic," another statutorily defined term, a paragraph "C" provides additional functional criteria that must be met for a claim to succeed. Paragraph C criteria, which are not applicable for all listed mental health disorders, are only assessed if the criteria in Paragraph B are not satisfied. A similar structure is present for each category of mental disorder except for those that do not contain a paragraph C (see below).

Treating clinicians providing medical information for a patient's SSDI claim might want to familiarize themselves with that patient's relevant "listed" diagnosis and associated parameters of functional impairment. The SSA has nine listed categories of mental disorders, based on the Diagnostic Statistical Manual of Mental Disorders (DSM), diagnoses and their criteria (American Psychiatric Association 2000):

1. Organic Mental Disorders
2. Schizophrenic, paranoid and other psychotic disorders
3. Affective disorders
4. Mental retardation
5. Anxiety-related disorders
6. Somatoform disorders
7. Personality disorders
8. Substance addiction disorders
9. Autistic disorder and other pervasive developmental disorders.

Since these "listed" categories and their associated clinical symptoms are derived from the DSM, they should be familiar to mental health clinicians. However, by reviewing the relevant category of Affective Disorders, particularly the SSA's criteria regarding functional impairment, Mr. Smith's psychiatrist is able to better provide the specific types of information that the SSA is seeking to support the primary diagnosis and degree of Mr. Smith's impairment. Mr. Smith's treating psychiatrist is able to quickly access the relevant SSA criteria regarding Affective Disorder from the SSA's website (Social Security Administration 2012d). He finds the following information:

Affective disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic, or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders are met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

[Paragraph] A [criteria]. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:
    a. Anhedonia or pervasive loss of interest in almost all activities; or
    b. Appetite disturbance with change in weight; or
    c. Sleep disturbance; or
    d. Psychomotor agitation or retardation; or
    e. Decreased energy; or
    f. Feelings of guilt or worthlessness; or
    g. Difficulty concentrating or thinking; or
    h. Thoughts of suicide; or
    i. Hallucinations, delusions, or paranoid thinking; or
2. Manic syndrome characterized by at least three of the following:
    a. Hyperactivity; or
    b. Pressure of speech; or
    c. Flight of ideas; or
    d. Inflated self-esteem; or
    e. Decreased need for sleep; or
    f. Easy distractibility; or
    g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
    h. Hallucinations, delusions, or paranoid thinking; or
3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

And

[Paragraph] B [criteria]. Resulting in at least two of the following:

1. Marked restriction of activities of daily living (ADL); or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

Or

[Paragraph] C [Criteria]. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of one or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

The SSDI claim analysis begins with diagnosis, based on Paragraph A criteria for a "listed" diagnosis. A statutorily recognized or "listed" medically determinable psychiatric impairment that causes disability is a diagnosis that the SSA has determined may meet the severity requirement of its definition of disability. Treating mental health professionals should be certain that their SSDI report indicates whether an officially SSA "listed" mental disorder or its equivalent is present. Only DSM diagnoses should be used. If clinical circumstances dictate, clinicians should point out that comorbidity, or combinations of psychiatric disorders, or psychiatric and physical disorders may be equivalent to a "listed" mental disorder, since disability claims may be approved on the basis of equivalence to a listed diagnosis.

The supplied SSA form will direct the treating clinician to provide Mr. Smith's diagnosis and the clinical observations and history that support this diagnosis. It will not ask Mr. Smith's treatment provider to indicate whether he believes Mr. Smith meets the Paragraph A criteria or not. Thus, Mr. Smith's treating psychiatrist provides the SSA with the following diagnostic assessment, which he then supports with specific data conforming to the DSM (and thus SSA) criteria for establishing them: Bipolar I Disorder, most recent episode mixed (in partial remission); Alcohol Abuse, in remission, and Personality Disorder NOS. Dr. Smith's psychiatrist provides a current Global Assessment of Functioning (GAF) score of 48, and a highest past year score of 48, again as per the DSM (American Psychiatric Association 2000).

If the SSA deems that Paragraph A criteria are satisfied, that is, if a claimant meets criteria for a DSM diagnosis that is a "listed impairment" or its equivalent, the SSA then assesses functional restrictions as delineated in Paragraph B and, if necessary, Paragraph C. The functional limitations and restrictions listed in Paragraphs B and C must be the result of the clinical findings related to the mental disorder outlined in Paragraph A. The listings for mental disorders are so constructed that an individual meeting or equaling the criteria of the listed mental disorders could not reasonably be expected to engage in gainful work activity.

Paragraph B lists functional limitations related to the listed diagnosis. Paragraph B criteria comprise four categories, consistent across listed diagnoses:

1. Restriction of Activities of Daily Living (ADLs)
2. Difficulty in Maintaining Social Functioning
3. Deficiencies of Concentration, Persistence, or Pace
4. Episodes of Decompensation, each of extended duration

At least two or three of the four Paragraph B criteria (see Table 7.1) must be met for claimants to demonstrate functional restrictions. Paragraph B impairments are rated on a severity scale containing five levels of limitation: none, mild, moderate, marked, or severe. To satisfy the Paragraph B criteria, the impairment must be at least "marked" or greater in two or more of the four areas of functional limitation. An extreme rating on any of the first three criteria will satisfy the listings requirements, as will a rating of "four or more episodes of decompensation" for criterion four. If a claimant satisfies the "B criteria" severity requirements, then they are judged not to be capable of SGA.

SSA expects mental health professionals to assess the independence, appropriateness, effectiveness, and sustainability with which the claimant can successfully negotiate the activities of daily living. Marked difficulties in maintaining social functioning refers to the claimant's ability to interact independently, appropriately, effectively, and on a sustained basis with other individuals in social or work settings. Deficiencies of concentration, persistence, or pace refer to the ability to pay attention and concentrate well enough to complete the sorts of tasks commonly involved in work settings in a timely and appropriate manner. Limitations in concentration, persistence, or pace are best observed in work settings, but can also often be assessed through clinical examination, including mental status examination or psychological testing.

Repeated episodes of deterioration or decompensation in work or work-like settings refers to exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning. SSA specifically defines "repeated episodes of decompensation" as "three episodes within one year, or an average of once every four months, each lasting for at least two weeks" (Social Security Administration 2008). If the episodes are more frequent but of briefer duration, or less frequent but of longer duration, the adjudicator is required to use judgment to determine whether the functional effects are comparable to those set forth in the listings.

These episodes are considered to be manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation also may be demonstrated by worsening symptoms or signs that would ordinarily require increased treatment, placement in a less stressful situation, or a combination of these two interventions. Episodes of decompensation may also be inferred from the history of present illness, past psychiatric history, medical records that show significant changes in medication, documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directed household); or other relevant information in the record about the existence, severity, and duration of the episode.

In the case of Mr. Smith, the treating clinician, as prompted by the DDS form, indicates that over the past 12 months Mr. Smith demonstrated mild restrictions of activities of daily living, marked to extreme difficulties in maintaining social functioning, and marked difficulties in maintaining concentration, persistence, and pace, giving specific examples of each as per Table 7.1. With regard to episodes of decompensation, the clinician indicates that Mr. Smith has had multiple

Table 7.1 Paragraph B—Functional Impairment Criteria

Category	Examples of related activities
1. Marked restriction of ADLs	• Cleaning, shopping, cooking • Taking public transportation • Paying bills • Maintaining a residence • Caring appropriately for grooming and hygiene • Using telephones and directories • Using a post office
2. Marked difficulties in maintaining social functioning	• Ability to interact independently, appropriately, effectively, and on a sustained basis with other individuals • Ability to get along with other persons, including family members, friends, neighbors, grocery clerks, landlords, or bus drivers • A history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation • Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity • In work situations: interactions with the public, coworkers, and persons in authority (e.g., supervisors) • Frequent failure to complete tasks in a timely and appropriate fashion in work settings • Ability to work at a consistent pace for acceptable periods of time and until a task is completed • Ability to repeat sequences of action to achieve a goal or an objective • Ability or inability to complete tasks under the stresses of employment during a normal workday or workweek (i.e., 8 hour day, 40 hour week, or similar schedule) • Ability to complete tasks without extra supervision or assistance and in accordance with quality and accuracy standards, at a consistent pace, without an unreasonable number and length of rest periods, and without undue interruptions or distractions

(continued)

Table 7.1 (continued)

Category	Examples of related activities
3. Deficiencies of concentration, persistence, or pace	• Withdrawal from the work situation • Exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing ADL, maintaining social relationships, or maintaining concentration, persistence, or pace • Worsening symptoms or signs that would ordinarily require increased treatment, a less stressful situation, or a combination of the two interventions • Documentation of the need for a more structured psychological support system, such as hospitalizations, placement in a halfway house, or a highly structured and directed household
4. Repeated episodes of deterioration or decompensation in work or work-like settings	

exacerbations over the previous years. Mr. Smith's more recent exacerbations have resulted in job loss and other social and interpersonal problems. He adds that Mr. Smith's history, as described above, is one of nearly total inability to maintain employment on a sustained basis since age sixteen, consistent with a poorly controlled Bipolar I Disorder.

Paragraph C lists additional criteria for certain disorders deemed potentially chronic, specifically Organic Mental Disorders; Schizophrenic, Paranoid and Other Psychotic Disorders; Affective Disorders; Mental Retardation; and Anxiety-Related Disorders. The DDS reviews and considers "C" criteria only if the "B" criteria are not met by the evidence. This modification was effected because of the realization that an additional test of *functional limitation* was necessary for conditions that tend to be chronic and disabling, but that might not meet the severity requirements of the "B" criteria.

The Paragraph C criteria apply to individuals who are marginally adjusted and for whom an even minimal increase in mental demands or change would be predicted to cause the individual to decompensate. Documentation should demonstrate a chronic disorder of at least 2 years duration that has caused "more than minimal limitation of ability to do basic work activities" (Social Security Administration 2008). An inability to function outside a highly supportive living arrangement need only have lasted 1 year, although in the past, 2 years had been required. With regard to the "Paragraph C criteria," which may apply in a claimant with an Affective Disorder, Mr. Smith has a documented history of an Affective Disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do any basic work activity. Mr. Smith's symptoms currently are attenuated to a limited degree by medication and psychosocial support. However, Mr. Smith has not experienced a sustained period of improvement.

If the claimant's condition or diagnosis is not "listed," SSA makes a decision as to whether the claimed diagnosis is of equal severity to a condition that is listed. If it is, the claimant is found to be disabled. SSA also allows for consideration and evaluation of severity of the effects of a combination of impairments in determining disability for work. If a combination of impairments precludes work, then the person would be considered disabled even if no single impairment alone would be considered severe. Claimants may also be found to be disabled based on reports indicating that they are experiencing medically equivalent impairments comparable to the criteria of the listings for mental disorders (Social Security Administration 2008).

In all cases, clinicians should be certain to document whether the disorder interferes with the individual's ability to function in a work setting. Clinicians should comment on the degree and duration of functional limitation resulting from the diagnosed condition. These requests are made explicit in the evaluation request. They should also indicate whether any limitations have lasted or are expected to last at least 12 months, even if there may be some periods of time during the 12 months when the claimant may function well (Metzner and Buck 2003). Clinicians should provide specific details of the claimant's condition over time, including the length and frequency of exacerbations and remissions of the

claimant's mental disorder, accompanied by descriptions of the claimant exacerbations and remissions (Krajeski and Lipsett 1987).

A common problem in documentation provided by treating clinicians is failure to provide the supporting data necessary to establish a mental disorder or offering a non-DSM or idiosyncratic diagnosis. Alternatively, treating clinicians may not correlate impairments in function with the mental disorder, may not indicate severity of functional impairments, or may not indicate that impairments are expected to last for at least 12 months. Generalizations or overly broad conclusions rather than specific examples may reduce the credibility of a report and compromise the success of the claim.

Problems or lack of sufficient or relevant information in clinicians' initial reports can result in the denial of a claim, in a request for additional information from the treating clinician, or in a request for a second opinion, which the SSA refers to as a Consultative Examination (CE). Disagreements among treating medical professionals and conflicting information regarding diagnosis or severity of impairments may also prompt the DDS to seek a CE.

Consultative Examiners

If the DDS is unable to come to a determination regarding a claimant's eligibility for SSDI benefits based on the treating clinician's documentation, the DDS may seek additional information by arranging a paid CE. CEs, unlike initial requests for information, are reimbursed at fees set by each state and typically require a file review. An additional fee is paid if the medical file to be reviewed is 25 pages or longer. The SSA may also require that additional forms be completed. If so, separate fees are paid for their completion.

Social Security ALJs also may order psychiatric evaluations at their discretion after hearing evidence presented at an appeal hearing. ALJs are required to develop the evidence to make a decision, and they are given broad latitude in ordering additional expert opinions when necessary to resolve issues raised in a case. Alternatively, as part of the appeal or litigation process, a claimant's attorney also may request that the DDS obtain a CE.

In the case example, it happens that Mr. Smith was evaluated by four different treatment providers over the previous 2-year period. Most agreed that Mr. Smith had Bipolar I Disorder Type, Alcohol Abuse, and behavioral problems. However, there was disagreement regarding the degree and extent of his functional impairment resulting from the conditions. Mr. Smith was denied SSDI benefits on initial application and again on reconsideration. He retained an attorney to assist in an appeal hearing. The attorney requested a mental health evaluation from a nontreatment provider Consultative Examiner, and requested that the Consultative Examiner provide the following opinions:

(1) Did Mr. Smith suffer from an Affective Disorder that met the severity indicated in the SSA listings for an Affective Disorder?
(2) If Mr. Smith suffered from an Affective Disorder that impaired his employability, but did not meet or equal in severity indicated in the SSA criteria, did the diagnosed impairments significantly limit Mr. Smith's ability to work on a reasonably continuous sustained basis?

Who Provides a Consultative Examination?

CEs may be conducted by qualified mental health professionals for their own patients or as independent clinical examiners of non-patients (Social Security Administration 2008). As noted, the SSA's process of determining mental health disability emphasizes medical evidence provided by the claimant's treating psychiatrist or psychologist. Similarly, the treating clinician is also the preferred providing source for CEs. The SSA will provide payment to treatment providers for conducting a CE of their own patients when the treating source is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment and can furnish complete and timely reports.

Despite the preference for a treating clinician's additional examination information, SSA's rules provide for using a non-treating clinician if:

- the treating clinician prefers not to perform the examination;
- conflicts or inconsistencies exist in the file that cannot be resolved by going back to the treating clinician;
- the claimant prefers another clinician and has a good reason for doing so;
- prior experience indicates that the treating clinician may not be a productive source.

In the case example, Mr. Smith's attorney requested that an independent examiner conduct Mr. Smith's CE because she did not believe that any of Mr. Smith's treating clinicians could resolve the disagreements regarding the severity of Mr. Smith's impairment.

Any qualified mental health clinician can become a Consultative Examiner for his or her state DDS, providing CEs for his or her own patients or as an independent evaluator. The SSA considers a medical source holding a current state license and with the training and experience to perform the type of examination or test requested and qualified to perform a CE. The SSA expects Consultative Examiners to have a good understanding of SSA's disability programs and their evidence requirements. Generally, Consultative Examiners are selected based on appointment availability, distance from a claimant's home, and ability to perform specific examinations and tests. The Consultative Examination guide (also known as the "Green Book") was developed by SSA in 1999 to provide information to physicians about the CE process and is available on the SSA website (Social Security Administration 2012e).

Both general and forensic mental health professionals may want to consider becoming a Consultative Examiner for their state DDS. Evaluations performed as a Consultative Examiner provide practice in conducting efficient assessments of individuals with a wide variety of disorders, present an opportunity to refine diagnostic conceptualization and writing skills, and hone assessments that integrate the concepts of impairment, psychiatric conditions, and disability as they impact a person's ability to work. In addition, serving as a Consultative Examiner presents the opportunity to provide quality professional services within the public sector, an area where additional services are always needed.

The Professional Relations Officers in each state's DDS office recruit and to the extent necessary, train mental health professionals to perform evaluations and write reports that contain the information required to make decisions on applications. Clinicians can apply to become Consultative Examiners through the Professional Relations Officer in their state (see Social Security Administration 2012f).

The Consultative Examination and Report

The SSA requires that Consultative Examiners provide information in order to determine whether a claimant meets the stringent SSDI disability requirements. The mental health CE consists of a review of medical records provided by DDS or the referring attorney, a face-to-face mental health evaluation of the applicant, and the provision of a written report. Examiners should bear in mind that the examination is requested because someone involved in the disability determination process, either the DDS or the claimant, has determined that more information than the treating mental health clinician has already provided is required to fully evaluate the disability claim. Therefore, the CE report should be complete enough to enable an independent reviewer to determine the nature, severity, and duration of the impairment, and the claimant's ability to perform basic work-related functions.

When conducting the CE, the purpose of the psychiatric evaluation should be explained to the claimant. Examinees should be advised of the limitations on confidentiality associated with their status as an applicant for SSDI. They should be advised that the interview is for evaluation purposes only, and that no treatment will be provided. Claimants should also be informed that a copy of the evaluation will be provided to the SSA. As a matter of policy, the Consultative Examiner is allowed to directly furnish a copy of the evaluation to a treating physician. Many Consultative Examiners prefer to have the claimant assume responsibility for requesting the report be sent from the SSA to other parties, thus avoiding any potential violation of confidentiality guidelines.

Mental health professionals should also be aware of safety concerns in conducting CEs. A review of the file or other source of information accessed before the evaluation begins may indicate that the evaluation should be conducted in a secure facility. As with any other type of psychiatric evaluation, if the mental health professional conducting the CE feels that beginning an examination, or once

begun, continuing the examination, becomes unsafe, the examiner should cancel or stop the evaluation and notify DDS of the reasons.

The CE report itself has many elements in common with a treatment provider's disability report, but Consultative Examiners are usually expected to provide more information than treatment providers. CE reports should specifically include detailed information concerning mental restrictions, residual functional capacity (RFC) (see below), and functional limitations relative to ADLs; social functioning; concentration, persistence, or pace; and episodes of decompensation. The SSA specifies, "A complete CE is one that involves all the elements of a standard examination in the applicable medical specialty" (Social Security Administration 2012f). Mental health CE reports should therefore include:

- The claimant's major or chief psychiatric complaint(s)
- Detailed description of the history of the major psychiatric complaint(s)
- Description, and disposition, of pertinent "positive" and "negative" detailed findings based on the history, examination, and laboratory tests related to the major psychiatric complaint(s), and any other abnormalities or lack thereof reported or found during examination or laboratory testing
- Results of laboratory and other tests (e.g., psychological testing) performed in accordance with the requirements provided by the DDS
- Diagnosis and prognosis for the claimant's impairment(s)
- Statement about what the claimant can still do despite his or her impairment(s). This statement should describe the opinion of the consulting medical source about the claimant's ability, despite his or her impairment(s), to do work-related activities. In cases of mental impairment(s), the opinion of the medical source about the individual's ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting
- Explanations or comments regarding the claimant's major psychiatric complaint(s) and any other abnormalities found during the history and examination or reported from the laboratory or psychological tests.

Assessment of capability should also include whether the individual can manage awarded benefits responsibly.

The SSA is interested in facts and evidence-based conclusions as they bear upon impairments of specific functional capabilities that have an impact on disability without reference to causation (Williams 2010). The suggested content of the examination and format of the reports conforms to those of other general psychiatric examinations, with added emphasis on functional assessment (see Appendix I). For example, the chief complaint section should include the claimant's primary psychiatric complaint as well as the claimant's reason for not working. Liberal use of direct quotes accumulated during the evaluation gives the narrative report life and substance, and can provide useful information for adjudicators. For example, in his evaluation Mr. Smith stated, "The anti-depressants help me to relax and I stopped losing my temper as much," a brief but informative statement regarding the specific effects of Mr. Smith's medication.

The Consultative Examiner should carefully evaluate and describe the effect of the emotional or mental disorder on claimants' abilities to function at their usual and customary personal, social, and occupational level of adjustment. Specific observations and reporting of the claimant's ADL, along with relevant psychiatric history, and a data-supported mental status examination are crucial to the examination's utility. Consultative Examiners are asked to:

- Provide evidence that serves as an adequate basis for disability decision making in terms of the impairment it assesses.
- Provide evaluations that are internally consistent. All the diseases, impairments, and complaints described in the history should be adequately assessed and reported in the clinical findings.
- Correlate their conclusions with the medical history, the clinical examination, and laboratory tests, and explain all abnormalities.
- Be consistent with the other information available within information and opinions generally available and held in the mental health profession.
- Address all important or relevant mental health complaints noted in other evidence in the file (Social Security Administration 2012f).

The report should include a description, based on the mental health professional's own findings, of the individual's ability to do basic work-related activities. DSM (American Psychiatric Association 2000) diagnoses and diagnostic criteria are expected and emphasized, as these provide a more uniform basis for application of the relevant statues. Conclusions in the report should be consistent with the objective clinical findings found on examination and the claimant's symptoms, laboratory studies, demonstrated response to treatment, and with all available documentary evidence. Where they are not, SSA expects the Consultative Examiner to explain inconsistencies. Consultative Examiners, like mental health treatment providers, should not include an opinion on whether claimants meet the SSA's definition of disability (Social Security Administration 2012f).

The information included in a CE should focus on elements involving diagnostic assessment and the claimant's functioning. For example, including a description of the claimant's "typical day" illustrates the present level of reported functioning, including ADLs. In the case of Mr. Smith, the Consultative Examiner obtained and reported the following information:

> Mr. Smith arises at 5 or 6 a.m. "I spend 45 minutes getting ready. I spend an hour or so doing chores. I go to an outpatient treatment program from 9 AM to 4 PM. I come home, help fix dinner, and then watch comedy and go to bed at 10 o'clock." Mr. Smith prepares his own meals, does his own laundry and housecleaning, and manages his own finances. He has limited social interaction, stating he does not do much socializing, "just at the program." Mr. Smith lives at a halfway house, and likes having his own room.

The findings in the mental status examination should be specifically described. These are considered objective evidence for purposes of disability determination. Conclusions such as "concentration and memory are grossly normal" unsupported by documented testing should be avoided. Mental retardation should not be

diagnosed without formal intelligence testing. The individual case facts will determine the specific areas of mental status that need to be emphasized during the examination, but generally the evaluation should include all elements of a standard mental status examination and the report should document these, as well as relevant subjective responses.

For example, Mr. Smith's Consultative Examiner documented part of the mental status examination as follows: "Regarding paranoid ideation, Mr. Smith has felt like he has been under surveillance. 'I sometimes still wonder if I am being staked out. It seems like too many coincidences.' He has had thoughts both of suicide and homicide, 'but not recently.'" In the summary and discussion portion of the report, a general conclusion such as "some paranoia but no suicidal or homicidal ideation" is sufficient, but the body of the report should contain the specific findings upon which these conclusions are based.

Additional Documentation: Residual Functional Capacity

Consultative Examiners may also be asked to complete a Mental Residual Functional Capacity (RFC) Assessment form. The ALJ or an attorney representing the claimant at the hearings stage of the appeal process may request that this be completed in conjunction with the CE. The SSA defines RFC as "a multidimensional description of work-related abilities which an individual retains in spite of medical impairments" (Social Security Administration 2008). RFC is a description of what the claimant can still do in a work setting, despite the limitations caused by the claimant's impairments. If a claimant is capable of doing some work, or, can perform any type of work in the national economy, he or she will not be considered disabled for purposes of receiving SSDI benefits.

The RFC Assessment is a measure of the claimant's ability to perform functions necessary to employment. Each mental activity is evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Individuals, who have an impairment not meeting one listed by the SSA and not equivalent to any listed disorder may in some instances be found disabled by the SSA if the demands of jobs in which the person might be expected to engage, considering the claimant's age, education, and work experience, exceed the individual's remaining capacity to perform (Gold and Shuman 2009; Kennedy 2002; Krajeski and Lipsett 1987; Metzner and Buck 2003).

The four general areas of assessment for RFC correspond to Paragraphs B and C criteria of the listings for mental disorders and describe an expanded list of work-related capacities that may be impaired by mental disorders (see Table 7.2). Each activity is rated "not significantly impaired," "moderately limited," "markedly limited," or "no evidence of limitation." Evaluators may also indicate that they do not have enough information to rate the specific activity.

Section I of the RFC form is completed by providing summary conclusions for each of the findings listed in Table 7.2. Section II asks evaluators to specify what

Table 7.2 Criteria for Assessment of Residual Functional Capacity (RFC)

Criteria	Examples for assessment
1. Understanding and memory	Ability to remember • Procedures related to work • Short, simple instructions • Detailed instructions
2. Sustained concentration and persistence	Ability to • Carry out short, simple instructions • Carry out detailed instructions • Maintain attention and concentration for extended periods of time • Perform activities within a given schedule • Maintain regular attendance • Be punctual within customary tolerances • Sustain an ordinary routine without special supervision • Work with or near others without being distracted • Complete a normal workday and workweek without interruptions from psychologically based symptoms • Make simple work-related decisions • Perform at a consistent pace without an unreasonable number of and unreasonably long rest periods
3. Social interaction	Ability to • Interact appropriately with the general public • Get along with coworkers and peers without distracting them or exhibiting behavioral extremes • Maintain socially appropriate behavior • Ask simple questions or request assistance • Accept instructions • Respond appropriately to criticism from supervisors • Adhere to basic standards of neatness and cleanliness
4. Adaptation	Ability to • Respond appropriately to changes in the work setting • Be aware of normal hazards and take appropriate precautions • Use public transportation and travel to and within unfamiliar places set realistic goals • Make plans independently of others

additional information is needed if a lack of evidence to make a determination was indicated in any category. Section III requires that evaluators elaborate on their conclusions regarding the preceding capacities in narrative form. Evaluators are instructed to provide a thorough discussion and analysis of the objective medical and other evidence, including the claimant's complaints of pain and other symptoms, and the evaluator's personal observations, if appropriate. Evaluators are also asked to include a resolution of any inconsistencies in the evidence as a whole and

provide a logical explanation of the effects of the symptoms, including pain, on the claimant's ability to work.

In the case of Mr. Smith, the Consultative Examiner, utilizing the SSA's RFC form, indicates that Mr. Smith demonstrates marked limitations present (or present within the last six months) in the ability to:

- maintain attention and concentration for extended periods;
- perform activities within a schedule, maintain regular attendance, and be punctual within usual tolerances;
- work in coordination with or proximity to others without being distracted by them;
- complete a normal workday and workweek without interruptions from psychologically based symptoms the ability;
- perform at a consistent pace without an unreasonable number and length of rest periods;
- interact appropriately with the general public;
- maintain socially appropriate behavior;
- set realistic goals or make plans independent of others.

In the narrative section, the Consultative Examiner draws upon his examination and Mr. Smith's psychiatric records to provide the bases of his conclusions. In addition, he provides his opinion regarding the severity of Mr. Smith's impairments, addresses the disagreement on this subject among Mr. Smith's treatment providers, and explains why differing access to information may be the basis for their differing opinions.

Additional Information: Psychological Testing

Psychological testing may be included in the evaluation (Williams 2010). Again, the SSA defines what it considers relevant and acceptable psychological testing (Social Security Administration 2012d). First, psychological tests should have validity, reliability, appropriate normative data, and a wide scope of measurement. Second, the tests must be "individually administered by a qualified specialist." A qualified specialist for purposes of SSA evaluations is defined as "licensed or certified in the State to administer, score, and interpret psychological tests and have the training and experience to perform the test." (See Chap. 5 for discussion of psychological testing in disability evaluations.)

The SSA allows for use of intelligence testing (IQ testing); personality measures such as the Minnesota Multiphasic Personality Inventory-Revised (MMPI-II); and projective techniques, such as the Rorschach and the Thematic Apperception Test (TAT) (Social Security Administration 2012d). Psychological test results may be useful when combined with other evidence, including results from other psychological tests and information obtained in the course of the clinical evaluation, from treating and other medical sources, other professional health care

providers, and nonmedical sources. Any inconsistency between test results, developmental history, and clinical history and observation should be explained in the narrative description.

Consultative Examiners may also request and utilize comprehensive neuropsychological examinations, including test batteries such as the Luria-Nebraska, or the Halstead-Reitan, or a battery of tests selected as relevant to the suspected brain dysfunction, to establish the existence and extent of compromise of brain function, particularly in cases involving organic mental disorders. Again, the SSA requires these be accompanied by a clinical interview geared toward evaluating pathological features known to occur frequently in neurological disease and trauma, such as emotional lability, abnormality of mood, impaired impulse control, passivity and apathy, or inappropriate social behavior. The mental health specialist performing the examination must be properly trained in this area of neuroscience (Social Security Administration 2012d).

The Consultative Examination: Summary and Discussion

The Consultative Examination report Summary and Discussion should synthesize the record review, the interview, and any psychological test results. In addition, the referring source may have posed specific questions in the assignment letter that require a response. The detail and format for reporting the results of the medical history, physical examination, laboratory findings, and discussion of conclusions should follow the standard reporting principles for a complete medical examination (Gold and Shuman 2009). However, Consultative Examiners, like treating clinicians, should not offer an opinion regarding disability. This section of the case example might read as follows:

> Mr. Smith has a primary diagnosis of Bipolar I Disorder, which is retrospectively clear based on contemporary mental health clinic notes dating from 2009 to 2011, and a Secondary Diagnosis of Alcohol Abuse in remission. The clinicians at the mental health center consistently diagnosed Bipolar I Disorder on multiple occasions. Bipolar I Disorder is the diagnosis most consistent with the clinical history, psychological testing, and current findings. There is a positive family history reported for Bipolar I disorder, which further strengthens confidence in the diagnosis.
>
> Mr. Smith's long history of alcohol abuse is likely to represent an attempt at self-medication for his primary diagnosis of Bipolar I Disorder. His arrests and incarcerations most likely arose out of a combination of effects of irritable hypomanic or manic states and alcohol abuse. This situation is referred to as a "dual diagnosis" condition. It is generally accepted that the onset of Bipolar Disorder occurs during adolescence, which corresponds with the onset of Mr. Smith's legal and alcohol problems.
>
> In the past 12 months, despite appropriate treatment, Mr. Smith has had a deterioration in functioning. Mr. Smith demonstrates mild restrictions of ADL, marked to extreme difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, and pace, and four or more episodes of decompensation, each of extended duration. With regard to episodes of decompensation, Mr. Smith has had no periods of employment, in contrast to his early history that demonstrated the potential for some periods of extended employment. Currently, Mr. Smith is no longer able to maintain independent housing, and to prevent relapse and homelessness, needs to live in a halfway house.

Mr. Smith's attorney's first question was whether Mr. Smith suffers from an Affective Disorder that meets or is equal in severity to the SSA Listing for Affective Disorders. In response, the Consultative Examiner indicates that Mr. Smith does qualify for an Affective Disorder, namely Bipolar Disorder, that meets the severity criteria of a listed Affective Disorder, and lists the Paragraph A Criteria, which are essentially the DSM criteria, that are satisfied by Mr. Smith's history and examination. Mr. Smith's attorney's second question was if Mr. Smith suffered from an Affective Disorder that impaired his employability, did the diagnosed impairments significantly limit his ability to work on a reasonably continuous sustained basis. Utilizing the Paragraphs B and C criteria as guidelines for a response, the Consultative Examiner explains in narrative form how Mr. Smith's symptoms prevent him from maintaining employment.

The SSA appreciates timeliness, and a suggested practice is to dictate or write-up all Social Security evaluations within 24 hours of the interview. If the report is inadequate or incomplete, the DDS will contact the medical source and ask for additional information or even a revised report (Social Security Administration 2012d).

Beyond the Consultative Examination

Direct involvement in a patient/claimant's SSDI claim beyond providing information as treating clinician and/or as Consultative Examiner is not common among either general or forensic mental health professionals. However, hearings in front of an Administrative Law Judge, and subsequent Appeals Court and Federal Court reviews may require testimony from treating clinicians and Consultative Examiners. These proceedings are much like trials, with evidence being presented and witnesses being called for testimony. Other than this, however, mental health clinicians typically play limited and very proscribed roles in the SSDI determination process in the hearing, appeal, and litigation phases.

Conclusion

Most mental health clinicians will be asked to provide information documenting their patients' claims for SSDI benefits. Some mental health clinicians will provide additional information or "second opinions" in the form of IMEs as Consultative Examiners. In making determination regarding eligibility for federal disability benefits, the SSA is seeking specific types of information, organized in specific ways. Determination of eligibility for benefits at the initial review and DDS levels depends primarily on information providing by treating mental health clinicians, and if needed, additional information provided by Consultative Examiners.

Mental health clinicians should become familiar with the SSA's provisions, which are easily accessed on the SSA's website. Familiarity with and understanding of the SSA's terms, definitions, requirements, and adjudication processes will enable mental health clinicians, whether treatment providers or Consultative Examiners, to more effectively and objectively provide the information that will assist both claimants and the SSA by facilitating the SSA's determination process.

Key Points

1. Conduct a standard psychiatric evaluation utilizing the DDS guidelines. Record the primary data obtained in the evaluation, not just conclusions.
2. Employ only DSM-IV diagnostic criteria in making diagnoses.
3. Be familiar with SSA's terminology and definitions, and utilize these whenever possible in initial reports and CEs.
4. Provide support for and specific examples of the severity of functional impairments.
5. Refrain from offering opinions on whether the claimant is disabled or qualifies for disability benefits.

Appendix I: Consultative Examination Content and Narrative Report

I. General Observations

   a. How did the claimant come to the examination:

      i. Was the claimant alone or accompanied
      ii. Distance and mode of transportation
      iii. If by automobile, who drove

   b. General appearance:

      i. Dress and grooming
      ii. Attitude and degree of cooperation
      iii. Posture and gait
      iv. General motor behavior, including any involuntary movements

II. Informant:

   a. Identify the person providing the history (usually the claimant)
   b. Provide an estimate of the reliability of the history

III. Chief Complaint: The claimant's allegations concerning any mental and/or physical problems

IV. History of Present Illness

a. Include a detailed chronological account of the onset and progression of the claimant's current mental/emotional condition with special reference to:

i. Date and circumstances of onset of the condition
ii. Date the claimant reported that the condition began to interfere with work, how it interfered
iii. Date the claimant reported inability to work because of the condition and the circumstances

b. Attempts to return to work and the results
c. Outpatient evaluations and treatment for mental/emotional problems including:

i. Names of treating sources
ii. Dates of treatment
iii. Types of treatment (names and dosages of medications, if prescribed), and
iv. Response to treatment

d. Hospitalizations for mental disorders including:

i. Names of hospitals
ii. Dates, and
iii. Treatment and response

V. Functional information, preferably conforming with format suggested by Paragraph B criteria, includes narrative report of functioning on a typical day:

a. Activities of daily living:

i. Give complete description of ADLs
ii. Can the claimant take care of cooking, cleaning, grocery shopping etc.? Give examples
iii. Does the claimant need assistance with self-care? Give examples
iv. Can the claimant handle their own money?

b. Social functioning:

i. Does the claimant socialize with family or friends or is he or she socially isolated?
ii. Does the claimant attend church groups, clubs, or other social events regularly?

c. Concentration, persistence, and pace: Can the claimant

i. Read a book, work at hobbies, play on the computer, etc? Give examples of hobbies or interests and how long they can sustain activity
ii. Finish ADLs in a timely manner?

d. Deterioration or decompensation, especially in a work-like setting
e. Functioning on a typical day

VI. Past History: should include a longitudinal account of the claimant's personal life

a. Relevant educational, medical, social, legal, military, marital, and occupational data and any associated problems in adjustment
b. Details (dates, places, etc.) of any past history of outpatient treatment and hospitalizations for mental/emotional problems, and
c. History, if any, of substance abuse, and/or treatment in detoxification and rehabilitation centers

VII. Mental Status: should include a detailed description of the claimant's

a. Appearance, behavior, and speech (if not already described)
b. Thought process (e.g., loosening of associations)
c. Thought content (e.g., delusions)
d. Perceptual abnormalities (e.g., hallucinations)
e. Mood and affect (e.g., depression, mania)
f. Sensorium and cognition (e.g., orientation, recall, memory, concentration, fund of information, and intelligence)
g. Judgment and insight, and
h. Capability (i.e., is the individual capable of handling awarded benefits responsibly

VIII. Psychological and/or Neuropsychological test results
IX. Diagnosis utilizing standard nomenclature as set forth in the current "Diagnostic and Statistical Manual of Mental Disorders" (APA 2000)
X. Prognosis:

a. Likely future course of illness
b. Recommendations for treatment, if indicated
c. Recommendations for any other medical evaluation (e.g., neurological, general physical), if indicated

XI. Summary and Discussion, including responses to any specific referral questions.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition (Text revision). American Psychiatric Association, Washington, DC (2000)
Christopher, P.P., Arikan, R., Pinals, D.A., et al.: Evaluating psychiatric disability: Differences by forensic expertise. J. Am. Acad. Psychiatry Law **39**, 183–188 (2011)
Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**, S3–S50 (2008)

Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. Springer, New York (2009)

Kennedy, C.: Disability determination of mental impairments: A review toward an agenda for research in the measurement of work disability. In: Wunderlich, G.S., Rice, D.P., Amado N.L. (eds.) The Dynamics of Disability: Measuring and Monitoring Disability for Social Security Programs, pp. 241–280. National Academy Press, Washington, DC (2002)

Krajeski, J., Lipsett, M.: The psychiatric consultation for Social Security Disability Insurance. In: Meyerson, A.T., Fine, T., (eds.) Psychiatric Disability: Clinical, Legal and Administrative Dimensions, pp. 287–311. American psychiatric press, Inc., Washington, DC (1987)

Metzner, J.L., Buck, J.B.: Psychiatric disability determinations and personal injury litigation. In: Rosner, R., (ed.) Principles and Practice of Forensic Psychiatry, 2nd edn., pp. 260–272. Arnold, London (2003)

Privacy Act of 1974, 5 U.S.C. § 552a (1974)

Social Security Administration: Annual Statistical Report on the Social Security Disability Insurance Program. SSA Publication No. 13-11827. http://www.ssa.gov/policy/docs/statcomps/di_asr/2010/di_asr10.pdf (2010). Accessed 1 June 2012, Aug 2011

Social Security Administration: Disability Programs: Benefits for People with Disabilities. http://www.socialsecurity.gov/disability (2012c). Accessed 2 June 2012, May 2012

Social Security Administration: Disability Programs: Health School Professionals. http://www.ssa.gov/disability/professionals/procontacts.htm (2012f). Accessed 1 June 2012, May 2012

Social Security Administration: Disability Programs: Medical/Professional Relations, Disability Evaluation under Social Security, 12.0 Mental Disorders. http://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm#12_04 (2012d). Accessed 2 June 2012, May 2012

Social Security Administration: Disability Programs: Medical/Professional Relations, Disability Evaluation Under Social Security (Blue Book- September 2008). SSA Pub. No. 64 039. http://www.ssa.gov/disability/professionals/bluebook/index.htm (2008). Accessed 2 June 2012, Sept 2008

Social Security Administration: Disability Programs Medical/Professional Relations: Consultative Examinations: A Guide for Health Professionals. SSA Publication No. 64-025. http://www.ssa.gov/disability/professionals/greenbook/index.htm (1999). Accessed 1 June 2012, Nov 1999

Social Security Administration: Historical Background and Development of Social Security. http://www.ssa.gov/history/briefhistory3.html (2012a). Accessed 1 June 2012, May 2012

Social Security Administration: The Official Website of the Social Security Administration. http://www.socialsecurity.gov (2012b). Accessed 2 June 2012, May 2012

Strasburger, L.H., Gutheil, T.G., Brodsky, A.: On wearing two hats: Role conflict in serving as both psychotherapist and expert witness. Am. J. Psychiatry **154**, 448–456 (1997)

Williams, C.D.: Disability and occupational assessment: Objective diagnosis and quantitative impairment rating. Harv. Rev. Psychiatry **18**(6), 336–352 (2010)

Wunderlich, G.S., Rice, D.P., Amado, N.L. (eds.): The Dynamics of Disability: Measuring and Monitoring Disability for Social Security Programs. National Academic Press, Washington, DC (2002)

Chapter 8
Workers' Compensation Evaluations

Albert M. Drukteinis

Case Example

G. D. is a 44-year-old driver for a package delivery service who was in a motor vehicle accident. While driving on an icy road in midwinter, he lost control of his van; it spun around, struck a guardrail, and then landed in the opposite lane in the face of oncoming traffic. The van was seriously damaged but, fortunately, no other vehicle struck him. To police and ambulance attendants who arrived on the scene, G. D. reported pain in his mid to low back. He was also visibly distressed and shaking. After being transported by ambulance to the local hospital, he was examined and released with the diagnosis of "back strain" and "anxiety reaction."

In follow-up with his primary care physician (PCP), G. D. continued to complain of discomfort in his back. His PCP advised that he not return to work until he had been thoroughly evaluated by an orthopedic surgeon. When this surgeon found no evidence of significant medical pathology G.D's PCP began discussing the possibility of returning to work. At this, G. D. became tearful and started shaking. He claimed that he was afraid to go back to driving for the delivery service. He also admitted he was concerned, because he had a letter of warning from his supervisor for a prior motor vehicle accident. In that accident, he was not injured, but was cited by the police for negligent operation of his vehicle. At this point, G. D.'s physician referred him to a mental health clinician for treatment and assessment of psychiatric disability from a work-related injury.

A. M. Drukteinis (✉)
Department of Psychiatry, Dartmouth Medical School,
1750 Elm Street #601, Manchester, NH 03104, USA
e-mail: aldruk@aol.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_8,

Mental Health Clinicians and Workers' Compensation

Disability assessment under workers' compensation differs from Social Security or private disability insurance assessments, and from personal injury disability in ordinary civil litigation. Under Social Security and private disability insurance, no separate assessment is made of the cause or circumstances that led to the disability, only that there is a genuine disabling condition. In personal injury litigation, a separate assessment is made to determine whether the disabling condition was the fault of the party being sued, either intentionally or negligently. Workers' compensation claims fall somewhere between the other two, in that no fault needs to be shown but the injury and/or disability must be proven to arise out of and in the course of employment (Lenesis 1998).

The treating clinician to whom G. D. was referred would, therefore, have to determine whether G. D. has a mental condition that arose out of and in the course of his work as a package delivery driver, in order to identify who would be responsible for treatment, and whether there was any work-related disability. Treating clinicians may be reluctant to engage in such assessments, but unless they choose not to accept workers' compensation referrals, they will usually be drawn into them. G. D. is also in a bind, as his own health insurance will not cover his mental health treatment if it is work related. Once clinicians assume treatment under workers' compensation, that is, the treatment is work related, invariably they are asked to provide opinions on impairment and disability. In turn, they then may be asked to submit a report addressing the workers' compensation issues, and perhaps to testify at a labor or industrial board hearing.

Disability assessment by the treating clinician often starts as a request from the patient directly or consequently to observation by the clinician that time away from the workplace is needed. This is such a common scenario that the treating clinician may not realize that it represents the first step in a process that may not be well founded factually. It may appear relatively innocuous and of little impact to excuse a patient from work for a couple of weeks because of work stress; but, in fact, this allowance establishes an implied contract between the clinician and patient, in which there is presumed to be a temporary disabling condition, a potential for aggravation of the condition in the workplace, and perhaps an assumption that the workplace caused the condition.

If the patient follows up with the clinician in a couple of weeks and reports no improvement, he or she may believe that, because nothing has changed, the clinician will support more time away from work. This can easily progress to extended periods of time out of work, with the clinician reluctant to not advocate for the patient, in the absence of apparent exaggeration or inconsistency. In time, a number of such situations will become claims for extended or permanent disability.

At this point, the treating clinician may be called upon to defend a claim with very limited information about the actual circumstances of the stress, alternative reasons for the claim, and other factual information not available within the context of a treatment relationship. Thus, G. D.'s clinician may face new

questions: Does G. D. really want to go back to work? Is G. D. exploiting mental symptoms for extended impairment? What is the natural course for a mental disorder such as his; and, if the course is prolonged, why would G. D. be an exception?

Unlike forensic clinicians who often provide opinions of this kind, treating clinicians may be uncomfortable with the legal arena in general and not so willing to become involved beyond the treatment of their patients. In some cases, the patient's attorney may seek out an independent forensic clinician for that purpose. However, this is costly, and frequently there is a presumption that treating clinicians may be more credible because of their established relationship with the patient and their greater knowledge of the patient's condition. On the other hand, employers and their insurers may have fewer financial constraints, and retaining an independent forensic clinician is their way of validating a workers' compensation claim.

If G. D.'s period of disability is relatively short, and his treating clinician can document how the motor vehicle accident led to his mental condition, a further independent evaluation may not be necessary. If, however, the period of disability is prolonged or permanent, then an independent evaluation can be expected. Insurers are skeptical of mental claims because of their subjective nature; and, historically, the workers' compensation system has tried to exclude them, or required objective circumstances to help validate them (Lawrence 1983).

Much has been written about the advantages of a treating clinician versus a forensic clinician in performing mental health evaluations in a legal context (Gold et al. 2008; Strasburger et al. 1997). This is applicable for workers' compensation as well as for all disability evaluations. Certainly, issues of therapeutic alliance for treating clinicians may impede objectivity, in that they may be more accepting of their patient's presentation and historical narrative. This does not mean that if a patient's account is delusional or grossly distorted that a treating clinician would not confront it. Similarly, over time and with the development of trust, the treating clinician may learn of alternative factors impinging on the patient's life or distortions, which the patient may harbor with regard to impairment. However, for the most part, treating clinicians will accept a plausible account from their patient. This is true not only in regard to the distress the patient reports, but also as to the source of that distress. Treating clinicians are not privy to much independent corroborating information, and once committed to the therapeutic alliance, may advocate for the patient even when inconsistent information is uncovered.

Forensic clinicians may not be hampered by the therapeutic alliance, and may have access to much more information. By virtue of their experience, they should be asking for complete records and background data that provide a more complete understanding of the evaluee's history, workplace issues, and the circumstances of the claimed injury. Forensic clinicians may also be more knowledgeable about the legal process, rules of evidence, and the legal standards to which their opinions are applied. Of course, they may not always be objective either. They could have a built-in bias from philosophical positions, or an allegiance to a theoretical stance. Because there are different schools of thought, one or another may dominate the

forensic clinician's thinking. There is also a question of agency and compliance to the agency relationship that can interfere with objectivity.

Financial factors are a potential source of bias, too, but not, as usually thought, just for the forensic clinician. Treating clinicians also may lean toward a favorable workers' compensation opinion for their patients, to ensure they will be paid for their service. More recently, studies have shown that another impediment for performing disability evaluations, including workers' compensation, is that either treating clinicians or forensic clinicians lack training in these types of evaluations. Both may focus more on challenging the other's conflicts of interest, rather than on the technical expertise that either may or may not have (Christopher et al. 2011; Gold 2011).

Mental Disability Claims

Workers' compensation laws began to be adopted in the United States in the early 1900's (Kiselica et al. 2004). Workers' compensation was developed as a no-fault system to serve as a compromise between employee and employer at a time when industrial injuries were on the rise and remedies through common law were not easily attained. As part of the compromise, the employee is denied the right to sue for unlimited damages, but instead receives a certain percentage of wages during the period of disability, and medical care at the employer's (insurer's) expense. The employer, at least in theory, does not have to defend against fault and is liable only for limited statutorily set damages.

Traditionally, workers' compensation required an accidental injury. What an "accidental injury" means is not as clear as it may seem. It does not have to represent a discrete event, but may occur slowly over the course of time. In physical claims, repetitive-stress injuries, such as carpal tunnel syndrome of the wrist, are acknowledged conditions, even though there may be dispute as to what forces are required to produce the condition. By analogy, repetitive or cumulative stress may be acknowledged mental health issues; but, again, demonstrating the forces or factors that produced a mental injury is not always easy. With the subjective nature of stress claims, these causal connections are more likely to be challenged (Lawrence 1983).

Accidental injury language, on its face, is more applicable to a physical rather than a mental/stress event. In the early years, mental conditions were essentially excluded (Tucker 2010). Even after mental conditions became more widely recognized, they were required to have a physical connection. Two types of claims are found using that connection: physical trauma leading to a mental disorder (i.e., physical–mental claim) and mental trauma leading to a physical disorder (i.e., mental–physical claim) (Larson and Larson 2005).

In physical–mental claims, there is a clear precipitating physical injury with psychological consequences. In mental–physical claims, some emotional or stress circumstances led to a mental disorder that includes objectively measured physical

consequences. Emotional or stress circumstances needed to be clearly identified initially as a discrete event or "nervous shock" (Larson and Larson 2005). Prolonged or cumulative stress was less likely to result in an accepted claim, and in many jurisdictions continues to not be accepted.

The more controversial category of mental–mental claims is mental trauma that leads to a mental disorder with no requirement of a physical component (Tucker 2010). The difficulty in evaluating these claims is caused by problems in defining a personal injury primarily attributed to an intangible force that produces a mental condition that may also be intangible. When the mental injury represents a single or limited sequence of events, it may be easier to identify its traumatic potential.

For example, stress resulting from a fire at a plant may be easily corroborated by the affected worker and/or other observers, and further validated by the magnitude of the threat, the proximity to the worker to the blaze, and the ensuing alarm. In contrast, the stress imposed by a plant supervisor who is unduly harsh and demanding may be more difficult to ascertain, hence to corroborate. It is more problematic to measure the cumulative effects of exposure to such a noxious aspect of the work environment, where the perspectives of the worker and the employer can differ widely. Moreover, because work stress is assumed to be virtually ubiquitous today, even where mental–mental claims are allowed, there is frequently statutory language in place that requires more than what is considered ordinary stress, which all employees may experience, to sustain the claim (see below).

In G. D.'s case, the motor vehicle accident could be regarded as both a physical and mental stressor. But to make a viable physical–mental claim, G. D. might have to show that his mental condition was related to the back injury itself, perhaps as a result of unremitting pain. However, no significant medical pathology was identified in G. D.'s case; and the only diagnosis was back strain. Therefore, G. D. might be thwarted in claiming a significant mental reaction to the physical injury, because the physical consequences of the injury itself were deemed negligible. G. D. could, alternatively, pursue a mental–physical claim, asserting that the frightening nature of the accident was the mental stress, and that the back pain was a physical consequence of the stress.

To the extent that a physical component was required to help objectify such claims, chronic pain without more evidence may be just as subjective as a mental condition. In some jurisdictions, the resultant condition needs only to have physical manifestations and not a specific physical injury, again, to help objectify the claim (e.g., West Virginia Code 2010). That said, subjective physical manifestations are quite common. For example, G. D. could claim that he suffers from insomnia, shaking, gastrointestinal disturbance, elevated blood pressure, or other autonomic nervous system responses to stress. It is important, therefore, to know the type of mental claims that are honored by statute or case law in one's jurisdiction, and what the parameters for those claims may be.

With a better understanding of mental disorders and their psychological and physiological bases, there has been a rise in mental workers' compensation claims (McDonald and Kulick 2001). At times these mental disorders may be independent

of any physical condition; but quite often they accompany and complicate the physical condition. For example, depression alone doubles the time of sick leave generally, and employees who are depressed prior to experiencing a physical work injury are at a greater risk for a complicated and delayed recovery (Kessler et al. 1999). At the same time, those individuals whose recovery from a physical injury is delayed are at a far greater risk of developing depression as a consequence (Bruce et al. 1994). Depressive symptoms are also pervasive in workers with musculoskeletal injuries, transient for some, but often not diagnosed or treated (Franche et al. 2009). It has been argued, therefore, that limitation or denial of mental–mental claims frustrates an important purpose of workers' compensation law (Tucker 2010).

As noted above, work and stress are, today, considered almost synonymous. The very nature of work imposes forces and pressures on the worker, either from external requirements or personal drive, which require adaptation. Stress has several prompts: having to be at work at a particular time, remaining there for a prescribed number of hours, coping with physical and/or intellectual demands, meeting deadlines or quotas, achieving a prescribed level of quality or accuracy, and interacting with co-workers and superiors. Stress is exacerbated by the requirement to tolerate personality differences, face one's own shortcomings, deal at times with unreasonable authority, or overwhelming tasks, and answer to unreasonable demands of clients or customers.

All these factors are inherent in work, but the stress from them is not pathologic. Even the distress or discomfort that may flow from the aforementioned obligations is not pathologic. Few individuals are completely satisfied with their jobs and workplace, and most feel distress at one time or another, if not regularly. The issue then is not whether a worker suffered stress or even distress, but how adaptive or maladaptive the worker was in the face of it.

Corroborating Information

In order to properly assess disability in workers' compensation cases, as well as related issues, reliable corroborative information is needed. In a case such as G. D.'s, treating clinicians may have only limited information available. They typically receive a telephone call or letter from the PCP, perhaps a report of the orthopedic consultation, and often not much more. If G.D.'s treating clinician learns that G. D. had a history of mental disorders or mental health treatment, he or she may make an attempt to retrieve some of those records; but, often, even those are not readily attainable.

This means that G. D.'s account may be the main source of information. If aspects of G. D.'s account are unclear to the clinician, he or she may make an attempt to speak to a spouse or other relative. If, on the other hand, G. D.'s account appears coherent, other information may not be part of the typical clinical evaluation. In the course of G. D.'s treatment, more will no doubt be learned from him,

but it may be overshadowed by the workers' compensation claim and G. D.'s need to attribute the mental disorder to the work-related injury.

Even when relevant information is later obtained in treatment, clinicians may already have committed themselves to insurance forms and reports from their earliest impressions. Therefore, one of the fundamental problems for treating clinicians providing opinions in workers' compensation claims is the lack of sufficient information. This does not, however, automatically preclude a treating clinician from providing such opinions about a patient such as G. D. Indeed, it would be impractical and cumbersome to gather all the necessary information before starting treatment and committing to a mental disorder diagnosis, or to determine whether the diagnosis is work related or results in impairment. Nevertheless, treating clinicians should be aware of the limitations of their opinions and couch their reports with those limitations in mind (see below).

A forensic clinician retained either by the patient's attorney or the employer/insurer will typically have much more information available when preparing what is usually referred to as an independent medical evaluation (IME). This could include corroborating information about the injury, accident, or circumstances surrounding the claimed stressor. In G. D.'s case, this might mean police reports from the motor vehicle accident, ambulance reports, and records from the hospital where he was first taken. The information from these sources may or may not be consistent with the severity of the accident described by G. D., his initial response to the accident, and other historical information he provided.

Understanding the nature of a patient/evaluee's work is critical to assess impairment for that work. The patient/evaluee's job duties, the stress associated with those duties, and the abilities required to perform them should be explored. A minority of claimants will grossly misrepresent or fabricate a workplace stress situation; more commonly though, individuals may only embellish or exaggerate the stressor, rather than lie outright about it. That is why it is important to seek verification of the workplace conditions and what actually occurred. It might be helpful in G. D.'s situation to explore his usual driving duties and other work responsibilities, his time on the road, and what he likes or does not like about his job.

Prior medical and mental health records may also be important, even if they do not appear to be related to the claimed injury. For example, G. D. may have a prior history of back pain or other physical ailments that are poorly explained by medical pathology. There may be evidence in his medical records of prior psychiatric symptoms, and treatment for other or recurrent mental disorders. PCP records frequently note stressors that preceded an accident, which may or may not be more substantial than those arriving from the accident itself; and later physician records may either confirm the reported course of the patient/evaluee's condition or suggest a different and inconsistent course to that reported.

Personnel records can also be an important source of background information. These records are created and maintained by the employer and pertain to all employees. They include such documentations as employment applications, performance evaluations, disciplinary actions, payroll records, injury reports, internal investigations, and other related materials. Employment applications and other

data contained in the personnel records can establish a chronological history of the employee's education and prior employment, along with, at times, gaps in employment. Such information may provide evidence of inconsistency and prior injuries, as well as the means to develop potential alternative work capabilities.

A personnel file may also include e-mail records and various other types of correspondence. Some employers may have internal communications they do not include in these records but which may be relevant to certain personnel issues. If not formalized as part of the personnel records themselves, access to such communications may still be important in some cases. When internal communications have not been disclosed to the employee, the employer may be reluctant to release them to the clinician evaluating the case, knowing that the clinician's file may need to be produced to the employee's attorney by request or subpoena, and by extension to the employee himself or herself.

Nonetheless, if relevant information is contained within these internal communications, particularly when the workplace circumstances surrounding the claim are in dispute, they should be reviewed. One frequently seen problem with personnel records is when the employer (e.g., manager or supervisor) fails to conduct regular performance evaluations, or conducts them in a perfunctory manner simply indicating that the employee does or does not meet expectations without further scrutinizing job performance. If, subsequently, an issue about the employee's actual performance is raised, perhaps to argue that the employee's stress was a result of his or her own substandard work, the evidence will not have been formalized in the personnel records, and credibility will suffer.

With regard to G. D.'s personnel records, the following may need to be investigated: What kind of employee was G. D.? Did he perform well as a delivery driver? Was he a motivated worker? Did he have a poor relationship with his supervisor? Were any personnel issues potentially a more substantial source of stress than the accident itself? What information is available in regard to the letter of warning for the previous motor vehicle accident? Was loss of his job actually threatened? To the extent that employment records are incomplete, speaking to G. D.'s supervisor, after obtaining appropriate consent, could help establish the effect the letter of warning had on his motor vehicle accident.

Other corroborating information may include, but not be limited to, prior injuries and workers' compensation claims, and hearing decisions about those claims; ergonomic assessments; telephone records; police investigation reports and criminal records; occupational safety and health administration (OSHA) investigations; Facebook and other social networking sites with information about the employee; tax returns; and, at times, images from facility surveillance cameras.

As to obtaining corroborative information from covert surveillance, this is a controversial area, particularly in mental claims (Gold et al. 2008). Even in instances of alleged physical injury, surveillance pictures or video films within a discrete period of time may not accurately reflect an individual's overall functional capabilities. For example, by necessity, many disabled people must exert themselves briefly beyond their actual capabilities, and pay the physical consequences afterward. For individuals with mental disorders, it is even more difficult to assume that a

discrete period of surveillance is representative of total functioning capability: a surveillance camera cannot capture internal emotional states. In some circumstances, however, if a person has represented that certain activities are impossible to perform or never performed, then a surveillance camera may be able to disprove this assertion. Insurers often use surveillance with equal anticipation of important findings in mental disorders as in physical disorders; but this may be an erroneous assumption. Surveillance as a tool is limited, and thus should not be overly credited.

Conducting the Evaluation

The core elements in conducting a mental disability evaluation should be similar for both treating and forensic mental health professionals. Both treatment providers and forensic evaluators are interested in gathering history from the patient/evaluee in an interview that is of sufficient length to learn what is necessary to make as accurate an assessment as possible. Treating clinicians may seem to have an advantage, because they probably have had multiple treatment sessions with the patient, but this can be misleading if some or most of the time sessions were merely short medication or status checks.

Forensic clinicians, in contrast, are "starting from scratch" and so will often take several hours to interview evaluees and trace their history in considerable detail. Forensic clinicians also will often face evaluees who are "on the defensive," especially if the clinician is not retained by the evaluee's attorney, and so is perceived as an "enemy" from the insurance company. Thus, patient/evaluees may not be as candid with the information they provide. Forensic clinicians should be aware of and understand this posture, and be respectful of evaluees throughout the evaluation, to help them maintain dignity. By taking a respectful, nonconfrontive approach, most patient/evaluees, even in the setting of an IME, will become more at ease and be more willing to make difficult disclosures.

Forensic clinicians do have an advantage in that they typically have reviewed a great deal of information about evaluees prior to the interview, and can use that as a springboard to gather a more detailed and complete history. They can then explore consistencies and inconsistencies in the recorded information with evaluees. This should be done carefully so evaluees do not feel attacked or that their credibility is being questioned. Most historical inconsistencies are not due to fabrication but to misattribution and cognitive distortion.

The clinical interview is more than an opportunity to gather information, though certainly that is a primary objective. It also serves as a setting in which to formally observe patient/evaluees' emotional state as they discuss current complaints and past history. The setting should, therefore, be one in which patient/evaluees can feel comfortable in revealing intimate aspects of their emotional life, and expressing the feelings that surround them. This can occur even when forensic clinicians alert the patient/evaluees to the nature of the evaluation and its limited confidentiality.

Therefore, anything that prevents emotional expression by the patient/evaluee is an impediment to the interview. In IMEs, this is very apparent when the attorney, a family member, supports person or other interested party insists in being in the room during the evaluation. Some jurisdictions now have statutory language in workers' compensation cases stating that a witness may be in the room (New Hampshire Revised Statutes Annotated 2011). Others allow the patient's doctor or any doctor to be in the room (Maine Revised Statutes Annotated 2001). Still others allow audio/video recording of the evaluation (Vermont Statutes Annotated 2009). The treating physician does not have to deal with this type of impediment. It is an unfortunate development for IMEs where similar emotional observation is needed. Forensic clinicians should be aware of the law in the jurisdiction where they plan to conduct IMEs, so they are not caught unawares when the evaluee is accompanied by an interested third party.

In addition to the clinical interview, a carefully performed mental status examination and/or psychological testing by the forensic clinician may reveal cognitive impairment, severity of clinical complaints, vulnerability to fragmentation under stress, exaggeration, and other useful impairment parameters (Drukteinis 2010). Clinical observation in a setting of respect for the patient can provide a wealth of information. Along with typical mental status observations from such an examination, a dramatic or histrionic presentation by the evaluee, or one that is inconsistent with the history of complaints, can raise doubt about the severity of the mental disorder. An angry, belligerent presentation may, at times, lead a clinician to conclude that the evaluee is highly symptomatic, when, actually the behavior represents a defensive posture to avoid closer scrutiny. An evaluee's ease during the clinician's interview and in conversation, as well as during more formal testing of mental processes, may suggest adequate cognitive functioning despite claims to the contrary.

In the case of G. D., for example, does he demonstrate pain behaviors or magnify pain complaints? If so, are these pain behaviors consistently present during the entire evaluation? Does he also appear as anxious and depressed as he reports? Is his presentation generally consistent with his account? If psychological testing is conducted, does it demonstrate symptom exaggeration, manipulative personality traits, or any other sign that casts doubt on his self-reports?

In conducting the clinical evaluation of G. D., the interview should begin in an open-ended fashion so as not to restrict him to a question/answer format. At the same time, it is important to obtain as detailed a chronological history as possible, including all the particulars of the accident and his experience in it, and to trace the detailed events that followed immediately and over time, to ensure they are not reduced to generalities, a tendency of many patients. It is also important to trace G. D.'s functioning in his personal life both before and after the accident, and to compare his symptoms with his claimed lack of functioning for consistency or inconsistency. If G. D.'s anxiety symptoms include posttraumatic features, in what settings do those symptoms arise or do not arise? Can he go back to the scene of the accident? Can he drive at all? Does he return to his workplace for any reason? What does he regard as his impairment? Does it affect all aspects of his life or just

some? Do his depressive symptoms keep him from leisure activities? Pursuing interests? What is he doing to overcome his depression besides continued mental health treatment?

It is sometimes possible to corroborate an evaluee's functioning by surveying a typical day in the patient's life (Drukteinis 2010). Tracing the day, hour by hour, can be quite informative. Using this technique, an evaluee may not be able to rely as easily on generalizations, and the details obtained in such an inquiry could show areas of preserved functioning that may be analogous to work duties. So, asking about an evaluee's hobbies, recreation, and social interactions can confirm or contradict claimed impairment. In addition, when evaluees have become completely nonfunctional, the reasons why they have accepted an invalid role must be explored.

For G. D., along with a routine clinical history and exploration of his background, the best evaluative tool is an accurate and reliable longitudinal history. Tracing his life sequentially in detail to the point of working for the package delivery service, and his personal and work history while at that job is essential. Is there evidence that G. D. had any of his now reported symptoms prior to the motor vehicle accident? To what extent does the letter of warning affect him? What was his perception of his job security? How does his own history differ from recorded and other outside information?

In some instances, interviewing individuals who know the evaluee may be helpful, again with appropriate consent, especially when the evaluee is a poor historian (Drukteinis 2010). These individuals may include family members, employers, co-employees, or other parties. The reliability, or lack thereof, of all such sources, however, must be taken into account. For example, family members may be as vested in a workers' compensation claim as the claimant and so may distort the history in support of the evaluee's claim. Similarly, an employer or manager may provide misleading information about the employee to show that the claim of disability is fabricated, or that the employee was at fault. Even in the no-fault system of workers' compensation, fault is frequently raised by all parties. The inherent bias of all informants, as well as the consistency of reported information, should therefore be scrutinized.

Disability Opinions: Making a Diagnosis

As in other types of disability assessment, opinions in workers' compensation cases first must identify a psychiatric condition with an actual diagnosis based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* (*DSM-IV*) (American Psychiatric Association 2000). Many diagnoses in the *DSM-IV* have as a criterion "clinically significant distress or impairment in social, occupational, or other important areas of functioning." Therefore, impairment that could lead to disability in those diagnoses is often presumed. Serious diagnoses such as schizophrenia are more

likely to result in significant impairment in many areas of functioning, compared to adjustment disorders in which significant impairment is not necessarily present, or is not as global. Also, when a patient/evaluee has more than one mental disorder, the combination may have a compounding impact on functioning. It is important, however, to keep in mind that even when a valid diagnosis has been made, it alone does not establish impairment or disability; that is a separate determination.

In G. D.'s case, possible psychiatric diagnoses include pain disorder associated with both psychological factors and a general medical condition; pain disorder associated with psychological factors; as well as nonpain-related conditions such as Posttraumatic Stress Disorder, Anxiety Disorder, Depressive Disorder, and others. Unless G. D. has a pain disorder associated with psychological factors, that is, the psychological factors are playing the major role, any impairment from that condition is typically a medical and not psychiatric determination (Drukteinis 2009). Psychological factors may otherwise help in understanding impediments to rehabilitation but the condition is not solely or even primarily in the province of mental health.

However, there are mental conditions that may be solely the focus of mental health. Does G. D. describe anxiety that, depending on the fulfillment of other criteria, could represent Posttraumatic Stress Disorder, or just a more generic form of Anxiety Disorder? Similarly, G. D.'s depression could, depending on the circumstances, represent a relatively minor Adjustment Disorder, but could also have evolved into a Major Depressive Disorder. A complete understanding of his personal and mental health history can suggest preexisting or recurrent mental disorders with the same symptoms that he now reports. All of these diagnostic issues become relevant for the next question: What is the cause of the mental disorder?

Disability Opinions: Causation

As indicated earlier, workers' compensation disability evaluations must address whether the mental condition arose out of and in the course of employment (an accidental work-related injury). Although this language is typically incorporated in workers' compensation statutes in all 50 states as well as the Federal Employee Compensation Act (FECA), there are significant differences, and clinicians should be aware of the specific language used in the jurisdiction where the evaluation is being conducted. There may also be differences, defined by case law, where the statute in a jurisdiction is incomplete or ambiguous. These too are important to know.

Treating clinicians are less likely to be aware of these local distinctions than forensic clinicians. The language on workers' compensation treatment forms may ask only if the condition is work related. Arguably, it is appropriate for treating clinicians to simply address those words and leave the rest to be dissected by attorneys and hearings officers. However, when treating clinicians are drawn into the legal process, particularly with the requirement of testimony, the questions posed address more than just whether the condition is work related; they will query

the distinctive statutory language of that jurisdiction. Treating clinicians who believe firmly that their patient's condition is work related, and advocate for their patient, may find their efforts to support their patient are undermined if they are not aware of those distinctions.

Inherent to the first set of distinctions seen in some jurisdictions is, as discussed earlier, whether the mental disorder requires a physical component to be accepted in a workers' compensation claim (i.e., physical-mental, or mental-physical). In various jurisdictions, one or the other, or both, may be the only type of claim accepted (e.g., *Kovach v. Henry Ford Hospital* 1994; *U S. Airways v. Workers' Compensation Appeals Board* 2001). Where a straight mental–mental claim is accepted, it may be narrowed by restrictive language such as "greater emotional strain than that to which all workers are occasionally subjected" (*Ryan v. Connor* 1986); or if an employee has a pre-existing (mental) weakness, there is no recovery unless the stress of the workplace "contributed something substantial… greater than is encountered in normal non-employment life" (*New Hampshire Supply Company v. Steinberg* 1979).

Causation is often highly contested in workers' compensation claims (Gold et al. 2008); ultimately, causation is determined by a labor or industrial board through an administrative hearing. An administrative hearing is less formal than a trial, but clinical reports and the testimony of clinicians, nevertheless, will be challenged vigorously by the opposing attorney and/or the hearing officer(s) as if it were a trial. Therefore, conclusions about the cause of a claimant's mental disorder as related to his or her work must have a solid foundation. This is as much factual as it is clinical. Missing or erroneous facts can easily undermine opinions about causation. In approaching the causation issue, once the jurisdictional definitions are known, the following inquiries may be helpful:

1. Is there a diagnosable mental disorder?
2. Are all the symptoms consistent with the disorder, or might they represent some other condition?
3. Has the degree of distress been determined based on the individual's account, or has it been verified by collateral sources?
4. Is the injury, physical or nonphysical, likely to have resulted in such a disorder?
5. Is the injury verifiable?
6. Generally, how well adjusted was this individual to family, work, and life prior to the claimed injury?
7. When the injury occurred, what was the individual's employment status? Did undesirable employment conditions exist?
8. Are there alternative explanations for this disorder, considering the longitudinal life history and personality of the individual?
9. Is this a typical course of illness and/or response to treatment? If not, why not? Is there motivation to recover?

In G. D.'s case, the motor vehicle accident represents a specific event that is well documented and involves physical trauma, even if the resulting physical injury is no longer clear. A physical impact initially, and/or autonomic nervous

system/pain reactions subsequently, may help qualify the mental disorder as either a physical-mental claim or a mental–physical claim. If a mental–mental claim is asserted, could the accident and its consequences have been sufficient to result in an anxiety disorder or depressive disorder? Could it have met the threshold for Posttraumatic Stress Disorder? Even if G. D. has a predisposition to, or actual history of a mental disorder, the accident still could be an aggravation, using the known principle in law, that you take your plaintiff as you find him (i.e., the eggshell skull rule) (Speiser et al. 1985).

Another important area in causation analysis is whether or not the stressor is a personnel issue. Unlike employment stress that flows from the type of work, the amount of work, or circumstances that are a direct result of work duties, personnel issues are a by-product of the employer–employee relationship (Drukteinis 1997). Routinely, employers take personnel action to resolve conflicts or to advance the needs of the organization, and this creates stress. Such personnel actions are ubiquitous in the workplace. They either cause sufficient stress overtly to lead to a mental disorder, or more covertly precede a stress claim that is ostensibly for another reason. The types of personnel actions from an employee's behavior include the following:

- performance problems
- personality disturbance
- motivational issues
- employee misbehavior
- employment insecurity

In a no-fault system such as workers' compensation, it is difficult to deny a claim that arose out of and in the course of a stressful personnel action without more clarification. Therefore, many jurisdictions have added statutory language to deal with these potential mental–mental claims, such as: "[The stressful situation] cannot be a reaction to normal employment events such as a job transfer, a disciplinary action or job termination" (e.g., *Cairns v. City of East Orange* 1993); or there is no recovery if the personnel action was "in good faith" (e.g., Schrimpf 1987). In G. D.'s case, the letter of warning for his previous accident was a personnel action that apparently caused sufficient stress to lead him to believe the current accident would threaten his job. If it can be shown that the prior personnel action was, or any anticipated new personnel action is, in good faith, and that this is the more substantial reason for his mental condition, G. D. may not satisfy the causation requirement for his mental claim.

Disability Opinions: Impairment and Disability

A mental disorder does not automatically equate to impairment, and impairment does not automatically equate to disability (Drukteinis 2010). These distinctions are important, and explained in the American Medical Association (AMA) *Guides*

to the Evaluation of Permanent Impairment, 6th Edition (American Medical Association 2008). *Impairment* is defined as "a significant deviation, loss, or loss of use of any body structure or body function, in an individual with a health condition, disorder, or disease." (p. 5). Such alterations to an individual's health status are assessed by medical means. In contrast, *disability* is defined as "activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease."(p. 5). Despite the clear delineation between these terms, they are often used interchangeably. But, in workers' compensation claims, making the distinction is important because in many jurisdictions the type of impairment has ramifications for the extent and duration of lost income coverage and for ultimate monetary awards or settlement.

There are four main categories of impairment considered in workers' compensation cases (Metzner et al. 1994):

- temporary partial
- temporary total
- permanent partial
- permanent total

It is understandable that some types of mental disorders will be more likely to have temporary rather than permanent impairment, and some may be more likely to have partial but not total impairment. Any combination of these impairments can occur; and the projected impairment can change over time and with the course of treatment. In conjunction with this, and at least before any conclusions for long-term disability are drawn, it is often necessary to determine whether the patient has reached maximum medical improvement (MMI) (American Medical Association 2008). The meaning of these terms varies in different jurisdictions, but generally they are used to indicate that the course of treatment has now plateaued and that further treatment is not likely to result in a substantial change to the condition. This, then, triggers the need for an impairment assessment. MMI, sometimes referred to as medical end result (MER), typically means that a worker may be entitled to an amount of money for the permanent impairment sustained as a result of the work injury. That amount of money is derived from formulas that vary from jurisdiction to jurisdiction. Some jurisdictions specifically do not allow permanent impairment for mental disorders, again reflecting the subjective nature of such conditions (New Hampshire Revised Statutes Annotated 2008).

The most commonly used source of assessing medical impairment is the AMA *Guides*, *6th Edition* (American Medical Association 2008). Prior editions of the AMA *Guides* listed several categories of impairment in the "Mental and Behavioral Disorders" Chapter, but did not specify percentage estimates of mental impairment, indicating: "There are no precise measurements of impairment in mental disorders. The use of percentages implies a certainty that does not exist" (American Medical Association 2001, p. 361). In those jurisdictions, where a percentage rating of impairment was required even for mental disorders, alternative methods were used (Colorado Code Regulations 1996).

In *DSM-IV*, a multiaxial system for different domains of diagnostic information includes Axis V, Global Assessment of Functioning (GAF) (American Psychiatric Association 2000). But, the GAF provides only a means of reporting impairment and not of actually assessing it. In the AMA *Guides, 6th Edition*, a modified position has been taken to include percentage impairment ratings for the following groups of diagnoses (American Medical Association 2008, p. 349):

- Mood Disorders, including Major Depressive Disorder, and Bipolar Affective Disorder
- Anxiety Disorders, including Generalized Anxiety Disorder, Panic Disorder, Phobias, Posttraumatic Stress Disorder, and Obsessive Compulsive Disorder
- Psychotic Disorders, including Schizophrenia.

The AMA *Guides* specifically lists other disorders that are not ratable by a percentage impairment including psychiatric reactions to pain, somatoform disorder, dissociative disorders, personality disorders, psychosexual disorders, factitious disorders, substance use disorders, sleep disorders, mental retardation, and neurologically based conditions (which are covered in another chapter, "The Central and Peripheral Nervous System" (American Medical Association 2008, p. 349).

The AMA *Guides*, *6th Edition* also has revised the categories of impairment for mental and behavioral disorders to now include (American Medical Association 2008, p. 352):

- self-care, personal hygiene, and activities of daily living
- role functioning and social and recreational activities
- travel
- interpersonal relationships
- concentration, persistence, and pace
- resilience and employability

Some jurisdictions use modified categories of impairment from the Social Security Administration or AMA *Guides, 5th Edition* (2001), or other variations. Clinicians should be aware of which categories are used in their jurisdiction; more importantly, they should think in terms of categories to provide a framework for their assessment. The actual method of arriving at the psychiatric impairment rating scale (PIRS) in the AMA *Guides*, *6th Edition* (American Medical Association 2008) is based on a median, or middle value of percentages, derived from the Brief Psychiatric Rating Scale (Hedlund and Viewig 1980), the GAF scale from *DSM-IV-TR* (American Psychiatric Association 2000), and the PIRS impairment score found in the AMA *Guides* (American Medical Association 2008, p. 356). Once again, before proceeding to use this more recent psychiatric impairment rating or any rating scale, it is important that clinicians know whether it is accepted in their jurisdiction.

Another quite recent protocol proposed for workers' compensation psychiatric impairment ratings (Williams 2010) uses a grid to triangulate criteria from three published rating scales: GAF in *DSM-IV* (American Psychiatric Association 2000);

Classes of Impairment due to Mental and Behavioral Disorders in the AMA *Guides* (American Medical Association 2008): and the Washington State Permanent Impairments of Mental Health (Washington State Legislature 1974), to approximate an impairment severity rating. It then utilizes objective psychological test instruments (e.g., Minnesota Multiphasic Personality Inventory-2 (MMPI-2)) (Butcher et al. 2001) to introduce an element of quantitative objectivity into the process. Whether this protocol or some modification will be adopted in any jurisdiction remains to be seen. Regardless, the use of any rating scales or instruments that have not been accepted within a jurisdiction are of no real value. The purpose of all proposals and established protocols is to help objectify impairment.

Notwithstanding, the AMA *Guides'* change in position with regard to rating impairment in some types of mental disorders, a precise understanding of impairment and disability is hampered by the subjective nature of mental disorders. Frequently, treating clinicians assess disability based on the presence of a sufficiently severe mental disorder, and by their intuition about the credibility of the patient's self-reports of impairment. This is not a very objective method, and may rely on extremely limited information about actual functioning of the patient/evaluee.

In addition, patient/evaluees are often invested in gaining disability status, which can skew their self-reports. Even when their reports are reliable, it is never possible to address the totality of their circumstances without following them in their everyday lives and monitoring their activities. Much of a patient/evaluee's report is anecdotal and may or may not be representative of actual functioning. In that sense, all assessments of disability are only an approximation. The approximation can be made more reliable, however, and thus lead to better conclusions about impairment and disability. The following are proposed questions useful in assessing impairment:

1. In which categories of function, specifically, has the patient/evaluee demonstrated impairment?
2. What clear examples of impairment were provided?
3. Is reliable corroboration of the diagnosis and daily functioning available?
4. What is the nature of the patient/evaluee's work duties that can no longer be performed?
5. Are clinical tools (e.g., mental status examination, psychological testing) available to confirm the level of impairment and the degree of symptomatology?
6. Are there alternative explanations for the disability claim?
7. Does the context of the claim suggest that impairment or choice is the more substantial factor?

The most common alternative explanation to poorly supported claims is that the individual chooses not to work rather than is unable to work. Because of the subjective nature of mental disorders, this is not an easy distinction for any mental health professional evaluator to make. No white line separates the two scenarios;

choosing not to work and being unable to work due to impairment lie on opposite sides of a continuum along which both may be operative. It is the task of the evaluator to assess which is the more substantial factor. Here, too, the best tool in this process is an accurate and reliable longitudinal history.

In all assessments of impairment, it is important to know that patient/evaluees form impressions about their own impairments from cumulative incidents, which then may be expressed as generalities. Such statements have value in understanding the mind-set of the patient/evaluee but alone are not of much value in an assessment. For example, if a patient/evaluee says, "I have no energy," or "I can't concentrate," it does not literally mean he or she has no energy and no ability to concentrate. Those generalities are used to emphasize but not to explain.

In the course of critical practice, it may not be as important to dissect such statements; but in a more formal disability assessment, it is crucial. Therefore, the circumstances, degree, frequency, and context of such statements must be ascertained. With regard to categories of impairment, a level of dissection seeking specific examples in each category is necessary. Some patient/evaluees are too disconnected in their thought processes, or lack mental skills to process and articulate such details. Other patient/evaluees do not give reliable examples, because they are evasive or uncomfortable with being questioned about particulars. The lack of reliable examples of impairment, after sufficient dissection, may show that the patient/evaluee has not demonstrated the actual impairment or disability. Concrete examples of impairment, in contrast, can be compelling and are less likely to be contrived.

Has G. D. demonstrated sufficient detail of functional loss, and offered clear examples of impairment, to conclude that he is disabled? What reasons does he give for his impairment? Mostly to physical pain, or mental distress? If it is pain he is emphasizing, then his psychiatric impairment may not independently create a disability, and the ultimate determination should be medical. If, instead, he says he is too anxious to drive a van, either because of Posttraumatic Stress Disorder or anxiety more generally, is that consistent with all corroborating information? Is there work he could be doing at the company other than drive a van? What efforts has he made to obtain treatment or to return to this job or find other work? Has he undergone psychological tests that may show inconsistencies or exaggerations? Is G. D. claiming disability primarily because he feels his job is threatened, and so views disability as a needed escape from a situation that might be quite damaging to him or his family? Even if he does have valid diagnoses, are his symptoms reinforced by the secondary gain of financial security through workers' compensation?

Disability Opinions: Job Restrictions

Another question both treating and forensic clinicians must answer in a workers' compensation report or evaluation is under what conditions should a patient/evaluee be allowed to return to the same job, that is, what restrictions should be

proposed? This is easier to answer, to some extent, in the case of physical injuries where impairment may be more objective. In the case of mental disorders, however, clinicians may be pressed to offer similar opinions. Without understanding the nature of the job, or presuming to know what the patient/evaluee's job functions are, it may be impossible to accurately make suggestions, much less define restrictions.

In some instances, because of the nature of the mental disorder (e.g., Posttraumatic Stress Disorder), it may be necessary for the patient/evaluee to avoid the circumstances of the stressor at the workplace or in that line of work. For example, if a firefighter is suffering from posttraumatic stress symptoms after failing to rescue a child from a burning house, he may not be able to return quickly to firefighting. But, that does not necessarily mean that he could not fill a desk job at the fire station. Of course, some firefighters may never be able to return to firefighting after such an experience, and a temporary desk job may not be a permanent solution.

In other circumstances, the restrictions sought may be vague or unrealistic. For example, if an office clerk claims to suffer severe anxiety because of his or her supervisor, is it realistic for the clinician to restrict that patient/evaluee from working under that supervisor? Is it realistic for a clinician to recommend that the clerk work in a no-stress environment? Such restrictions may be more a reflection of the clinician's advocacy for the patient rather than an objective recommendation; and sometimes that advocacy presumes fault on the part of the supervisor which, without factual information, may not be well founded.

Clinicians are also frequently asked to determine whether a patient/evaluee can work part-time, even though the impairment precludes full-time work. Such opinions may be reasonable, but not when there is an incomplete understanding of the patient's specific work duties (Gold et al. 2008). The clinician should try to discern what objectively makes part-time work possible, and full-time work not possible. Does the patient/evaluee have obligations outside of work that compete with work time? If so, does it follow that the mental disorder prevents full-time work? Some patient/evaluees will complain that their mental symptoms are caused by working considerable overtime, and clinicians may recommend against further overtime. Is this objective? How big a role does preference or simply desirability, and not actual mental limitations, play a role in the patient/evaluee's perspective?

Disability Opinions: Pain Disorders

Treating and forensic clinicians are commonly called upon to provide opinions on impairment and disability that include pain disorders. As indicated earlier, the AMA *Guides*, *6th Edition* includes impairment ratings for selected major mental illnesses; at the same time, it precludes "psychiatric reactions to pain" and "somatoform disorders" (American Medical Association 2008). Instead, the impairment rating for a physical condition, which presumably is provided by a

medical evaluator, should have taken into account both the pain and the psychological distress associated with the physical impairment. It would seem, then, that clinicians should not be involved at all in impairment ratings of pain disorders. The pain-related impairment in the AMA *Guides* is determined by using the Pain Disability Questionnaire, which is made up of a functional status component and a psychosocial component. Where the pain disorder is accompanied by objective findings of injury, the pain-related impairment does not, by itself, add to the percentage of whole person impairment, but only indirectly within the net adjustment formula. Clearly, then, a medical evaluator would be providing the impairment rating, and modifying it according to the formula that takes into account pain-related impairment.

At times, however, when specific circumstances present, mental health clinicians may become involved in the rating of pain disorders. The first of these is when the pain disorder is not accompanied by objective findings; and from a purely physical standpoint there would be a zero percent whole person physical impairment. This would correspond to the *DSM-IV* diagnosis of Pain Disorder associated with psychological factors, in which the psychological factors are playing the major role (American Psychiatric Association 2000). Here, the AMA *Guides* would only allow an impairment rating based directly on the pain-related impairment, again, as per the Pain Disability Questionnaire, which results no more than 0–3 %. This low cap is based on the presumption that such conditions present problems of reliability and validity.

The second instance is where a pain disorder is accompanied by a comorbid mental disorder such as a Mood Disorder or an Anxiety Disorder, which, according to the AMA *Guides*, is a well-validated major mental illness (American Medical Association 2008). The difficulty in this situation, however, is that symptoms compromising the psychosocial components in pain-related impairments can overlap with symptoms of the mental disorder. It is not unusual, for example, for patient/evaluees with a pain disorder to have difficulty with sleeping, concentrating, or to suffer from depression, tension, and anxiety; symptoms so closely tied to the pain itself that without it those symptoms would disappear. Many patient/evaluees, in fact, will acknowledge that the only reason they have these symptoms is because of their pain.

Often, in attempting to rate impairment with a comorbid mental disorder, psychiatrists will use the GAF in *DSM-IV* (American Psychiatric Association 2000). But, the GAF specifically does not include impairment in functioning due to physical limitations. It is often difficult to separate the degree of impairment that is attributable to the mental disorder alone, especially when the patient/evaluee's predominant focus is on the pain and is the overwhelming reason the patient/evaluee sees himself or herself as impaired. In summary, mental health clinicians should be cautious when venturing into determinations of impairment and disability in pain disorders. In most cases, the determination is really a medical one. When psychological factors or an independent mental disorder may warrant an impairment rating, care should be taken not to blur the lines between physical and mental impairment.

Mental Disability Reports

When patients are pursuing a workers' compensation claim for stress-related disability, inevitably they will need to show that their medical doctor or mental health clinician supports such a claim. The support may come from a simple note to the employer, a more formal letter, and/or release of the treatment records to the employer's legal representative. Treating clinicians should be prepared to establish the basis of their opinion about the patient's disability from both the available clinical and factual information available. As indicated earlier, treating clinicians should also be aware of the limitations in their opinions when more comprehensive and corroborating information is lacking.

Typically, treating clinicians will not prepare lengthy and detailed reports, believing that their treatment records will demonstrate sufficient evidence for their opinion; or that a simple professional statement should suffice. It is rare that a treating clinician will not encounter patients who already have or will have work-related stress issues with the potential for a workers' compensation claim that includes impairment or disability, thus requiring such a report. Understandably, in cases where treating clinicians genuinely believe that an impairment or disability exists they may wish to advocate for their patients. It is reasonable for clinicians to formally express those opinions, even recognizing that there may be relevant missing information and other perspectives about the circumstances of the work stress. One approach in issuing such opinions is to utilize language that acknowledges the potential for conflicting or disputed information. In G. D.'s case, alternatives might include:

- "Based on the information available and my clinical evaluation of G. D…"
- "If G. D.'s assertion is correct…"
- "While more comprehensive investigation into G. D.'s workplace circumstances is beyond the scope of my clinical evaluation of G. D., in my opinion…"

If the patient's attorney receives correspondence utilizing such terms from the treating clinician, the attorney may suggest sending the clinician supplemental information, personnel records, and other relevant materials that are part of the file. Whether or not the treating clinician should undertake the task of reviewing this additional information is controversial. Some clinicians have no interest in entering any legal arena; others are more than willing to do so. Willingness can be, in some instances, motivated by additional fees charged for the review of this information or perhaps arising from an interest in forensic work.

Generally speaking, switching roles in this manner can be problematic and potentially harmful to the therapeutic relationship, and could be unethical as well. For example, if the clinician learns that G. D. is driving his own truck, and the clinician is no longer as confident of his or her opinion about a driving impairment, this could seriously undermine G. D.'s claim. If such a disputed fact cannot be easily resolved by the treating clinician, can he or she continue advocating for the patient? Yet, as attorneys and most forensic clinicians know, all facts are subject to

interpretation, and so this is best resolved by a fact-finder charged with addressing all of the accepted evidence in its best form. Therefore, it is safer for the treating clinician to simply provide clinical opinions based on the information typically available in the course of treatment. This allows advocating for the patient while at the same time recognizing that there may be factual issues for others to decide.

Forensic clinicians are asked for opinions in workers' compensation claims either after a review of records, or a full personal evaluation (i.e., an IME). When a forensic clinician is asked to perform just a record review, a verbal report back to the lawyer or insurance carrier may be considered a protected work product, and is not necessarily disclosed to the opposing side. An IME report, in contrast, usually must be produced regardless of whether it is favorable or unfavorable to the side that requested it. To the extent that a review of records does lead to a formal report, the question becomes whether reviewing records alone can serve as the basis of opinions expressed to within reasonable medical/psychological certainty. It may be that the opinion does not dispute a diagnosis, but simply assesses circumstantial information on issues of causation or extent of injury.

Nevertheless, forensic clinicians should take care in drawing unfettered, sweeping conclusions without ever having seen the evaluee. Not only can this lead to later impeachment of their opinions, but they probably lack sufficient foundation in the first place. When a forensic clinician does give an opinion based only on a record review, it may be prudent to clearly indicate the limits of that opinion. For example, having only reviewed G. D.'s records, the report could say:

- "The records do not establish…"
- "Although I have not conducted a personal evaluation, the records show…"
- "I am prepared to conduct a personal evaluation of G. D., but from the records…"

There are a number of reasons why a full IME may not be requested. One is that it may appear too costly for the claimant or the claimant's attorney. Second, if the defense requests it, the claimant's attorney may try to block it. Third, the request may not come in a timely fashion, and expert disclosure deadlines may have already passed. In any case, this should not change what the forensic clinician would customarily do as part of a comprehensive evaluation; and should not force a forensic clinician to draw conclusions beyond what is reasonable under the circumstances.

Full IME reports by forensic clinicians vary in length and in form. In workers' compensation claims, a report with opinions on impairment and disability may be sufficient in lieu of any testimony at a labor or industrial board hearing. In such a case, the report should be sufficient to show a thorough understanding of the evaluee's history and other related information, and to provide the basis for all opinions. Where factual disputes arise, contingent opinions may be expressed with the recognition that resolution of the factual issues in one way or another could lead to a different opinion.

Forensic clinicians should be familiar with workers' compensation law and may want to express their opinions on causation consistent with the specific language of

the jurisdiction where the IME is conducted. At the same time, they should take care not to assume knowledge of the law which, in some places, may be in flux. Asking the referral source for clarification is a good approach. If impairment ratings must be quantified, this too should be consistent with what is accepted in that jurisdiction. It is important to know that all quantified impairment ratings in mental disorders may imply, as the AMA *Guides*, *5th Edition* (2001) indicated, a level of certainty that does not exist. Still, the percentages given may be the best estimate from the information available.

Forensic clinicians may also express recommendations for treatment and rehabilitation, including vocational avenues that might be pursued for the evaluee. In that respect, an in-depth understanding of the nature of the evaluee's job, for which the disability is claimed, is necessary, along with knowledge of the evaluee's other skills and capabilities that would allow for alternative work. Opinions about permanent disability should be made cautiously and be consistent with the natural course of the mental disorders that are asserted as the reason for the disability.

The following is a list of typical questions to be addressed in a forensic IME report:

1. What is the mental disorder?
2. Has the mental disorder been properly diagnosed?
3. Did the workplace cause or contribute to the mental disorder?
4. What is the current level of impairment?
5. Is the treatment reasonable and necessary as a result of the claimed work injury?
6. Has the treatment been appropriate?
7. Is the treatment likely to reverse the impairment?
8. Has the evaluee reached MMI or MER?
9. Does the evaluee have any permanent psychiatric impairment as a result of the claimed work injury?
10. Does the impairment result in disability for that job? Any job?

Conclusion

Workers' compensation evaluations of mental disability claims are challenging for both treating and forensic clinicians. Both should be aware of potential limitations imposed by insufficient corroborating information, and other impediments to a comprehensive evaluation. Treating clinicians, especially, should be cautious in expressing opinions about work relatedness, impairment, and disability in reliance only on the treatment relationship. It is important to know how work relatedness is defined in the jurisdiction where the evaluation is conducted, as well as the acceptable methods of addressing impairment.

All mental health professionals should be aware that the diagnosis of a mental disorder does not equate to impairment, which requires an independent

assessment. That assessment includes an understanding of the nature of the patient/evaluee's work, the circumstances of the work injury or stressor, potential personnel issues, and alternative explanations for the claimed impairment. Impairment is best demonstrated by inquiry into categories of function. Conclusions about extent and duration of disability should take into account the natural course of the diagnosed mental disorder, and the factors that prevented, or should have prevented, successful treatment.

Key Points

1. Assess both diagnosis and categories of work impairment.
2. Become familiar with applicable workers' compensation law in regard to work relatedness and impairment.
3. Seek corroborating workplace and personal information.
4. Limit opinions to the extent of the information available.
5. Explore alternative explanations for claims of work impairment.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th edn., Text revision. American Psychiatric Association, Washington, DC (2000)

Bruce, M.L., Seeman, T.E., Merrill, S.S., et al.: The impact of depressive symptomatology on physical disability: MacArthur studies on successful aging. Am. J. Public Health **84**(11), 1796–1799 (1994)

Butcher, J.N., Graham, J.R., Ben-Porath, Y.S., et al.: Minnesota Multiphasic Personality Inventory-2: Manual for Administration and Scoring. University of Minnesota Press, Minneapolis (2001)

Cairns v. City of East Orange, 267 N.J. Super. 395, 631 A. 2d 978 (App Div. 1993)

Cocchiarella, L., Landersson, G.B.J. (eds.) American Medical Association: Guides to the Evaluation of Permanent Impairment, 5th edn. American Medical Association, Chicago (2001)

Colorado Code Regulations, 7 Sec. 1101-3 (1996)

Christopher, P.P., Arikan, R., Pinals, D., et al.: Evaluating psychiatric disability: Differences by forensic expertise. J. Am. Acad. Psychiatry Law **39**(2), 183–188 (2011)

Drukteinis, A.M.: Personnel issues in workers' compensation claims. Am. J. Forensic Psychiatry **18**(3), 3–23 (1997)

Drukteinis, A.M.: Pain disorders in litigation: Psychiatric update and evaluation guide. Am. J. Forensic Psychiatry **30**(1), 5–105 (2009)

Drukteinis, A.M.: Disability. In: Simon, R.I., Gold, L.H. (eds.) Textbook of Forensic Psychiatry, 2nd edn., pp. 283–301. American Psychiatric Publishing, Inc., Washington, DC (2010)

Franche, R.L., Carnide, N., Hogg-Johnson, S., et al.: Course, diagnosis, and treatment of depressive symptomatology in workers following a workplace injury: A prospective cohort study. Can. J. Psychiatry **54**(8), 534–546 (2009)

Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**(Suppl 4), S3–S50 (2008)

Gold, L.H.: Commentary: Challenges in providing psychiatric disability evaluations. J. Am. Acad. Psychiatry Law **39**(2), 189–196 (2011)
Hedlund, J.L., Viewig, B.W.: Brief Psychiatric Rating Scale: A comprehensive review. J. Oper. Psychiatry **11**, 48–55 (1980)
Kessler, R.C., Barber, C., Birnbaum, H.G., et al.: Depression in the workplace: Effects on short term disability. Health Aff. **18**(5), 163–171 (1999)
Kiselica, D., Sibson, B., Green-McKenzie, J.: Workers' compensation: A historical review and description of a legal and social insurance system. Clin. Occup. Environ. Med. **4**(2), 237–247 (2004)
Kovach v. Henry Ford Hospital, 207 Mich. App.107, 523 N.W.2d 800 (1994)
Larson, A., Larson, L.K.: Workers Compensation Law. Matthew Bender and Co., Newark (2005)
Lawrence, J.: The causation issue in workers' compensation mental disability cases: An analysis, solutions and a perspective. Vanderbilt Law Rev. **36**, 263 (1983)
Lenesis, P.M.: Workers Compensation: A Reference and Guide. Quorum Books, Westport (1998)
Maine Revised Statutes Annotated, 39-A, Sec. 207 (2001)
McDonald, J.J., Kulick, F.P.: The rise of the psychological injury claim. In: McDonald, J. (ed.) Mental and Emotional Injuries in Employment Litigation, 2nd edn., pp. xxxvi–xxxviii. Bureau of National Affairs, Washington, DC (2001)
Metzner, J.L., Struthers, D.R., Fogel, M.A.: Psychiatric disability determination and personal injury litigation. In: Rosner, R. (ed.) Principles and Practice of Forensic Psychiatry, pp. 232–241. Arnold, London (1994)
New Hampshire Revised Statutes Annotated 281-A:32 (2008)
New Hampshire Revised Statutes Annotated 281-A:38, II (2011)
New Hampshire Supply Company v. Steinberg 400 A. 2d 1163 (1979)
Rondinelli, R.D. (ed.) American Medical Association: Guides to the Evaluation of Permanent Impairment, 6th edn. American Medical Association, Chicago (2008)
Ryan v. Connor, 28 Ohio St. 3d 406, 503 N.E. 2d 1379 (1986)
Schrimpf, S.A.: Workers' compensation for mental stress arising from personnel decisions. Cincinnati Law Rev. **56**, 587–613 (1987)
Speiser, S.M., Krause, C.F., Gans, A.W.: The American Law of Torts. Clark Boardman Callaghan, Deerfield (1985)
Strasburger, L.H., Gutheil, T.G., Brodsky, A.: On wearing two hats: Role conflict in serving as both psychotherapist and expert witness. Am. J. Psychiatry **154**(4), 448–456 (1997)
Tucker, A.: A matter of fairness: How denying mental–mental claims frustrates the central purpose of workers' compensation law. J. Leg. Med. **31**(4), 467–484 (2010)
U.S. Airways v. Workers' Compensation Appeals Board (Panyko), 779A.2d 1233 (Pa. Commw. Ct 2001)
Vermont Statutes Annotated, 21 Sec. 655 (2009)
Washington State Legislature: Categories for evaluation of permanent impairments of mental health. http://apps.leg.wa.gov/wac/default.aspx?cite=296-20-340 (1974). Accessed 4 Mar 2012
West Virginia Code Sec. 23-4-1f (2010)
Williams, C.D.: Disability and occupational assessment: Objective diagnosis and quantitative impairment rating. Harv. Rev. Psychiatry **18**(6), 336–352 (2010)

Chapter 9
Long-Term Disability Evaluations for Private Insurers

Stuart A. Anfang and Barry W. Wall

Case Example

The ABC Insurance Company is seeking an independent medical examination (IME), including psychological testing, for a claimant, Dr. Jones. Dr. Jones is a 47-year-old anesthesiologist who claims inability to perform his occupational duties due to Bipolar Disorder NOS and opiate dependence, now in full sustained remission. Dr. Jones stopped working when state authorities discovered he was diverting and abusing controlled substances. After entering a residential substance abuse program, Dr. Jones has now maintained sobriety for 12 months and is in ongoing psychiatric treatment (including therapy and medications). He plans to leave anesthesia permanently, and has obtained a full time job as an addiction medicine specialist. Dr. Jones' treating psychiatrist maintains that working in any job, including as an anesthesiologist, in which Dr. Jones has access to controlled substances is likely to lead to a relapse of both Bipolar Disorder and substance abuse. Dr. Jones has an "own occupation" policy through his former group practice (which limits benefits for mental/nervous conditions) as well as an individual disability policy. He files claims for disability benefits under both policies.

S. A. Anfang (✉)
Adult Outpatient Psychiatry, Baystate Medical Center,
Tufts University School of Medicine, Main Street Suite 3D 3300,
Springfield, MA 01199, USA
e-mail: saanfang@aol.com

B. W. Wall
Department of Behavioral Healthcare Development, Disabilities and Hospitals,
Eleanor State Hospital, 8269Cranston, RI 02920, USA
e-mail: barrywwall@gmail.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_9,

Introduction

Disability evaluations are among the most frequently requested psychiatric evaluations for non-treatment purposes, and are commonly performed by psychiatrists and psychologists, with or without specific forensic expertise. Disability benefits may be administered through public or private entities, and these programs may seek independent medical examinations. Private insurers can provide coverage either as a privately purchased individual policy or as a benefit of employment.

Employment-based coverage can include short-term disability (STD) and long-term disability (LTD). Many employers also utilize private insurers to meet their legal obligations to provide workers' compensation programs (see Chap. 8). STD benefits typically begin within 30 days of claimed disabling impairment and typically extend for 90–180 days before exhaustion of benefits. Given the limited time frame of coverage/benefits and the expectation that the majority of STD claimants will return to work within the coverage period, it is less common for a private insurer to seek an independent medical examination in these cases (although they may perform vigorous internal claim review/case management).

If employed individuals continue to claim disabling impairment after the exhaustion of STD benefits, they may then qualify for LTD benefits, either with the same insurance carrier or a different carrier. LTD benefits are typically provided under a group policy, such that every employee (or every individual within a certain class of employees) receives the same type of coverage, with the same elimination period (the waiting period between onset of disability and eligibility to receive benefits), definition of disability, length of benefits, and other policy terms. LTD coverage through the employer is typically paid for by the employer, occasionally with part of the premium paid by the individual often with pre-tax dollars. As a result, LTD benefits are typically subject to individual income tax.

Privately purchased individual policies (often called IDI or independent disability insurance) may be considered analogous to individually purchased life insurance or other insurance policies, with set premiums, policy definitions, terms of coverage, amount of benefits, and medical underwriting all tailored specifically to the individual purchasing the policy. An individual may choose a policy with a shorter elimination period (typically anywhere between 90 and 365 days); a broader definition of disability (e.g., coverage for a person's specific "own occupation" vs. any gainful occupation); shorter or longer length of benefits (e.g., for 5 years, to age 65, or lifetime); and other policy terms, all of which would impact the premium/cost of the insurance benefit. Historically, these types of policies were purchased by self-employed professionals, such as physicians, dentists, other health care professionals, attorneys, accountants, and small business owners. Individuals who pay these policy premiums sometimes pay with post-tax (non-deductible) dollars. As a result, any benefits received are not subject to individual income tax.

Over the past two decades, economic changes negatively impacted many of these professionals and small businesses, and there was a simultaneous increase in

policy holders filing IDI claims. In response, the insurance industry began to scale back on IDI programs by narrowing disability definitions (less "own occupation" coverage), limiting benefits for certain illnesses (including mental illness), limiting length of benefits, and more closely scrutinizing initial underwriting, both financial and medical. As a result, an individual looking to purchase a new IDI policy in 2012 will likely find a more limited (and/or much more expensive) range of available coverage. However, for individuals who purchased such policies several decades ago and kept them "in force" by continually paying premiums, these "non-cancellable" policies with more generous/flexible benefits remain active, with policy holders now in their fifties and sixties.

Disability claims involve both forensic experts conducting IMEs as well as general clinicians, who may be asked to provide certification of psychiatric impairment on behalf of their patients. As a practical and ethical matter, treating clinicians are not providing "independent evaluations" of their patient's disability. Issues of alliance, advocacy, and preserving the treatment relationship are involved. Treating clinicians typically do not seek out collateral information or obtain psychological testing to substantiate a patient's claimed impairment; clinicians generally and appropriately focus on addressing (and treating) the patient's symptoms and subjective complaints.

How should a treating clinician approach these requests for certification? Perhaps the cleanest ethical and practical approach is to educate the patient about dual agency and the difference between the evaluative/forensic role and the treatment relationship/alliance. Treating clinicians may take the position that their role is to treat symptoms and impairment and not assess eligibility for public or private disability benefits, which fundamentally is a legal or regulatory decision, not a clinical question. With the patient's consent, clinicians may complete insurance documentation required for the patient's disability claim and release relevant medical records. Often, the release of records will suffice rather than completing the insurer's (or government agency's) specific forms. The medical records should ideally provide enough clear contemporaneous clinical data about symptoms, functioning, restrictions (what the patient should not do), and limitations (what the patient cannot do). If clinically appropriate, the clinician can provide more detailed data in the treatment note in anticipation that it will be used for disability determination purposes.

Some treating clinicians try to avoid using the word "disability," or providing an opinion that their patient is "disabled." These clinicians see their role as providing clinical data regarding functional impairment, and their treatment notes and/or completed forms provide the necessary information. The claims adjudicators must then determine how this information meets the insurer's specific criteria. This approach is not always as easy or straightforward as it seems, particularly for short-term disability benefits which tend to be approved (or not) based entirely on the information provided by the treating clinician. Occasionally, a treater will get phone calls from a clinician reviewing the claim on behalf of the insurance company seeking additional clarification or information. More information can be provided with appropriate patient consent.

Treating mental health clinicians will rarely be asked to do more beyond completing initial claims forms, providing a copy of the actual treatment records, and perhaps speaking with the claims adjustor or medical professional employed directly by the insurance company. If the patient is denied benefits, clinicians may need to explain to patients that the determination of disability is not under the clinician's control. This may require processing together that the clinician's role is that of a treatment provider and that available clinical data was provided with the patient's consent. Differentiating between the role of the treating clinician and the function of the disability claims adjudicator can allow for more therapeutic exploration and alliance around further treatment goals, expectations, interventions, and the therapeutic benefits of work.

In contested disability claims, it is not unreasonable, especially for long-term disability claims, for treating clinicians to suggest that the insurance company seek an independent evaluation. This can preserve the integrity of the treatment relationship and remove the disability claim conflict from the therapeutic dyad. By deferring the disability assessment to an independent evaluator, the treating clinician can focus therapeutic efforts around alliance building, shared treatment goals, optimizing the patient's functioning, and perhaps return to occupational duties, ideally without becoming involved in the financial/legal aspects of the disability claim.

Typically, the IME evaluation is not seen as establishing a patient-doctor treatment or healthcare relationship. The IME evaluator has a much more limited relationship, does not owe the same duties, and provides a much different type of service (see Chap. 2). The IME evaluator aims to bring scientific honesty and objectivity to the question of impairment and disability, while the treating clinician works to establish an effective therapeutic relationship, building alliance and progress toward shared treatment goals.

Definitions

The independent examiner asked to opine about impairment should understand the specific language/definitions of the policy in question. Private insurers offer a variety of definitions of disability and impairment, depending on the specific terms and nature of the policy. Typically, definitions of disability are framed as inability to perform occupational duties due to injury or illness. These can include any occupation (e.g., inability to engage in any gainful occupation for which one is reasonably fit by education, training or experience), own occupation (e.g., inability to perform the material and substantial duties of the individual's current occupation), and other partial or modified definitions. These definitions may vary considerably in language and specificity, often depending on the year when the policy was written or put into force.

In a disability evaluation, mental health clinicians are often asked to consider whether the evaluee's psychiatric signs and symptoms are severe enough to limit

or restrict ability to perform specific occupational functions. Restrictions are generally understood as what an individual should not do. Limitations can be described as what the individual cannot do due to severity of psychiatric symptoms. An individual with Bipolar Disorder may be restricted from irregular extended night hours because of the risk of triggering a manic episode. The individual might be limited in the ability to sustain focus beyond two hours due to decreased concentration and racing thoughts.

Policy language including limitations on benefits for impairment due to psychiatric illness (often called mental/nervous or M/N benefits) are increasingly common (as in the opening case vignette). For example, a policy may provide coverage for medical impairment up to age 65, but only 5 years of benefits for impairment due to a psychiatric illness. While this has led to allegations and litigation around discrimination and lack of parity, courts have generally upheld the employer's (and insurer's) right to specify the terms of what is a privately contracted benefit (e.g., *Wilson v. Globe Specialty Products, Inc.,* 2000).

If there is an M/N illness limit, it is essential for evaluating clinicians to understand the policy definition of mental/nervous illness. Again, these definitions may vary considerably in language and specificity, often with older policies being more vague and broad, attempting to make clear distinctions between "functional or subjective" and "biologically-based" psychiatric illness. More recently written policies may define M/N illness based on the conditions included in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association 2000).

In the case of Dr. Jones, his "own-occ" group disability policy specifies that claims based on psychiatric disorders must demonstrate no pre-existing conditions. Dr. Jones' diagnosis of Bipolar Disorder had been made when he was 25, and Dr. Jones had been able to work successfully as an anesthesiologist despite this diagnosis. In contrast, the policy did not exclude substance dependence disorders unless they pre-existed the date the policy coverage began, and Dr. Jones' opiate dependence postdates the starting date of his coverage. Therefore, although Dr. Jones did not qualify under this policy for disability benefits on the basis of his Bipolar Disorder, he did qualify for benefits on the basis of his opiate dependence.

Prior to receiving a referral for an IME, the clinician can anticipate that the private insurer has conducted its own initial internal evaluation of the claim. This can often be quite extensive, depending on the nature and duration of the claim, as well as the extent of benefits provided. Typically, the medical information in the claim file (medical records, statements from the certifying physician) has already been reviewed by a licensed healthcare provider consulting to (or employed by) the insurer. This may be a physician, psychologist, nurse, social worker, or other health professional, although the extent of expertise in mental health may be variable.

In addition to reviewing the documentary medical information in the claim file, the health professional may be asked to communicate directly with the treating physician or provider certifying the individual's disability, generally referred to as the attending physician. Such communication, by phone and/or written letter, seeks to obtain additional clinical information to clarify the nature and severity of

the claimant's condition and treatment. Note that an attending physician does not necessarily have to be a physician, especially in cases involving a mental health disability claim when a psychologist, social worker, or other licensed therapist may be certifying impairment. The insurance company typically has the claimant sign an appropriate release of information from all relevant treating clinicians as a requirement in filing the claim.

In addition to an internal clinical review (and possibly direct communication with the attending physician), insurers may seek additional data regarding the claimant's functional status. This may include "field visits" (when a representative of the insurer meets directly with the claimant to obtain further information) and additional data collection (e.g., obtaining the claimant's financial data, Internet searches about legal and business involvements, pharmacy records to confirm prescriptions filled).

For more complicated claims where there may be a question of claimant veracity, insurers may arrange for covert (but legal) surveillance of the claimant. Surveillance may include having the claimant observed for several days, focusing on activities outside the home. Such surveillance may provide relevant data contradictory to claimant's reported impairment (e.g., a claimant claiming severe orthopedic impairment is observed carrying heavy weights or exercising without difficulty; a claimant reporting significant panic, agoraphobia, and social isolation is observed shopping at a crowded mall without difficulty). If available, often this additional data will be provided to the IME examiner to be considered in context with all other data. Given the nature of psychiatric conditions and claimed impairment, such surveillance is rarely fully dispositive of the question of disability. However, surveillance can offer relevant data that appears to confirm or contradict the claimant's reported level of symptoms and impairment.

Arranging the Independent Medical Evaluation

An insurance company Claim Representative typically contacts the prospective independent examiner to request and arrange the Independent Medical Evaluation (IME). The company's legal department may make the initial contact in cases that have become adversarial, particularly when internal reviews have already resulted in the company's denial of payment, which, in turn, has prompted legal action by the claimant. Note that sometimes an insurance company may retain a third party agency that acts as liaison to schedule and arrange the IME.

The Claim Representative typically does not have clinical experience, but should be able to provide a brief profile of the claimant, the claimant's type of work and stated reason for disability, the policy type (e.g., own occupation versus any occupation), the length of time the person has been on claim, and whether the case is in litigation. It may be helpful to ask for the names of the claimant's care providers to rule out potential conflicts of interest.

At the outset, the examiner should clarify the specific consultation questions, and should ultimately receive them in writing, usually with the medical documentation. These commonly include questions regarding diagnoses; assessment of current treatment; estimation of treatment needs to return to optimal functioning; motivation to return to work; and opinions regarding limitations and restrictions. It is also important to clarify at the outset whether the examiner will be asked to provide an ultimate opinion on disability. Insurance companies may reserve the right to internally determine disability under the terms of the policy after receipt of the IME report. If the company asks the examiner to provide an ultimate issue opinion on disability, it is important to obtain the policy's definition of disability.

The evaluator should review the scope of work involved for the specific IME with the Claim Representative. The evaluator can estimate the number of hours it will take to meet with the claimant, review insurance records and treatment records, and to conduct third-party interviews. Third-party interviews may include contacting past or current treatment providers as well as individuals in the claimant's personal life, such as a spouse or work peer. The evaluator should ask whether psychological testing is complete or will be required. If completed, it should be included as part of the information packet. If not, the IME clinician should discuss whether it should be conducted by the clinician, if qualified, if testing is being arranged contemporaneously with a qualified psychologist, or whether the decision to obtain testing will depend on the evaluator's impression of a need for it (see the opening case example). If psychological testing becomes part of the IME, such findings will require integration into the full report.

Other considerations may require review at the time of initial contact with the Claim Representative depending on the nature of the request. For example, it may be important to ask whether surveillance has been conducted; whether there have been prior IMEs and if so whether those reports will be made available for review; whether an audio or video recording of the face-to-face interviews is indicated; whether the claimant desires an observer in the room; and whether it is necessary to check a drivers license to confirm the claimant's identity. Occasionally, an examiner may be asked to travel to another city or state to conduct the evaluation. Examiners conducting a forensic evaluation in a state where they do not hold an active medical license should first check the applicable state regulations or policies. Fee arrangements should be discussed and finalized with the claim representative or retaining agency.

It is helpful to clarify with the referral source any expectations about the IME evaluator discussing the findings directly with the evaluee. In general, the insurance company typically requests that no specific information regarding opinions be shared directly during the evaluation, and that the report will be going directly only to the insurer. Occasionally, an inexperienced adjustor may ask the evaluator to tell the patient (or treating clinician) directly what "correct treatment should be". This practice should be avoided; it can confuse the evaluee and treater about the role of the IME, and suggest a more active doctor–patient relationship. If the evaluator has specific recommendations around treatment (i.e., particular medications or therapeutic approaches), it is best practice to include that in the written

report and suggest that the report be forwarded to the treating clinician, who can consider the recommendations. Throughout the process, the IME evaluator should make clear to the evaluee that the evaluator is not providing/prescribing treatment, and responsibility for treatment advice or decisions rests solely with the treating clinician.

Clinicians who conduct IMEs should consider providing a letter of engagement at the time of referral. A letter of engagement is helpful in documenting the verbal discussion with the Claim Representative, and can memorialize the scope of work, the estimation of the time it will take to conduct the evaluation and prepare the report, the cancelation policy, and reimbursement. The Claim Representative should also be asked to inform claimants that they will have to sign a consent form authorizing the release of the IME report from the evaluator to the insurance company.

The IME appointment is generally scheduled with the Claim Representative, who, in turn, forwards the information to the claimant. It is helpful to include in the letter of engagement not only a date and time for the appointment, but also an estimate of how much time the claimant should be expected to be at the examiner's office. Providing directions to the office or directing evaluees to a web site where they might access directions can be helpful.

Special Issues in the Private Disability IME

At the outset of the face-to-face examination, it is helpful to orient the claimant to the evaluation process and the office environment. The evaluator may wish to put the claimant at relative ease by stating the amount of time that has been set aside for the evaluation, explaining it is permissible to request and take breaks, and pointing out practical issues such as the location of bathrooms, water, and tissues. Signing the consent form authorizing the release of the report to the insurance company is an initial priority, as is providing a warning on the limitations of confidentiality.

Depending on the circumstances, the examiner may wish to ask whether the claimant is taping the interview, as state laws for clandestine taping vary. Similarly, the examiner may wish to ask whether the claimant desires an audio or video recording of the interview; this can be reassuring to some claimants but offensive to others. If the claimant is planning to audio record the interview, it is recommended that the examiner also record this interview for documentation. Consent to recording, from both examiner and evaluee, needs to be clarified at the outset of the interview. If the evaluee insists on recording and the evaluator is uncomfortable (or unprepared) to proceed, the interview can be suspended or rescheduled until the issue is clarified with the insurance company and appropriate resolution or arrangements are reached.

Evaluees whose claims have already become adversarial before the IME may also include a request to have third-parties present to observe the interview.

Third parties can consist of the client's attorney or a supportive family member or friend. Because the presence of a third party may impact the examination, it may be helpful to offer instead to make an audio or video recording of the evaluation. While a recording of the interview may be used in cross-examination should the claim ultimately come to litigation, recordings of interviews can be largely protective of the evaluator as well as the claimant.

If a third-party observer is insisted upon at the last minute, it is important to contact the insurance company prior to conducting the evaluation. If an agreement is reached between both parties to have an observer present, it is important at the outset to arrange the chairs so that the third party sits diagonally behind the claimant, out of the claimant's eyesight but within the evaluator's eyesight. This helps avoid non-verbal communication between the claimant and the observer, and allows the examiner to observe both parties. Both the claimant and observer should be informed that the evaluation will be ended if either attempt to communicate with the other.

The face-to-face interview includes obtaining many elements of a standard psychiatric interview. These include identifying data, history of present illness, personal history, family history, medical history, substance abuse history, legal history, and mental status examination.

Other elements of the examination should include areas not traditionally covered in a standard psychiatric interview. It is important to discuss the claimant's current and pre-disability income; understanding of disability benefits and policy terms; whether the claim is currently receiving benefits under the policy; and whether the claimant is presently working in any other capacity. The claimant's work history should be extensively reviewed, including the job description, functioning up to the time of disability, what contributed to the disability, and what has changed in terms of ability to function. There should also be emphasis on prior work history. Efforts at (and responses to) treatment, as well as efforts at returning to work during or after treatment, should be reviewed.

It is important to review current symptoms and stressors and a description of the claimant's typical day before and after the onset of disability. This would include a general chronology and description of daily activities, focusing on what is different compared to pre-disability activities. Recognizing that psychiatric symptoms/impairment can sometimes fluctuate over time, it can be helpful to ask claimants for a description of both a "good day" and a "bad day" for a more complete understanding of reported functional impairment. The evaluator should also explore the claimant's current attitude toward work and disability, future plans, and self-prognosis. Because these elements are not always covered in standard mental health treatment, the examiner may obtain far more detailed information about work function than the treating clinician or attending physician.

The examiner should adopt a neutral, non-confrontative tone in the face-to-face interview, and remain polite and respectful at all times. If malingering is suspected, the most useful approach is to focus on discrepancies in the data instead of becoming directly confrontative. If an evaluee becomes angry or confrontational, the examiner should respond in an appropriate and calm clinical manner: do not

escalate the situation, offer a short break if necessary, and set clear behavioral limits and expectations, including potential termination of the interview if the evaluee is unable to regain control.

Third-party information in the form of medical records, work records, surveillance, and past IMEs can be available in advance of the interview. While the face-to-face interview is a primary source of information, using multiple sources of information can help to establish the diagnoses and functional assessment. Information obtained from third parties, including surveillance if available as discussed above, can corroborate the claimant's self-report, increase the examiner's certainty of opinions offered, and bolster the examiner's credibility should the report be challenged.

Examiners have different approaches to reviewing written or video information before the face-to-face claimant interview. Some review it thoroughly in advance to learn the details of the case and prepare questions. Others only briefly review it in advance to avoid having their preliminary impressions affected by it to appreciate the claimant's perspective at the outset. Either approach is reasonable. Thorough review before the examination can provide for more focused questioning, especially around potential discrepant or inconsistent information; however, there may be a potential risk of pre-conceived bias or impressions. A brief advance review may allow for learning the claimant's perspective on a "blank slate", but a second interview may then be needed to address questions or inconsistencies that arise after the subsequent detailed record review.

Written consent forms should be obtained prior to conducting interviews with care providers. It is typically expected that the IME examiner will communicate with the attending physician (and perhaps other mental health treaters if applicable) to discuss the treater's current clinical formulation, treatment plan, and estimated prognosis. While the IME examiner is not typically expected to provide the attending physician a "second opinion" regarding treatment, often the attending physician/therapist may welcome some constructive peer input, especially since the IME examiner may likely be the only other mental health professional (or sometimes the only psychiatrist) who has evaluated the claimant. It can be reasonable for the evaluator to share with the treater general recommendations (such as suggesting to a primary care attending physician prescribing psychotropics to consider referral for a psychiatric consultation, or making general suggestions about a change in medication/therapy approach). However, the IME examiner should make clear that treatment responsibility rests solely with the treating clinician, and the IME is not consultation or supervision to the treating clinician. The IME examiner can include any other specific treatment recommendations in the written report, with the recommendation that the insurance company forward the report to the treating clinician.

Independent evaluators should keep the conversation with the treatment provider/therapist professional and cordial; it is reasonable to ask appropriate questions about treatment and lack of progress, but avoid being critical or condescending. If the IME examiner does offer general treatment suggestions or recommendations, it is essential from the outset to clarify that the examiner is not dictating a particular

treatment approach or medication regimen, and as previously discussed, sole treatment responsibility rests with the attending mental health clinician.

Verbal consent should also be obtained and documented before conducting interviews with family, friends, and peers. The claimant may have valid reasons for attempting to withhold access to third party interviews, but because of the seeming paucity of objective findings with many psychiatric disorders, insurance companies may be concerned about the potential to malinger mental illness. Family members and work peers can provide specific examples of functional impairment.

While issues of secondary gain, potential malingering, and motivation to return to work are common throughout all disability evaluation settings, these can be particularly relevant and complex for the private disability insurance evaluation. Many of these individuals generated high income pre-disability, and benefits may be tax free (even in the context of the claimant working and earning income in other activities). Depending on the insurance policy, benefits, and other activities, claimants may make as much income (if not more) collecting disability benefits than they did when working prior to the claim.

As the economy has changed and working conditions for professionals have evolved (e.g., more managed care and decreased income for health care professionals; decreased business opportunities or challenging legal practice climates), motivation to return to prior employment may also be impacted by economic and non-clinical factors. In these cases, evaluators may find that non-clinical factors are more significant than are clinical issues. If so, evaluators should clearly delineate findings of symptoms that create clinical impairment, and findings of alternate factors affecting motivation, employability, economic conditions, and other issues.

In the case of Mr. Jones, the IME examiner reviewed the clinical data, collected collateral information and reviewed the psychological testing. The records indicated that Mr. Jones had been diagnosed and treated for Bipolar Disorder since age 25, but had been able to complete his training and work as an anesthesiologist for 20 years despite the presence of this disorder. The IME examiner concluded that Mr. Jones' opiate dependence was of relatively recent onset, and was in fact the primary cause of his occupational impairment. He agreed with Dr. Jones' treating clinician, that at the present time working in any job where Dr. Jones had access to controlled substances would likely result in a recurrence of Dr. Jones' substance abuse as well as his Bipolar Disorder. This assessment was based on Dr. Jones' current and recent history, and was not necessarily a determination of permanent impairment, restrictions or limitations.

Finally, some policies may be very specific in terms of own occupation coverage, typically compared to the duties a claimant performed immediately prior to claim. For example, an attorney who was doing full time personal injury litigation prior to claim may report losing the ability (and motivation) to do this work due to depression, but is comfortably able to do transactional/non-litigation work in real estate law—and may still qualify for disability benefits under the terms of an "own-occ" policy.

In the case example, Dr. Jones had two policies, one limited and one unlimited in regard to coverage for psychiatric disorders. As discussed above, Dr. Jones' "own-occ" policy entitled him to disability benefits on the basis of his opiate dependence, but not on the basis of diagnosis of Bipolar Disorder. This policy did not disqualify Dr. Jones from receiving disability benefits because he was working full-time since he was not working in his own prior occupation. In contrast, Dr. Jones' individual disability policy, while unrestricted in terms of coverage for psychiatric disorders, provided benefits based on a demonstrated loss in actual income. Therefore, because Dr. Jones was working and his annual income was actually more than the maximum amount insured for benefits (there was no income loss), his claim for disability benefits under his individual policy was denied. The IME examiner approaching these complex cases needs to have a clear understanding of the policy definitions, the pre-disability occupational duties, any current occupational functions, and potential non-clinical factors that may impact motivation/secondary gain.

Reports in Private Disability IMEs

IME reports contain similar information as a standard psychiatric evaluation, but with some significant differences in detail and structure. Some insurance companies may request a specific format, which should then be followed. The specific referral questions should be listed, and the discussion section should supply clear answers to each specific referral question.

The data section of the IME report should include a synopsis of the third-party information or interviews. It is essential to reference the extensive data reviewed, but usually only necessary to summarize (as opposed to directly quoting massive amounts of records, which only appears to lengthen the report and potentially inflate the evaluation cost). Similarly, summarizing relevant portions of psychological testing can help to add to the credibility of opinions regarding legitimate impairment in the diagnostic and functional assessment, while discrepancies can support opinions of malingering or symptom exaggeration. It may be helpful to append a copy of the psychological test report to the IME report, although typically the insurer has already received a copy. If there are significant differences of opinion between the IME examiner and the psychological testing report, it is essential to explain the bases for the differences (such as additional relevant data reviewed or information obtained).

As a result of the complex factors generally involved in private insurance disability evaluations, IME reports are typically longer and more detailed than standard psychiatric evaluations. The referral source usually expects a detailed report, and it is not uncommon for an IME report to run from 15 to 25 pages or more. As discussed above, this is one reason that it is often helpful to clarify with the claim representative the expected length (and cost) of the evaluation report prior to finalizing the terms of engagement. Bear in mind that the insurance

company is looking for clear opinions and analysis, with sufficient data presented to substantiate and explain the opinions. However, while it is necessary to detail and summarize the data reviewed (especially the history as presented by the claimant), it is not necessary to re-quote in excessive detail all the past medical records reviewed. Rather, evaluators should focus on summarizing the parts relevant to their analysis and opinion.

Usually, the insurer will routinely provide the report to treating mental health professionals, often inviting them to respond in writing to the IME report (especially when the IME comes to different clinical conclusions/impressions than are offered by the treating clinicians). If an attorney is involved representing the claimant, the insurer will typically also release the report to the attorney. Therefore, clinicians should expect that claimants will ultimately receive the report from their clinicians or attorneys. In addition, as discussed in Chap. 2, the Office for Civil Rights, which is responsible for enforcing compliance with the Health Insurance Portability and Accountability Act (HIPAA), has made it clear that an IME evaluee is to be provided access to records held by an IME clinician who is a covered entity under HIPAA.

As a result, when writing the IME report, the examiner should anticipate that other parties besides the insurer, such as claimants themselves, the treating clinicians, and claimants' attorneys, will eventually see the report. Examiners should craft reports using appropriate clinical language and terminology, and avoid making judgmental or pejorative statements.

Post-evaluation Issues

Typically, the report is released directly to the referring insurance company, and this is often specified in the referral letter requesting the IME. As a matter of practice, it is recommended that the IME provider not offer to send the report directly to the claimant or attending physician. That responsibility is left to the insurer, although as noted, evaluators can recommend that the insurer release the report to the evaluee's treatment provider. Evaluees and/or their treatment providers should be directed to obtain a copy of the report from the referral source. This should be made clear to claimants when they come to the evaluation, and to the attending physician or other treaters with whom the IME examiner may have phone contact as part of the IME. IME evaluators may want to address this issue with the claims adjustor at the time of initial contact, and advise the insurance company representative that any requests for report copies will be referred back to the insurer.

After the report is released to the insurer, often there is no further contact with the IME examiner. Independent evaluators may never be advised of the outcome of a claim or even litigation over a claim. However, depending on the case and the findings in the IME evaluation, the examiner may have ongoing involvement with the case. Initially, this may include contact from the insurer seeking additional clarification about the IME findings. Such contact is typically from a clinician

(physician, psychologist, nurse, or other mental health professional) reviewing the IME for the insurer and who poses further questions for clarification, either by phone or in writing. A brief written addendum report may be requested, especially if additional new data is provided for the IME examiner to review.

As noted above, the IME report is typically provided by the insurer to the treating mental health clinicians and possibly other treatment providers, and the attending clinician may be asked to respond to the report in writing, especially if the IME comes to different conclusions than those of the treating clinician. The attending physician's written response back to the insurer may be sent to the IME examiner for further review and written comment, especially on areas of disagreement. Sometimes, additional data is provided for the IME's review, including the claimant or attending physician offering their own expert's opinion or testing to counter the IME report. Occasionally, this can develop into a few written exchanges if there remains a significant difference of opinion.

In these cases, such exchanges should be mediated by the insurer and never take place directly between the independent evaluator and the claimant's treating clinician. The IME examiner should remain professional, objective, and dispassionate. Treating psychiatrists or psychologists advocating for their opinions and their patient (or attorneys advocating for their client) may criticize and even insult a differing IME opinion. While independent evaluators should defend their opinions (including potentially re-evaluating opinions if new relevant data is presented), they should avoid any temptation to get into defensive "name calling" or personal criticism of treating clinicians or claimant's experts. Respectful professional disagreements are fully acceptable and expected; however, when the dispute devolves into something more akin to ad hominem attacks or biased advocacy of one side or another, it reflects poorly on the professionals and their professions.

Depending on the case, it is possible that an independent examiner's involvement in a disability claim is limited to a single evaluation and report; however, sometimes the process becomes more longitudinal and ongoing. An examiner may be asked to re-evaluate additional data as they become available, and may be asked to re-examine the claimant again in the future for change in clinical status. Updates can result in benefits being terminated or reactivated. The independent evaluation can sometimes exceed the time that the treating psychiatrist ever meets with the claimant, both longitudinally and in total examination time. This can create transference and countertransference dynamics directly between the evaluee and the IME examiner, as well as toward the insurance company and personnel. As in clinical treatment situations, IME examiners should monitor their own reactions for unconscious bias or emotions that may potentially impact a neutral objective evaluation. Peer review and consultation with a colleague, particularly someone with experience conducting disability IMEs, can be helpful when evaluators suspect these issues have arisen.

The examiner may have contact with several insurance company employees over the years as well, including in-house counsel. Finally, if the claim is contested by the insurer or the insured and leads to further litigation, the examiner may be

contacted for deposition and potential trial testimony. This may occur several months or even years after the original examination, underscoring the importance of thorough data collection/storage and detailed records/report. Dr. Jones in the case example contested the insurance company's finding that he was not entitled to benefits under his individual disability policy. Although the basis of Dr. Jones' claim was legal rather than medical, the IME clinician was required to defend his opinions at a deposition and again at trial over the course of 3 years following the initial evaluation. The IME clinician's records and report were essential in his ability to provide detailed descriptions of the bases of his opinions.

Finally, if examiners feel that they are being pressured to alter their opinions or distort their reports, principles of professional ethics and integrity apply. Over the past decade, there has been increased scrutiny of disability insurer practices around claim management and IMEs (including allegations that companies "shop" for biased experts to support the insurer's position). As a result, insurers typically try to avoid any perception that they seek to influence, alter, or bias the "independence" of an outside examiner. Examiners should make clear to the insurer that an opinion is independent, based on a balanced thorough review of available data, and not subject to manipulation/influence in favor of the insurer. While an examiner may fear that an opinion "unfavorable" to the insurer could adversely impact future IME referrals from that company, it is critical to maintain professional objectivity, consistency, and integrity. The insurance company is seeking an "independent" evaluation; a scientifically based, honest, and well-founded opinion helps insurers achieve their goal of doing business with honesty and integrity.

IME Liability

Liability issues are reviewed in Chap. 2 and a helpful review of appellate case law regarding IME physician liability is provided in the appendix to that chapter. In brief, potential liability in conducting independent psychiatric evaluations centers on several issues:

- Does an IME constitute a doctor–patient relationship?
- Is alleged negligence in conducting an IME an action of medical malpractice?
- Does the IME evaluator owe a direct duty to the claimant/patient?
- Can the actual IME constitute an injury, including infliction of emotional distress?
- Does sharing information collected during an IME with the referral source constitute a breach of confidentiality?
- Do IMEs qualify for quasi-judicial immunity?

These are typically state law issues, with case law at the level of a state appellate court or state highest court often asking for a review of a trial court's determination of summary judgment or verdict in favor of the defendant IME examiner.

From a clinical perspective, good risk management principles apply to issues of liability in conducting IMEs as they do in general forensic and clinical practice. Evaluators should conduct a thorough evaluation; document well the data reviewed and opinions reached; treat the claimant with honesty, respect, and objectivity while making clear the evaluation is not for treatment purposes and is not intended to establish a treatment relationship; and make clear to the claimant the process of the evaluation, what will happen to the data collected, and the distribution of the report. In the event of a medical emergency (e.g., acute suicidality), evaluators should use appropriate clinical judgment and interventions as clinically appropriate.

As noted in Chap. 2, liability is rarely found against the IME examiner. In those cases where liability was found, typically these were in situations where the examiner acted in bad faith or inconsistent with standards of good medical practice. If a claim against an examiner is brought by a disgruntled claimant, it is likely that the insurer will be brought into the action and seek to support the position of the IME examiner. While such defense may be helpful, especially in providing information about the context and arrangement of the evaluation, examiners will likely want to retain their own legal representation.

Some complaints may be brought outside of civil court, such as through a professional society or state medical board alleging the IME examiner's misconduct or unethical behavior. These complaints can become complex and costly. Examiners should therefore educate themselves about applicable and relevant case law in their jurisdiction, as well as the policies of their state medical boards and professional societies in the event of a complaint. Examiners should maintain appropriate professional liability insurance that covers professional activities such as IMEs and that will provide representation in the event of litigation, state medical board complaints, and complaints brought to professional societies.

Conclusion

Disability evaluations are among the most frequently requested psychiatric evaluations for non-treatment purposes, and are commonly performed by psychiatrists and psychologists, with or without specific forensic training or expertise. Treating clinicians should be clear about their role in providing clinical data about their own patients, and that they are thus not in a position to provide an independent assessment. Clinicians performing independent examinations should provide a comprehensive evaluation and detailed report; address the specific questions in clear language understandable to the non-mental health clinician; and use all available data to substantiate the logical conclusions in a fair, accurate, and objective manner.

Key Points

1. Understand the relevant policy definitions and specific questions posed for the independent evaluation.
2. Access sufficient collateral information to provide a complete evaluation, including relevant clinical records, communication from attending physician, and possible other data such as surveillance or psychological testing.
3. Maintain a professional, objective, dispassionate, scientifically honest, and respectful demeanor at all times, both in speaking with the evaluee and clinicians, and in written reports.
4. Apply good risk management principles in disability evaluations, just as is recommended in general forensic and clinical practice.
5. Ensure that professional liability insurance covers forensic work, including disability IMEs.

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th edn., Text Revision. American Psychiatric Association, Washington, DC (2000)

Anfang, S.A., Wall, B.W.: Psychiatric fitness for duty evaluations. Psychiatr. Clin. N. Am. **29**, 675–693 (2006)

Anfang, S.A., Faulkner, L.R., Fromson, J.A., et al.: American Psychiatric Association Resource Document on guidelines for fitness for duty evaluations on physicians. JAAPL **33**, 85–88 (2005)

Gold, L.H., Davidson, J.E.: Do you understand your risk? Liability and third party evaluations in civil litigation. JAAPL **35**, 200–210 (2007)

Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Process, Model, and Analysis. Springer, New York (2009)

Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: American Academy of Psychiatry and the Law practice guideline for the forensic evaluation of psychiatric disability. JAAPL **36**, S3–S50 (2008)

Wall, B.W., Appelbaum, K.A.: Disabled doctors: The insurance industry seeks a second opinion. JAAPL **26**, 7–19 (1998)

Wilson v. Globe Specialty Products, Inc., 117 F. Supp 2d 92 (D. Mass., 2000)

Chapter 10
The Americans with Disabilities Act (ADA) and the Americans with Disabilities Act Amendments Act in Disability Evaluations

Patricia R. Recupero and Samara E. Harms

Introduction

Practicing mental health clinicians often find themselves in the position of being asked by a patient to assist in employment-related questions. Oftentimes, the question is not simply the need for a medical leave of absence or assistance in filing for disability benefits, but, rather, the more complicated issue of finding a way for the person to continue to be able to work under the protection of the Americans with Disabilities Act (ADA). Patients may be unfamiliar with the ADA and how it protects them in the workplace. Mental health professionals (MHPs)—clinicians and forensic specialists alike—should have at least a basic knowledge of the ADA and how it may apply to the patients they treat or the evaluees they see. To illustrate important aspects of the ADA for MHPs and their patients or clients, we present a hypothetical case example involving an attorney ("Mr. A") and his psychiatrist ("Dr. D").

> Mr. A is a 40-year-old Senior Associate in the Litigation Department at a large law firm. He has struggled with Bipolar Disorder since his early 20s, and he sees Dr. D, a psychiatrist, for monthly medication management appointments. Until recently, Mr. A's Bipolar Disorder has had little noticeable impact on his career and professional life.
>
> Within the past four months, Mr. A has taken on an increasingly demanding case load and initially excels at the work. Although it is not abnormal for Mr. A to "pull an all-nighter" to prepare for a case, he begins doing so with increasing frequency. He ceases taking his medication regularly. During this time, the quality of his work declines.

P. R. Recupero (✉)
Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906, USA
e-mail: precupero@butler.org

S. E. Harms
Maple Key Consulting, 910 Hope Street #5B, Stamford, CT 06907-2322, USA
e-mail: Samara.harms@gmail.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_10,

His briefs and memoranda begin to contain rambling philosophical observations and an informal writing style. After Mr. A misses an important deadline to file a pre-trial motion, his supervisor warns him that he "better shape up if he wants to keep his job." Mr. A responds angrily and defensively. Following this meeting, Mr. A loudly berates the department's Administrative Assistant for not reminding him of the deadline and "storms out of the office." Mr. A's supervisor takes him off a challenging, high-profile case and assigns the case instead to a junior colleague whom Mr. A considers his rival. Another argument ensues between Mr. A and his supervisor.

Mr. A calls Dr. D and explains the problems he has been experiencing at work. During the phone call, Dr. D learns that Mr. A has not been taking his medication, and she recognizes some warning signs of an escalating manic episode. After talking with Dr. D, Mr. A agrees to voluntarily sign himself into a psychiatric hospital for a brief inpatient stay. Because he has exhausted his personal days, Mr. A must use extended sick leave. Dr. D submits a doctor's note explaining Mr. A's need for extended leave due to a medical condition, and the firm approves Mr. A's request without further inquiry.

At the end of three weeks, Mr. A has resumed his regular medication regimen, and his symptoms have improved dramatically. He is eager to return to work but concerned about an upcoming performance evaluation. His supervisor is unaware of Mr. A's Bipolar Disorder and its role in his recent difficulties. Mr. A believes it may be in his best interest to provide a full explanation of the situation to his employer before his annual performance review, but he is unsure of how to approach the issue.

Clinicians like Dr. D can help patients like Mr. A to explore ADA-related questions, such as how to disclose a disability to an employer, how to go about asking for reasonable accommodations, and what accommodations might be appropriate. Psychiatric disorders, particularly affective and anxiety disorders, are among the most common impairments identified in complaints of employment discrimination (Gold and Shuman 2009). While some individuals with mental illness may be unable to work due to the severity of their impairments, stigma and discrimination remain significant barriers for persons with mental illness, like Mr. A, who are nonetheless able and qualified to work. Although MHPs cannot provide advice regarding an individual's legal rights under the ADA (such advice falls to the responsibility of legal professionals), they can offer assistance with ADA cases in a number of other helpful ways.

MHPs can assist in ADA matters as consultants or expert witnesses for a court, an employer/defendant, an employee/plaintiff, or an administrative body, such as the Equal Employment Opportunity Commission (EEOC). Goodman-Delahunty (2000) describes four ways in which a MHP might become involved in an ADA case: (1) providing assistance to support a determination of disability (e.g., by evaluating and documenting the employee's level of functional impairment, treatments that might improve functioning, etc.); (2) providing assistance for determinations of whether an individual is qualified for a particular job (e.g., by analyzing and explaining how a psychiatric disorder affects the individual's ability to perform specific job functions); (3) making recommendations for specific accommodations that might enable an employee to overcome disability-related impediments to work; or (4) assessing damages resulting from disability-based discrimination. A MHP may become involved in an ADA case at the litigation stage as an expert witness, but often the medical professional is consulted before a

claim becomes a dispute (Gold and Shuman 2009), as in the case of Mr. A and Dr. D Although some cases do eventually entail litigation, many ADA cases are informally resolved through settlement negotiations, mediation, conciliation, arbitration, or reasonable accommodations in the workplace, thus eliminating the need for costly and stressful court proceedings (Gold and Shuman 2009; Hickox 2011).

Dr. D, like most clinicians, has probably had experience working with patients who are temporarily disabled and need a leave of absence from work or perhaps are permanently disabled and need to apply for Social Security benefits. However, as Gold and Shuman note: "ADA mental health evaluations differ in important respects from the more common and familiar disability evaluations… ADA evaluations focus not only on an individual's impairments but also on remaining work skills and what an employer can do to support them" (Gold and Shuman 2009, p. 210). Nonetheless, an ADA evaluation shares some similarities with other employment-related psychiatric examinations, such as fitness-for-duty and return-to-work evaluations. Much of Dr. D's work with Mr. A will need to focus on vocational and work-related aspects of Mr. A's impairment. With this in mind, this chapter is organized around ADA-specific legal concepts and how they relate to the MHP's work with a patient or evaluee. A brief review of the relevant legal history will help to place these concepts in context.

A Brief History of the ADA

Enacted on July 26, 1990, the Americans with Disabilities Act (ADA) is legislation intended to protect the civil rights of persons with disabilities in the United States in the workplace as well as in places of public accommodations, such as transportation. Under the ADA, a disability is "(A) a physical or mental impairment that substantially limits one or more major life activities of [the] individual [first prong]; (B) a record of such an impairment [second prong]; or (C) being regarded as having such an impairment [third prong]" (ADAAA 2008). In the year following the ADA's passage, the EEOC issued regulations guiding the implementation of the act (EEOC 1991). The employment provisions in Title I of the ADA became effective for private employers with 25 or more employees in 1992 and for private employers with 15 or more employees in 1994 (EEOC 2001). Title I prohibits disability-based discrimination "in any aspect of [the disabled] person's employment, including applications and hiring processes, and advancement, benefits, and discharge policies. Title I also requires employers to make 'reasonable accommodations' for 'disabled' but qualified individuals, unless the accommodation would impose an 'undue hardship' on the employer" (Gold and Shuman 2009, p. 211). These terms will be explained in further detail throughout this chapter. Most ADA evaluations will relate to Title I employment claims, but a mental health expert like Dr. D may also be asked to assist a licensing board (such as Mr. A's state bar association) in evaluating a professional's fitness for duty in

cases brought under Title II of the ADA (Timmons 2008), which covers public services including state-level disciplinary proceedings.

In 1999, the US Supreme Court began to limit the class of persons entitled to protection under the ADA. In three cases that later became known as the Sutton trilogy (*Sutton v. United Air Lines, Inc.,* 1999, *Murphy v. United Parcel Service, Inc.*, 1999, and *Albertson's v. Kirkingburg* 1999), the court ruled that "… the ADA's coverage is restricted to only those whose impairments are not mitigated by corrective measures" (Sutton 1999, at 487). In other words, if medication adequately controlled an employee's symptoms such that she was no longer substantially limited in performing a major life activity, then she would fall outside the protected class of "disabled" persons under the ADA (Feldblum et al. 2008). In 2002, the Supreme Court further restricted the ADA's reach by holding that the terms "substantially limited" and "major life activity" (hereinafter, "MLA") should be "interpreted strictly to create a demanding standard for qualifying as disabled" (Toyota 2002, at 197). The court defined MLAs as "activities that are of central importance to most people's daily lives" and held that "substantially limits" means "prevents or severely restricts" (Toyota 2002, at 198).

The Supreme Court's holdings marked a trend toward increasingly restrictive interpretations of the ADA. These cases and subsequent decisions by lower courts often focused on determining whether or not a plaintiff was "disabled" within the meaning of the statute (Feldblum et al. 2008). Around the mid-1990s, estimates showed that in over 90 % of ADA employment cases, the defendant-employer succeeded, often because the plaintiff was unable to demonstrate that he or she was "disabled" within the courts' restrictive interpretations of the term (Center and Imparato 2003). The success rate for ADA claims in employment continued to fall, with some evidence suggesting that over 97 % of ADA employment claims by 2006 were dismissed (Hickox 2011). For a worker like Mr. A, whose disability is mild when controlled by medication, this would have posed a significant barrier.

The ADA's protection of persons with mental illness has been a controversial topic since before the bill's passage, when several senators proposed excluding all DSM diagnoses from the Act's coverage (Smith 2006). The controversy continues to this day and has led to confusing and sometimes contradictory court holdings in ADA cases involving persons with mental disabilities. Courts often found that workers with psychiatric disorders (like Mr. A) were not impaired enough to meet the criteria for being "disabled" under the ADA, e.g., if medications adequately controlled their symptoms, or if the impairment was episodic or context specific (Bazelon Center 2008; Center and Imparato 2003; Hensel 2002; Timmons 2005). Under these restrictive standards, if Mr. A's impairments were sufficiently severe and long-standing to meet the courts' strict criteria for a "disability," he was likely to be so disabled as to be unable to work at all. Physicians like Dr. D were thus stuck in a frustrating balancing act, compelled on the one hand to document significant impairment in order to invoke the ADA's protection, but on the other hand to downplay the impact of any impairment on the person's work performance (Thomas and Gostin 2009).

Frustrated by courts' restrictive interpretations of the ADA, civil rights advocates and members of the disability community coordinated an effort to restore the original legislative intent of the ADA. Working together with members of the business community and with bipartisan sponsorship, they helped to develop new legislation that explicitly rejected the Supreme Court's holdings in Sutton (1999) and Toyota (2002) in favor of a less restrictive interpretation of the ADA (Bazelon Center 2008; Mitka 2008). The Americans with Disabilities Act Amendments Act (ADAAA) of 2008 contains a rule of construction emphasizing that the definition of disability "shall be construed in favor of broad coverage … to the maximum extent permitted by the terms of this Act." The EEOC's final regulations reinforce the ADAAA's purpose to broaden coverage of disabilities under the ADA and to provide protection for disabled persons, including those with mental impairments (29 C.F.R. § 1630 [Appendix] [2012]).

Fortunately for Dr. D and her patient, Congress specifically mentioned major psychiatric disorders as disabilities for which plaintiffs had been unable to successfully bring an ADA claim and for which the ADAAA was intended (EEOC 2011b). In fact, the EEOC regulations list (among others) intellectual disability, Autism, Major Depressive Disorder, Bipolar Disorder, Posttraumatic Stress Disorder (PTSD), Obsessive–Compulsive Disorder (OCD), and Schizophrenia as examples of impairments that should easily be concluded to represent a disability and to substantially limit an MLA (EEOC 2011b). Important changes made by the ADAAA and associated EEOC regulations include less restrictive interpretations of the terms "substantially limits" and "major life activity," rejection of the Supreme Court's holding in Sutton (1999) that the assessment of impairment should consider the effect of mitigating measures, and clarification that episodic or remitting impairments can be disabilities. (These changes and their interpretation for a case like Mr. A's will be discussed in following sections of this chapter.)

The Establishment of Disability Under the ADA

As noted by Gold and Shuman (2009), the ADA's definition of "disability" differs significantly from how disability may be defined in other contexts. In order to establish that one has a "disability" under the ADA, one must first show that he or she has an "impairment." Although the terms are similar, "impairment" and "disability" are not synonymous for purposes of ADA evaluations. According to the EEOC:

> Physical or mental impairment means (1) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine; or (2) Any mental or psychological disorder, such as an intellectual disability (formerly termed "mental retardation"), organic brain syndrome,

> emotional or mental illness, and specific learning disabilities. (EEOC 2011b, p. 17000, citing 29 C.F.R. § 1630.2(h) [2011])

"Impairment" is defined broadly, such that courts typically recognize most "disorders" as "impairments" (but not necessarily as "disabilities") under the ADA (Fram 2008).

The ADAAA, as interpreted by the recent EEOC regulations, clarifies the legal definition of the term "disability" under the ADA. Whether an impairment rises to the level of a disability is an individualized inquiry and depends upon the facts in an individual case. The EEOC expressly rejected the proposed requirement that an impairment last for a minimum of 6 months in order to meet criteria for a disability under the first prong or past history of a disability under the second prong of the test for disability (EEOC 2011b). The EEOC notes that the determination does not require extensive analysis and that:

> An impairment is a disability within the meaning of this section if it substantially limits the ability of an individual to perform a major life activity as compared to most people in the general population. An impairment need not prevent, or significantly or severely restrict, the individual from performing a major life activity in order to be considered substantially limiting. (EEOC 2011b, p. 17000)

It is therefore important for a clinician like Dr. D to have some understanding of the impact of her patient's psychiatric disorder on the performance of various MLAs.

Substantial Limitation of a Major Life Activity

The ADAAA of 2008 introduced some important changes to the definition of "substantially limits" and "major life activity" (MLA). Under the ADAAA, "[t]he term 'substantially limits' is defined as 'materially restricts' which is intended, on a severity spectrum, to refer to something that is less than 'severely restricts,' and less than 'significantly restricts,' but more serious than a moderate impairment which is in the middle of the spectrum" (Feldblum et al. 2008, p. 236). The EEOC's final rule does not quantify the meaning of "substantially limits;" instead, the regulations state simply that "substantially limits" is a lower standard than "prevents" or "severely or significantly restricts" (EEOC 2011b). Hickox (2011) suggests that in some cases (e.g., when the extent or nature of a limitation is in dispute) expert medical testimony may be necessary in order to establish a "substantial limitation" under the newly amended ADA.

A clinical MHP like Dr. D need not analyze whether a patient's limitation would be deemed "substantial" by a court or the EEOC. On the contrary, the clinician should focus on the *clinical* aspects of her patient's limitation(s). MHPs like Dr. D can provide helpful assistance by understanding and explaining the impact of a patient's mental illness on his ability to perform various MLAs. The ADAAA clarifies that a substantial limitation in only one MLA can be sufficient to meet the

disability threshold (Scott 2010). The EEOC in its final rule (EEOC 2011b) removed the definition of MLAs as "those basic activities that most people in the general population 'can perform with little or no difficulty,'" opting instead to provide a nonexhaustive list of activities that may be considered MLAs:

> [M]ajor life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working… [A] major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (ADAAA 2008)

It is important for the MHP to note that "major life activity" is a *legal* concept and is not identical to the *clinical* concept of "activities of daily living" ("ADLs"). However, a clinician's understanding of the impact of psychiatric disorders on patients' ADLs can provide a helpful starting point for an assessment of limitation in different MLAs. The MHP may consider the EEOC's regulations which set forth the following factors: the impairment's nature and severity, its duration or expected duration, and its long-term impact on the individual (EEOC 2011b). In the case of Mr. A, for example, the EEOC (1997) has recognized that Bipolar Disorder may significantly restrict the MLAs of interacting with others and caring for oneself and that these impairments may be severe, of indefinite duration, and potentially long term. Under the ADAAA, determinations of whether an impairment substantially limits an MLA should *not* consider the "ameliorative effects of mitigating measures such as… medication…; reasonable accommodations or auxiliary aids or services; or learned behavioral or adaptive neurological modifications" (ADAAA 2008). In other words, even if Mr. A's symptoms are so well controlled by his medication that they pose only minimal problems for him, he may still have a protected disability under the ADA. Although the ADAAA lowered the severity threshold required for an impairment to be "substantially limiting," a MHP like Dr. D would still need to assess and understand the effect of the psychiatric disorder on the performance of MLAs (Fram 2008). For this assessment, the MHP may consider the "condition, manner, or duration" under which each specific MLA may be affected (EEOC 2011b).

It is important to consider a patient's or evaluee's level of impairment during time periods outside that of the current psychiatric evaluation. Even an individual who is asymptomatic at the time of the consultation may be significantly impaired in other settings or at other times (Scott 2010). For example, fears of germ contamination associated with OCD may not be apparent in the MHP's office, but may pose significant problems for the evaluee if his job requires him to shake hands with clients or business partners during the work day. Oftentimes, family members can provide information about day-to-day functioning or symptoms of which the patient may not be aware. If the patient agrees to let the clinician speak with relatives or significant others, collateral information can be very useful to determinations about limitations in various MLAs. Particularly for evaluees suffering from a psychiatric disorder, disability may be context specific, and the MHP

should consider different settings and contexts in which the symptoms may emerge. The ADAAA clarifies that "[a]n impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active" (ADAAA 2008). However, a showing that the impairment in question is "transitory and minor" can be fatal to an ADA claim (Siber 2009).

A MHP like Dr. D may consider some specific MLAs to be of particular importance in an individual patient's (or evaluee's) ADA case:

"Interacting with Others"

One of the most controversial MLAs, and one which frequently appears as a topic for discussion in cases involving psychiatric disabilities, is "interacting with others." Courts' interpretations on the issue have varied significantly (Hartman 2005), with some courts holding that "interacting with others is not a major life activity, while at the same time finding it is an essential function of virtually every job" (Hensel 2002, p. 1189). The ADAAA itself does not provide guidance on the issue (Long 2008), but the EEOC—even prior to the passage of the ADAAA—has indicated that "interacting with others" is indeed a MLA (EEOC 1997). Controversy notwithstanding, the fact that the final regulations cite "interacting with others" as an example of a MLA (EEOC 2011b, p. 16980) suggests that the term and the concept will remain significant in ADA evaluations (Scott 2010).

Examining a patient's or evaluee's social functioning and interpersonal relationships is one way in which to assess the degree of impairment as well as its impact on the individual's employment. Thus, Dr. D's ADA evaluation of Mr. A might entail an examination of how Mr. A's Bipolar Disorder or symptoms impair his ability to interact with others. The EEOC has provided some guidance for such an assessment:

> Some unfriendliness with coworkers or a supervisor would not, standing alone, be sufficient to establish a substantial limitation in interacting with others. An individual would be substantially limited, however, if his/her relations with others were characterized on a regular basis by severe problems, for example, consistently high levels of hostility, social withdrawal, or failure to communicate when necessary. (EEOC 1997, under "Substantial limitation")

It is important for the MHP to consider whether the patient or evaluee has difficulty interacting with *one* person or with interacting with people in general. The former may be common, while the latter would be more suggestive of a substantial limitation. Dr. D, for example, might note that during manic phases of his illness Mr. A has had arguments and hostile verbal altercations with several coworkers as well as family members, while during depressed periods he is quiet and withdrawn and avoids contact with others. The EEOC (1997) has recognized that various types of mental illnesses, including Schizophrenia and Bipolar Disorder, can cause impairment in one's ability to interact with others.

An impaired ability to interact with others need not necessarily pose problems in the workplace in order to constitute a substantial limitation. The degree to which such an impairment interferes with work may depend upon the type of job one performs; for an assembly-line worker, an autistic spectrum disorder may not be problematic, whereas for a litigation attorney like Mr. A such an impairment could be a major concern. When an impairment in interacting with others does negatively impact work performance, it will be relevant to questions regarding whether the worker can perform the essential functions of his job, which will be discussed later in this chapter.

Cognitive Functions

Cognitive functions or brain functions, such as "concentrating," "thinking," and "learning," may be MLAs. Courts have considered different variations of the terms and similar concepts, including "the ability to perform cognitive functions" (*Brown v. Cox Med. Ctrs.* 2002; *Battle v. UPS* 2006) and "remembering" (*Gagliardo v. Connaught Labs* 2002). As with "interacting with others," courts' interpretations of the issue are not always consistent. For example, in *Pack v. Kmart Corp.* (1999), "concentrating" was not considered a MLA but, rather, a "component" of other MLAs, such as learning or communicating (Paetzold 2005). Presumably, this holding may have been superseded by the ADAAA. Numerous psychiatric disorders can involve a substantial limitation in cognitive functions; for example, "…a person with post-traumatic stress disorder who experiences intermittent flashbacks to traumatic events is substantially limited in brain function and thinking" (EEOC 2011b, p. 17011). The EEOC has recognized that an anxiety disorder can be disabling when concentration is impaired by irrelevant thoughts (EEOC 1997). Similarly, delusions can impair thinking in individuals with psychotic illness, and auditory hallucinations may cause difficulties in concentration among persons with Schizophrenia. In the case of Mr. A, his psychiatrist might note his difficulty maintaining focus and concentration during meetings and depositions.

Other MLAs to Consider with Psychiatric Disorders

Several other MLAs (or potential MLAs) that the clinical or forensic MHP might consider in an ADA psychiatric evaluation include "caring for oneself," "performing manual tasks," "sleeping," "speaking," and "communicating" (ADAAA 2008; EEOC 1997). Additionally, some psychiatric disorders or symptoms may affect other MLAs (e.g., "eating" may be impaired in persons with eating disorders). Side effects of medications commonly prescribed to treat mental illness may also result in impairments (e.g., "bodily waste functions" may be impaired by medications that cause urinary retention or gastrointestinal disturbance). For activities not identified as MLAs in the ADAAA's "non-exhaustive" list (such as

operating a motor vehicle), litigation concerning whether or not they are MLAs may continue (Fram 2008).

From Dr. D's perspective, exploring multiple potential MLAs can help to elicit more detailed, specific information about how Mr. A's symptoms affect his day-to-day functioning. For example, during depressed phases of Mr. A's illness, he sometimes neglects attending to his grooming and personal hygiene; Dr. D could therefore indicate that Mr. A's Bipolar Disorder substantially limits his ability to care for himself. Similarly, Mr. A reports a significantly diminished appetite during both manic and depressed phases of his illness, and past medical records indicate weight loss of 25 pounds during one depressed phase following his divorce. These facts illustrate the adverse impact which Mr. A's Bipolar Disorder has had on his MLA of "eating." Mr. A's Bipolar Disorder also causes significant disruption of his ability to sleep. During manic phases of his illness, he reports an inability to sleep, frequently due to racing thoughts. During depressed phases, he often wakes several hours early and reports fatigue and drowsiness during the day. Dr. D could therefore provide several examples of limitations in MLAs caused by Mr. A's Bipolar Disorder.

Mitigating Measures

Mitigating measures are steps or tactics taken that may minimize the effect of an impairment. Examples of mitigating measures include medications, psychotherapy, behavioral therapy, and learned behavioral or adaptive neurological modifications (EEOC Q&A; Scott 2010). Prior to the passage of the ADAAA, mitigating measures may have rendered an impairment not disabling under the ADA (see, e.g., *Pack v. Kmart Corp.* 1999). In *McMullin v. Ashcroft* (2004), a security guard and former law enforcement officer with a history of depression was unable to use the ADA to contest his firing. The court's reason for dismissing McMullin's ADA claim was the Supreme Court's holding in Sutton (1999) that the effect of any mitigating measures (in this case, successful treatment of his depression) must be taken into account when determining whether a plaintiff is "disabled" within the meaning of the ADA (McMullin 2004, at 1295, 1296). Because McMullin's treatment with antidepressant medication had successfully resolved his insomnia (limitation in the MLA of sleeping) and his difficulty working the graveyard shift (limitation in the MLA of working), the court found that he was not substantially limited in either MLA and that he therefore did not fall within the class of individuals protected by the ADA.

The ADAAA has changed the way in which mitigating measures are relevant to the evaluation for plaintiffs like McMullin. Aside from glasses or contact lenses, the use or success of "mitigating measures" should be ignored when making the determination as to whether or not someone has a disability under the ADA (as amended by the ADAAA). The determination must focus on whether the person would be substantially limited in performing an MLA *without* the

mitigating measure(s). After the ADAAA, a plaintiff such as McMullin would likely have a strong case.

An employer cannot require an employee to use a mitigating measure, but that employee's failure to use a mitigating measure may render him unqualified for the position or may support a contention that the employee poses a direct threat (EEOC 2011b). For example, a history of repeated treatment noncompliance or "going off one's meds" might increase the risk that an individual poses in the workplace. In *Keoughan v. Delta Airlines* (1997), medication noncompliance by an employee with Bipolar Disorder rendered her not qualified for her job. To the extent that Dr. D relies on medication to control Mr. A's Bipolar Disorder, adherence to the medication regimen is an important component of the treatment plan.

Impact of the Disability in the Workplace

It is not the responsibility of the MHP to determine whether or not an individual with a disability is qualified for a particular position. However, the MHP may be asked to provide some clarification or explanation of the impact of the person's disability on his or her work performance. Clinical MHPs (such as Dr. D) may find themselves in the position of helping their patients to evaluate whether or not they are able to perform the essential functions of a job, with or without reasonable accommodations. Before advising patients on such matters, clinicians like Dr. D may need to acquire a thorough understanding of the job's essential functions (just as in any disability or return-to-work evaluation), and to compare them to the patient's present abilities or expected abilities pending successful treatment.

The American Academy of Psychiatry and the Law (AAPL) suggests obtaining job descriptions from both the employer and the worker (Gold et al. 2008). Specific job functions may relate directly to individual MLAs, and clinicians may find it helpful to explore the relationship between the patient's ability or limitation in various MLAs and the essential functions of the job. A person with paraplegia, for example, might be able to perform the job functions of a financial analyst but not those of a firefighter. A severe psychiatric disability may render an employee or applicant unqualified for a particular job, but in the case of Mr. A, well-controlled Bipolar Disorder would not render him unqualified for most jobs.

"Essential Functions" of a Job

In the case of Mr. A, Dr. D is not the judge as to whether a particular task is appropriately characterized as an "essential" job function. However, Dr. D may be asked to explain the potential impact of Mr. A's disability on his performance of specific functions associated with his job description. In ADA cases involving mental illness, several specific job functions may appear more frequently:

Attendance and Adherence to a Set Work Schedule

For many positions, regular and timely attendance or presence at the job site is an essential job function (*Samper v. Providence St. Vincent Medical Center* 2012; Gold and Shuman 2009; Matejkovic and Matejkovic 2009). For some jobs, speed and efficiency, or adherence to a set work schedule and deadlines, may be critical (Timmons 2005). As a litigation attorney, Mr. A's job requires him to meet important filing deadlines. Since missing a deadline can be fatal to the success of a case, adhering to the court schedule would be an essential function of Mr. A's position. In some jobs, punctuality or presence at the job site may *not* be essential. Even prior to the passage of the ADAAA, the EEOC often considered "attendance … a matter of employment policy, not an essential function" (Goodman-Delahunty 2000, p. 201).

The EEOC (1997) states that an employer may discipline an employee for tardiness but that the employer should first consider whether a reasonable accommodation (such as a modified work schedule) may enable the employee to perform the essential functions of the job. Examples of such reasonable accommodations will be discussed below. In the case of Mr. A, a modified work schedule would not enable him to perform essential job functions, since timely arrival for court appearances and attendance at pretrial conferences and important meetings are essential functions of the job.

Interpersonal Skills

For some positions social skills are critical to the performance of essential job functions. In *Jakubowski v. The Christ Hospital* (2010), the Sixth Circuit upheld summary judgment for a hospital that had fired a family medicine resident with Asperger's Disorder whose poor interpersonal communications skills had resulted in repeated negative evaluations and serious errors that would have caused harm to patients had they not been caught by other physicians. The court noted that communicating clearly and effectively with patients and other hospital staff was an essential job function for a family practice resident, and that Jakubowski's deficiencies had put patients in danger. The importance of interpersonal skills varies by job; the director of Jakubowski's residency program had offered to help him transition to pathology (a specialty requiring little to no communication with patients), where interpersonal skills would not have been as critical to the work. It is important to note that a substantial limitation in the MLA of "interacting with others" does not automatically make an employee unqualified for a job requiring strong interpersonal skills. In the case of Mr. A, for example, his Bipolar Disorder has caused a substantial limitation in the MLA of "interacting with others," but he may still be well qualified to perform the essential functions of his job, as medication significantly improves his functioning.

Compliance with Workplace Standards and Codes of Conduct

Most workplaces have standards for physical appearance and behavior, such as dress codes. In many cases, compliance with these standards is a valid essential job function. As an attorney who makes court appearances, Mr. A must adhere to professional standards of business dress or risk being held in contempt of court for an unprofessional appearance or demeanor. The ability to refrain from disruptive behavior is an essential function in many jobs. In *Husowitz v. Runyon* (1996), disruptive behavior including "episodes of loud singing, playing the radio at excessively high volumes, procrastination, disturbing coworkers, and other instances of misconduct and insubordination" (*Husowitz v. Runyon* 1996, at 826) led to the suspension of an employee with Bipolar Disorder. Although the court acknowledged that the employee's behavior was directly caused by his disability, his continued disruptive behavior conferred evidence that he was not able to perform the essential functions of his job.

Mental illness and related impairments may manifest themselves in the form of problematic behaviors in the workplace. When a psychiatric disorder results in conduct that violates reasonable workplace standards, disciplining or terminating an employee for that conduct is not usually held to be a violation of the ADA. Courts have upheld the employer's right to terminate a disabled employee for illegal or unethical behavior (*Despears v. Milwaukee County* 1995; *Fields v. Lyng* 1988), even when the behavior is directly related to the disability (*Jones v. Am. Postal Workers Union* 1999, at 429). For example, if Mr. A were embezzling the firm's money to support a mania-driven spending spree, the firm would not be violating the ADA by subjecting Mr. A to the same discipline that would be applied to any employee engaged in such conduct.

Courts have upheld an employer's right to terminate an employee for behavior that constitutes harassment of others, even if that behavior is caused by a disability (Gold and Shuman 2009; *Jacques v. DiMarzio* 2004; Timmons 2005). Indeed, permitting continued harassment of other employees, particularly when such harassment might be construed as discriminatory (such as when it contains racist or sexist epithets), might constitute a violation of Title VII of the Civil Rights Act or other antidiscrimination legislation. In *Ray v. Kroger Co.* (2003), for example, a grocery store stocker with Tourette's Syndrome was terminated for using profanity and racial slurs on the job. Although it concerned the Rehabilitation Act rather than the ADA, the case of *Maes v. Henderson* (1999) is also illustrative; in that case, a postal service employee with Bipolar Disorder was demoted following another employee's complaint that he had created a hostile work environment through inappropriate sexual joking and verbal harassment. The court held that the Rehabilitation Act (upon which the ADA was modeled) "serves to protect individuals from being treated differently on the basis of their disability" but that "[i]t cannot be used … to allow disabled employees to engage in behavior that would justify the discipline or discharge of any other employee" (*Maes v. Henderson* 1999, at 1289). Uncontrolled hypersexuality, even if it is caused by a disability like Bipolar Disorder, need not be tolerated in the workplace.

Professionalism, Integrity, and Reputation

In some careers, such as Mr. A's legal practice, the employee is expected to conform to certain standards of professionalism, integrity, and ethics. The ability to refrain from behavior or conduct that would mar the individual's credibility or reputation, or adversely impact the employer's reputation, may be an essential function of Mr. A's position as well as many other professions. This issue may emerge in the context of an employee's criminal behavior. For example, in *Fields v. Lyng* (1988), a labor negotiator with Borderline Personality Disorder was deemed not qualified for his position following several convictions for criminal behavior that undermined his credibility. In a similar case, Judge Posner addressed the limitation of an employer's duty to accommodate a disabled worker's unlawful conduct:

> It is true that the Americans with Disabilities Act … require[s] the employer to make a reasonable accommodation of an employee's disability, but we do not think it is a reasonable required accommodation to overlook infractions of law. (*Despears v. Milwaukee County* 1995, at 637)

In recent years, the spread of information technology and the Internet have increased the salience and reach of negative publicity. When news of a public figure's unethical behavior "goes viral" through social media, the detrimental impact on the credibility and reputation of the business or agency is almost immediate (Solove 2007). Suppose that after a frustrating hearing, Mr. A went online and posted an angry diatribe on his blog or social networking site about the "corrupt nature of the legal system" and the "suspicious" friendship between the judge and opposing counsel. Even if he were to delete the post shortly thereafter, once it has been posted online it is no longer within Mr. A's control, and within minutes the post could be forwarded to others; the effect on the firm could be devastating. For Mr. A, a remaining concern would be whether he would be able to prevent himself from engaging in similar behavior in the future. Although the ADAAA may result in more individuals meeting the ADA's definition of "disabled," the importance of professionalism and integrity as essential job functions may increase in the coming years due to advances in information and communication technologies.

Other, Job-Specific Essential Functions

Some jobs require advanced or specialized cognitive abilities, such as logical reasoning, ability to maintain concentration, organizational skills, the ability to prioritize work and manage multiple projects, an aptitude for handling stressful situations and deadlines, attention to detail, mathematical ability, analytical problem solving, and the ability to learn and master specialized computer software. Mr. A's work, for example, requires sustained periods of intense concentration and advanced reading comprehension. If the patient or evaluee has a

substantial limitation in performing cognitive functions, it will be important for a MHP like Dr. D to ascertain the impact of this limitation on the person's ability to perform related job functions.

Direct Threat

Even if an individual is otherwise able to perform the essential functions of a position, he may not be qualified for the job if he poses a "direct threat" to himself or others in the workplace. A direct threat is "a significant risk to the health and safety of others that cannot be eliminated by reasonable accommodation" (42 USC §12111(3); cited by Gold and Shuman 2009, p. 232). An employer's belief that a worker poses a direct threat must be supported by evidence and should not be based on discriminatory stereotypes, such as the misconception that by nature of having a mental illness the employee is likely to be violent. Dr. D's assistance may be especially useful in ensuring that Mr. A does not pose a direct threat (Smith 2007) and in helping to educate employers or courts about the nature of mental illness (e.g., by correcting misconceptions, addressing stigma and stereotypes).

For some jobs, such as law enforcement or transportation (e.g., airplane pilot), the risk threshold to constitute a direct threat may be lower (Gold and Shuman 2009). Courts have held that "where the essential job duties necessarily implicate the safety of others, [then] the burden may be on the plaintiff to show that [he or she] can perform those functions without endangering others" (*McKenzie v. Benton* 2004 at 1354). Teitelbaum and Thomas (2009) provide a helpful discussion of a case (*Jarvis v. Potter* 2007) in which an employee whose symptoms of PTSD—including violent behavior—posed a direct threat that could not be resolved through reasonable accommodation. In Jakubowski (2010), the employee physician's skill deficiencies posed a threat to patient safety. One might also argue that an impaired lawyer could pose a direct threat; for example, to a criminal defendant potentially facing the death penalty, ineffective assistance of counsel by the defense attorney could mean the loss of one's life.

The assessment of whether a direct threat exists must be made on an individual basis, and the opinion should reflect sound medical judgment (*School Board of Nassau County v. Arline* 1987). In making the determination, a MHP like Dr. D should consider: "(1) [the] duration of the risk; (2) [the] nature and severity of the potential harm; (3) [the] likelihood that the potential harm will occur; and (4) [the] imminence of the potential harm" (EEOC 1997, p. 25, n. 75). In its enforcement guidance, the EEOC offers several helpful case examples to illustrate the direct-threat concept in the context of mental illness (EEOC 1997). In some cases, reasonable accommodations may be able to eliminate the threat (Foote 2003).

Positive *or* negative effects of mitigating measures can be taken into account when determining whether an individual poses a direct threat. For example, a school bus driver who takes a prescription medication that has a side effect of

somnolence may pose a threat to the well-being or safety of the schoolchildren; he therefore might not be qualified for the job. Conversely, a file clerk with Schizophrenia and a history of medication compliance whose command hallucinations and violent behavior are absent while taking antipsychotic medication may not pose a direct threat to coworkers, even if some somnolence were present. A MHP may be able to help determine whether a direct-threat concern is legitimate or based on uninformed and discriminatory stereotypes.

Requesting Reasonable Accommodations for a Disability

The ADA requires employers to provide disabled employees or prospective employees equal access to the benefits or privileges of employment that are available to non-disabled workers. One way in which an employer may comply with this requirement is by providing reasonable accommodations, which are modifications or adjustments that enable a qualified individual with a disability to compete equally with non-disabled applicants or employees, and to enjoy equal access to the benefits and privileges of employment (Miller 1997; 29 C.F.R. § 1630.2 (o) (2011)). The EEOC (2011a) groups potential accommodations into three categories: changes to the job application process, changes to the work environment, and changes relating to benefits and privileges of employment. Costs for implementing most accommodations are minimal; drawing upon several published research studies, the EEOC estimates that approximately half of all requested accommodations have zero cost (EEOC 2011b).

Employers are expected to engage in an interactive process with the employee to determine what reasonable accommodations might be available and must demonstrate a good-faith effort to accommodate the disabled employee (Collins and Phillips 2011; Matejkovic and Matejkovic 2009). A request for a particular accommodation is not "reasonable" if it attempts to exempt the employee from performing an essential function of his or her job (Smith 2006). Dr. D can work with Mr. A to identify potential accommodations that might make it possible for him to continue his work as a Senior Associate. Dr. D may also help Mr. A to make a request for accommodations. A request for reasonable accommodations can be made in plain English and need not specifically reference the ADA (EEOC 1997). However, the employer is not required to grant a specific accommodation request but may choose a different accommodation as long as it is reasonable and effective (EEOC 2011a). An employee is not entitled to a proposed accommodation if it poses an "undue hardship" to the employer. While a thorough discussion of what constitutes "undue hardship" is beyond the scope of this chapter, other scholars have discussed this topic in more detail (see, e.g., Collins and Phillips 2011; Matejkovic and Matejkovic 2009), and their research may be helpful to MHPs who are considering recommendations for reasonable accommodations.

Determinations of reasonable accommodations must be made on a case-by-case basis; "[t]here are no standard or guaranteed accommodations for everyone with a particular disability or diagnosis" (Gold and Shuman 2009, p. 226). Recommendations should be specific, and the request for (or suggestion of) a particular accommodation should include an explanation or illustration of how the accommodation would enable the employee to fulfill his or her job's essential functions. Failing to demonstrate how a proposed accommodation would address any problems or deficiencies at issue can severely damage an employee's chances for obtaining an accommodation or pursuing an ADA claim. For more difficult or complicated accommodations, the MHP may suggest the assistance of a job coach or vocational rehabilitation specialist (Gold et al. 2008). The ADAAA has not provided any clarification of what is a "reasonable" accommodation (Long 2008).

The MHP can assist the employer by suggesting specific accommodations and helping to facilitate understanding and communication between the employer and the employee (EEOC 1997). While providing accommodations for physical disabilities (such as making wheelchair-accessible facilities) may seem straightforward, accommodating psychiatric disabilities in the workplace can be less obvious and more challenging to the employer (Gold et al. 2008). Unfortunately, "[w]orkers with mental health disabilities are almost one half less likely to receive accommodations than workers with other disabilities" (Zwerling et al. 2003, p. 520). However, the enactment of the ADAAA may result in improved access to reasonable accommodations for workers with psychiatric disabilities.

If the need for accommodation is not obvious (as is often the case among individuals with mental illness), the employer may request supporting or additional documentation about the impairment and its impact on the employee's functioning. If Mr. A's employer requires more detailed information about his treatment and the impact it may have on his work performance, for example, Dr. D might submit documentation similar to the following:

> Mr. A's Bipolar Disorder is well controlled by taking a mood-stabilizing medication. This medication needs to be taken four times a day. After taking his mid-day dose, Mr. A needs to have a half hour to rest due to initial drowsiness which resolves rapidly. Mr. A also sees a clinical psychologist for psychotherapy once a week. These appointments take approximately 50 minutes, and the therapist's office is located nearby. Mr. A will need some flexibility with regards to scheduling and the use of paid or unpaid leave in order to allow him to attend these therapy sessions; perhaps an extended lunch hour once a week might be an option.

Dr. D would need to work closely with her patient in deciding what information to provide to the employer. Whatever information Dr. D provides would need to respect Mr. A's privacy and confidentiality rights while at the same time disclosing sufficient information for the employer to take appropriate actions to accommodate Mr. A's disability. Before providing any information to Mr. A's employer, Dr. D should ensure that her patient is aware of the extent and nature of the information to be disclosed and that he has given proper authorization for the disclosures.

Employees, particularly those with stigmatized illnesses, may be hesitant to authorize the release of their medical information to an employer. However, the employer may need more information about the disability in order to determine reasonable accommodations. If an employee refuses to provide this information, a court might hold that the employee did not act in good faith to assist the employer in accommodating his or her disability (Matejkovic and Matejkovic 2009). The employee may be able to limit unnecessary disclosure of confidential or personal information by using an employer-provided Employee Assistance Program (EAP) or speaking directly with human resources personnel rather than disclosing the details of a disability to a direct supervisor.

Types of Reasonable Accommodations

The EEOC (1997) lists several examples of possible reasonable accommodations for individuals with psychiatric disabilities, including:

- time off from work (e.g., use of accrued paid leave, provision of additional unpaid leave, switching to part-time hours)
- a modified work schedule (e.g., change in the working hours to accommodate side effects of medication)
- physical changes to the workplace, such as "room dividers, partitions, or other soundproofing or visual barriers between workspaces" for disability-related difficulties with concentration
- reducing noise-related distraction by moving the employee to a quieter work location, reducing the volume of workplace noise like telephones, or permitting the use of headphones
- access to equipment such as a tape recorder to review training or meetings
- changes in workplace policy, such as allowing more frequent breaks, changing a policy prohibiting beverages at work stations (to accommodate an employee whose medication causes dry mouth)
- increased supervision and guidance, or changes in the method of supervision, for employees with disability-related concentration difficulties
- provision of a job coach
- reassignment to a different position, when reasonable accommodation is not possible for the current position or would pose an undue hardship to the employer

The use of leave time and flexible work schedules are among the most common accommodations for individuals with mental impairment (Gold and Shuman 2009), and the EEOC predicts that requests for "break times, reduced hours, or job redesign" are more likely among those whose coverage under the ADA has been clarified by the ADAAA (EEOC 2011b).

Scheduling Changes

Examples of scheduling changes include switching an employee from the night shift to the day shift, agreeing upon a later starting time (e.g., to accommodate fatigue resulting from a medication taken at bedtime), reduced hours (e.g., from full- to part-time), or specific or additional breaks during the workday (e.g., to enable the employee to attend therapy sessions). An employer might also consider allowing discretionary breaks for stress reduction or phone calls to a supportive therapist, friend, or relative (Timmons 2005). In *Breen v. Department of Transportation* (2002), an employee with OCD had difficulty completing work assignments due to frequent disruptions during normal working hours. As a reasonable accommodation, she was given a modified work schedule in which she would work an additional hour, uninterrupted, at the end of each day and take a day off every 2 weeks to compensate for the additional time.

Use of Paid or Unpaid Leave

Most employers offer some paid leave as a benefit of employment to all employees, regardless of disability status. In some cases, an employer's medical and leave policies may be adequate reasonable accommodation for a disabled employee (*Hankins v. The Gap* 1996). The use of "sick days" may sufficiently accommodate an employee who requires brief inpatient hospitalization for a crisis or medication adjustment, for example. An employer who provides each employee five "personal days" per year might allow an employee with depression to use the accrued personal leave on an hourly basis (as opposed to taking the entire day off) to attend weekly therapy sessions. Unpaid leave may be appropriate for an employee who has exhausted his paid leave but requires additional time for treatment and recovery. Under the Family and Medical Leave Act (FMLA) of 1993 (29 U.S.C. §§2601 et seq.), the employee may be able to use up to 12 weeks of job-protected unpaid leave, which may be used intermittently to address an FMLA-covered "serious health condition" (Gold and Shuman 2009), for example, for weekly psychotherapy, doctor's appointments, or "mental health days."

However, "unduly prolonged medical leave of absence or indefinite leave is not a reasonable accommodation" (Gold and Shuman 2009, p. 229). As regular and reliable attendance may be an essential function of some jobs, excessive use of unplanned leave may not be a reasonable accommodation. In *Samper v. Providence St. Vincent Medical Center* (2012), a neonatal intensive care unit nurse with fibromyalgia brought an ADA challenge of her termination for excessive unplanned absences and unreliable attendance. Finding for the defendant-employer, the Ninth Circuit held that attendance was an essential job function for a neonatal intensive care nurse and that the plaintiff's "request so far exceeds the realm of reasonableness that her argument leads to a breakdown in well-established ADA analysis" (*Samper*, at 16). As the court explained, "Samper [the plaintiff] essentially asks for a reasonable accommodation that *exempts* her from an essential [job] function"

(*Samper*, at 17). The MHP may be able to assist in the determination of what amount of leave is clinically indicated for the employee's condition.

Monitoring and Supervision

Enhanced monitoring and workplace supervision are frequently recommended for impaired professionals. With respect to behaviorally disruptive physicians, Meyer and Price (2006) write:

> The psychiatric examiner is also required to move conceptually beyond the psychiatric treatment setting and consider how to implement monitoring and supervision of an examinee in the examinee's workplace. Examiners are routinely required to make recommendations about how symptoms of a mental illness may be manifested in the workplace and how to educate workplace supervisors regarding relevant indicators of recurrence of diagnosed psychiatric disorders. (Meyer and Price 2006, pp. 76, 77)

Similar accommodations might entail facilitating contact with counselors through an EAP or having the employee check in periodically with the office's employee health nurse, if it has one. Providing a job coach or access to similar vocational rehabilitation resources may also be a reasonable accommodation (EEOC 1997). However, for some jobs, increased supervision may not be a "reasonable" option. In *Bolstein v. Reich* (1995), the court rejected an attorney's request of increased supervision, since one of the qualifications that justified his job title and pay grade was an ability to work with minimal to no supervision. In the case of Mr. A, Dr. D might ask her patient if he thinks it might be helpful for a trusted colleague (e.g., perhaps his direct supervisor's manager) to be informed of common warning signs of mania or depression to facilitate understanding and early intervention should problems arise in the future.

Job Transfer or Reassignment

In some cases, transferring an employee to a different position may be a reasonable accommodation. For example, a graphic designer with a severe mood disorder who has been working the third shift might be assigned to a vacant position with a day shift, where the job would be essentially the same but the hours would be less problematic. However, logistical factors can make reassignment impractical. The ADA does not require employers to create a new position for the employee, to grant a requested promotion to effectuate a transfer, to "bump" another employee to accommodate the one requesting reassignment, or to transfer an employee when the transfer poses undue hardship or fails to address the problems that prompted the request (Gold and Shuman 2009). Employees with impaired social functioning may request assignment to a different supervisor or different work group. While employers are not *required* to grant such a reassignment request (*Kennedy v. Dresser Rand Co.* 1999), "nothing in the ADA would prevent an employer and

[an employee] from agreeing to a supervisory change for reasons related to a disability" (EEOC 2011a, under "Actions not required as reasonable accommodation"). In Mr. A's case, there may be several different teams in the Litigation Department, and he might request transfer to a vacant but similar position on a different team whose members are less prone to arguments and hostile confrontations. A MHP like Dr. D may be able to assist in determining whether a request for reassignment is a reasonable accommodation for the employee's disability.

Job Restructuring or Changes in Work Assignments

In some cases, an employer may be able to reassign marginal job responsibilities to a different position or employee in order to accommodate a disabled worker. For example, in *Overton v. Reilly* (1992), a chemist with severe depression requested an accommodation of job restructuring so that he would not be required to have contact with the public; in overturning summary judgment for the employer, the Seventh Circuit noted that there was a genuine question as to whether reasonable accommodations were possible, such as allowing the employee's coworkers to cover incidental aspects of the work that required public contact. In some cases, an employee's request for changes in work assignments (e.g., from more complex to less complex tasks) may not be a "reasonable" accommodation, since it would eliminate an essential function of the position.

With the spread of information and communication technology, telecommuting has gained attention as a possible reasonable accommodation (EEOC 2005), and many employers offer the option to disabled and non-disabled workers alike. Citing the Ninth Circuit's ruling in *Humphrey v. Memorial Hospital Association* (2001), Gold and Shuman (2009, pp. 229, 230) note that in some cases, employers may be required to allow an employee to telecommute as a reasonable accommodation when the essential functions of the work could be performed at home without imposing an undue hardship on the employer. In *Humphrey*, a medical transcriptionist with OCD was unable to arrive at the workplace in a timely manner due to rituals she had to perform before leaving home; her disability did not, however, impair her ability to type. Partial telecommuting may also be an option for jobs in which some, but not all, of the work must be done on-site.

Requests for job restructuring may be aimed at stress reduction for the employee. Prior to the passage of the ADAAA, courts often rejected the idea that such requests would be "reasonable" forms of accommodation, holding instead that the employer is not obligated under the ADA to eliminate stress in the workplace (Gold and Shuman 2009). Following the ADAAA's mandate that the ADA be construed to broaden coverage and provide more protection to individuals with disabilities, however, changes that aim to *reduce* the disabled employee's stress level without posing undue hardship upon the employer may be deemed reasonable accommodations. However, the ADA does not require employers to eliminate or restructure *essential* job functions or transfer essential job functions to a different position or employee (Matejkovic and Matejkovic 2009).

Considerations for the Forensic Mental Health Evaluation and Report

At some point, the complexities of a case like Mr. A's may exceed the scope of practice of a clinical MHP like Dr. D, and consultation with a forensic specialist may be necessary. The following suggestions are offered for the forensic MHP who would be conducting an ADA evaluation of an employee or litigant, but even a clinical MHP like Dr. D may find it useful to understand the basic elements and considerations for a forensic evaluation and report in ADA cases.

Basis for the Mental Health Professional's Opinion

It is important for the forensic MHP to obtain a thorough understanding of the evaluee's background and the circumstances in the ADA case. AAPL suggests reviewing the following written records for a disability evaluation: (1) job description; (2) psychiatric, substance use, medical, and pharmacy records; (3) employment records; (4) academic records; (5) other experts' evaluations; and (6) personal records (such as military or financial records and private journals) (Gold et al. 2008). The results of any psychological or neurological testing may be useful for quantifying the degree of impairment. In addition to written documents, the MHP may also consider information that has been communicated verbally, such as the content of a telephone conversation with the evaluee's therapist or other third parties who may provide helpful collateral information. The evaluee's self-report is also relevant but must be considered in the context of other information.

Diagnosis

A significant level of impairment is often one of the diagnostic criteria for major psychiatric disorders in the DSM, such as Major Depressive Disorder (MDD) (Miller 1997). If the evaluee meets criteria for a diagnosis of MDD, for example, this may be sufficient to establish that the individual has a disability within the scope of the ADA. The EEOC notes the relevance of the DSM while cautioning that "[n]ot all conditions listed in the DSM-IV, however, are disabilities, or even impairments, for purposes of the ADA" (EEOC 1997, quote from "Impairment"). Numerous sources caution against overemphasis on diagnosis in establishing disability under the ADA, as the ADA's model of "disability" is based on functional impairment rather than a medical definition (Smith 2006).

Some general trends relating to an evaluee's diagnosis or symptomatology will be relevant for the forensic MHP to consider in an ADA evaluation. For example,

persons with thought disorders characterized by psychosis, severely impaired social skills, and a sparse work history frequently have substantial difficulties in workplace functioning (Foote 2003). AAPL also notes that:

> Certain disorders are more likely to result in work impairment than others. Psychotic conditions such as schizophrenia or severe bipolar disorder routinely cause major impairment in social and occupational functioning. Certain chronic anxiety and depressive disorders that do not respond to treatment can be disabling, if not for all types of work, then perhaps for the type of work an employee was formerly capable of doing. (Gold et al. 2008, pp. S19, S20)

For example, short-term impairment due to Adjustment Disorder may not be a disability under the ADA (EEOC 1997). Similarly, Axis V codes indicating significant psychosocial problems are not in themselves covered by the ADA (Gold and Shuman 2009). The ADA specifically excludes from coverage several diagnostic codes from the DSM, including "… various sexual behavior disorders [such as transvestism], compulsive gambling, kleptomania, pyromania, and psychoactive substance use disorders resulting from current illegal use of drugs" (EEOC 1997, n. 8).

The status of substance abuse under the ADA depends upon whether the use is current or past. Current illegal substance abuse is not protected by the ADA, and employers are not obligated to provide accommodations for an employee's drug abuse (Matejkovic and Matejkovic 2009; *Brown v. Lucky Stores* 2001). However, recovering and rehabilitated drug addicts and alcoholics are protected by the ADA (Foote 2003; Timmons 2005). In order for substance abuse to reach the severity threshold for a disability under the ADA, there must be evidence of a substantial limitation in a MLA; in other words, "[a] casual drinker would probably not be considered disabled, whereas one who is alcohol-dependent would be" (Foote 2003, p. 284).

Although personality disorders were not listed in the ADA statute, the EEOC's regulations (1997) include personality disorders among the mental impairments covered under the ADA. However, "… it is rare that a personality disorder diagnosis constitutes the sole or even primary diagnosis in a case [invoking the ADA]; rather, it is usually one of several conditions asserted as the basis for actual or perceived disability." (Smith 2006, p. 109) Axis II personality disorders may interact with Axis I mental illness or substance use disorders in complex ways, and it can be difficult to determine whether an evaluee's problematic behavior arises from the personality disorder, the Axis I disorder, the interaction between the two, or some other cause. While personality disorders may be covered by the ADA, individual personality *traits* generally are not entitled to ADA protection (Smith 2006). The EEOC notes that "[t]he definition of an impairment … does not include common personality traits such as poor judgment or a quick temper where these are not symptoms of a mental or psychological disorder" (EEOC 2011b, p. 17007). Gold and Shuman also provide a non-exhaustive list of additional personality traits or characteristics that are not in themselves impairments under the ADA, including arrogance, irresponsible behavior, irritability, chronic lateness, low stress

tolerance, poor social skills resulting in interpersonal conflict, and poor impulse control (Gold and Shuman 2009, p. 222).

Evaluating MHPs may encounter organic or general medical conditions and neurological impairments that produce behavioral symptoms, such as emotional volatility or erratic behavior. Diabetes, for example, may cause impaired concentration, irritability, and mood swings, resulting in problematic behavior in the workplace (Timmons 2005). Similarly, medications prescribed to treat general medical conditions may have psychiatric side effects, such as difficulty concentrating. Frontal lobe injuries and other neurological impairments may result in inappropriate behavior and poor judgment. Learning disabilities may also be considered disabilities or impairments under the ADA (Foote 2003). A complete discussion of the role of diagnosis in the ADA is beyond the scope of this chapter, but readers may find Simon and Gold's discussion of psychiatric diagnosis in litigation helpful (see Simon and Gold 2010).

Extent of Impairment

Possibly the most important section of the MHP's report in an ADA case is the explanation of how the evaluee's disorder affects his or her ability to perform the work in question. It is important for the MHP to address not simply the evaluee's diagnosis (if any), but also the referring party's specific question(s) about whether or not the evaluee is able to safely and effectively perform the job function(s) at issue. The relevant question for the report or testimony to answer may not be whether or not the evaluee has a disability, as expert medical testimony is not required in order for a court to find that a claimant is "disabled" under the ADA (Gold and Shuman 2009). Instead, the extent and nature of the evaluee's functional impairment is a critical question for the MHP to address. The ultimate decision as to an employee's disability status under the ADA is a legal question to be determined by the court, not a medical question to be decided by the evaluating MHP (Gold et al. 2008).

Failing to address the connection between an evaluee's mental illness and functional impairments or job performance can be detrimental to a disabled employee's case for discrimination under the ADA. In *McWilliams v. Jefferson County* (2006), the Tenth Circuit rejected the ADA claim of an employee with depression, in part because she was unable to demonstrate how her impairments or limitations affected her ability to perform her job (Hickox 2011). A thorough assessment of work-related functional impairment is essential to the ADA consultation process. The MHP may also be asked how treatment (e.g., medication side effects) might affect the evaluee's work functioning or to explain the expected impairment or improvement. For example, Mr. A's prescribed medication might cause drowsiness or difficulties in concentration, potentially impacting his ability to maintain concentration while reviewing case law or drafting legal memoranda. According to AAPL's practice guideline:

> Descriptions of an employee's functioning should include compelling anecdotal examples provided by the evaluee as well as examples derived from sources of collateral information. … Psychiatric opinions regarding impairment (and, if requested, regarding disability) should demonstrate that the psychiatrist appreciates the requirements of the particular job and how the impairment may affect the ability to fulfill job responsibilities. (Gold et al. 2008, p. S20)

It may be helpful to illustrate the severity or extent of an impairment by comparison to "the average person," a standard which has been used by courts in ADA litigation (Fram 2008).

Prognosis

The MHP's opinions regarding the evaluee's prognosis are an important part of an ADA case. An employee's likelihood of recovery and performance improvement is relevant to whether she is otherwise qualified for the position in question. A poor prognosis for improvement may suggest that the worker is unlikely to be able to perform the essential job functions in the foreseeable future. The likelihood of a relapse (as demonstrated by past relapses) of substance abuse or mental illness may render an employee unqualified for his or her job. Gold and Shuman (2009) have observed that employers are not obligated to provide an accommodation such as a leave of absence or repeated leaves of absence to an employee whose prognosis for recovery is poor. The MHP should consider a number of different factors in the determination of prognosis, including the evaluee's diagnosis, work history, existing skills and strengths, treatment compliance, extent of impairment, and efficacy of the current or planned course of treatment.

Recommendations

The MHP's recommendations for treatment options may overlap with recommendations for reasonable accommodations. For example, one might recommend that the employer allow the evaluee to attend weekly psychotherapy sessions during the workday, which might require the use of medical, personal, or FMLA leave. The MHP may be asked to provide information regarding the expected duration and cost of treatment. The benefits of treatment, such as improvements in employee productivity or lower employee turnover, may help to offset the cost (Foote 2003). After performing an evaluation and possibly also submitting a written report, the MHP might need to meet with the employer and employee to discuss possible accommodations and a plan for moving forward. Some forensic MHPs suggest the use of a written return-to-work contract that details and describes the employee's and the employer's responsibilities (Foote 2003). It is not the role of the MHP to decide whether a proposed accommodation is "reasonable"

(Gold et al. 2008). Rather, the MHP's expertise can be helpful by offering an opinion as to whether a proffered accommodation would adequately meet the employee's needs.

Resources for Further Information

Numerous resources are available to help both clinicians and forensic specialists to conduct structured ADA evaluations and make recommendations for reasonable accommodations. AAPL provides the following guidelines to help the MHP "correlate the mental disorder with occupational impairment: … (1) assess categories of function; … (2) seek descriptions and clear examples of impairment; … (3) assess complaints of impairment for internal consistency; … (4) correlate the requirements of the job with the claimed impairments; … (5) assess functional history and correlate it with the current level of impairment; … (6) use rating scales whenever appropriate or requested; … (7) utilize psychological testing when indicated" (Gold et al. 2008, pp. S15-S18). AAPL also offers the following summary of points to consider during an ADA evaluation:

> Determine whether the employee meets criteria for a recognized psychiatric disorder. Assess for substantial impairment of [MLAs] related to the disorder. Determine the duration of impairment of [MLAs]. Include in the disability evaluation report all of the [MLAs] that are impaired and the duration of the impairment of each activity. Be familiar with the essential functions and training necessary for the employee's job. Assess the employee's capacity related to essential and nonessential job functions. Assess whether the employee can perform these functions with or without accommodations. Suggest accommodations that may enable the employee to perform essential job functions for which he or she is qualified. Assess whether the employee poses a direct threat of danger to self or others. (Gold et al. 2008, p. S38)

Gold and Shuman (2009, p. 235) also provide a helpful list of guidelines for conducting ADA evaluations. Foote (2003) describes the return-to-work contract for a scientist who had received inpatient treatment for schizophrenia; the plan includes issues such as the employee's responsibility to comply with her medication regimen and the employer's agreement to provide enhanced monitoring to enable early intervention at the first signs of a problem. Finally, Shultz and Rogers (2011) have published a comprehensive guide to help MHPs understand the relationship between psychiatric impairments and occupational functioning in the workplace.

The EEOC's website (http://www.eeoc.gov/) contains numerous helpful resources, including the full text of various enforcement guidance documents, FAQs, information about the ADA in relation to specific professions (e.g., attorneys), guidelines for ensuring that work-related medical examinations do not violate the ADA (EEOC 2000), and information about the ADAAA and its implications for older EEOC rules. Although the EEOC's guidance on psychiatric disabilities (1997) was produced prior to the ADAAA, much of the information it

contains will be relevant to psychiatrists and other MHPs who conduct ADA evaluations or treat patients with mental illness. The document offers numerous examples and diagnosis-specific guidance for conditions including depression, Bipolar Disorder, Adjustment Disorder, Schizophrenia, and anxiety (EEOC 1997).

The Job Accommodations Network (JAN) is a consulting agency (a service of the U.S. Department of Labor's Office of Disability Employment Policy) that offers free, confidential, and expert assistance regarding accommodations and disability issues in the workplace. The JAN website (http://askjan.org/) contains examples of accommodation ideas by disability, by occupation, or by other topics, and provides links to other helpful resources on the Web, including local and regional offices. State rehabilitation agencies and independent disability organizations often provide assistance in determining and offsetting the cost of accommodations in the workplace (EEOC 2011a). Tax credits and deductions may also be available (EEOC 2011a). These offices and their websites may provide useful ideas for MHPs to consider during an ADA consultation.

Conclusion

In the coming years, demand for the expertise of MHPs as consultants in potential ADA cases will likely increase as employers and employees alike seek to avoid costly litigation and find agreeable compromises through reasonable accommodations or alternative dispute resolution (Gold and Shuman 2009; Scott 2010). Attorneys may also seek assistance from MHPs in determining a potential litigant's options and obligations under the newly amended ADA. Many commentators have predicted that the ADAAA will result in an increase in ADA employment litigation as more plaintiffs are likely to meet the definition of "disabled." Simultaneously, the prevalence of self-reported mental health disability has risen dramatically in recent years (Mojtabai, 2011). The need for assistance from forensic psychiatrists or other MHPs as expert witnesses may correspondingly increase, as more plaintiffs with mental disabilities come forward with ADA discrimination complaints (Fram 2008; Hickox 2011). To date, "[t]he Supreme Court has never weighed in on whether or to what extent medical evidence is required to establish disability" (Smith 2007, p. 17, n. 65), but MHPs may help courts to understand mental illness or other psychiatric impairments in the context of the ADA.

Since previously many cases were dismissed at the summary judgment stage (on the grounds that the plaintiff-employee could not demonstrate a "disability"), there has been speculation that following the implementation of the ADAAA there may be an increase in jury trials as more cases proceed beyond the summary judgment stage (Siber 2009). Legal scholars have suggested that once these cases do proceed beyond the initial stage, disputes and inquiries will focus on whether or not the claimant is able to perform essential job functions and whether reasonable accommodations are available (Collins and Phillips 2011). For these inquiries, the training and expertise of a forensic MHP will be especially relevant.

Critics of the ADAAA have expressed concern that the legislation may be used "as a preemptive protective measure for subpar employees against employer discipline" (Glaser 2011, p. 96). Because the ADAAA increases the pool of employees who might be considered "disabled," critics fear that workers with only marginal impairments may seek to invoke the ADA's protection in order to avoid lawful and nondiscriminatory disciplinary actions (such as termination or suspension for poor work performance). Legal commentators have also expressed concern that following the passage of the ADAAA, problems such as excessive or problematic Internet use may be considered disabilities under the ADA, particularly if they are chosen for inclusion as disorders in the forthcoming DSM-V (Bertagna 2008). As with other types of disability evaluations, a MHP may be asked to evaluate the veracity of an employee's claims, and the usual concerns regarding malingering and secondary gain will apply.

Before the ADAAA, courts rarely had to address the question of how much, if any, objectionable conduct an employer must "accommodate" for an employee with a psychiatric disability. Cases that may have been dismissed before the ADAAA because the plaintiff was unable to show that he or she was "disabled" may now progress to more complicated and nuanced inquiries about the relationship between disability and employment. Furthermore, several of the core legal concepts in the ADA (including disability, impairment, substantial limitation, and reasonable accommodation) are still subject to dispute or varying interpretations by the courts (Gold 2010). As these questions move to the forefront of discussions about the ADA, MHPs can play a vital role in shaping future policies about mental disability in the workplace.

Key Points

1. The ADA and ADAAA protect individuals against discrimination in the workplace (and in other places) on the basis of disability, including psychiatric disability.
2. Clinicians will find it helpful to have a working familiarity with the definitions and protections specified in the ADA and the recent ADA Amendments Act of 2008.
3. If a patient's psychiatric symptoms cause significant impairment in the workplace, clinicians may wish to discuss whether or not it would be appropriate to invoke the ADA's protections.
4. If a patient's difficulties become complicated or may require litigation or formal dispute resolution proceedings, general clinicians might consider advising the patient to obtain a forensic evaluation in order to obtain a specialized consultation and avoid role confusion.
5. Clinicians may be able to assist patients in disclosing a disability to an employer as well as in requesting reasonable accommodations from the employer.

References

Americans with Disabilities Act, Pub. Law No. 101-336, 104 Stat. 327 (1990), 42 U.S.C. §12101 et seq

Americans with Disabilities Act Amendments Act, Pub. Law No. 110-325, 122 Stat. 3553 (2008), 42 U.S.C. §12101 et seq

Albertson's, Inc. v. Kirkingburg, 527 U.S. 555 (1999)

Battle v. United Parcel Serv., Inc., 438 F.3d 856 (8th Cir. 2006)

Bazelon Center. Press Release: President signs ADA Amendments Act, Sept 25, 2008. http://www.bazelon.org/newsroom/2008/9-18-08ADAA.htm (2008). Accessed 25 July 2011

Bertagna, B.R.: The internet: Disability or distraction? An analysis of whether "internet addiction" can qualify as a disability under the Americans with Disabilities Act. Hofstra Labor Employ. Law J. **25**, 419–481 (2008)

Bolstein v. Reich, 1995 U.S. Dist. LEXIS 731, 3 Am. Disabilities Cas. (BNA) 1761 (D.D.C. 1995), motion for summary affirmance granted, 1995 U.S. App. LEXIS 32536 (D.C. Cir. 1995)

Breen v. Department of Transportation, 282 F.3d 839 (D.C. Cir. 2002)

Brown v. Cox Med. Ctrs., 286 F.3d 1040 (8th Cir. 2002)

Brown v. Lucky Stores, Inc., 246 F.3d 1182 (9th Cir. 2001)

Center, C., Imparato, A.J.: Redefining "disability" discrimination: A proposal to restore civil rights protections for all workers. Stanf. Law Policy Rev. **14**, 321–345 (2003)

Collins, G.T., Phillips, P.J.: Overview of reasonable accommodation and the shifting emphasis from who is disabled to who can work. Hamline Law Rev. **34**, 469–502 (2011)

Despears v. Milwaukee County, 63 F.3d 635 (7th Cir. 1995)

Feldblum, C.R., Barry, K., Benfer, E.A.: The ADA Amendments Act of 2008. Texas J. Civ. Liberties Civil Rights **13**, 187–240 (2008)

Fields v. Lyng, 705 F. Supp. 1134 (D. Md. 1988)

Foote, W.E.: Forensic evaluation in Americans with Disabilities Act cases. In: Goldstein, A.M., Weiner, I.B. (eds.) Handbook of Psychology: Forensic Psychology, vol. 11, pp. 279–300. Wiley, New York (2003)

Fram, D.K.: Practitioners' note: The ADA Amendments Act: Dramatic changes in coverage. Hofstra Labor Employ. Law J. **26**, 193–221 (2008)

Gagliardo v. Connaught Labs, Inc., 311 F.3d 565 (3d Cir. 2002)

Glaser, A.H.: The Americans with Disabilities Act Amendments Act: Legal implications and the effect on employer-employee relationships. La. Bar J. **59**, 94–97 (2011)

Gold, L.H.: The workplace. In: Simon, R.I., Gold, L.H. (eds.) Textbook of Forensic Psychiatry, 2nd edn, pp. 303–334. American Psychiatric Publishing, Inc, Washington, DC (2010)

Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Model, Process, and Analysis. Springer, New York (2009)

Gold, L.H., Anfang, S.A., Drukteinis, A.M., Metzner, J.L., Price, M., Wall, B.W., Wylonis, L., Zonana, H.V.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36** (Suppl 4), S3–S50 (2008)

Goodman-Delahunty, J.: Psychological impairment under the Americans with Disabilities Act: Legal guidelines. Prof. Psychol. Res. Pract. **31**(2), 197–205 (2000)

Hankins v. The Gap, 84 F.3d 797 (6th Cir. 1996)

Hartman, P.A.: "Interacting with others" as a major life activity under the Americans with Disabilities Act. Seton Hall Circuit Rev. **2**, 139–173 (2005)

Hensel, W.F.: Interacting with others: A major life activity under the Americans with Disabilities Act? Wis. Law Rev. **2002**, 1139–1196 (2002)

Hickox, S.A.: The underwhelming impact of the Americans with Disabilities Act Amendments Act. Univ. Baltimore Law Rev. **40**, 419–494 (2011)

Humphrey v. Memorial Hospital Association, 239 F.3d 1128 (9th Cir. 2001)

Husowitz v. Runyon, 942 F. Supp. 822 (E.D. N.Y. 1996)

Jacques v. DiMarzio, Inc., 386 F.3d 192 (2d Cir. 2004)

Jakubowski v. The Christ Hospital, Inc., No. 09-4097 (6th Cir., 8 Dec, 2010)
Jarvis v. Potter, 500 F.3d 1113 (10th Cir. 2007)
Jones v. Am. Postal Workers Union, 192 F.3d 417 (4th Cir. 1999)
Kennedy v. Dresser Rand Co., 193 F.3d 120 (2d Cir. 1999)
Keoughan v. Delta Airlines, No. 96-4072, 1997 U.S. App. LEXIS 12232 (10th Cir. 1997)
Long, A.B.: Introducing the new and improved Americans with Disabilities Act: Assessing the ADA Amendments Act of 2008. Northwest. Univ. Law Colloquy **103**(44), 217–229. http://www.law.northwestern.edu/lawreview/colloquy/2008/44/index.html (2008). Accessed 15 Nov 2011
Maes v. Henderson, 33 F. Supp.2d 1281 (D. Nev. 1999)
Matejkovic, J.E., Matejkovic, M.E.: What is reasonable accommodation under the ADA? Not an easy answer; rather a plethora of questions. Miss. Coll. Law Rev. **28**, 67–96 (2009)
McKenzie v. Benton, 388 F.3d 1342 (10th Cir. 2004)
McMullin v. Ashcroft, 337 F. Supp. 2d 1281 (D. Wyo. 2004)
McWilliams v. Jefferson County, 463 F.3d 1113 (10th Cir. 2006)
Meyer, D.J., Price, M.: Forensic psychiatric assessments of behaviorally disruptive physicians. J. Am. Acad. Psychiatry Law **34**(1), 72–81 (2006)
Miller, S.P.: Comment: Keeping the promise: The ADA and employment discrimination on the basis of psychiatric disability. Calif. Law Rev. **85**, 701–747 (1997)
Mitka, M.: Federal government seeks to clarify the Americans with Disabilities Act. JAMA **300**(8), 889 (2008)
Mojtabai, R.: National trends in mental health disability, 1997–2009. Am. J. Public Health **101**(11), 2156–2163 (2011)
Murphy v. United Parcel Service, Inc., 527 U.S. 471 (1999)
Overton v. Reilly, 977 F.2d 1190 (7th Cir. 1992)
Pack v. Kmart Corp., 166 F.3d 1300 (10th Cir. 1999)
Paetzold, R.L.: Mental illness and reasonable accommodations at work: Definition of a mental disability under the ADA. Psychiatr. Serv. **56**(10), 1188–1190 (2005)
Ray v. Kroger, Co., 264 F. Supp.2d 1221 (S.D. Ga. 2003), aff'd, 90 Fed. Appx. 384 (11th Cir. 2003)
Samper v. Providence St. Vincent Medical Center, No. 10-35811, 2012 U.S. App. LEXIS 7278 (9th Cir., April 11, 2012)
School Board of Nassau County v. Arline, 480 U.S. 273 (1987)
Schultz, I.Z., Rogers, E.S. (eds.): Work Accommodation and Retention in Mental Health. Springer, New York (2011)
Scott, C.E.: The Americans with Disabilities Act Amendments Act of 2008: Implications for the forensic psychiatrist. J. Am. Acad. Psychiatry Law **38**, 95–99 (2010)
Siber, L.: ADA Amendments Act of 2008: New hope for individuals with disabilities. Rutgers Law Rec. **33**, 65–73 (2009)
Simon, R.I., Gold, L.H.: Psychiatric diagnosis in litigation. In: Simon, R.I., Gold, L.H. (eds.) Textbook of Forensic Psychiatry, 2nd edn, pp. 151–173. American Psychiatric Publishing, Inc, Washington, DC (2010)
Smith, D.M.: Who says you're disabled? The role of medical evidence in the ADA definition of disability. Tulane Law Rev. **82**, 1–76 (2007)
Smith, D.M.: The paradox of personality: Mental illness, employment discrimination, and the Americans with Disabilities Act. George Mason Univ. Civil Rights Law J. **17**, 79–156 (2006)
Solove, D.J.: The Future of Reputation: Gossip, Rumor, and Privacy on the Internet. Yale University Press, New Haven (2007)
Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999)
Teitelbaum, C., Thomas, P.: Post-traumatic stress disorder, employment discrimination, and direct threat claims. J. Am. Acad. Psychiatry Law **37**(1), 109–111 (2009)
Thomas, V.L., Gostin, L.O.: The Americans with Disabilities Act: Shattered aspirations and new hope. JAMA **301**(1), 95–97 (2009)

Timmons, K.C.: Accommodating misconduct under the Americans with Disabilities Act. Fla. Law Rev. **57**, 187–294 (2005)

Timmons, K.C.: Disability-related misconduct and the legal profession: The role of the Americans with Disabilities Act. Univ. Pittsburgh Law Rev. **69**, 609–635 (2008)

Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002)

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. Regulations to implement the equal employment provisions of the Americans with Disabilities Act. Federal Regist. **56**, 35726 (26 July 1991), codified at 29 C.F.R. § 1630, rev. 1 July 2005. http://www.access.gpo.gov/nara/cfr/waisidx_04/29cfr1630_04.html (1991). Accessed 29 July 2011

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. EEOC enforcement guidance: The Americans with Disabilities Act and Psychiatric Disabilities. EEOC Notice No. 915.002, 1997. http://www.eeoc.gov/policy/docs/psych.html (1997). Accessed 29 July 2011

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. Enforcement guidance: Disability-related inquiries and medical examinations of employees under the Americans with Disabilities Act (27 July 2000, updated 24 March 2005). http://www.eeoc.gov/policy/docs/guidance-inquiries.html (2000). Accessed 25 July 2011

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. Americans with Disabilities Act: Questions and answers (Febr 2001, updated 9 Oct 2008). http://www.ada.gov/qandaeng.htm (2001). Accessed 25 July 2011

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. Work at Home/Telework as a reasonable accommodation, 27 Oct 2005. http://www.eeoc.gov/facts/telework.html (2005). Accessed 25 Sept 2011

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. Questions and answers on the final rule implementing the ADA Amendments Act of 2008 (no date). http://www.eeoc.gov/laws/regulations/ada_qa_final_rule.cfm. Accessed 25 July 2011

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. Reasonable accommodations for attorneys with disabilities (last modified 2 Febr 2011). http://www.eeoc.gov/facts/accommodations-attorneys.html (2011a). Accessed 31 Oct 2011

U.S. Equal Employment Opportunity Commission, U.S. Department of Justice, Civil Rights Division. Regulations to implement the equal employment provisions of the Americans with Disabilities Act, as amended, 29 C.F.R. Part 1630, RIN 3046-AA85. Federal Regis. **76**(58), 16978–17017 (2011b)

Zwerling, C., Whitten, P.S., Sprince, N.L., Davis, C.S., Wallace, R.B., Blanck, P., Heeringa, S.G.: Workplace accommodations for people with disabilities: National health interview survey disability supplement, 1994–1995. J. Occup. Environ. Med. **45**(5), 517–525 (2003)

Chapter 11
Workplace Violence Evaluations and the ADA

Ronald Schouten

Introduction

Mental health clinicians who have concerns about the risk their patients pose for committing violence in the workplace face unique challenges, as do all clinicians who are asked to provide violence risk assessments and fitness for duty evaluations. Independent mental health clinicians may be asked to provide fitness for duty evaluations that address violence risk assessments for employees who have raised concerns that they may become violent in the workplace. These clinicians must bring their knowledge and expertise to these fitness for duty evaluations in a workplace context in which multiple factors must be assessed. The following example portrays a common workplace violence scenario, and will be used to highlight the issues that arise in this difficult area.

Case Example

Frank had worked at ABC manufacturing for 10 years. Skilled at math, he had struggled in school due to verbal learning problems and Attention Deficit Hyperactivity Disorder (ADHD), but with ongoing treatment he did well when it came to math and technical skills. Deciding that college was not for him, after high school he went to work at ABC. Within 2 years, Frank had progressed from sweeping floors to operating a hi-tech machine on the shop floor. Frank was

R. Schouten (✉)
Law and Psychiatry Service, Department of Psychiatry, Massachusetts General Hospital, Harvard Medical School, 15 Parkman Street WAC 812, Boston, MA 02114, USA
e-mail: rschouten@partners.org

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_11,

30 years old, unmarried, and lived with his parents. Still in treatment for ADHD, Frank saw his psychiatrist a few times a year for medication management.

At work, Frank stayed to himself and did not socialize with his peers. His only interaction with coworkers was an occasional discussion regarding guns, gun collecting, and target shooting scores with a few other employees who shared these interests. Coworkers teased Frank about his disheveled appearance, isolation, and his habit of talking to himself. At times, the foreman would intervene, telling the others to back off, but it was of limited help.

After a week's worth of particularly severe teasing, Frank reacted one morning when someone tampered with his machine. He grabbed a length of pipe, walked over to a group of laughing coworkers, and pushed the end of the pipe under the ringleader's chin. "If you ever mess with me again, I'll kill you," Frank declared. He then turned to the others and said "The same goes for you." He threw the pipe down, accidentally hitting a co-worker in the foot, and went back to his machine.

The foreman, having heard the commotion, came out of his office just as Frank was walking away. Frank's coworkers reported the physical and verbal threats, and said Frank had "deliberately" hit his coworker on the foot. The foreman then asked Frank what had happened. Frank said, "Nothing. They were just being assholes and I told them off." Within a few minutes, the foreman handed Frank a letter telling that he was being suspended from work pending investigation of the events. The foreman insisted that he leave immediately.

One week later, Frank received a phone call from the Director of Human Resources at ABC, telling him the investigation had determined that he had violated the company's workplace violence policy. Neither Frank, nor his coworkers, were aware of any such policy. Indeed, coworkers routinely made half-joking comments about "killing" other employees, and there were even some fights in the parking lot that were ignored by management. Management had determined that Frank could return if he got a note from a doctor saying that he was fit to work and not a danger to anyone. ABC told Frank he could see whomever he wanted, and should use his insurance coverage, as the company would not pay for any evaluation.

The Scope of the Workplace Violence Problem

The National Institute of Occupational Safety and Health (NIOSH) defines workplace violence as: "Violent acts (including physical assaults and threats of assault) directed toward persons at work or on duty" (Centers for Disease Control 2002). Incidents of workplace violence are divided into four categories based upon the relationship of the perpetrator and the target, as follows:

Type I. Acts with Criminal Intent. These are committed by individuals who enter the workplace for the purpose of robbery or committing another crime. Perpetrators may include current or former employees.

Type II. Customer/Client/Patients. These are acts of violence on the part of anyone to whom the employer is providing a service.
Type III. Coworker. This category includes all acts of violence by current or former employees, supervisors, or managers.
Type IV. Personal. These acts include those by someone who is not employed by the employer but who has a personal relationship with an employee or is known to an employee (OSHA 2011).

Workplace violence has been a major concern of employers since the late 1980s, when the unfortunate term "going postal" gained currency after a series of shootings at U.S. Postal Service facilities by disgruntled employees. In fact, U.S. Postal Service employees have a lower risk of homicide than other employees (Report of the United States Postal Service Commission on a Safe and Secure Workplace 2000). Public perception of an epidemic of workplace violence was eventually disproved through studies conducted by the United States Department of Labor Bureau of Labor Statistics (BLS) starting in 1992. These ongoing studies have demonstrated that workplace homicides peaked in 1994, and have declined by more than 50 % since then (Bureau of Labor Statistics 2011a).

Statistics have also consistently demonstrated the inaccuracy of popular beliefs that disgruntled employees (Type III violence) are responsible for most workplace homicides. BLS studies have shown that the vast majority (75 %) of workplace homicides were committed by outsiders seeking to commit a crime at the workplace, i.e., Type I violence. The remaining were distributed as follows: Type II (Customers/Clients/Patients) 7 %, Type III (coworkers and former coworkers) 10 %, and Type IV (Personal) 7 % (Bureau of Labor Statistics 2011b). The final category is primarily composed of domestic violence cases that spill over into the workplace. This chapter focuses on Type III workplace violence, as it is the most likely category to give rise to mental health evaluations and issues that may involve protected rights under the Americans with Disabilities Act (ADA).

Workplace homicides, quite naturally, have attracted the most attention and concern. However, non-fatal incidents of workplace violence are far more common (Schouten 2008) and, taken as a whole, have a far greater impact on productivity and employee health. They are distributed differently from workplace homicides, as follows: 53 % Type I, 14 % Type II, 11 % Type III, and 22 % Type IV (Scalora et al. 2003). Still, for the most part it is the fear of the ultimate act of workplace violence that motivates employers and employees to take action in response to concerns about a specific employee.

The Response to Workplace Violence

In spite of widespread expressed concern over workplace violence, as of 2005, 70 % of American employers had not adopted workplace violence prevention programs (Bureau of Labor Statistics 2006). It took until 2012 for the United States

Occupational Safety and Health Administration (OSHA) to adopt guidelines for the investigation of workplace violence incidents by OSHA field offices (OSHA 2011).

An early response to workplace violence was the widespread use of "profiles" of potential perpetrators, with employers being wary of those employees who fit "the profile." There were, and are, a number of problems with profiles. First, the elements included in profiles were derived from anecdotes and not from scientific research. Risk factors were included without looking at their base rates in the general or specific population, and they were gathered retrospectively, rather than being studied longitudinally. In addition, the sample size is small. Although this is good news from a public health perspective, it limits any research conclusions. Second, as with any low incidence phenomenon, the rate of false positives for workplace violence profiles is excessively high, i.e., they identify far many more employees as being at risk than is actually the case.

Third, the profiles include a major focus on the existence of mental illness, and disregard the current understanding of the association between violence and mental illness discussed below. Fourth, and perhaps most importantly, the profiles are often applied in an effort to predict who might be at risk. Some of the risk factors have validity when applied in individual cases in which there has been evidence of threats or violence. However, the lack of underlying scientific validity and the false positive problem cited above make their use as prospective screening inappropriate. Such use of profiles is a potential source of more harm than good in terms of unnecessary exclusion of people from the workplace and setting the stage for employment discrimination claims arising from the stereotypical association of mental illness with violence (Schouten 2006, 2008).

Risk Factors for Type III Workplace Violence

As in the cases of presidential assassins, and school and campus shooters, there is no evidence that there is a valid profile of perpetrators of workplace violence (Drysdale et al. 2010; Fein et al. 1999; Vossekuil et al. 2000). Nevertheless, a number of validated individual and organizational risk factors for non-fatal Type III workplace aggression have been identified by multiple researchers (Schouten 2008). These are listed in Tables 11.1 and 11.2.

The risk factors can be divided into two groups: those that are static, such as past history of criminal behavior or several mental illness, and those that are dynamic, such as financial stress, acute symptoms of illness, and conflict with coworkers. Static factors cannot be altered, however, it is often possible to affect dynamic factors in such a way as to decrease risk (Douglas and Skeem 2005). Static and dynamic factors can themselves be divided into two groups: those that are protective and decrease the risk of violence and those that exacerbate the risk (Schouten 2006).

Table 11.1 Individualized Risk Factors for Workplace Aggression (Schouten 2008)

1. Perception of unfair treatment by others
2. Trait anger
3. Threat to identity through loss of status
4. Hostility, low frustration tolerance, and reactivity to stress
5. Life stressors, e.g., financial problems, domestic conflict, severe illness in self or family
6. Negative affectivity
7. Externalization of blame
8. Belief in revenge as a justifiable action
9. History of violence, including intimate partner violence
10. History of antisocial behavior
11. Acute workplace stressors, e.g., pay cuts or freezes, termination
12. Chronic workplace stressors, e.g., limited control over work, job dissatisfaction
13. Factors related to mental illness:
    a. Suicidal or parasuicidal behavior within 24 hours of criminal violence
    b. Hallucinations
    c. Acute conflicts with others
    d. Denial of psychiatric care within 24 hours of the violence
    e. Active psychosis
    f. Substance abuse

Table 11.2 Organizational Risk Factors (Schouten 2008)

1. Pay cuts and freezes
2. Use of many part-time employees
3. Changes in management
4. Reengineering
5. Budget cuts
6. Deteriorating physical work environment
7. Low work group harmony
8. Failure to discipline aggressive employee

Significant mental illness is, in fact, one of the consistently cited risk factors for workplace violence (Katsavdakis et al. 2011). The evidence that mental illness actually constitutes a consistent risk, however, does not extend beyond the research on violence and mental illness in the world at large. As summarized in a series of studies, mental illness is associated with a small, but statistically significant, increased risk of violence where there is a combination of serious mental illness, concurrent substance abuse or a history of substance abuse, and a history of conduct disorder or antisocial personality disorder (Elbogen and Johnson 2009). Contrary to widespread popular belief, but consistent with our knowledge in this area, some of the perpetrators of workplace violence may have a significant mental illness, but Axis II-related conditions play a larger role than those that fall under Axis I.

ADA Issues in Workplace Violence

The public perception of an association between mental illness and violence accounts for a substantial portion of workplace violence referrals. The initial request for a consultation often includes comments like, "We have an employee we're concerned about. He's kind of a loner. He's a bit odd, and he makes people nervous." With that, and the inherent perception of the employee as having a mental illness of some sort or perhaps knowledge that the employee has been treated for a mental disorder, the stage is set for a potential discrimination claim. As discussed in the previous chapter, individuals are protected by the ADA if they have a mental or physical disability, had such a disability in the past, or are perceived as having such a disability.

Employers tread a fine line when these concerns arise. On the one hand, it is important and appropriate for employers to be attuned to the emotional health and well-being of their employees. However, fear of disability discrimination litigation often prevents employers from addressing obvious signs of psychiatric or emotional disturbance among employees; what this author refers to as "Litigation Induced Paralysis." The result is that employees do not get the help and support they need, the risk of absenteeism and presenteeism (decreased productivity while staying on the job) increases, coworkers are distracted by concerns about the employee in question, and the risk of accidents, and occasionally violence, increases.

In addition to being good employee relations practice, employers have both the obligation and right to respond to situations where employee health and safety are in question. However, potential workplace violence situations give rise to significant disability discrimination issues, due to the stigma attached to mental illness and the limited, but real, association between mental illness and violence. Employers often find themselves facing a difficult choice when these concerns arise. They face potential liability if a violent event occurs and they have failed to act out of fear of a disability discrimination claim, and liability for disability discrimination if they respond to such incidents in a manner that suggests disparate treatment of those with disabilities.

Any adverse employment action, from being passed over for a promotion to being placed on a mandatory leave and sent for a fitness for duty evaluation to outright termination, may place the employer at risk of disability discrimination liability if employees without actual or perceived disabilities have not received the same treatment for similar behavior. For example, Frank had covered disabilities (ADHD and verbal learning disability) and was perceived as having other mental illness, thus affording him ADA protection. In addition, ABC had never applied its workplace violence policy to others who engaged in similar, or worse, behavior. Invoking the company workplace violence policy in suspending Frank and sending him for a fitness for duty evaluation sets the stage for a disparate treatment claim.

In Frank's case, it is clear that ABC had to take action based on Frank's behavior. In general, employers should take action based on behaviors, not on the

basis of actual or presumed existence of mental illness. ABC's workplace violence policy was typical in that it contained a "zero tolerance" clause calling for potential discipline "up to and including termination" for violations. Frank's actions were in clear violation of the policy, and his foreman had legitimate grounds for suspending Frank pending an investigation or even immediate termination. Indeed, one could argue that ABC was obligated to respond in accordance with its policy.

However, employers should treat all individuals equally, with no disparate treatment of those with past, current, or presumed disabilities. Employers are free to treat individual employees differently, so long as the decision to do so is not based on the employee's membership in a protected class, e.g., race, religion, ethnicity, gender, disability, or, in some states, sexual orientation. As noted above, ABC was well within its rights to suspend Frank or even terminate him because of the verbal threats and the actual act of violence. However, enforcing the policy with regard to Frank if other employees who made threats and engaged in acts of violence were never subject to investigation, suspension, or termination, would provide the basis for a discrimination claim.

Some clinicians, believing that the ADA protects disabled persons from any adverse action, express surprise that their patients are being disciplined for violating work rules. The ADA does not protect covered individuals from discipline for violations of work rules, even if the transgression arises from the disability, e.g., verbal or physical aggression by an employee with Bipolar Disorder (Equal Employment Opportunity Commission 1997). The key, as noted above, is whether there has been disparate treatment. The route taken with Frank—suspension pending the results of an investigation—is typical and appropriate. Alternatively, management could have simply terminated or otherwise disciplined Frank for violating the workplace violence policy. Both actions are defensible from a disability discrimination standpoint, so long as other non-disabled employees were treated the same way under similar circumstances.

Workplace Violence Risk Assessments and Treating Mental Health Clinicians

Even employers who are dedicated to the equal treatment of people with disabilities can find themselves accused of violating, or in actual violation, of the ADA and related state statutes when workplace violence situations arise. Thorough, objective assessments of workplace violence risk can provide the best protection for both employers in such situations and for employees' rights. Any investigation of a potential workplace violence situation needs to be fair, objective, and as confidential as possible.

In trying to make the decision regarding whether Frank should be allowed to return to work, ABC correctly looked to an outside source for an opinion.

However, despite taking the appropriate step of asking Frank to obtain a doctor's opinion regarding his fitness for duty, ABC's instruction to get a "note from a doctor" clearing him to return to work is problematic in a number of ways. It provided no guidelines as to the type of doctor, his or her skills, his or her relationship to Frank, or what information needed to be considered. Psychiatrists, psychologists, and other clinicians may be asked to evaluate an employee suspected of posing a risk of workplace violence. In these complex cases, all parties are best served when the evaluation is conducted by an independent evaluator rather than the employee's treating clinician.

Frank naturally turned to his treating psychiatrist when he was told that he needed to "get a note from a doctor" clearing him to return to work. While this is understandable, it is unwise for the employer to accept the treating clinician as the evaluator and for the psychiatrist to take on that assignment. There are multiple reasons why treating clinicians should not serve in roles that require an objective assessment of their patients, such as that of expert witness on behalf of a patient or evaluator of fitness for duty. These reasons include:

- Conflicts of interest that arise from the clinician's fundamental role as advocate for the patient.
- The clinician's various duties to his or her patient.
- The fact that treating clinicians primarily obtain their information from their patients rather than from multiple collateral sources.
- The necessary abandonment of confidentiality.
- The potential damage to the treatment relationship (Schouten 1993; Strasburger et al. 1997).

Experience has shown that treating clinicians who are asked to assume roles other than the provision of treatment tend to reach conclusions that are in accord with their patients' preferences. In addition, multiple examples exist of treating clinicians offering opinions about a patient's ability to function in his or her job when the clinician has no specific knowledge (even from the employee) of the industry, the workplace, the functions of the job, or the particular demands placed on the employee/patient.

In light of the above, treating clinicians should not be asked to provide an objective opinion regarding their patient's fitness to return to work, especially in high stakes situations such as the potential for violence. Treating clinicians should not accept that assignment, nor should employers look to treating clinicians for such an opinion, as they will be relying upon a potentially flawed assessment.

It is true that clinicians are routinely asked to provide notes for patients indicating that they need time off or are fit to return to work after a leave of absence. In fact, employers are required to accept the treating clinician's opinion that an employee is ready to return from leave under the Family and Medical Leave Act, unless they have some basis for challenging that opinion. While having treating clinicians in this role is not ideal, this common practice poses limited risk if both the employer and the clinician recognize the limitations on the clinician's ability to be objective and if the situation does not involve significant safety concerns.

However, Frank's psychiatrist was not being asked to certify that Frank was ready to return to work after a bout of low back pain, or even panic attacks, or depression. The psychiatrist was being asked to certify that Frank did not pose a risk of violence to himself for others at work after violating the company workplace violence policy. Unfortunately, on Frank's request, Frank's psychiatrist agreed to provide a letter asserting that Frank could return to work, without understanding the exact nature of the evaluation being requested, without understanding the exact nature of Frank's job functions, and while serving as Frank's treating psychiatrist. This was in fact one of those situations in which both Frank and the employer would have been better served had the psychiatrist offered his clinical opinion, noting his limited ability to perform a complete and objective assessment, and left the evaluation to be done by an independent evaluator to be retained by the employer.

The Role of the Independent Mental Health Professional

The independent mental health clinician is a non-treating clinician retained by the employer to conduct an assessment in pursuit of an answer to a particular question or questions. As in any other forensic role, the independent evaluator has an obligation to reach an objective conclusion based upon the available information considered in the context of the question that has been asked. In addition to objectivity, the independent mental health clinician who agrees to conduct a fitness for duty evaluation in the assessment of a concern regarding workplace violence situation has the obligations associated with any fitness for duty evaluation (see Chap. 12) as well as some other unique challenges associated with violence risk assessment.

There are two basic roles for independent evaluators in workplace violence assessments. First, the mental health clinician may directly assess the fitness for duty of a specific employee about whom there are violence risk concerns. Second, the independent evaluator can serve as a consultant, assessing the situation based on available materials and advising what to do about a given situation. In the former role, the evaluator will meet with the employee and conduct an assessment, in addition to reviewing information from collateral sources. In the latter, advice is offered based on interviews with collateral sources, and review of personnel records, company policies and procedures, correspondence, and any available background investigation materials.

Workplace violence assessments, such as complex clinical cases, often benefit from a team approach. Professionals from law enforcement, corporate security, human resources, employee assistance counselors, and employment law may all have specialized expertise in workplace violence. Those clinicians who wish to provide consultation on workplace violence issues are well served, as are their clients, if they are comfortable working as part of a team of such professionals that can analyze different aspects of threats as they evolve. Often referred to as threat

management teams (TMT) or threat assessment teams (TAT), they provide ongoing assessment of threats within an organization. Notably, mental health professionals are often asked to take a leadership role on these teams, in part because of the tendency to focus on mental illness as a violence risk factor. The skilled consultant will help redirect the team to focus on behavior, rather than diagnosis, and assist the team in understanding illness when it is present.

Mental health professionals should also carefully consider whether they have the expertise necessary to conduct the evaluation. Fitness for duty evaluations, especially those involving workplace violence risk assessment, require specific knowledge and expertise distinct from the violence risk assessments conducted as a basic part of clinical practice. Those seeking to build upon the general expertise and knowledge regarding violence in clinical training can attend continuing education conferences and courses on the subject. For example, the Association of Threat Assessment Professionals (ATAP) is an organization of law enforcement, security, legal, and behavioral science professionals who have a specific interest in threat assessment and management. ATAP holds an annual meeting as well as regional conferences (www.atapworldwide.com). More specific training courses on workplace violence risk assessment are also available around the country (White and Meloy 2007).

Independent mental health clinicians should keep in mind that violence potential is not an all or nothing affair. Workplace violence and the circumstances that give rise to workplace violence represent a dynamic process that provides an opportunity for evaluators to both assess violence risk and help manage it. As described by Calhoun and Weston (2003), workplace and other forms of targeted violence can be conceptualized as progressing in a stepwise fashion, initiating with a grievance, moving on to violent ideation, and then through various decision making and planning stages that, if unchecked, can escalate to an attack. Their model describes the pathway to violence, and makes clear that it is possible for people who are on that pathway to change course.

Mental health clinicians who have agreed to provide workplace violence risk assessments for individuals who are not their patients have an opportunity to utilize their clinical skills to provide suggestions to manage the situation in a way that decreases violence risk. While the purpose of the fitness for duty evaluation is not treatment, it can still have a therapeutic effect, merely by providing an opportunity for the employee to be heard or providing insights as to help address individual violence risk factors.

The Basics of a Workplace Violence Risk Assessment

There are basic elements to an assessment of workplace violence potential, whether conducted by an independent evaluator, a clinician who wants to determine the violence risk potential of a patient, or a clinician who agrees, despite the practical and ethical conflicts presented, to evaluate a patient on behalf of an

employer. Clinicians should be certain to address these elements to lay the groundwork for the evaluation or consultation. The basic questions that a referral for a workplace violence assessment should answer include:

- What are the referral question(s) that need(s) to be answered?
- Do you have the necessary expertise?
- Who is seeking answers to the referral questions(s)?
- What is the goal of the assessment?
- What is the specific basis for concern regarding violence risk?
- Is specific knowledge about the job and workplace in question available and accessible?

Clinicians should first have a clear understanding of the referral question(s). As with any other consultation, it is essential that the mental health professional undertaking the violence risk assessment understands the question being asked. Is this an evaluation for return to work, for disability, to consider the advisability of a leave of absence, or whether to terminate the employee for violating workplace rules? Whatever the question, it is important to understand the employer-specific, as well as clinical, criteria for answering it.

Clinicians also need to establish who is asking the question they are being asked to answer. Requests for assessments of workplace violence potential may come from employers or other organizations, from attorneys representing either the employee or the employer, from union representatives, or other sources. While the source of the question should have no impact on the evaluating clinician's objectivity or response, it does influence the nature of the question and the framing of the answer. For example, the question(s) associated with the potential for workplace violence of an executive of a small company as part of the due diligence efforts of a larger company seeking to purchase the smaller entity will differ from that of a factory employee who brought a firearm to the workplace.

The goal of the assessment should also be clearly established. Once the requesting party and the mental health clinician have a mutual understanding of the question to be answered, it is important to determine whether the evaluation should be done at all. Is this a situation that calls for a fitness for duty evaluations or should the employee be placed on medical leave in order to obtain treatment?

In many cases, employees are referred for mental health fitness for duty evaluations when the employer has no desire or intention to continue to employ the person, although the employer may not directly say as much to either the mental health clinician or the employee. Hoping that the mental health clinician will deem the person unfit for duty, the referral is made as a way to temporize, to shift the blame or responsibility for termination to the mental health professional rather than management, or to induce an employee who does not want to be evaluated to quit.

Employers who send an employee for a mental health fitness for duty evaluation should be advised that there is a 50/50 chance that the evaluator will deem the person fit to work, and that the fitness for duty evaluation cannot be relied upon to accomplish their goal of being free of the employee. Moreover, it is essential that the mental health clinician not be placed in the position of lying to the evaluee, i.e.,

representing that continued employment is still a possibility, when that is not the case. It is always wrong to lie to evaluees, but it is also dangerous to do so when dealing with potentially violent individuals.

Alternatively, employees in crisis may be referred for a fitness for duty evaluation as a way of getting them immediate attention. After discussion with the referral source, the clinician may determine that the employee is too unstable for a fitness for duty evaluation. Treatment and safety concerns are primary for an employee who is possibly experiencing a mental health crisis and is potentially violent. Workplace violence assessments and fitness for duty evaluations are not designed to provide any type of treatment, urgent or otherwise. An independent assessment regarding any employment issue should be secondary to the individual's need for appropriate urgent treatment. Employers or their agents should be advised to refer such individuals to a mental health professional or emergency room for urgent or emergent treatment.

Another basic element that evaluating mental health professionals should establish is the specific basis for the concern about violence risk. Has the employee exhibited specific behaviors, or communicated or stated such as threats? Does the employee have a past history of violence, conflict with others, substance abuse, mental illness, or some combination of these? If a history of mental illness or active symptoms is the only source of the concern, the clinician should ask how the employer handles similar situations when there is no indication of illness, and perhaps suggest a consultation with the employer's employment attorney.

Mental health professionals need specific knowledge about the job and workplace in question, including the level of aggression in that workplace, in order to conduct a violence risk assessment. Evaluating clinicians should therefore determine whether this kind of information is available and whether they will be able to access it before undertaking the assessment. For example, is this a workplace in which verbal and physical aggression is fairly common and generally tolerated, or is such behavior unheard of and therefore noteworthy when it occurs? In Frank's case, his conversations about guns might be less noteworthy in a workplace or geographic region where shooting sports are common than when it occurs somewhere where guns are rarely spoken of, let alone used.

Certain employee populations and professions, and their workplaces, have unique cultures and characteristics that relate to stress levels, labor-management relations, safety risks, and employee interactions. The evaluator should obtain a copy of the formal job description from the employer. In addition, it is important to get a verbal description of the job and the workplace in order to determine what the work truly involves, as written job descriptions often do not capture the nuances and stresses of a given position.

Finally, evaluators should establish what organizational risk factors for violence are present. Poor labor-management relations, recent or imminent reductions in force, or failure to enforce workplace rules, especially those related to workplace violence, are organizational rather than individual risk factors. Nevertheless, they are part of the dynamic process involved in workplace violence and risk and so need to be assessed. Similarly, evaluators should assess organizational protective

factors, such as the presence of a viable open door grievance policy, adequate pay and benefits, supportive human resource policies, and an active employee assistance program.

The Evaluation

Whether functioning in the role of fitness for duty evaluator or workplace consultant, it is important to gather as much information as possible to provide a basis for an opinion. The following information should be obtained from multiple sources, including the employer:

- Personnel records
- Statements from coworkers to supervisors
- Background investigation materials (including results of surveillance)
- Review of e-mail and postings to social media, e.g., Facebook and Twitter
- Statements from family members (in certain circumstances)

As noted above, in a fitness for duty context, the employee should be evaluated directly. Psychological testing is rarely necessary if the purpose of the fitness for duty evaluation is violence risk assessment, however, guided assessment tools such as the WAVR-21 can be useful, both for those who are still acquiring expertise in the field and for experienced evaluators (White and Meloy 2007).

Mental health evaluations of fitness for duty that include or are centered around violence risk assessment should include evaluation of a number of factors. Although some of them are not directly connected to workplace issues, evaluation of potentially violent behavior is not limited to the workplace, and may inform opinions regarding workplace risk. For example, what has the evaluee's demeanor been like around scheduling the evaluation with the mental health clinician and the clinician's staff? Has the evaluee been cooperative? Has he or she been cooperative in making arrangements for the evaluation, or has the evaluee been resistant, belligerent, or intimidating? How does the evaluating clinician experience sitting with the evaluee as a history is obtained and the mental status examination conducted? Direct observation of impulsivity, irritability, or hostile or threatening interactions indicate a capacity for threatening or violent behavior not limited to the workplace, but certainly indicating that the evaluee is unlikely to be fit for duty.

Clinicians should be certain to explore the evaluee's attitude and perceptions toward the workplace. Does the evaluee view the workplace as safe from violence for him or herself individually and safe generally? In the case example, Frank is unlikely to feel safe in the workplace since he was the object of taunting and derision. Does the evaluee feel that he or she is being treated unfairly? In Frank's case, if others had exhibited similar behavior and had not been disciplined, despite the workplace zero tolerance policy, Frank might feel unfairly singled out.

An assessment and discussion of violence risk factors and protective factors is essential. As discussed above, static and dynamic risk factors should be reviewed. In addition, any other individual and organizational risk and protective factors that are present should be considered. In addition, the evaluee's perception of individual and organizational risk factors should also be explored. For example, a mental health clinician may consider ABC's no tolerance violence policy to represent an organizational protective factor. Discussion with Frank and collateral workplace sources might demonstrate that this policy is never enforced, or enforced so inconsistently, that it does not truly constitute a protective factor against the risk of violence.

As in any mental health evaluation, the information gathered and observed by the clinician, including a thorough mental status examination, should inform the assessment. What does a detailed history demonstrate regarding the evaluee's mental health history, substance use history, and past history of violence? Does the evaluee deny a history of violence despite arrests for violent behavior? If there is a history of violence, does this occur at times when mental illness is acute or when the evaluee is abusing substances? How does the information obtained from the evaluee compare to the information obtained from other materials, including work history? Lack of consistency or lack of insight may be significant in the clinician's final conclusions.

Mental health clinicians should consider the entire range of possible risks. Experience demonstrates that individuals who are blowing off steam trigger the majority of violence risk fitness for duty evaluations consultations. That experience is also borne out by data that consistently indicate that workplace violence, although a serious problem because of the potential risks involved, is a low base rate event. As a result, mental health clinicians may become complacent purely on the basis of these odds. Each situation needs to be evaluated on its merits, with a fresh look at each new set of facts.

Finally, evaluators should bear in mind that an individual who is referred for a violence risk assessment may present a risk of violence to the clinician or the clinician's staff. In addition to whatever behavior or circumstances triggered an employer's concern regarding potential violent behavior, clinicians should bear in mind that most evaluees are unhappy, uncomfortable, or frankly angry about what they often perceive as being forced to see a "shrink." If clinicians conclude that the evaluee's behavior while arranging the evaluation appointment or interacting with the staff and evaluator suggests violence risk, they should consider issues of safety and whether it is advisable to proceed with the evaluation.

Information related to specific risk factors should be obtained from the referral source when deciding where the evaluation should take place. When it comes to violence risk, the words of the late Dr. Carl Sagan hold true: "Absence of evidence is not evidence of absence." Any person referred for a violence risk assessment should be considered to pose at least some risk. As such, at the very least, evaluations should not take place in isolated settings. Depending upon the preliminary information that is available, precautions may range from scheduling the appointment when others are certain to be available, arranging for security to be present outside the room, or conducting the evaluation in the emergency room.

The Opinion

After gathering all of the collateral and, where possible and necessary, first-hand information, it is time to reach a conclusion and offer an opinion. This should not be done in a vacuum. Risk assessment is a dynamic process, and it is important to determine if there have been any new developments since the mental health evaluation was first undertaken. As noted above, risk assessment is also best conducted as a team activity, in which the behavioral health specialists contribute their observations, as do the other specialists on the team, and then a group conclusion is reached as to the level of threat and how to manage it.

As in other types of clinical forensic work, the referral source should be asked if a report is desired and, if so, whether a special format or language should be used. The length and format will depend not only on the referral source's needs, but on the degree of complexity of the data and the analysis. In addition to following the suggested process described in Chap. 12 on fitness for duty evaluations, assessments of violence risk benefit particularly from consideration of what information was available and what information would have been useful but was not available. After reaching a conclusion, the evaluator should present alternative conclusions that might have been reached if additional information were available. This same approach should be taken with the consensus opinion and action plan reached by the team.

In Frank's case, for example, information regarding the coworkers' behavior is critical. If this information was not available, it might appear that Frank was spontaneously threatening and potentially violent. The information that coworkers were taunting and humiliating Frank changes the dynamic context of Frank's behavior. Information from a thorough investigation by corporate security or human resources might reveal that Frank had not deliberately struck anyone with the pipe, another factor that points to lower risk of violence. Frank might still be found not fit for duty, but the mental health clinician would have a more complete understanding of Frank's actual potential risk for violence in the workplace, and could suggest changes in policy and practices that might improve safety for all of ABC's workers.

The outcome in Frank's case was not satisfactory to either Frank or his employer. When Frank's impending return was reported to coworkers, many of them complained that they were afraid of Frank. Shortly after Frank returned to work, some of Frank's coworkers again began taunting him. Frank's psychiatrist had urged him to stand his ground and not be bullied. Before going to the foreman to complain, Frank jokingly commented to his coworkers, "If you guys are so worried about me going postal, you might want to be a little more careful. You remember my gun collection, right?" One of the other employees relayed Frank's comments about "going postal" and the gun collection to the foreman before Frank could speak with the foreman. Shortly thereafter, the foreman approached Frank, accompanied by an armed police officer. Frank was told that he was being terminated immediately. He was handed a no-trespass/stay away letter that forbade

him from entering onto company property or contacting ABC or its employees. Frank was walked out of the plant flanked by the officer.

Frank's treating psychiatrist had successfully advocated for Frank's return to work, but he did not provide ABC with an analysis of Frank's violence risk factors, which were low. He also did not suggest how ABC might be able to mitigate violence risk in their workplace by addressing the taunting by Frank's coworkers and ABC's intermittent enforcement of its zero tolerance violence policy. Frank lost his job, and consulted an attorney, who filed a complaint against ABC for disability discrimination.

An independent fitness for duty evaluation, alone or in conjunction with a workplace violence risk assessment, might have changed this outcome. Although the information provided by Frank's treating psychiatrist was important, it was not considered in the broader context necessary for understanding the circumstances that led to the behavior for which Frank had been suspended in the first place. A more objective violence risk assessment would have considered individual and organizational risk factors and mitigating factors based on multiple sources of information. That could have led to recommendations for interventions for both Frank and ABC company that would have allowed Frank to continue working, avoided ABC's loss of a valuable employee, decreased the risk of disability discrimination litigation, and improved the safety of the workplace for all ABC's employees.

When presenting an opinion, clinician evaluators should be mindful that they are consultants and, as such, the referral source is free to "take it or leave it" when it comes to the final opinion and recommendations. Negative information, i.e., bad news, tends to be valued more highly than good news. In other words, a client is more likely to accept and value an opinion that warns of significant risk than one that offers reassurance of low risk. Individuals within organizations who have become fearful of coworkers, rightly or wrongly, are often difficult to convince that there is less risk than they perceive. Here again, the clinical skills that are useful in working with individuals and families can be extremely beneficial.

Conclusion

Concerns about workplace violence are widespread and show no signs of decreasing, in spite of the promising statistics that the frequency of such events has declined over time. Workplace violence risk assessments are complex and require specific skills and experience. Clinicians with the proper training and experience can serve useful roles as evaluators and consultants regarding workplace violence risk assessment, using their clinical and forensic skills to identify risk, and help to manage both that risk and the concerns of the client. Moreover, the knowledgeable clinician serving in these roles can help the employer avoid the pitfalls of relying upon false beliefs of the relationship between violence and mental illness, and thus unintentionally or inadvertently taking action which discriminates against individuals with mental illness.

Key Points

1. Although workplace violence is a low base rate phenomenon, when it arises as a potential concern, mental health clinicians are often asked to provide evaluations.
2. Fitness for duty evaluations that involve violence risk assessments require additional skills and training typically not held by general mental health clinicians. Requests made for such evaluations for a clinician's own patients are best referred to a qualified independent mental health clinician.
3. Workplace violence risk assessment and management of potentially violent situations can be enhanced through a team approach that includes professionals from a variety of disciplines.
4. Workplace violence risk assessments should be based on multiple sources of information and should consider all individual and organizational risk factors and mitigating factors in conjunction with events in the workplace that precipitated the referral, in order to provide a complete evaluation.
5. Workplace violence risk assessments should include an explicit violence risk assessment and possible interventions that could reduce the threat of workplace violence.

References

Bureau of Labor Statistics: Survey of Workplace Violence Prevention, 2005. U.S. Department of Labor, Washington, DC (2006)

Bureau of Labor Statistics: National Census of Fatal Occupational Injuries in 2010 (Preliminary Data). News Release 25 August 2011. U.S. Department of Labor, Washington, DC http://bls.gov/news.release/cfoi.nr0.htm (2011a)

Bureau of Labor Statistics: Census of Fatal Occupational Injuries: Occupational Homicides by Selected Characteristics, 1997–2010 U.S. Department of Labor, Washington, DC. http://www.bls.gov/iif/oshwc/cfoi/work_hom.pdf (2011b)

Calhoun, F.S., Weston, S.W.: Contemporary Threat Management: A Practical Guide for Identifying, Assessing, and Managing Individuals of Violent Intent. Specialized Training Services, San Diego (2003)

Centers for Disease Control and Prevention, National Institute for Occupational Health: Occupational Hazards in Hospitals. DHHS (NIOSH) Pub. No. 2002–101. U.S. Department of Health and Human Services, Washington, DC. http://www.cdc.gov/niosh/docs/2002–101/#5 (2002)

Douglas, K.S., Skeem, J.L.: Violence risk assessment: Getting specific about being dynamic. Psychol. Public Policy Law **11**, 347–383 (2005)

Drysdale, D., Modzeleski, W., Simons, A.: Campus Attacks: Targeted Violence Affecting Institutions of Higher Education. U.S. Secret Service, U.S. Department of Homeland Security, Office of Safe and Drug-Free Schools, U.S. Department of Education, and Federal Bureau of Investigation, U.S. Department of Justice, Washington, DC (2010)

Elbogen, E.E., Johnson, S.C.: The intricate link between violence and mental disorder. Arch. Gen. Psychiatry **66**(2), 152–161 (2009)

Equal Employment Opportunity Commission: EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities. EEOC NOTICE Number 915.002, U.S. Equal Employment Opportunity Commission, Washington, DC, 25 March 1997

Fein, R., Vossekuil, B.: Assassination in the United States: An operational study of recent assassins, attackers, and near-lethal approachers. J. Forensic Sci. **44**, 321–333 (1999)

Fein, R., Vossekuil, B., Borum, R., et al.: Threat Assessment in Schools: A Guide to Managing Threatening Situations and to Creating Safe School Climates. United States Secret Service and United States Department of Education, Washington, DC (2002)

Katsavdakis, K.A., Meloy, J.R., White, S.G.: A female mass murder. J. Forensic Sci. **56**(3), 813–819 (2011)

National Center on Addiction and Substance Abuse at Columbia University: Report of the United States Postal Service Commission on a Safe and Secure Workplace. National Center on Addiction and Substance Abuse at Columbia University, New York (2000)

Occupational Safety and Health Administration: Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents. Directive Number: CPL 02-01-052, U.S. Department of Labor, Washington, DC. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=5055 (2011)

Scalora, M.J., Washington, D.O., Casady, T., et al.: Nonfatal workplace violence risk factors: Data from a police contact sample. J. Interpers. Violence **18**, 310–327 (2003)

Schouten, R.: Pitfalls of clinical practice: The treating clinician as expert witness. Harv. Rev. Psychiatry **1**, 64–65 (1993)

Schouten, R.: Workplace violence: An overview for practicing clinicians. Psychiatr Ann. **36**, 790–797 (2006)

Schouten, R.: Workplace violence and the clinician. In: Simon, R.I., Tardiff, K. (eds.) Textbook of Violence Assessment and Management, pp. 501–520. American Psychiatric Press, Washington, DC (2008)

Strasburger, L.H., Gutheil, T.G., Brodsky, A.: On wearing two hats: Role conflict in serving as both psychotherapist and expert witness. Am. J. Psychiatry **154**, 448–456 (1997)

Vossekuil, B., Reddy, M., Fein, R.: Safe School Initiative: An Interim Report on the Prevention of Targeted Violence in School. U.S. Secret Service, Washington, DC (2000)

White, S.G., Meloy, J.R.: Workplace Assessment of Violence Risk. Specialized Training Services, San Diego. http://www.wavr21.com/brief.html (2007)

Chapter 12
Fitness-for-Duty Evaluations

Robert M. Wettstein

Introduction

For most individuals, work and regular employment are an important and gratifying aspect of their lives. On the other hand, many individuals complain about their jobs and are stressed by their job duties, managers, or coworkers. The contemporary workplace is a major source of emotional and physical stress for many workers. Treating clinicians commonly encounter patients whose chief complaint is coping with a stressful workplace, whether due to the work activity itself or its interpersonal demands.

While work can cause emotional distress and problems for the employee, the reverse also holds true. Various forms of psychopathology are well known to cause impaired work functioning, performance, and attendance (Adler et al. 2006; Aikens et al. 2008; Bearden et al. 2011; Comtois et al. 2010; Hasin et al. 2007; Huang et al. 2012; Huxley et al. 2007; Reynolds 2002; Taylor et al. 2006; Tolman et al. 2009; Wald 2009). Occupational impairment can be caused by subsyndromal psychiatric symptoms, individual psychiatric disorders, or comorbid mental and physical disorders (Rai et al. 2010). An individual's psychopathology may become exacerbated, with no obvious precipitating factor, resulting in symptoms that impair workplace functioning. Many psychiatric disorders are episodic, and individuals may have long periods of remission, but may decompensate for no obvious reason.

However, individuals with pre-existing vulnerabilities to psychiatric disorders may be more sensitive to workplace stressors, and these may precipitate an exacerbation of pre-existing illness or a first episode of a new onset disorder. Regardless, when an employee's symptoms impair functioning or disrupt the

R. M. Wettstein (✉)
University of Pittsburg, 401 Shady Avenue Suite B103, Pittsburg, PA 15206, USA
e-mail: wettsteins@aol.com

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_12,

workplace, employers are generally entitled to seek a mental health evaluation, referred to as a fitness for duty (FFD) evaluation, to determine whether the employee should remain at work. Employees who refuse to cooperate with a request for a FFD examination can be terminated from their jobs, often without any recourse (*Brownfield v. City of Yakima*, 612 F.3d 1140 (9th C.C.A. 2010)).

Case Example

The Human Resources (HR) department of a local corporation requests a mental health FFD evaluation of Ms. Smith, a 26-year-old, married, clerical worker. Several months ago, Ms. Smith's company underwent a reduction-in-force. Many of her workplace friends' jobs were terminated. Ms. Smith was assigned a new supervisor as a result of the personnel changes. Ms. Smith has not gotten along well with her new supervisor, becoming increasingly uncooperative and at times overtly angry. Ms. Smith's work performance became erratic and declined from her previous good levels of performance.

In the weeks immediately prior to the FFD referral, Ms. Smith, was irritable, overtly unhappy, and argumentative with coworkers. Ms. Smith's grooming and makeup became more dramatic if not bizarre. Ms. Smith had not voiced any specific threats of violence, but her coworkers were becoming increasingly frightened by her unpredictable behavior. After an argument with her supervisor during which Ms. Smith yelled at him abusively, Ms. Smith stormed out of the office, slamming doors and throwing papers. When Ms. Smith returned to work the next day, her supervisor and an HR representative advised her that she was being placed on administrative leave pending a fitness for duty evaluation. The HR representative contacted a local mental health professional to conduct an independent FFD evaluation.

The Purpose of a Fitness for Duty Evaluation

FFD evaluations are in many ways similar to other forensic, non-treatment oriented evaluations. For example, in competency to stand trial evaluations, clinicians need only provide opinions on a narrow set of questions regarding an evaluee's capacities to participate meaningfully in legal proceedings. In testamentary competency evaluations, evaluators need only provide opinions regarding whether individuals have the requisite capacities to execute a legal will.

Similarly, mental health professionals conducting FFD evaluations are asked to provide opinions regarding whether individuals have the capacities to perform their jobs' necessary functions and responsibilities. FFD evaluators are required, both by ethical principles (see discussion below) and legal constraints (see Chap. 2), to limit their communications, and sometimes even the scope of the evaluations, to this specific subject. Thus, like other types of mental health evaluations conducted for

non-treatment purposes, FFD evaluations differ significantly from treatment oriented clinical interviews (Rappeport 1982). Therefore, prior to conducting a FFD evaluation, mental health clinicians should ask themselves whether they are qualified to conduct such evaluations, and if so, is it advisable for them to do so (Reynolds 2002).

Determining Whether to Conduct the Evaluation

Treating Clinicians or Independent Evaluators?

Many employers, mediating agencies, or other referral sources consider the treating mental health clinician to be the professional best qualified to provide opinions regarding fitness for duty because they assume that the treating clinician best knows the employee. An employer with concerns regarding an employee's ability to continue performing job functions safely and without disruption to the workplace often will ask employees to contact their primary care physician, psychotherapist, or treating psychiatrist and have them provide clinical information as well as render a professional opinion about the employee's ability to perform the essential functions of the job. At times, with the consent of the employee, employers may contact mental health treatment providers directly to obtain this information.

However, mental health clinicians who perform FFD evaluations for their own patients and opine about a patient's fitness to work enter a minefield of potential ethical dilemmas that complicate the evaluation and can interfere with the treatment (Strasburger et al. 1997). There is usually no problem or conflict for treating clinicians in providing clinical information about their patients to an employer, again always with a patient's informed consent. That information includes history of the disorder, symptoms, signs, diagnoses, current treatment, and treatment plan. In contrast, major problems can arise for the patient and for the treating clinician when the treating mental health clinician provides an opinion about fitness for work and other related employment issues such as restrictions, limitations, and accommodations.

First, the treating clinician may not have the requisite experience, time, resources, or relevant data to complete the evaluation. Unlike a clinical evaluation conducted for treatment purposes, a FFD evaluation requires that the mental health evaluator not simply take the employee's self-report at face value. Rather, the FFD evaluator should consider all sources of information, and identify or obtain additional data from others or from documents. Discrepant data may then need to be reconciled, a situation that may possibly involve challenging the patient's self-report. Such challenges to a patient's self-perception or goals, which may damage the treatment alliance, can be both clinically and ethically problematic.

In addition, patients often expect their mental health treatment providers to act as allies and advocates when work problems arise. The bond of a treatment alliance often creates a sense of loyalty to the patient, and treating clinicians in fact do

often ally with their patients in the belief that if a patient is experiencing work problems related to mental health, their role is to be the patient's advocate. This stance can interfere with rendering a fair, accurate, and objective opinion about the patient's functional abilities, resulting in an incomplete or inadequate evaluation, or again, a possible challenge to the patient's self-perception. Similarly, a mental health FFD evaluator should not have had a previous personal, social, or business relationship with the employee or the employer. Such relationships may also interfere with the evaluator's ability to conduct a thorough, proper, or independent evaluation (Simon and Wettstein 1997).

Mental health clinicians who conduct a FFD evaluation for their own patients also risk compromising the efficacy of treatment. The time needed to conduct the FFD examination will necessarily detract from the patient's face-to-face treatment time. The mental health evaluator must also spend considerable time reviewing documents, a service for which a patient's health insurance carrier likely will not provide compensation. Conducting the FFD evaluation has the potential for redirecting the focus of the sessions from general treatment issues, including employment problems, to employment problems alone. It can complicate, or even permanently damage, the therapist–patient relationship when the treating clinician and patient differ in their beliefs regarding whether the patient is able to continue performing job functions.

For these reasons, treating clinicians should be reluctant to perform a comprehensive FFD evaluation, especially when other accessible mental health clinicians can do so. This is all the more imperative a consideration if treating clinicians do not wish to be drawn into an adversarial conflict between their patients and their patients' employers. Differences of opinion between these parties often result in administrative conflict or litigation. In the event of litigation, mental health clinicians can expect to be challenged to defend their evaluation procedures and conclusions. Ethical and practical conflicts will be used to cast doubt on the mental health clinician's objectivity, experience, and reasoning.

Exceptions to the recommendation for treating clinicians to avoid performing FFD evaluations for their own patients arise in certain areas, such as some rural locations, or settings, such as public mental health clinics, where access to other mental health evaluators is limited or non-existent, as well as in some military settings. Where possible, treating mental health clinicians may serve their patients' interests best by providing clinical information for a FFD evaluation as circumstances allow and with the patient's consent, but suggesting that patients obtain a FFD evaluation from an independent, qualified mental health clinician.

Treating clinicians anticipating conflict when they refuse a patient's request to conduct a FFD evaluation may be anxious or uncomfortable. Patients may indeed become angry and may seek another treatment provider who may be more amenable to the request. Hopefully, the treatment alliance is strong enough to allow the treating clinician and patient to work through the circumstances, allowing a more appropriate referral that will preserve the treatment relationship, and may even provide a useful "second opinion" regarding diagnosis and treatment.

FFD Evaluations: Prioritizing the Evaluee's Needs

Employers sometimes seek a FFD evaluation for an employee who is in need of urgent or emergent mental health treatment rather than a psychiatric evaluation that is not going to result in the provision of treatment. An employee who has expressed suicidal ideation to a supervisor, or who has become cognitively impaired due to a mood disorder, or whose irritability or mood lability has become resulted in threatening behavior in the workplace, is typically not stable enough for a FFD evaluation. Usually, such employees have been put on administrative or medical leave before the FFD evaluator is contacted. By placing the employee on leave, the employer has already administratively determined that the employee is not fit for duty. When the employee may return to work is a secondary issue; the most immediate need for that employee is treatment. However, employers may be unsure how to direct the employee toward treatment, and may believe that a mental health FFD evaluation will result in getting the employee mental health assistance.

Mental health professionals considering conducting a FFD should speak directly to the referral source and attempt to determine the evaluee's degree of psychiatric acuity. An individual with severe disturbance in mood, suicide ideation, or with psychosis or delusional thinking, needs treatment before a reasonable FFD evaluation can be conducted. If the mental health clinician contacted is the treating clinician, treatment needs may be quickly assessed and addressed. The treating clinician can then consider whether he or she is the best person to conduct a subsequent FFD evaluation, as per the issues reviewed above.

However, if the mental health professional contacted to perform the FFD evaluation is an independent evaluator, prioritizing the evaluee's needs may not be quite so straightforward. Independent evaluators should spend enough time discussing the circumstances surrounding the employee and the referral with the referral source to determine the evaluee's degree of acuity, need for treatment, type of needed treatment, and best treatment setting. If FFD clinicians conduct an evaluation and find that the evaluee is acutely ill, suicidal, or potentially violent, then clinicians have a duty to address the issue (see Chap. 2). Although mental health clinicians conducting independent evaluations such as FFD examinations have limited duties to an evaluee, they do have some duties. These duties are likely to become the focus of concern when an evaluee is acutely dangerous to self or others or unable to provide for basic needs, such as obtaining necessary medical treatment.

In the case of Ms. Smith, the HR representative contacts Dr. B, an independent mental health evaluator, the day after Ms. Smith left the workplace, requesting a FFD evaluation. After reviewing Ms. Smith's circumstances and behavior, Dr. B concluded that Ms. Smith should be evaluated for treatment before she was evaluated for fitness for duty. The HR representative did not know whether Ms. Smith was currently in treatment, so the independent evaluator gave the HR representative the names of some local clinicians, but also suggested that Ms. Smith might be directed to a hospital emergency department, as it sounded as

if her need for treatment was at least urgent, if not emergent. Ms. Smith agreed to go to the hospital emergency room, and then admitted to a psychiatric unit for 2 weeks, diagnosed with Bipolar Disorder, treated with mood stabilizers, and began to improve. After an additional 2 weeks in a partial hospitalization program, Ms. Smith believed that she was ready to return to work. At that point, when the HR representative contacted Dr. B again, he agreed to conduct a FFD evaluation.

Establishing the Contractual Relationship with Referral Source

If after assessing intervention priorities, both parties conclude it is appropriate to move forward with the FFD evaluation, as in any contractual relationship, the mental health FFD evaluator and employer or retaining party should address a variety of issues before the evaluation can proceed. These should be addressed verbally, and then memorialized in writing. The parties should mutually understand and agree upon the nature of the evaluation, its anticipated duration and procedures, and approximate cost. Some practical issues cannot be determined at the outset, such as how many interviews the FFD examiner may require to complete the evaluation or whether specialized testing such as laboratory, psychological, neuropsychological, or other medical tests are indicated. Nevertheless, FFD examiners should consider discussing the possibility that these might be useful or needed at the outset. The FFD evaluator and the referring party also should clarify the type and extent of the required written report, if any.

Some FFD evaluators routinely request that the retaining party sign a prepared written contract before undertaking the evaluation. Others simply request that the retaining party submit correspondence indicating that the referral source is retaining the evaluator to conduct the FFD evaluation under the terms of the earlier verbal discussion, and will be responsible for the cost of the evaluation. Treating mental health clinicians who conduct FFD evaluations for their own patients might, due to the pre-existing relationship request, overlook these contractual issues and procedures and simply proceed to perform the evaluation, which omission could result in future misunderstandings and conflict. As will be discussed more extensively below, poorly defined boundaries regarding contractual arrangements are only one of the potential pitfalls for mental health clinicians when they provide FFD evaluations for their own patients.

Clarifying the Referral Question

An essential task of any consultant or evaluator is to determine the precise question at issue. If the evaluator is unclear about the referral question, the evaluation will lack direction and likely fail to meet the needs of the evaluee and

the referral source. The referral source may be an agency experienced in retaining mental health evaluators to conduct FFD evaluations, and the referring source may know exactly what they need and expect. There may be multiple referral issues including diagnosis, recommended treatment, prognosis, risk of harm to self, risk of harm to others, and ability to work under specific circumstances, among others.

Sometimes, however, referral sources may not have specifically formulated the referral question. In such cases, the evaluator can assist the agency in clarifying the relevant issues. The evaluator should be alert for unrealistic expectations on the part of the referral source, such as the expectation that mental health evaluators will directly advise evaluees of the results of their evaluations or that FFD evaluators will initiate treatment. These misapprehensions should be addressed and corrected as soon as possible.

In the case of Ms. Smith, the company contracts its FFD evaluations through an agency that retains evaluators directly. Ms. Smith agrees to the FFD evaluation, and the agency retains Dr. B, a forensically trained clinical psychiatrist, to conduct the evaluation. As noted above, Dr. B has agreed to the evaluation after Ms. Smith obtained urgent treatment and has improved to at least some degree. On behalf of the employer, the retaining agency asks Dr. B to provide opinions regarding diagnosis, treatment recommendations, job impairments related to psychiatric symptoms, and whether Ms. Smith can return to the workplace. They also ask Dr. B to provide opinions regarding prognosis, both with and without treatment, restrictions, limitations, and length of time Ms. Smith might have to remain out of the workplace.

Obtaining Records

Some records are essential for the FFD evaluator to review, while others are recommended or merely optional (Piechowski 2011). It is difficult to establish a universal rule about this matter, given the variety of evaluation types, referral questions, and employment settings. Practical considerations such as time limits to complete the evaluation and the availability of older medical or mental health records may constrain the evaluator from obtaining certain records.

Nevertheless, documents are essential in conducting the evaluation in part due to the inherent difficulties in formulating an objective opinion if information is based on data obtained through only one source, especially if that source is one of the involved parties. The evaluee's self-reported information, which inevitably reflects the evaluee's conscious and unconscious biases and distortions, is essential to the evaluation, but only as the initial step in the process. Any story has more than one side; evaluators err by soliciting just one perspective on the evaluee's work situation, performance, and history. Records from several sources can provide alternative perspectives that allow formulation of more objective and accurate opinions.

It is essential for mental health evaluators to have a written job description for the evaluee, and this should be provided by the employer. However, the written job description may not be complete if it just contains general boilerplate language or overlooks many of the evaluee's real-world job responsibilities (e.g. function in a team-oriented work environment). In addition, evaluators should not necessarily assume that they understand job duties, even if they seem obvious. For example, a facility maintenance worker's responsibilities for care of a physical plant may be clearly delineated and understood, but stresses or hazards, such as working at night, problematic coworkers, or having to drive under hazardous conditions, may not be recognized unless the evaluee describes them. Mental health clinicians should be certain to ask evaluees to describe their responsibilities as indicated on the written job description and other aspects of their jobs that may not be formally indicated on the employer's job description, including their work schedule.

Documentation by the employer of the current referral issues, including the employee's behavior and presentation that prompted the evaluation, is also essential information for the evaluator. The employee's personnel file frequently provides other essential data such as documentation of prior work events, disciplinary issues such as warnings or letters of reprimand, and performance reviews. Employee files may also contain grievances filed by the employee or grievances filed against the employee that may be relevant or informative.

It is helpful for the evaluator to have copies of the evaluee's current mental health records before the clinical interview. Treating clinicians have important information for the evaluation (i.e., symptoms, functioning, diagnoses, medications, treatment course), and employees may not be the best reporters of their own histories, as they may have a different perspective than that of their treating clinicians. Past mental health records may be invaluable when assessing the course of a chronic psychiatric disorder such as Bipolar Disorder or recurrent Major Depression, given that such information will be necessary to evaluate the evaluee's current treatment and return to work prognosis. Similarly, the evaluee's current medical records from a primary care physician or treating specialists can be useful or essential. As noted, many primary care physicians and their staff assume mental health treatment responsibilities for their patients, and this information may be essential in the FFD evaluation.

However, if such records exist, they may not be available to the employer. Employers may be unaware that the employee had been obtaining mental health treatment, as most employees, except under certain circumstances, usually are not required to reveal past or present mental health treatment. Even if employers are aware of mental health treatment, access to these confidential records is highly regulated. Typically, employers are not legally entitled to access these documents. In addition, employees and their union or legal representatives may object to the release of records.

Sometimes, the employer has only a brief note from the treating clinician indicating that the employee is fit or unfit for duty, without an explanation, and no clinical records. The employer can request that the employee contact current providers to authorize the release of current and recent records to the evaluator in

time for the evaluation. Even if employees agree to do so, which usually is not a required condition of employment, time pressures to conduct the evaluation may preclude their arrival prior to the interview. Alternatively, treating clinicians may be uncomfortable releasing records and may believe that it is in the patient's best interests not to release full records, but rather to provide a treatment summary or agree to speak with the evaluator to discuss clinical history and current treatment issues. In these circumstances, follow-up interviews with the employee may be necessary after review of the treatment records or contact with the treating clinician.

In any event, access to treatment records can be a thorny issue that ultimately plays out at an administrative or legal level. FFD evaluators are not in a position to resolve such conflicts. Time pressures and other practical considerations may require that the mental health FFD evaluation be conducted without these records. In these cases, evaluators should note that they are aware that these records exist and might be relevant to their opinions, but that they have not had the opportunity to review them.

On occasion, the referral issues may involve current or recent criminal charges. Police reports and court documents might be relevant and reasonable to obtain. Some of these records are in the public domain, and evaluators can request that employers provide these. Evaluees may possess additional records relating to the incident(s) that are not necessarily in the public domain. The evaluator can request that the evaluee provide these, but evaluees are not under obligation to do so, and should probably be advised to contact their attorney before providing a mental health FFD evaluator with documents if legal issues are pending.

Presence of Others: Photographing, Audio- or Videotaping

Evaluees sometimes request or demand that a third party be present during the psychiatric FFD interview for a variety of reasons. Some indicate that they need a witness to the evaluation; others feel that they need social or legal support to get through the evaluation. At times, evaluees are anxious or fearful and may not be able to verbalize why they feel the need to have someone accompany them in the clinical interview. Employer representatives may similarly expect or request to attend the interview. Attorneys, spouses, partners, or other family members sometimes appear without notice at the interview expecting to be accommodated in this regard. Many FFD evaluators routinely videotape evaluations conducted for non-treatment purposes. Some evaluators photograph the evaluee to provide verification of identity beyond inspecting a legal photo identification such as a driver's license. Similarly, the employee, without advance notice, may request to tape the interview.

These issues may be governed by applicable law, employer policy, or union contract. Evaluators should not expect to be able to sort these issues out themselves, particularly at the last minute just as they are preparing to conduct the

clinical FFD interview. Mental health professionals should, therefore, routinely bring up or discuss these issues with referral sources in advance of the interview. For example, if the employer or employee wants to audiotape the interview, and the evaluator agrees to this, then evaluators should arrange for a third party to set up and monitor equipment. Requests for others to be present during the interview should also be resolved prior to the interview. Despite the most careful planning, unexpected issues regarding the FFD evaluation may arise on the day of the interview, thus surprising the evaluator. If this occurs, FFD evaluators should contact the referral source to determine the appropriate course of action, which may ultimately include delaying the evaluation until the issue is resolved.

Conducting the Interview

Informed Consent

Before beginning the clinical interview, mental health FFD evaluators should obtain the evaluee's consent both to conduct the interview and to release information generated by the interview (see Chap. 2) (Gold et al. 2008). A discussion regarding the nature and purpose of the interview, including limitations on confidentiality, should precede the clinical interview. Many mental health FFD evaluators obtain written consent documenting the evaluee's consent to proceed with the evaluation and release information to the employer, but all evaluators should document that informed consent discussion with the evaluee has occurred (Granacher 2011). Discussions regarding informed consent should be revisited during the course of the interview if evaluators suspect that evaluees have misunderstood some aspect of the earlier discussion or if new information arises that should be specifically addressed from the perspective of limited confidentiality.

The mental health FFD clinician and the evaluee should also discuss the intended recipients and extent of information that will be released to the employer, and that the FFD clinician has no control over further disclosures by the employer. Again, evaluees should provide oral or written consent indicating they have understood the discussion. If consent is oral, FFD evaluators should document the discussion. Although an employer, agency, or their respective representatives have requested the evaluation and retained the mental health clinician to conduct the evaluation, evaluators cannot guarantee that only the retaining party will have access to the report (Gold et al. 2008). Other parties may subsequently request and may be entitled to a copy of the report, including the Social Security Administration (if a disability claim is filed), attorneys for the employee, union representatives, and state licensing boards or other governmental agencies.

Mental health FFD evaluators should advise both the retaining party and the evaluee at the outset of their respective interactions that reports will be provided to the retaining party, and that evaluees' requests for a copy of their report should be

directed to the retaining party or employer. Nevertheless, legal considerations such as compliance with HIPAA can supersede these arrangements when the employee subsequently seeks a copy of the report (Gold and Metzner 2006; see Chap. 2 for more information on evaluees' access to the evaluator's reports). Therefore, a thorough discussion of the elements of consent should include the mental health evaluator's lack of control over access to the information.

If the evaluee refuses to give consent in writing to the evaluation and information disclosure, then FFD evaluators should consider whether to proceed with the clinical interview and should immediately contact retaining parties to advise them of this development and seek guidance. Similarly, if after conducting the clinical evaluation, the evaluee contacts the FFD evaluator and withdraws consent, verbally or in writing, evaluators should not forward the reports or reveal information to the retaining party. FFD evaluators should advise the retaining party to discuss the issue with the evaluee, and should only release the report if consent is provided.

The Interview

The interview with the evaluee should occur in the appropriate setting, privacy, and comfort suitable for any clinical mental health interview. Evaluees are often anxious about FFD examinations. Evaluators should be sensitive to this and be careful to avoid intentionally causing additional distress. Long interviews are routine in FFD evaluations, and appropriate breaks should be offered to the evaluee. Under certain circumstances, more than one interview, rather than an especially long single interview, may be desirable. A second interview also provides an opportunity to obtain data at more than one time point, which is helpful in assessing mood and personality disorders or identifying changes in functioning over time.

Sometimes, evaluees are angry about undergoing the mental health FFD evaluation. An adversarial relationship, including potential litigation, may already exist between the evaluee and the employer, which the employee carries over to the FFD evaluation. Employees may not agree with the need for a mental health evaluation, and may oppose a mental health evaluation, perceiving it as stigmatizing, or may believe that they are being punished by the employer. Evaluees may believe that undergoing a mental health FFD evaluation is a step in the process of "being set up to be fired." Mental health clinicians should keep an open mind but should explore in-depth these emotional reactions to the FFD evaluation. In some cases, the mental health clinician conducting the FFD evaluation may in fact conclude that the referral was indeed abusive and punitive, as has been known to happen. The evaluee's perceptions may provide highly important data about the psychiatric diagnosis, treatability, prognosis, and occupational functioning.

The FFD mental health clinician should obtain relevant psychiatric and medical history as in any clinical assessment, but should also remain oriented to the

occupational issues at hand. Extraneous personal issues, for example, sexual functioning or orientation, are ordinarily not relevant and should not be addressed, explored, or reported. Beyond reviewing the psychiatric and medical data, the FFD evaluator should obtain a comprehensive history of the presenting problem, previous occupational problems, job satisfaction, work attitudes, and relevant job conflicts and stressors. Relevant interview areas include:

- History of the present problem
- History of previous occupational problems
- Job satisfaction
- Work attitudes
- Job conflicts and stressors
- Social–family support or stressors
- Employee's self-assessment about ability to work
- Employee's wish and motivation to work
- Relevant psychiatric history
- Relevant medical history

Non-work factors that should be explored in the evaluation include social–family support or contributing personal stressors, as these often are relevant in a mental health FFD evaluation because they may impact occupational function.

FFD evaluators should ask evaluees for their own assessment about their ability to work, and their wish and motivation to work. Mental health evaluators should solicit evaluees' beliefs and thinking regarding the current work situation, and barriers to returning to work if presently on leave of absence, or to returning to full duty if on limited or light duty. Evaluees should be encouraged to provide detailed explanations regarding whether they believe they are able or unable to return to full or partial functioning, what are the bases for their opinions, and whether they believe accommodations or subsequent psychiatric or other intervention might be helpful. Sample interview questions with regard to work issues include:

- What problems have you been having at work?
- How do others see the situation?
- How do you reconcile these different perspectives?
- Is your supervisor part of the problem, the solution, or neither? Why?
- Are you having marital or family problems which you cannot leave at home?
- Are your family and spouse supportive of your work stressors and problems?
- How have you been coping with these family stressors?
- Are you able to work at your job? Why, or why not?
- What specific mental or emotional problems interfere with your working?
- Under what conditions are you able to work at your job?
- Do you want to work at your job? Why, or why not?
- What are the barriers or obstacles to your continuing to work at your job?
- What can be done to address these problems?

Psychological and Other Testing in FFD Evaluations

A variety of psychological tests might be useful in conducting FFD evaluations (see Chap. 5). Some evaluators utilize brief, self-report symptom inventories in conjunction with the diagnostic interview. There are many such inventories used to quantify depressive, anxiety, or somatic symptoms. Evaluators should attach limited significance to the use of these instruments given that they are self-report in nature, transparent to the evaluee, and therefore subject to inaccurate self-report or self-perception. However, a zero or minimal score on such an inventory in the face of reports of current substantial symptoms suggests inaccurate reporting such as minimization and denial.

Psychological testing of the evaluee can be useful in selected cases for discrete purposes. Assessment of symptoms and disorders and their reliability, can be enhanced with the use of standardized instruments such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and Personality Assessment Interview (PAI). Response style and symptom validity assessment can be accomplished through the numerous validity scales on standardized instruments embedded in these two psychological testing instruments, or through formal symptom validity testing using neuropsychological measures. Cognitive testing can be assessed with a battery of neuropsychological tests.

As in any mental health assessment, clinicians should be appropriately trained and experienced with administering the psychological tests that they use. For most physician evaluators, referral to an experienced psychologist will be needed to address whether testing would be useful, as well as the test selection, administration, and interpretation. Testing can lengthen the evaluation process and thus burden the employer and evaluee, both of whom may be seeking a quick turnaround time for completion of the evaluation. Cost considerations can also play a role in test use and selection. Questions about the ecological validity, or clinical meaningfulness, of the test findings sometimes arise. Standardized tests may not ultimately clarify a psychiatric diagnosis or provide direct input into the determination of work impairment.

In some settings, blood and urine testing is useful to detect current or recent substance use or substance-related toxic effects, such as alcohol-induced hepatitis. Neurological tests such as head CT or MRI scans, with appropriate neurological consultation, may be needed in situations involving traumatic brain injuries.

Conducting Collateral Interviews

Obtaining information from others is typically an essential component of any independent mental health evaluation (Gold et al. 2008; Heilbrun et al. 2003; Wettstein 2010). Such information is especially important when conducting work-related evaluations if the employer has a different perspective concerning the

evaluee's work behavior than does the evaluee. Possible work collateral contacts include human resource staff, supervisors, coworkers, vendors, and customers of the business. The employer can suggest a format and location for these interviews to avoid inconveniencing the coworkers and minimizing work loss. Other potential collateral interviewees include the evaluee's spouse or other family members. Interviewing collaterals by telephone rather than in person is often more convenient and timely, and thereby allows the evaluation to be completed more quickly.

Whether endorsed by the employer or the evaluee, suggested collateral sources of information may have their own agendas or may have biased perceptions for personal or employment reasons. Family members may be invested in the evaluee maintaining employment and so may attempt to minimize the evaluee's psychiatric symptoms and impairment. Coworkers or supervisors who may have become fearful of the evaluee may be more comfortable with the evaluee's absence, and so may emphasize odd or problematic behaviors. Evaluators should, therefore, use discretion and clinical judgment when considering the accuracy, weight, and relevance of information gathered from collateral sources (Heilbrun et al. 2003).

Collateral interviews of coworkers, supervisors, or other workplace personnel should originate with and be authorized by the employer, and in some cases the evaluee should provide consent. At the outset of the collateral interviews, evaluators should inform interviewees of the nature, purpose, and non-confidentiality of the interview, and the likely distribution of the information, including the fact that both employer and evaluee will have access to the report. Evaluators should obtain their own oral or written consent from collateral sources of information and document their informed consent discussions with the collaterals. Neither employers nor FFD evaluators can require that the evaluee's spouse or family members participate in the evaluation. If family members decide to be interviewed, then, consent should be obtained from the family members, and documented.

Special Concerns About Violence Risk Assessment

Many FFD evaluations are prompted by concerns for the safety of the employee or the safety of others, including coworkers, customers, vendors of the business, visitors at the work site, or the general public (VandenBos and Bulatao 1996). Employers and their management staff vary in their perception of employee risk, their tolerance for it, and their views about the appropriate response to the employee's behavior. Once safety or violence issues are raised, employers typically take them seriously. An employee may have directly or indirectly threatened a coworker or supervisor, either verbally, or in writing, in an e-mail, or other document. Threats can be highly specific or quite vague, and involve property damage or bodily injury (Warren et al. 2011). Any suspicion of threatening behavior is likely to trigger a referral for a FFD evaluation specifically addressing safety and/or violence risk assessment (Stone 2000) (see Chap. 11).

Most workplaces have zero tolerance policies regarding workplace violence, although not all may be well enforced. Mental health FFD referrals precipitated by concerns of potential violence may be made even in the absence of overt threatening behavior. Coworkers may perceive an employee exhibiting odd or unusual behavior as menacing and intimidating, even if that individual has not been overtly threatening. Managers may have reported that the employee disregards their authority and prior disciplinary action, also raising concerns about safety in the absence of direct threats. Employers may therefore, request FFD evaluations both in the event of overt threats or violent behaviors or when coworkers have rightly or wrongly become concerned about an individual's risk of violence.

Most FFD evaluations prompted by concerns about violent behavior focus on threat assessment. Mental health clinicians conducting these FFD evaluations may need additional training and expertise in specialized mental and behavioral health threat assessment/violence risk evaluations (see Chap. 11). These FFD evaluations may involve conducting a site evaluation and obtaining information beyond that provided by the employer. For example, extra interviews with coworkers may be needed. In such situations, it may be more efficient for mental health FFD evaluators qualified to conduct these complex evaluations to interview coworkers at the workplace rather than in the clinician's office or by telephone. Those interviews should be authorized by the employer and again, appropriate consent from the employer and interviewed party should be obtained.

FFD mental health evaluators should consider both static (i.e. fixed) and dynamic (i.e. changing) factors associated with violent behavior, paying particular attention to the evaluee's history of violence or aggressive behavior, if any, whether at home, with peers, or with strangers. Details of past violent or abusive behavior including type and severity, use of weapons, and impulsivity should be ascertained. Current domestic violence is of special importance. Personality traits to be considered include psychopathy, distrust, vengefulness, and sadism. Although most aggressive behavior or violence is not associated with the presence of mental disorders, substance use and psychosis should be identified and considered. Similarly, the relationship of mood to aggressive or violent behavior should be examined, including suicide ideation, impulses, and attempts.

Violence risk assessment instruments typically used in criminal settings are unlikely to be helpful in occupational threat assessment evaluations because they have not been standardized in a non-criminal, employed population. One published instrument, the Employment Risk Assessment-20 (ERA-20), was specifically designed to assist in the evaluation of an individual's risk for workplace violence. The instrument consists of 20 items obtained from the psychiatric literature, but it has undetermined empirical support (Bloom et al. 2002). Historical and clinical interview data will be more informative in workplace violence risk assessment FFD evaluations than use of structured risk instruments, though structured instruments can be used to guide the interviews.

Mental health evaluators should also carefully consider how best to communicate their opinions regarding an evaluee's risk of violent behavior to the employer. Relevant circumstances and factors include the type, magnitude, and

imminence of potential violence, and the likely contextual predictors. Evaluators should carefully consider suggesting appropriate courses of action for the employer, since some risk factors are amenable to treatment but others are not. In addition, discipline and work termination do not end the violence risk potential for the employee or its consequences to the employer and others, as many examples of post-discipline mass violence have demonstrated (Kausch and Resnick 2003).

Malingering and Dissimulation

As a general matter, evaluees in FFD evaluations are seeking to maintain their employment and therefore are inclined to dissimulate, that is, minimize or deny problems, such as psychiatric symptoms, substance misuse, violent thoughts or preoccupations, non-adherence to psychotropic medication, or related functional impairment whether at work or otherwise (Brooks et al. 2010). Both unconscious and conscious minimization or defensiveness can occur in this regard (Gold and Shuman 2009). In contrast to other types of disability evaluations in which evaluees may benefit from exaggerating or feigning illness, evaluees in FFD evaluations are unlikely to falsely endorse mental health symptoms or work impairment since this will not further the goal of returning to or maintaining employment.

A variety of techniques are available for mental health FFD clinicians to assess evaluees' response styles and establish the validity of self-reported history. Multiple interviews may help detect inconsistency in the relevant history. Collateral interviews with third parties provide an opportunity to cross-check the evaluee's self-report. Clinical records may contain evaluees' accounts of symptoms provided earlier or contemporaneously to treatment providers, allowing independent mental health evaluators to review them for consistency of report. Legal or administrative records, including personnel department documents, may also contain useful information in this regard.

Psychological testing such as the use of MMPI-2 can provide information about the evaluee's response style and symptom validity. Self-report scales or brief symptom inventories are of limited use in this context, as noted above, due to the absence of symptom validity components and the transparency of the inventories. Nevertheless, pervasive denial of every psychiatric symptom is consistent with dissimulation. In the event that a self-report inventory suggests minimization, denial, or dissimulation of symptoms, mental health evaluators can then seek to explore other evidence to ascertain the evaluee's current psychiatric symptoms.

Fitness for Duty Decision Making

Mental health FFD clinicians should base their opinions regarding an evaluee's fitness for duty on a comprehensive review of the relevant records and clinical interviews. Premature conclusions may fail to adequately consider all of the data

and the discrepant perspectives in the situation and should be avoided. Before formulating opinions, mental health FFD evaluators should consider whether they have considered and addressed, given the circumstances of each specific case, all relevant issues and sources of data in any FFD evaluation, as indicated above and including additional questions, such as:

- Do you have training and experience in conducting FFD evaluations?
- Have you identified and considered potential conflicts of interest, such as those that might adversely affect a treatment relationship?
- If conflicts of interest are present, have you considered referring the case to another clinician?
- Have you discussed and obtained informed consent from the evaluee, especially in regard to confidentiality issues, and appropriately documented it?
- Have you considered whether you are able to provide an objective opinion in regard to avoiding advocacy for the evaluee, employer, or for your own beliefs regarding public policy issues?
- Have you obtained data from as many sources as are available, and avoided relying solely on the referral source's or evaluee's version of events?
- Have you obtained an adequate data base upon which to form expert opinions, including a thorough description of the evaluee's job?
- Have you allotted and spent enough time to do a comprehensive evaluation?
- Have you considered non-medical factors that might impair job functioning, including motivational factors and family stressors?
- Have you considered and addressed the potential lag time between symptom recovery and recovery in occupational functioning? Could the evaluee return to work even if some symptoms remained?
- Have you considered and assessed the possibility of dissimulation or malingering?
- Have you identified data that might conflict with your opinion, and attempted to explore and reconcile this data with your conclusions?
- Have you carefully considered what information to include in your report to avoid inappropriate disclosure of non-relevant personal or medical data?

Not each of these will be required in every evaluation, but mental health evaluators who fail to consider some of these issues when they are relevant may compromise the validity of their opinions. FFD evaluators should not attempt to resolve factual disputes regarding specific work events by discounting one party's version of an event over another; the employer has the responsibility to make this determination (Piechowski and Drukteinis 2011).

Referral sources often request an opinion regarding prognosis for the evaluee's chronic mental disorder and its impact upon work functioning (Gold and Shuman 2009). Such prognostic opinions likely require some prediction of the effects of the other stressors in the evaluee's life (i.e. serious illness in spouse or child, employment of the spouse, completion of evaluee's out of work time educational

program). Thus, reaching a prognostic opinion may require analysis of more information than just the evaluee's mental health history.

Mental health clinicians should have multiple data points to consider, all in reference to the reason for the FFD referral. The behavioral or mental problem that precipitated the FFD referral may have been prompted by an acute exacerbation of a chronic, episodic mental disorder or the new development of another mental disorder. Non-work stressors such as family illness, divorce, death, legal problems, or financial problems can readily trigger a new disorder or exacerbate a pre-existing one. Even when an evaluee's current exacerbation of a chronic mental disorder is related to a work stressor, mental health clinicians should assess the relapse risk for the disorder. Careful review of the evaluee's psychiatric history, response to treatment, and adherence to treatment are then essential, along with familiarity with the psychiatric research literature with regard to that disorder.

A high relapse risk for a given disorder, even if in remission at the time of the evaluation, may preclude a return to work until the evaluee's recovery has been sustained for some reasonable period of time. FFD evaluators should bear in mind that improvement in occupational functioning often lags behind treatment response for the specific mental disorder at issue. For example, although depressive symptoms may improve with treatment over several weeks, occupational functioning typically improves only after several months of treatment (Aikens et al. 2008). If evaluators fail to appreciate the time needed to recover work functioning, and recommend premature return to the workplace, based, for example, on improvement in vegetative depressive symptoms, then the evaluee is at risk for relapse and a failed return-to-work attempt. Similar considerations apply in the case of Bipolar Disorder in that even when euthymic, patients experience cognitive impairment that can interfere with occupational functioning for an extended time period (Bearden et al. 2011; Fagiolini et al. 2005; Huxley and Baldessarini 2007; Mann-Wrobel et al. 2011).

Mental health FFD evaluators should identify specific areas of functional impairment with regard to the evaluee's job duties, and not simply search for psychiatric symptoms; the presence of a psychiatric diagnosis does not equate to work impairment or disability. In contrast, specific deficits in cognitive function, especially including executive function, are often central to occupational functioning. Essential, specific, work-related capacities include tasks such as performing work tasks at the necessary pace; coming to work regularly and on time; following specific directions; communicating clearly with others; organizing work; collaborating with coworkers in a team; accepting feedback from supervisors; adhering to employer policy and procedure; multitasking; making appropriate decisions; coping with change; performing under stress; and taking responsibility for decisions and work product. These capacities should be assessed in as much detail as possible (Gold 2010).

In the case example of Ms. Smith, Dr. B found Ms. Smith to have good insight into her disorder, acknowledging that there was a strong family history of Bipolar Disorder, and although Ms. Smith was distressed, she was not surprised to hear she had this diagnosis. She reported that she was committed to taking her medication

and maintaining her functioning, as she had first-degree relatives who had not done so and "ruined their lives." Ms. Smith reported that her husband was supportive, and he had helped her obtain an outpatient psychiatrist and psychotherapist whom she was seeing regularly. Ms. Smith stated that the psychiatrist was still actively adjusting her medication. Dr. B contacted family members who confirmed that this was Ms. Smith's first episode of psychiatric disturbance, that she had a family history of Bipolar Disorder, and that she had for the past month been compliant with treatment. On mental status examination, Ms. Smith had pressured speech and some hyperactivity. Although she was not irritable, her mood was overly expansive and she acknowledged that she had not yet completely stabilized her sleep schedule. Nevertheless, Ms. Smith concluded that she was ready to return to work.

In his FFD report, Dr. B indicated that he agreed with the diagnosis of Bipolar Disorder and with the course of treatment. He reported that Ms. Smith's prognosis was good, in that she had good insight, family support, and was committed to and receiving appropriate outpatient treatment with initial response. However, Dr. B opined that an immediate return to work was premature. Ms. Smith's symptoms had not yet stabilized, and she appeared hypomanic on evaluation. In addition, she was still having sleep-related issues, which increased her risk for relapse, as the efficacy of Ms. Smith's medication regimen had not yet been maximized. Dr. B found Ms. Smith still had some impairments in cognitive and executive functioning. In addition, in her hypomanic state, Ms. Smith's self-confidence did not seem diminished although she exhibited limited insight into the problematic behaviors in the workplace that had precipitated her removal. Dr. B was concerned that any relapse of her affective disorder due to the stress of a premature return to the workplace might damage her self-esteem and confidence, making future attempts to return to the workplace more difficult.

Recommendations

The employer or retaining party may request that mental health FFD evaluators provide treatment recommendations and suggest a plan for the employee to address the problem that precipitated the FFD evaluation. In the case example of Ms. Smith, Dr. B recommended in his written report to the referring agency that Ms. Smith continue working with her psychiatrist to maximize the efficacy of her medication regimen, continue working with her psychotherapist, continue to participate in the outpatient program for at least two more weeks, and that Dr. B see her for re-evaluation in one month.

On re-evaluation, Dr. B finds that Ms. Smith's mental status is unremarkable, with the exception of some mildly pressured speech. Her only reported symptom is that she sometimes has difficulty falling asleep. Her cognitive and executive functioning has improved, and according to her family, she is back to her baseline. Ms. Smith and her family report that she completed another 2 weeks of outpatient hospitalization treatment, and remains adherent to outpatient management and

medication. Ms. Smith demonstrates improved insight into the problematic workplace behavior, and she no longer blames her supervisor for Ms. Smith's outbursts and inappropriate behavior. Dr. B provides an addendum to his original report, documenting his sources of information, his findings, and his opinion that Ms. Smith is ready to return to the workplace.

Suggestions for treatment and recommendations for interventions should not be communicated directly to the evaluee, as this may create the appearance and expectation of a treatment relationship, particularly if, as in the case of Ms. B, another evaluation may be required. Mental health clinicians providing independent FFD evaluations should not slip into the role of treatment providers, even if evaluees request they do so or if FFD evaluators believe the evaluees are not receiving adequate or appropriate treatment.

Similarly, independent FFD evaluators should not discuss their opinions regarding the evaluee's fitness for duty directly with the evaluee nor should they attempt to negotiate or challenge evaluees' self-assessments of their ability to return to work or need for mental health treatment. Such discussions are best left to treatment providers. If the evaluee has no treatment provider, then the FFD clinician can provide referrals in the written report to the referring agency, and urge them to share that information with the evaluee.

FFD evaluators may be asked to offer opinions regarding whether the evaluee is getting appropriate or adequate treatment, particularly in regard to the goal of returning to the workplace. Often, treatment providers identify their role as helping relieve psychiatric symptoms and disorders, and do not actively address issues such as attitudes, barriers, or obstacles related to the patient's return to work (see Chap. 4). They may be unaware of the need to incorporate the goal of returning an individual to the workplace as another treatment goal priority that may be appropriate even before the patient is symptom free. For example, the American College of Occupational and Environmental Medicine encourages employees' personal physicians or therapists to "facilitate the patient's return to function and encourage some type of work activity," given the treatment providers' responsibility to "optimize functional capability" (ACOEM 2008).

The mental health FFD evaluator's report can assist evaluees and their treatment providers by suggesting or recommending modifications in treatment that help both focus on return to work as a goal of treatment. The evaluator also may be able to assist the employer in developing a return-to-work plan for the evaluee, beyond specific treatment considerations, if requested to do so (see Chap.4). In the case of Ms. Smith, Dr. B suggested a gradual return to work, with slowly increasing hours and frequent breaks. He also suggested that Ms. Smith's employers accommodate her need to continue her mental health care by being flexible with work hours if she needs to attend scheduled appointments.

The employee's use of psychotropic medication may present a problem if side effects of pharmacotherapy impair job function. Certain types of pharmacotherapy (e.g. benzodiazepines, sedative-hypnotics, antidepressants, mood stabilizers) can have sedating or other adverse effects and may preclude or restrict driving, operation of heavy machinery, and carrying a firearm or other weapon. In some

contexts, employers may have a policy stating that an employee's use of such medication is a mandatory exclusion for certain jobs.

At times, mental health FFD clinicians cannot completely assess the adequacy of current treatment due to the absence of treatment records, for example, when only a brief written note, or the attending physician's claim form, is available, or the treatment providers fail to communicate despite the patient's consent. In these circumstances, FFD evaluators should state the limitations of their assessment, but can suggest what they would consider appropriate treatment, and again, encourage that this be shared with evaluees or their treatment providers. As in any case in which mental health professionals are providing opinions or consultations, FFD evaluators should avoid disparaging comments about treatment providers or other evaluators.

In contrast to most types of disability evaluations in which evaluees often accurately or inaccurately believe they cannot work, the evaluees in FFD evaluations typically wish to return to work, and may not recognize the need to address mental health issues before doing so. FFD evaluators can include recommendations that treatment providers engage their patients in discussions regarding returning to work while or after addressing any mental health issues, or that patients obtain mental health treatment providers to address these issues before returning to work. However, FFD evaluators should not directly engage or confront evaluees about differences in opinions regarding the ability to or desirability of returning to work or obtaining mental health treatment.

Job Restrictions and Limitations

The mental health FFD clinician may conclude that the evaluee is fit for duty but only with certain restrictions or limitations. Job restrictions are defined as tasks that the employee should not perform so as to avoid future risk or harm; job limitations are defined as job duties that the employee is unable to perform (Talmage et al. 2011). Relevant considerations for opinions regarding job restrictions or limitations include work hours, work schedule, office or work location, overstimulation at work, work pace, compatibility with certain coworkers, or specific work duties. The duration of these conditions, as temporary or permanent, may be initially estimated but often need to be re-evaluated in the future.

Mental health clinicians should be careful not to "medicalize" non-medical conditions such as work dissatisfaction or family discord (ACOEM 2008) by recommending job modifications or restrictions/limitations such as avoiding working certain shifts because of family conflict or avoiding a specific supervisor due to interpersonal conflict. Evaluators should also bear in mind that an employer may not be able to adopt the evaluator's recommendations, and may or may not be legally required to do so. Nevertheless, if mental health evaluators believe it certain that the evaluee should not or cannot perform certain job duties directly due

to a psychiatric disorder, FFD evaluators should include discussion of these restrictions and limitations, how long they might persist, and whether job accommodations could assist in limiting their consequences.

In the case of Ms. Smith, Dr. B stated that Ms. Smith was restricted from working evening hours or rotating shifts, as these would interfere with her sleep cycle and could cause an exacerbation of Bipolar Disorder. Dr. B stated that these restrictions would likely be permanent. However, he also recommended that Ms. Smith be limited initially to working no longer then 2–3 hours without a 15 minute break while she was gradually increasing her work schedule to 40 hours a week. He stated that he believed this limitation would be temporary, and Ms. Smith's ability to work a regular work day without additional breaks would likely return after a few weeks back on her previous schedule.

Preparing the Report

Ideally, the mental health FFD evaluator and employer or retaining party should discuss the nature and depth of the anticipated report as part of the initial retention agreement. That information will help mental health clinicians more efficiently focus the evaluation on those aspects of the evaluee's functioning, life, or history that are most important or relevant to the FFD evaluation (Piechowski 2011). The initial task in this regard is for the mental health professional to ascertain what form and length of report, if any, the referral source is requesting. Some referral sources provide a specific evaluation form, suggest a report format, or require that reports be dictated. Mental health FFD evaluators should understand from the outset the referral's report requirements. Cost considerations frequently play a role in the decision making regarding the extent and length of the report.

Some referral sources request a brief report that indicates the data sources for the evaluation and the mental health FFD evaluator's conclusions and recommendations. Others request a lengthy, detailed report. In these cases, referral sources often have prepared a written list of questions for the mental health clinician. These reports should include both the questions and the opinions responsive to them in the opinion section. A longer and more detailed report might be submitted to an occupational medicine referral source, while a shorter report would be sent to the employer's human relations department (Piechowski and Drukteinis 2011). Even if not requested, mental health evaluators should be aware and should advise referral sources that a detailed report may be needed when the case is already in litigation or is likely to be, or involves complex issues such as violence risk assessment. There is a substantial literature on the preparation of FFD and other reports that can provide guidance in report preparation (Buchanan and Norko 2011; Wettstein 2010).

Reports should be limited to relevant employment issues and should not contain unrelated psychiatric or medical information or opinions (Piechowski and Drukteinis 2011). Although sources of liability in employment mental health

evaluations are limited, one potentially problematic area is disclosure of damaging and irrelevant mental health information to an employer (see Chap. 2). As discussed above, the consent process includes advising evaluees that confidentiality is limited; however, mental health professionals still have an obligation to maintain some confidentiality, particularly in regard to information that has no bearing on the employment issue at hand. For example, past personal events such as history of sexual victimization, therapeutic abortions, or the evaluee's sexual orientation would likely be irrelevant to fitness for duty issues and should not be shared in the evaluator's report.

FFD reports should be relatively free of technical jargon or bias, convey the essence of the mental health clinician's conclusions, and thoroughly substantiate or explain them. The non-treating, independent, evaluator should refer to the subject of the evaluation in the report as the "employee," "examinee," "evaluee," but not the "patient," a practice that reinforces to all parties the non-treatment orientation of the FFD evaluation (Granacher 2011). Data contrary to the evaluator's opinions should be acknowledged, discussed, and properly reconciled but not disregarded. A common error in FFD and other types of independent mental health examination reports is to provide a report that states the mental health professional's opinions but fails to support them (Wettstein 2010).

Ethics Issues

Many ethics issues arise in the conduct of fitness for duty evaluations, and only the most pertinent can be reviewed in this discussion. Professional ethics codes from the American Academy of Psychiatry and the Law (2005), American College of Occupational and Environmental Medicine (2004), as well as the Specialty Guidelines for Forensic Psychology published by the American Psychology-Law Society (2012), are each relevant to the practice of forensic psychiatry, occupational medicine, and forensic psychology, respectively. These guidelines are typically aspirational rather than prohibitive in their presentation, but they are useful to mental health fitness for duty evaluators from each of these professional disciplines.

The first imperative ethical issue in mental health FFD evaluations is that of informed consent, discussed above. Informed consent to the evaluation, and to subsequent information disclosure, is an important consideration for the interview with the employee and any interviews with collaterals. There should be a clear understanding of the purpose and nature of the evaluation and the limitations of the confidentiality, to the extent possible. Despite such discussions, it is not unusual for non-relevant personal information about the evaluee, or even collateral sources of information, to surface unexpectedly. Mental health clinicians should use sound judgment when deciding to disclose confidential information generally, but should not reveal information that is personal and irrelevant to the fitness for duty issues.

Also, as discussed above, the evaluee's treating clinician who performs a FFD evaluation is confronted with numerous clinical ethical dilemmas. Striving for objectivity presents a significant challenge for both treating clinicians and independent evaluators who perform a FFD evaluation. Appropriate professional boundaries even for the independent mental health evaluator must be honored (Simon and Wettstein 1997). However, attempting to maintain an objective stance is a much more complex task when treating clinicians evaluate their own patients, whose employment may depend on the outcome of the evaluation.

From an ethics perspective, FFD evaluators are responsible for obtaining the relevant data to conduct the evaluation. They cannot simply rely upon the evaluee's self-report of work performance or mental health issues. Inexperienced FFD evaluators or treating clinicians who have a treatment alliance with their own patient-evaluees may fail to appreciate the need for collateral information and contacts. FFD evaluators who reach conclusions without at least attempting to obtain the relevant data are not meeting their ethical or professional responsibilities. The consequences of conducting FFD evaluations in this manner can range from providing incorrect diagnoses and treatment recommendations to loss of jobs and even the potential for violence in the workplace.

However, it is difficult for treating clinicians to preserve treatment alliances, and especially confidentiality, with their own patient-evaluees. Providing unfavorable opinions that cost a patient his or her job may irreparably harm a treatment alliance. As a general rule, "wearing two hats" in mental health FFD evaluations compromises both the provision of effective treatment and the ethical obligation to strive for objectivity owed to the retaining party (Strasburger et al. 1997), and should therefore be avoided to the extent possible .

Ethically, mental health FFD evaluators should have the requisite skills, training, experience, and knowledge to conduct FFD evaluations. Mental health FFD clinicians should not work outside the extent of their abilities, or opine about matters for which they lack expertise (Reynolds 2002). Some mental health FFD evaluations are quite complex, and involve other medical issues such as orthopedics or internal medicine. Mental health evaluators should not be tempted to address tissues outside of the realm of mental health, psychiatry, or neuropsychiatry when they arise in mental health FFD evaluations, but should suggest that the referral source obtain independent evaluations of these. Mental health evaluators should similarly not address purely administrative, organizational, or disciplinary issues that are exclusively within the realm of the employer's authority (Piechowski and Drukteinis 2011).

Mental health FFD evaluators' ethical obligations include being subjectively honest in rendering opinions that the evaluator in fact holds. Mental health clinicians who allow their opinions to be swayed under pressure from referral sources or modify opinions in the hopes of securing future referrals are clearly not meeting these ethical obligations. Similarly, FFD evaluators who offer opinions that an evaluee can and should return to work when the evaluator believes otherwise, perhaps in response to emotional pressure from an evaluee, are not meeting their ethical obligations. Unfortunately, there is evidence that mental health evaluators

do feel pressured by external forces to provide opinions with which they are not comfortable (Christopher et al. 2010, 2011). Evaluators should strive to neutralize the pressures, both internal and external, that may bias their opinions.

When conducting an independent or second opinion FFD evaluation, mental health clinicians should evaluate all of the available data and seek additional data, if such has been identified, which are needed to complete the evaluation. Mental health FFD evaluations should not unduly focus or directly attempt to rebut the opinions of treating clinicians or other independent evaluators. If asked to respond to another clinician's opinion, language and tone should be professional and non-judgmental.

Ethical practice directs mental health clinicians conducting independent evaluations such as FFD evaluations to strive for objectivity, while recognizing that everyone holds biases. Mental health FFD evaluators should not allow their own biases to unduly influence the evaluation or their opinions (Gutheil and Simon 2004). FFD evaluators who are tempted to interject their own values by verbally "disciplining" or "punishing" an evaluee or employer with whom they disagree should carefully review their own biases. Maintaining a non-judgmental stance may be challenging to mental health clinicians who hold beliefs regarding employment institutions or regulations, unions, or individuals who attempt to manipulate financial safety systems (Mischoulon 1999). Regardless, evaluators are ethically obligated to appropriately manage their own countertransference reactions and provide data and evidence-based mental health evaluations and opinions.

Case Example: Outcome

Ms. Smith returned to work following her second evaluation on a graduated return-to-work plan. Her employer accommodated her transition to full-time employment and suggested that it might be helpful for Ms. Smith to meet with her supervisor, at least initially, in the presence of another mutually agreeable supervisor. The employer did this to accommodate Ms. Smith's supervisor's anxieties about Ms. Smith's ability to maintain appropriate behavior when discussing assignments or receiving feedback regarding her work. The employer also arranged for Ms. Smith to use her Family and Medical Leave Act leave to attend regularly scheduled psychotherapy sessions. With the support of her employer and her family, Ms. Smith was able to successfully return to the workplace without relapse of her Bipolar Disorder.

Conclusion

The purpose of mental health fitness for duty evaluations is to determine whether the employee has a mental health or behavioral problem which significantly interferes with his or her ability to perform essential job functions while ensuring

the safety of the workplace (Borum et al. 2003). Mental health fitness for duty evaluations are among the most complex and challenging non-treatment oriented evaluations. Before undertaking such evaluations, clinicians should consider relevant ethical and practical considerations. Treating clinicians in particular have additional hurdles in conducting these evaluations of their patients due to the potential for jeopardizing the ongoing treatment and inability to complete a thorough evaluation if relevant data are limited. Evaluators should also be certain that they have the expertise to provide reasoned, accurate, and objective opinions, and be prepared to defend these opinions if challenged by referral sources or evaluees.

Key Points

1. Treating clinicians should consider whether performing a FFD evaluation for their own patients is advisable; referral to an independent evaluator is often necessary in these circumstances.
2. When referred a FFD evaluation, mental health evaluators should attempt to determine if the evaluee needs clinical treatment before undergoing a FFD evaluation.
3. FFD evaluators should focus assessment on specific functional deficits regarding the evaluee's job responsibilities and duties, and bear in mind that psychiatric symptoms and disorders do not necessarily result in work impairment or a finding of work disability per se.
4. Evaluators should prepare written reports only when requested, and disclose data to the employer to the extent necessary to address the relevant fitness for duty issues. Personal or sensitive data should not be disclosed to the employer if irrelevant to the present evaluation.
5. Evaluators should be familiar with relevant professional ethics principles and legal issues pertinent to conducting mental health FFD evaluations.

References

Adler, D.A., McLaughlin, T.J., Rogers, W.H., Chang, H., Lapitsky, L., Lerner, D.: Job performance deficits due to depression. Am. J. Psychiatry **163**, 1569–1576 (2006)

Aikens, J.E., Kroenke, K., Nease, D.E., Klinkman, M.S., Sen, A.: Trajectories of improvement for six depression-related outcomes. Gen. Hosp. Psychiatry **30**, 26–31 (2008)

American Academy of Psychiatry and the Law: Ethics guidelines for the practice of forensic psychiatry. American Academy of Psychiatry and the Law, Bloomfield, CT (2005)

American College of Occupational and Environmental Medicine Code of Ethics: Elk Grove Village. American College of Occupational and Environmental Medicine, IL (2004)

American College of Occupational and Environmental Medicine Code of Ethics: The personal physician's role in helping patients with medical conditions stay at work or return to work. Elk Grove Village. American College of Occupational and Environmental Medicine, Dec 11, IL (2008)

American Psychology-Law Society/American Psychological Association: Specialty guidelines for forensic psychology. http://www.apa.org/practice/guidelines/forensic-psychology.aspx. Accessed 5 Aug 2012

Bearden, C.E., Shih, V.H., Green, M.F., et al.: The impact of neurocognitive impairment in occupational recovery of clinically stable patients with Bipolar Disorder: A prospective study. Bipolar Disord. **13**, 323–333 (2011)

Bloom, H., Eisen, R., Webster, C.D.: Employment Risk Assessment-20. Workplace Calm, Toronto (2002)

Borum, R., Super, J., Rand, M.: Forensic assessment for high-risk occupations. In: Goldstein, A.M. (ed.) Handbook of Psychology, vol. 11, pp. 133–147. Wiley, NJ (2003)

Brooks, A., Hagen, S.E., Sathyanarayanan, S., et al.: Presenteeism: Critical issues. J. Occup. Environ. Med. **52**, 1055–1067 (2010)

Buchanan, A., Norko, M.A. (eds.): The Psychiatric Report: Principles and Practice of Forensic Writing. Cambridge University Press, New York (2011)

Christopher, P.P., Arikan, A., Pinals, D.A., et al.: Evaluating psychiatric disability: Differences by forensic expertise. J. Am. Acad. Psychiatry Law **39**, 183–188 (2011)

Christopher, P.P., Boland, R.J., Recupero, P.R., et al.: Psychiatric residents' experience conducting disability evaluations. Acad. Psychiatry **34**, 211–215 (2010)

Comtois, K.A., Kerbrat, A.H., Atkins, D.C., et al.: Recovery from disability for individuals with Borderline Personality Disorder: A feasibility trial of DBT-ACES. Psychiatric Serv. **61**, 1106–1111 (2010)

Fagiolini, A., Kupfer, D.J., Masalehdan, A., et al.: Functional impairment in the remission phase of Bipolar Disorder. Bipolar Disord. **7**, 281–285 (2005)

Gold, L.H.: The workplace. In: Simon, R.I., Gold, L.H. (eds.) Textbook of Forensic Psychiatry, 2nd edn., pp. 303–336. American Psychiatric Publishing, Washington (2010)

Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**, S3–S50 (2008)

Gold, L.H., Metzner, J.L.: Psychiatric employment evaluations and the Health Insurance Portability and Accountability Act. Am. J. Psychiatry **163**, 1878–1882 (2006)

Gold, L.H., Shuman, D.W.: Evaluating Mental Health Disability in the Workplace: Process, Model, and Analysis. Springer, New York (2009)

Granacher, R.P.: Employment: Disability and fitness. In: Buchanan, A., Norko, M.A. (eds.) The Psychiatric Report, pp. 172–186. Cambridge University Press, New York (2011)

Gutheil, T., Simon, R.I.: Avoiding bias in expert testimony. Psychiatric Ann. **34**, 260–270 (2004)

Hasin, D.S., Stinson, F.S., Ogburn, E., et al.: Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States. Arch. Gen. Psychiatry **64**, 830–842 (2007)

Heilbrun, K., Warren, J., Picarello, K.: Third party information in forensic assessment. In: Goldstein, A.M. (ed.) Handbook of Psychology, vol. 11, pp. 69–86. Wiley, NJ (2003)

Huang, H., Russo, J., Von Korff, M., et al.: The effect of changes in depressive symptoms on disability status in patients with diabetes. Psychosomatics **53**, 21–29 (2012)

Huxley, N., Baldessarini, R.J.: Disability and its treatment in Bipolar Disorder patients. Bipolar Disord. **9**, 183–196 (2007)

Kausch, O., Resnick, P.J.: Risk assessment for violence: A clinical approach. Directions Psychiatry **23**, 55–63 (2003)

Mann-Wrobel, M.C., Carreno, J.T., Dickinson, D.: Meta-analysis of neuropsychological functioning in euthymic Bipolar Disorder: An update and investigation of moderator variables. Bipolar Disord. **13**, 334–342 (2011)

Mischoulon, D.: An approach to the patient seeking psychiatric disability benefits. Acad. Psychiatry **23**, 128–136 (1999)

Piechowski, L.D.: Evaluation of Workplace Disability. New York, Oxford (2011)
Piechowski, L.D., Drukteinis, A.M.: Fitness for duty. In: Drogin, E.Y., et al. (eds.) Handbook of Forensic Assessment, pp. 571–591. Wiley, NJ (2011)
Rai, D., Skapinakis, P., Wiles, N., et al.: Common mental disorders, subthreshold symptoms and disability: Longitudinal study. Br. J. Psychiatry **197**, 411–413 (2010)
Rappeport, J.: Differences between forensic and general psychiatry. Am. J. Psychiatry **139**, 331–334 (1982)
Reynolds, N.T.: A model comprehensive psychiatric fitness-for-duty evaluation. Occup. Med.: State Art Rev. **17**, 105–118 (2002)
Simon, R.I., Wettstein, R.M.: Toward the development of guidelines for the conduct of forensic psychiatric examinations. J. Am. Acad. Psychiatry Law **25**, 17–30 (1997)
Stone, A.V.: Fitness for duty: Principles, methods, and legal issues. CRC Press, Boca Raton (2000)
Strasburger, L., Gutheil, T.G., Brodsky, A.: On wearing two hats: Role conflict in serving as both psychotherapist and expert witness. Am. J. Psychiatry **154**, 448–456 (1997)
Talmage, J.B., Melhorn, J.M., Hyman, M.H.: AMA Guides to the Evaluation of Work Ability and Return to Work (2nd ed). American Medical Association, Chicago (2011)
Taylor, S., Wald, J., Asmundsom, G.: Factors associated with occupational impairment in people seeking treatment for Posttraumatic Stress Disorder. Can. J. Community Mental Health **25**, 289–301 (2006)
Tolman, R.M., Himle, J., Bybee, D., et al.: Impact of Social Anxiety Disorder on employment among women receiving welfare benefits. Psychiatric Serv. **60**, 61–66 (2009)
VandenBos, G.R., Bulatao, E.Q. (eds.): Violence on the Job: Identifying Risks and Developing Solutions. American Psychological Association, Washington (1996)
Waghorn, G., Chant, G., Jaeger, J.: Employment functioning and disability among community residents with Bipolar Affective Disorder: Results from an Australian community survey. Bipolar Disord. **9**, 166–182 (2007)
Wald, J.: Work limitations in employed persons seeking treatment for chronic Posttraumatic Stress Disorder. J. Trauma. Stress **22**, 312–315 (2009)
Warren, L.J., Mullen, P.E., Ogloff, J.: A clinical study of those who utter threats to kill. Behav. Sci. Law **29**, 141–154 (2011)
Wettstein, R.M.: The forensic psychiatric examination and report. In: Simon, R.I., Gold, L.H. (eds.) Textbook of Forensic Psychiatry, (2nd edn.), pp. 175–203. American Psychiatric Publishing, Washington (2010)

Chapter 13
Fitness-for-Duty Evaluations of Physicians and Health Care Professionals: Treating Providers and Protecting the Public

Marilyn Price and Donald J. Meyer

Introduction

Health care providers practicing their profession with reasonable skill and safety is essential for the safety and well-being of the public. While this chapter focuses on the assessment of physicians, fitness for duty (FFD) evaluations of other health care providers such as nurses, pharmacists, psychologists, dentists, and social workers raises similar challenges. In today's regulatory environment that emphasizes testing and enforcement, all health care professionals' credentials and competence are scrutinized by a panoply of federal, state, and health care agencies. (AMA 2004; Gold et al. 2008; Meyer and Price 2012). Even those mental health professionals who may not anticipate performing FFD evaluations of physicians may find themselves in the position of having to treat or monitor an impaired medical health provider or participate on a peer review committee with oversight responsibilities. Thus, all mental health professionals would benefit from having a working knowledge of what issues arise, and those who conduct FFD evaluations for other health care professionals will find that the issues and concerns are similar.

Physicians may have their fitness for duty questioned by a variety of agencies tasked with oversight of physician behavior and competence. Physicians may be referred to a forensic psychiatric fitness-for-duty examiner by a hospital or state physician health committee, a hospital peer review committee, a medical licensing board, or an array of health care agencies of which the health care provider is a member (Anfang et al. 2005; Gold et al. 2008; Meyer and Price 2006). In addition

M. Price (✉) · D. J. Meyer
Beth Israel Deaconess Medical Center, Harvard Medical School,
11E, 1105 Massachusetts Ave. Suite, Cambridge, Boston MA 02138, USA
e-mail: mprice3@partners.org

D. J. Meyer
e-mail: donald_meyer@hms.harvard.edu

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_13,

to an agency referring a respondent physician to an examiner, a physician under investigation or a physician's attorney representing a defendant physician may directly initiate an assessment (Gold et al. 2008; Meyer and Price 2006).

Physician assessment may be triggered by credible reports and complaints of behavior that raised suspicion of impairment due to illness (Anfang et al. 2005; Federation of State Medical Boards 2011). The underlying neuropsychiatric illness may include any of a diverse spectrum of diagnoses: a primary biologically based psychiatric disorder, a personality disorder, maladaptive personality traits, a substance use disorder, a medical illness with neuropsychiatric symptoms, and neuropsychiatric side effects of the treatment of a medical illness or a primary neurological illness that impairs cognition and/or personality. In addition to reports of conduct suggesting illness triggering a referral for an FFD assessment, professional misconduct itself may also lead to this psychiatric assessment. An allegedly behaviorally impaired physician may be ordered to undergo evaluation even in the absence of any evidence of direct patient harm. In the absence of patient harm, the physician can be diverted away from the disciplinary investigation of the state board and to confidential treatment under the auspices of a physician health program (PHP), and thus avoid any disciplinary action (Federation of State Medical Boards 2011; Meyer and Price 2006).

Agency investigation of reports alleging a pattern of disruptive physician conduct, unduly sexualized behavior with patients or colleagues and unethical conduct may all result in referral for a mental health FFD evaluation. Finally, reports of a physician's misconduct occurring wholly outside of the workplace can also result in agency investigation of a physician's professional capacity. A physician's arrest for driving under the influence, for violent or threatening conduct, for possession of a non-criminal amount of marijuana, and any conviction for other than minor traffic violations may lead to an agency required mental health FFD evaluation (Anfang et al. 2005; Janofsky 2011; Meyer and Price 2006, 2012).

Mental health FFD evaluations can and should assess an examinee for a broad range of neuropsychiatric disorders. However, a physician's failure to practice safely may wholly be due to non-psychiatric factors such as deficits in skill, training, and medical knowledge (Anfang et al. 2005; Meyer and Price 2006). A psychiatric FFD evaluation cannot assess the physician's medical or surgical knowledge and skill (Anfang et al. 2005). The limitation of the purview of the FFD evaluation should be clearly stated in the report. A State Medical Society's Physician Competency Committee can make the necessary referrals for a medical skills assessment and determine the necessity of further educational remediation and professional supervision (Gold et al. 2008).

The mental health professional performing an FFD evaluation of a physician will be required to conduct a comprehensive assessment, which takes into account the impact of any disabling conditions, the prognosis with treatment, the side effects of treatment, and then opine about the present and future impacts on the practice of medicine. The evaluator will be asked for recommendations about whether treatment or professional workplace supervision may be needed to decrease the risk of future deterioration of professional capacities (Meyer and Price 2006).

Case Examples

The following vignettes were created for illustrative purposes and are fictional. The vignettes highlight the typical procedural process that precedes a referral for an FFD evaluation. Evaluations are triggered by a report of allegedly problematic behavior. It is the role of the evaluator to corroborate the reported misconduct and determine whether the behavior is related to a mental illness or a substance use disorder or due to personality traits or personality disorder as will be discussed in the chapter. The vignettes also describe dilemmas faced by mental health professionals who may be drawn into the process as either a treater or a prospective evaluator.

Vignette 1

Dr. Brown is a 43-year-old hospitalist whose behavior changed following the death of his wife from breast cancer. Hospital staff had become concerned because Dr. Brown, who had always been very responsive to staff and patients, was now not responding in a timely manner to pages and had become increasingly irritable and condescending when approached for clarification of orders or when asked to see a patient on an emergency basis. Several times he could not be reached at all and another physician stepped in to cover.

Because Dr. Brown was held in such high esteem and because of his recent loss, staff members were hesitant to report his conduct or to approach him. As a result, this behavior was allowed to continue over several months. Finally, Dr. Brown was asked to see a patient who was deteriorating. He arrived on the ward in an intoxicated state. The charge nurse intervened and directed him to leave the floor. She reported the conduct to her head nurse and, after further consultation with the Director of Nursing, the charge nurse made a written report of the events and submitted that report to the Chief of Medicine. No patient had been harmed.

In a meeting with his Chief, Dr. Brown agreed to a psychiatric evaluation through the State Medical Association's PHP. During this evaluation, Dr. Brown admitted that he had become depressed after the death of his wife and had started drinking heavily. As recommended by the examiner, Dr. Brown entered into supervised treatment of his alcohol abuse and depression. The PHP contracted with Dr. Brown to serve as the supervising agency and also required that Dr. Brown's therapist and psychiatrist provide reports about treatment compliance and specified the monitoring requirements and conditions under which anonymity could be maintained. No disciplinary action was taken by the hospital. Because of the absence of patient harm and the use of the diversion program, no report was made to the state board. Dr. Brown practiced in a small rural community, with limited access to psychiatrists. The psychiatrist to whom he was referred for treatment had no experience in dealing with the state PHP and was doubtful and conflicted about the required interaction with the PHP.

Vignette 2

Dr. Smith is a 49-year-old surgeon who has been referred for an FFD evaluation by the state licensing board. There had been numerous complaints of disruptive conduct by the nursing staff and the attending anesthesiologists. Behaviors had included yelling obscenities in the operating room, failing to respond to pages about patient emergencies and insulting staff who questioned him about patient care issues. Nurses had requested that they no longer be assigned to work with Dr. Smith because of his demeaning manner.

Dr. Smith maintained his behavior did not differ from that of the other surgeons. Rather, he explained, he was being singled out because other surgeons were jealous of his surgical volume and were he to be reprimanded, the deleterious effect on his practice would benefit his competitor critics. Dr. Smith described himself as a "whistleblower" and was openly critical of the nursing staff. He claimed the nurses lacked the training and experience to assist properly, thereby jeopardizing patient care. He had filed complaints with the administration about these deficiencies and maintained that as a result he has been "set up" by the nursing staff.

Although initially reluctant to confront Dr. Smith, the Chief of Surgery eventually began to follow the hospital policy for addressing physicians displaying disruptive behaviors. He repeatedly spoke to Dr. Smith informally about the numerous complaints without any beneficial change in Dr. Smith's conduct. Next, Dr. Smith received a letter of admonition. When the conduct continued, Dr. Smith was sent a final letter warning him of disciplinary consequences. When Dr. Smith's behaviors continued and escalated, a committee was convened to investigate. A hearing was held and Dr. Smith was found guilty of misconduct. His privileges were suspended for 60 days, an action which required notification of the state board.

Upon review of the report of Dr. Smith's suspension, the State Licensing Board requested an independent psychiatric evaluation. Dr. Smith was provided with the names of three state board approved forensic psychiatrists with experience in the assessment of physicians. Instead, Dr. Smith arranged to meet with a non-Board approved psychiatrist with special expertise in treating depression. This psychiatrist had never previously performed an independent evaluation for the Board and was unsure whether or not to proceed.

Background: Agencies with Oversight Responsibility

Psychiatrists performing evaluations of physicians requested by PHPs, a medical licensing board or any other oversight healthcare agency should have a well-developed appreciation of: (1) the complexities of working with each individual referring entity; (2) how the oversight agencies interact with each other; and (3)

the consequences to a physician in the event of a sanction following an investigation. The mission and responsibilities of each oversight agency vary, which, in turn, affects the referral concerns and questions to which an examiner will have to respond (Leape and Fromson 2006; Meyer and Price 2006).

Each state has passed a Medical Practice Act that has created a State Medical Board (Federation of State Medical Boards 2009; Janofsky 2011), an administrative law agency responsible for the licensure of physicians and regulation of the practice of medicine. In addition to State Medical Boards, other oversight administrative agencies include quality assurance, credentialing and medical executive committees of hospitals, clinics, independent practice associations, and third-party payers. The ethics committees of professional societies or hospitals may also investigate complaints. The PHPs may receive and investigate complaints about suspected physician impairment or act as a diversionary program for another agency (Jost 2003; Meyers and Price 2006).

General psychiatrists or other mental health professionals who will never perform an independent forensic evaluation of an impaired physician may nevertheless be tasked to treat or be a workplace monitor of another physician whose capacity has been questioned. In many jurisdictions, physicians are also often mandated reporters of colleagues suspected of impairment. A general psychiatrist or other mental health care professional may be appointed to serve on an ethics committee, peer review committee, or other oversight committee assigned to investigate and/or adjudicate complaints and allegations. All of these roles require a working knowledge of the process of investigating misconduct, an investigation that can lead to either confidential diversion for treatment or to non-confidential enforcement and discipline.

The 1986 Heath Care Quality Improvement Act, (42 U.S.C. 11101 et seq (1986)), created the National Practitioner Data Bank (NPDB). The NPDB is widely known as the repository of information about malpractice claims. However, the NPDB also receives information regarding certain types of disciplinary action. The formation of the NPDB resulted in a substantial increase of medical board restrictions on physicians' practices. This increase has been attributed to the licensing boards taking actions against physicians who had previously eluded the regulatory system by moving to another state or who, for lack of an accessible complete disciplinary record, had received lesser sanctions (Jesilow and Ohlander 2010). Closing these two potential loopholes was the initial conceptual basis for the creation of the NPDB in the 1986 Health Care Quality Improvement Act (HCQIA 1983).

In addition to its creating data repositories, the Health Care Quality Improvement Act changed the legal landscape of health care agency peer review of physicians. The Act provided a legal definition of peer review, the requisite due process for peer review, and also indemnified the peer reviewers from civil liability so long as the review comported with the requirements of the Act.

While physicians fear that a malpractice suit will significantly impact their practice of medicine, physicians who are disciplined by their medical board or by peer review generally face far greater challenges. Disciplined physicians may justifiably fear that their professional livelihood, both present and in the future, can

be damaged (Meyer and Price 2006). Many physicians are unaware of the serious collateral consequences of a finding of misconduct by a single agency. Independent practice associations, hospital-based physician organizations, hospitals, clinics, public and private third-party payers, and HMOs all typically have clauses in their contracts and bylaws that require notification by the individual physician following a disciplinary sanction. The clause will usually include a provision that failure to provide notification of certain types of disciplinary actions in a timely manner may result in further disciplinary action up to and including termination of the contract, of membership, or of privileges (Meyer and Price 2006). A finding of misconduct by a single administrative physician oversight committee or board can therefore produce a domino effect, with possible loss of privileges or removal from multiple insurance panels, including state and federal insurance plans, such as Medicare and Medicaid (Meyer and Price 2006).

Certain types of disciplinary actions or misconduct will be reported to the NPDB. Most physicians understand that hospitals use information contained in the NPDB during the initial credentialing process. However, hospitals are required to access the NPDB biennially to check on the status of health care practitioners. Waters et al. (2003) surveyed 1,038 health care organizations between March 1998 and February 1999, and found that 21 % of queries to the NPDB yielded previously undisclosed information. This resulted in changes in the physician's credentialing in 5 % of cases. Physicians, who mistakenly believe that the disciplinary action by a single oversight committee or board will go unnoticed by another, may risk not reporting and soon face the additional consequences of the failure to notify provisions.

The range of disciplinary actions taken by health care agencies may include a letter of concern or written warning, probation, practice restrictions, suspension, revocation, or expulsion (Kohatsu et al. 2004). Upon notification that disciplinary action has been taken against a physician, other health care agencies may decide to launch their own investigations or act directly on the findings of the other agency and impose a similar sanction. The other health care agencies may question the fitness for duty of the physician and request their own independent evaluation (Hilliard 2003; Meyer and Price 2006). In addition, third-party payers may decide that the physician should be removed from their panels depending on the nature and seriousness of the misconduct. Even when physicians are able to retain a license to practice, they may nevertheless find themselves unable to qualify for insurance reimbursement or to practice at a hospital or clinic of their choosing (Meyers and Price 2006). In the first vignette, Dr. Brown was able to return to practice after treatment with minimal impact on his professional standing. In contrast, Dr. Smith who had been sanctioned and reported to the Medical Board would face serious professional consequences.

Medical boards may post disciplinary actions along with malpractice history under the physician's profile on their websites. Members of the general public and colleagues can easily access this information. The number of physicians who have been disciplined is significant. The Federation of State Medical Boards (FSMB) reported that disciplinary actions had been taken against 6,034 physicians in 2011

(FSMB 2012). The specialties with the highest percentage of disciplined physicians included family practice, general practice, obstetrics and gynecology, and psychiatry. Board certification status may also be affected by disciplinary action (American Board of Medical Specialties 2011). A recent review by the North Carolina Medical Board (2011) highlights the variability among specialty boards concerning the effects on board certification following suspension, restriction, or revocation of a medical license.

A hospital will have procedures for handling a complaint as per the medical staff bylaws. Depending on the nature of the complaint, the hospital's Medical Staff Executive Committee, a Peer Review Committee, the Medical Staff Association Committee, or an Ad Hoc Committee may perform the initial investigation. When there has been patient harm resulting from a physician's misconduct, the physician would be subject to the disciplinary process. When there has been misconduct due to impairment but no patient harm, then the physician may be diverted for treatment and may avoid the disciplinary process.

Accreditation agencies such as the Joint Commission have required hospitals and other health care agencies to develop policies with regard to certain types of misconduct, including suspected physician impairment and disruptive behavior. These policies, in the absence of patient harm, allow for confidential referral and avoidance of the disciplinary arm and resultant serious consequences to a physician's career. Absence of patient harm is a required but not sufficient condition for a respondent to avoid the disciplinary route. A physician whose conduct has been egregious or persistent, a physician who is uncooperative may be disciplined even in the absence of patient harm as illustrated in the second vignette (Meyer and Price 2006).

Since January 1, 2001, the Joint Commission has required hospitals to establish a Committee on Physician Health responsible for identifying, and rehabilitating impaired physician staff and facilitating referral for confidential assessment, treatment, and rehabilitation. The committee was to function separately from the medical staff disciplinary arm (Joint Commission MS 2.6 2001).

In June 2000, the American Medical Association (AMA), based on its report, "Physicians with Disruptive Behavior," recommended that the "medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions of policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness—or equivalent—committee" (AMA 2000).

The Joint Commission issued Sentinel Event Alert #40 in 2008 noting the correlation of disruptive behavior with compromises in patient safety (Joint Commission 2008). The Joint Commission developed a new accreditation leadership standard, Leadership LD.03.01.01 (Joint Commission 2009) requiring hospitals to develop a code of conduct that defined both acceptable and disruptive and inappropriate behavior (EP4) and the procedures for peer review for disruptive and inappropriate behaviors (EP5). The AMA in turn has developed a model procedure for handling disruptive behavior (American Medical Association 2010).

In the second case example, the policy was followed. Dr. Smith could have agreed to an independent psychiatric exam earlier in the process but instead he chose to dismiss the concerns of his supervisors and continue his disruptive behaviors. As a result he was disciplined.

PHPs serve several central functions in the matrix of peer review and rehabilitation. PHPs provide "prevention, detection, intervention, rehabilitation and monitoring of licensees with potentially impairing illness" (FSMB 2011). Participants in the PHP may have been reported to and referred by the state board. Participants may also include physicians confidentially referred by another health care agency or who have self-referred but who have not been reported to and disciplined by the state board. Hospital-based Physician Health/Wellness Programs, mandated by the Joint Commission, may elect to refer an impaired or disruptive colleague to a State PHP. These are usually better equipped to arrange for comprehensive assessments of physicians and oversee the confidential treatment, to obtain random toxic screens as needed and to monitor the rehabilitation process. In the case example, Dr. Brown was referred to the State Physician Health Committee, which placed Dr. Brown on a monitoring contract. PHPs play a key role in aiding impaired physicians such as Dr. Brown. Dr. Brown was able to receive confidential assessment and treatment.

Despite the avenues available for confidential referral, several studies have raised questions about the preparedness of the medical profession to report impaired colleagues to an appropriate agency (DesRoches et al. 2010; Farber et al. 2005; Roberts et al. 2005). Physicians are reluctant to refer their colleagues for confidential treatment for a variety of reasons, including their own fears of disciplinary action, stigmatization, and retaliation. Other reasons include concern for the potential consequences to the reported physician: the loss of the ability to practice in the profession, loss of social status, and the loss of livelihood. When referrals are not made in a timely manner, impaired physicians will often remain untreated until overt impairment is evident in the health care setting (FSMB 2011). In the case of Dr. Brown, it was only when he was visibly intoxicated that action was finally taken. Fortunately for Dr. Brown, there had been no patient harm and he was able to qualify for diversion to a PHP. He did not face any disciplinary action. Dr. Smith's pattern of misconduct and uncooperative responses led to his case being adjudicated by a disciplinary process. The goals and missions of both the PHPs and FSMB are to "see healthy physicians providing excellent care to the patients they serve" (FSMB 2011). The Policy on Physician Impairment of the FSMB acknowledged that "PHPs have developed knowledge and experience in matters of physician health. They coordinate and monitor intervention, evaluation, treatment and continuing care of the impaired physicians as well as those with potentially impairing illness" (FSMB 2011).

The policy also recognizes that the FSMB and PHPs have different public policy mandates that effects the organization's balance between protecting the public and assisting the physician in his or her recovery. The FSMB policy on PHPs specifies that for PHPs to gain the confidence of regulatory boards and demonstrate a commitment to protect the public (the mission of the FSMB),

the PHPs "must develop audits of their programs that demonstrate an ongoing track record of ensuring safety to the public and revealing deficiencies if they occur" (FSMB 2011). The policy further advises that "such transparency and accountability to the medical and osteopathic boards is necessary to the existence of a viable PHP" (FSMB 2011).

Given the serious consequences to the career of a physician if behavior due to impairment results in discipline, early referral to a PHP, before illness has resulted in functional impairment (Federation of State Physician Health Programs 2005e) is most protective of the physician's professional future and present heath in addition to being most protective of public safety. Confidentiality can be maintained when the physician participant agrees to abide with the provisions of the contracted agreements with the PHP and so long as the physician does not pose a foreseeable risk of harm to the public. Both the licensing boards and PHPs support this option of maintaining confidentiality and avoiding physician discipline in order to motivate hospitals and medical staffs to refer physicians into a PHP early (FSMB 2011). The majority of PHPs will also accept referral of physicians exhibiting disruptive behavior (FSMB 2011).

PHPs will provide assistance and guidance through either a "voluntary track," in which personal identification to the state licensing board is initially not required, or through mandated referrals from a State Medical Board before or after a disciplinary process (FSMB 2011). According to the FSMB policy a voluntary track is, "A confidential process of seeking assistance and guidance through a PHP without required personal identification to the state licensure board whereby the potentially impairing illness is addressed. A voluntary track promotes earlier detection of potentially impairing illness before it becomes functionally impairing. The voluntary track participants are in a safe system whereby substantive non-compliance or relapse, depending on each state's non-compliance reporting requirement will be promptly reported to the licensure board by name" (FSMB 2011). In addition to PHP oversight of voluntary track participants, they also accept licensees whose referral has been mandated by investigation of the state board. A "mandated" referral can be via an informal (not publicly identified discipline) referral or via a formal disciplinary process that is public. In either instance, the board may require quarterly progress reports.

Boards have a non-disciplinary process for referral to PHPs to encourage early detection and intervention (FSMB 2011). Regardless of whether the physician is in a voluntary or mandated track, the PHPs are responsible for the monitoring of the continuing care to ensure compliance. Substantive non-compliance is defined as a "pattern of non-compliance or dishonesty in PHP continuing care monitoring or a [single] episode of non-compliance which could place patients at risk" (FSMB 2011). According to the FSMB policy, substantive non-compliance will result in a report to the Board and may result in forfeiture of the right to confidential treatment.

Many states have statutes that allow referral of a physician impaired by alcohol or substance abuse directly to a PHP. Further notification is not required provided the physician accepts the referral. A physician who voluntarily completes a PHP contact can thereby avoid punitive actions by regulatory agencies. Physicians sign

contracts compelling their adherence to a prescribed treatment and monitoring program. Because failure of adherence is reported to the state medical board, physicians remain at risk of disciplinary action and even loss of their license for non-compliance (Merlo and Greene 2010).

Physician Fitness-for-Duty Evaluation: Physician Impairment

As previously mentioned, the FSMB recently issued a policy on physician impairment (FSMB 2011).The FSMB defines physician impairment as: "The inability of a licensee to practice medicine with reasonable skill and safety as the result of mental disorder (as defined below); or

1. physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognition, motor, or perceptive skills; or
2. substance-related disorders including abuse and dependency of drugs and alcohol as further defined." (FSMB 2011)

This definition is consistent with that offered by the American Medical Association (AMA) (American Medical Association 2004). The FSMB's definitions of mental disorder and substance abuse and dependence follow the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (Text Revision) (DSM-IV) (American Psychiatric Association 2000) nomenclature. The FSMB also defines conduct such as compulsive gambling, compulsive spending, compulsive video gaming, and workaholism as "process addiction:" a "compulsive activity or process of psychological dependence on a behavioral activity. The process consumes the attention of the individual to the exclusions of other aspects of the individual's life and it thereby creates problems" (FSMB 2011). In so doing, the FSMB has identified some conduct that, though having no standing within existing diagnostic disorders in psychiatry, is nevertheless concerning to the FSMB.

The FSMB recognized that the presence of an "illness" does not necessarily denote that there is functional impairment and many physicians are still able to function safely especially early in the course. According to the FSMB policy, "Impairment is a functional classification which exists dynamically on a continuum of severity and can change over time rather than being a static phenomenon. When functional impairment exists it is often the result of an illness in need of treatment. Therefore, with appropriate treatment, the issue of 'potential impairment' may be resolved while the diagnosis of illness may remain" (FSMB 2011).

The AMA has issued ethics guidelines noting the physician's responsibility to maintain his or her own health. Physicians have a responsibility for maintaining their health by "preventing and treating acute and chronic disease, including mental illness, disabilities, and occupational stress" (American Medical Association E-9.0305 Physician Health and Wellness). Consistent with the FSMB policy, the AMA also cautions "when health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental

health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired." The guideline calls on impaired physicians to mitigate the problem by seeking appropriate help and to "engage in an honest self-assessment of their ability to continue practicing."

The AMA also considers it unethical for a physician to practice medicine while "under the influence of a controlled substance, alcohol or other chemical agents which impair the ability to practice medicine" (American Medical Association E-8.15).

Nevertheless, it is estimated that 10–12 % of all physicians will experience impairment because of alcoholism or drug dependency over the course of their careers, a percentage similar to that of the general population (Flaherty and Richmond 1993; Hughes et al. 1992; McLellan et al. 2008; Substance Abuse and Mental Health Services Administration 2009). Physicians are at higher risk for abuse of prescription medication than the general population because their occupational status allows them increased access. Health care providers using opiates and sedatives for induction of light and full anesthesia also have a higher incidence of abuse of these medications as a consequence of ease of access. Physicians monitored by a PHP reported diverting medications by stealing from an office or hospital, defrauding patients and insurers, using medication samples, or misusing valid prescriptions (Cummings et al. 2011).

Fortunately, the prognosis for recovery for physicians with alcohol or substance abuse/dependence is impressive when compared to that of the general population substance. Physicians enrolled in a PHP have abstinence rates ranging from 75 % to 90 % during the 5 years following chemical dependency treatment, a rate much higher than that reported for general clinical populations (American Medical Association 2003; Domino et al. 2005; Dupont et al. 2009a; McLellan et al. 2008; Pelton et al. 1993; Shore 1987). Dupont et al.'s (2009b) comprehensive survey of 49 state PHPs also showed that only 22 % of physicians in substance abuse monitoring contracts tested positive at any time during a 5-year period and 71 % were employed at the 5-year point. Domino (2005) identified several factors associated with an increased risk for substance abuse relapse. Risk factors included a family history of substance abuse, use of a major opioid such as fentanyl, and dual diagnosis. Physicians who participated in 5-year PHP contracts for alcohol/substance abuse/dependence with random drug screening reported high rates of satisfaction at 78.4 % despite the threat of a report to the medical board for relapse or non-compliance (Merlo and Greene 2010).

There is similar success in treating physicians on monitoring contracts for mental illness. About 74 % of physicians on monitoring contracts for mental and behavioral health problems at a PHP completed the program. Only 12 % relapsed and 14 % failed to complete the program (Knight et al. 2007). The prevalence of moderate to severe depression in physicians is about 11 % and studies have indicated that the depression can significantly impact the practice of medicine (Schenk 2008). The threat of loss of licensure may be key to understanding the high rates of physician adherence with treatment (Merlo and Greene 2010).

There have been questions about whether surgeons versus other physicians had different treatment outcomes (Krizek 2004; Kuerer et al. 2007). Buhl et al. (2011) found that surgeons were significantly more likely than nonsurgeons to enroll in a PHP because of alcohol-related problems (62.2 % vs. 46.9 %) and were less likely to enroll because of opioid use (23.1 % vs. 36.6 %). There was no statistical difference between surgeons and nonsurgeons with respect to having a positive drug test result, failing to complete the monitoring contract, or needing to extend the monitoring period beyond the original 5 years specified in their agreements. Approximately 20 % of participants in both groups were reported to their state licensing boards because of relapse or noncompliance with the terms of the PHP agreement. About 20 % of physicians had at least one positive test for drugs or alcohol.

There are special considerations when evaluating anesthesiologists and anesthesia residents. The rate of suicide among anesthesiologists is higher than that of other physicians and 2–3 times the rate of the general population (Rose and Brown 2010). In addition, anesthesiologists may be more prone to substance abuse. The mechanism is unclear but ready access to drugs, stress, genetic predisposition, environmental exposure, and psychiatric comorbidities have all been considered as possible explanations (Rose and Brown 2010). It is unclear whether anesthesia residents are at greater risk for relapse on re-entry after treatment compared to other residents. They are, however, at greater risk of death (Bryson 2009; Domino 2005). There was a 3 % incidence of death among residents after re-entry to an anesthesia training program (Bryson 2009). Whether an anesthesia resident should be allowed to continue in training after treatment for substance abuse or practice in another specialty has been debated because of the serious risks associated with re-entry (Alexander et al. 2000; Bryson 2009; Collins 2005).

Treators of Monitored Physicians: A Dual Relationship

The psychiatrist treating Dr. Brown had questions and misgivings about reporting requirements. Mental health clinicians treating a physician patient who has signed a monitoring contract with an oversight agency should clarify in advance the circumstances under which there will be a report regarding relapse, symptoms suggesting impairment, or non-compliance. The reporting requirements are determined by the oversight agency which has negotiated with the physician and his or her attorneys. PHP contracts will generally have provisions for reporting requirements (Janofsky 2011). Treatment providers need to understand the particular circumstances or provisions applicable to their patients.

Treating clinicians such as Dr. Smith's psychiatrist enter into a dual agency relationship with which they may be unfamiliar and uncomfortable. Treating clinicians need to have the opportunity to discuss and digest what they may reasonably perceive as an intrusion into the customary privacy of the doctor–patient relationship (Meyer and Price 2006).

Clinicians may have legitimate concerns about causing harm to their physician patients if they are forced to report relapses. Clinicians are typically unaccustomed to weighing the substantial risk impaired physicians poses to their patients. Physician respondents in a diversionary program have been given an opportunity to engage in treatment, and thus preserve their ability to practice medicine. Were the treator to fail to make a report as specified in the PHP contract, the public is put at risk and the confidence of the oversight agencies in the diversionary mechanisms is justifiably eroded. The public and the potential for physician rehabilitation will each suffer.

Monitoring agencies focus on treatment adherence and surveillance of behavioral relapse, and not on the content of psychotherapy. Monitoring agencies arrange for random toxic screens and will meet with the physician participant in the event of a positive test. Dr. Brown's treating psychiatrist needs clear guidance about his duties to the PHP. Dr. Brown must sign appropriate releases of information to allow contact with PHP, as specified in the monitoring agreement. Janofsky (2011) has provided sample letters that a treating psychiatrist may wish to use as a template when communicating with a regulatory agency. The legal authorization notwithstanding, any mental health clinician performing a mandated treatment needs to be personally reconciled with shouldering an unfamiliar disciplinary responsibility in the service of facilitating a peer's rehabilitation. In the absence of that personal reconciliation of ambivalent feelings, the clinician may consciously or unwittingly act out his misgivings, putting the patient and the public at risk.

Physician Fitness for Duty: Disruptive Physician Behavior

The AMA has defined disruptive physician behavior: "Conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team" (American Medical Association 2000). The definition does not require that the behavior resulted in patient harm. Nevertheless, disruptive behavior has serious negative consequences for patients, coworkers, and hospitals, clinics, and practices.

Studies surveying fellow health care providers indicate that disruptive behavior by medical professionals is prevalent and compromises safety, including contributing to adverse events and patient mortality (Rosenstein and O'Daniel 2008a). Disruptive physician conduct has been identified as a substantial contributing risk factor to medical errors, a key threat to patient safety (Rosenstein and Naylor 2011). Disruptive physician behavior can result in ineffective communication, and thus compromise the necessary cooperation and collaboration among staff members. It can impede the sharing of data and potentially affect safety and efficiency (Pfifferling 2008; Rosenstein and Naylor 2011; Rosenstein and O'Daniel 2008a, b). Of physicians, the specialties ranking highest among medical disciplines for prevalence of disruptive events were General Surgery, followed by Neurosurgery,

Cardiovascular Surgery, Orthopedic Surgery and Obstetrics, and Gynecology (Rosenstein and O'Daniel 2008a).

Disruptive behavior also may damage the public's and the employees' confidence in the institution's ability to fulfill its mission. The hospital may face exposure to patient and staff litigation (Kissoon et al. 2002; Meyer and Price 2006; Patel et al. 2011; Rosenstein 2011). Studies have correlated patient complaints about disruptive or unprofessional conduct of physicians with an increased malpractice risk (Hickson 2002; Stelfox et al. 2005). Confidence in the leadership of the hospital or physician practice may be eroded when the leadership is perceived as protecting the doctor and failing to rigorously investigate complaints as in the second vignette involving Dr. Smith. Staff morale, staff retention, and recruitment of nursing and other staff will be affected if the institution does not respond effectively (Pfifferling 2008; Piper 2003; Rosenstein 2002; Rosenstein et al. 2002).

A variety of behaviors are considered disruptive and can result in a referral for an FFD evaluation. Disruptive conduct includes exhibiting inappropriate anger, intimidating coworkers, or being uncooperative with coworkers. Disruptive physicians might use foul, sexualized, or racially inappropriate language, thereby producing a hostile or unsafe work setting (Meyer and Price 2006). They also may repeatedly fail to respond to on-call pages, fail to complete documentation in a timely manner, or fail to communicate appropriately with health care colleagues caring for patients in common (Irons 2001; Joint Commission 2009).

Physicians accused of manifesting disruptive conduct may deny the allegations. They may insist that the complaint about them was entirely unjustified. They may respond as did Dr. Smith in the case example with accusations of their own and they may threaten retaliatory actions. Disruptive behavior may continue despite efforts to intervene. Disruptive physicians may develop a reputation for being difficult. Staff members may respond to their behavior by avoiding or appeasing the physician, which may also compromise communication and patient care (Irons 2001; Meyer and Price 2012).

Physician Sexual Misconduct

A physician may be referred for an FFD evaluation because there have been allegations of sexual misconduct. Sexual misconduct with a patient has been defined as "behavior that exploits the physician-patient relationship in sexual way" (FSMB 2006). Sexual impropriety is defined as "behavior, gestures or expressions that are seductive, sexually disrespectful of patient privacy, or sexually demeaning to a patient" (FSMB 2006). A sexual violation is "physical sexual contact between a physician and patient, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual" (FSMB 2006).

FSMB has proffered guidelines for addressing physician patient sexual boundaries (2006). Janofsky (2011) has discussed the special considerations in the

evaluation of a physician accused of sexual impropriety or sexual violations. He notes that the referring regulatory agency will ask for an assessment of the psychological factors that contributed to the sexual misconduct and for an opinion about whether the respondent physician can be rehabilitated.

Sexual misconduct may or may not be related to a medical or psychiatric disorder. A physician with dementia may make inappropriate sexualized remarks to a patient. A physician who is manic may engage in inappropriate sexual conduct. Gabbard has described several categories of boundary violators: those suffering from psychosis or mood disorder; those with predatory psychopathology or paraphilia; those with love sickness (i.e., physicians who fall in love with their patients) or those with masochistic surrender (Gabbard 1994). This classification can be used when considering the risk of further misconduct.

Qualifications of the Examiner

Oversight agencies such as State Medical Boards and PHPs will typically provide a physician examinee with a list of approved mental health evaluators. The Federation of State Medical Boards Policy on Physician Impairment provides guidance on the selection of the mental health evaluator. This guidance is also relevant to the selection of experts by other health care agencies in need of a mental health evaluator in the process of their own investigations:

> Providers performing evaluations/assessments should have demonstrable expertise in the recognition of the unique characteristics of health professionals with addictive and/or psychiatric illness. The psychiatric history and mental status examination should be performed by a clinician knowledgeable in addictive and/or psychiatric illness.
>
> The selection of evaluator(s), whether an individual clinician or a multidisciplinary center, should be the responsibility of the PHP (should one exist in that state jurisdiction). Whenever possible, the licensee should be allowed to select an evaluator(s) from a PHP approved list of evaluators or facilities. The licensee should not be allowed to select an evaluator not approved by the PHP. (FSMB 2011)

The American Psychiatric Association's (APA) Resource Document on Guidelines for Fitness-For-Duty of Physicians (APA Guidelines) recommends that the examining psychiatrist confirm that the referral source has confidence that the examiner has sufficient expertise to conduct a competent evaluation (Anfang et al. 2005). If the examinee has been given a list of approved vetted examiners and seeks an evaluation with another psychiatrist or mental health provider, it is essential that the evaluator verify that he or she would be acceptable to the referring agency before proceeding. In the absence of agency assent, the agency may legitimately insist on a second assessment by an approved mental health examiner.

In the second vignette, Dr. Smith selected a psychiatrist who was not on the approved list. Were this psychiatrist to proceed with the evaluation, it is likely that the licensing board would have required that Dr. Smith undergo an additional assessment. Board approved evaluators have been fully vetted and have the

requisite experience to provide an objective independent opinion. At a later phase of adjudication, evaluees or their attorneys may select an expert of their own choosing for the purpose of rebutting the findings and opinions of the agency approved evaluators.

Because the evaluation is not health care per se, insurance typically will not provide reimbursement for the cost of the examination, and the evaluee is often responsible for all costs. Sometimes, the costs of the evaluation will be absorbed by a physician's employing health care agency (Meyer and Price 2006).

Agencies scrutinize the credentials and experience of psychiatrists who wish to become approved evaluators. The APA Guidelines recommend that examiners who contemplate performing a fitness-for-duty evaluation of a physician for an agency provide a recent curriculum vitae as well as a description of their experience in providing these assessments (Anfang et al. 2005). The APA Guidelines note that forensic training, experience, or certification while helpful, is not required. However, while certification in forensic psychiatry may not be mandatory, most of the approved evaluators have formal forensic training. In addition, only evaluators with specific expertise in the psychiatric evaluation of physicians are generally chosen by agencies to perform these FFD evaluations. The FSMB's Policy on Physician Impairment notes that in the case of disruptive physicians, "PHPs or boards should refer such cases to select individuals or evaluation/treatment facilities with extensive knowledge and expertise regarding the problem."

Psychiatrists and other mental health professionals who are considering conducting these evaluations should investigate whether their malpractice liability insurer will provide coverage for allegations stemming from performing forensic evaluations (Anfang et al. 2005). Some malpractice insurers explicitly exclude forensic work while others will cover forensic activities only with a separate costly rider. Since forensic evaluation may not be considered the practice of medicine, a malpractice policy may in some instances fail to clearly warn that forensic work is not covered. However, some insurers will cover forensic work under the basic malpractice policy at no additional charge (Vanderpool 2012, "personal communication").

Questions of potential bias or conflict of interest need to be resolved before performing the FFD evaluation (Anfang et al. 2005; Meyer and Price 2006). The evaluating psychiatrist should not have any current or past treatment or employment relationship with the physician being examined or the examinee-physician's employing health care agency as this may create problems in maintaining objectivity (Anfang et al. 2005). Evaluators would be well advised to refuse to perform assessments of physicians with whom they have a professional relationship. As in Dr. Smith's case, physicians will often deny the allegations of misconduct and blame the administration. An employee of the same hospital, medical practice, or organization could be viewed by the respondent as having a conflict of interest. A fellow member of the health care organization also may or may not be acceptable to the examinee. Real or perceived conflicts of interests of the examiner must be resolved prior to beginning an examination.

Agency Expectations

Prior to proceeding with the examination, a health care agency provides the mental health evaluator with written referral questions. The evaluator should know to whom to direct the completed report. The referral source provides information about the complaints and the context in which they occurred. There are often specific practice-based concerns that may have been raised, requiring the evaluator to have an understanding of the main work functions of the evaluee (Anfang et al. 2005; Meyer and Price 2006).

Most administrative agencies will ask for an opinion regarding the examinee's fitness for duty (Anfang et al. 2005; Meyer and Price 2006). However, the referral questions concerning fitness may reflect the agency's specific mission. For example, the questions typically posed by the State Medical Board would reflect the Board's mandate to protect the public. The Board will generally ask a series of questions such as

- Whether the physician examinee is currently fit to practice medicine with reasonable skill and safety.
- Whether the physician requires continued treatment to remain fit to practice.
- What specific types of oversight of treatment would be required?
- What sort of workplace monitoring is recommended? (Meyer and Price 2006)

State Medical Boards are understandably sensitive to the rates of recidivism of physicians when considering the severity of sanctions to be imposed and the intensity of monitoring requirements, particularly when the physician has been previously sanctioned. Concerns regarding recidivism are well-founded. Grant and Alford (2007) examined the Federation of State Medical Boards data concerning sanctions for 1994–1998 (Period A) and for 1999–2002 (Period B) to assess the rates of recidivism. Fully 20 % of physicians who had received either a medium or severe sanction during Period A were subsequently sanctioned during Period B. In view of the high recidivism rates, the authors suggested increased vigilance in the monitoring of disciplined physicians or less reliance upon rehabilitative sanctions.

A PHP, while concerned with public safety, is also focused on the examinee's health. Psychiatric FFD questions will concentrate on diagnosis, oversight, and treatment of the examinee. If the physician is currently unfit for practice, the PHP would be concerned about recovery and strategies for rehabilitation. Especially in evaluations of physicians exhibiting disruptive behavior, there may not be a causal Axis I DSM-IV diagnosis. The physician examinee may have a personality disorder, maladaptive personality traits that do not rise to the syndromal requirements of a personality disorder, and psychosocial "V" codes (Meyer and Price 2006). The evaluation should nonetheless provide recommendations for management of the objectionable behavior.

Hospitals and other health care institutions typically have clauses in their employment contracts or in their bylaws that delineate the ethics-related and

behavioral expectations of health care providers. For example a physician who accesses adult pornography at work, while not committing a crime, may nevertheless have violated a provision in an employment contract. Physicians may be referred when they have exhibited threatening behavior in the workplace. In this case, the referral questions would center on the risk to members of the staff and to the public. Evaluations may also be requested in response to allegations of sexual harassment, and the referral source may request an opinion about the examinee's future capacity to conform his or her conduct to the behavior expected by the institution. A medical training program may ask for an opinion about fitness for learning (Meyer and Price 2006).

Most agencies will also ask about the need for future psychiatric or substance abuse treatment and workplace monitoring. The mental health evaluator may be asked to describe the behaviors in the workplace that would signal a relapse of the mental illness or substance abuse. This allows the workplace monitor to be alert for indicators of recurrence and potentially to intervene before there has been a compromise in patient safety (Meyer and Price 2006; Wall 2005; Wettstein 2005).

The Exam and the Report

The APA's Resource Document on Guidelines for Psychiatric Fitness-for-Duty of Physicians (APA Guidelines) provides very practical information about performing the exam in a careful and comprehensive manner (Anfang et al. 2005). In addition, the American Academy of Psychiatry and the Law (AAPL) Practice Guideline for the Forensic Evaluation of Psychiatric Disability (Gold et al. 2008) has a section devoted to the evaluation of physicians that also provides guidance in conducting these complex examinations.

Informed Consent and Confidentiality

The APA Guidelines recommend that at the onset of the evaluation, the mental health examiner review the limits of confidentiality, the anticipated recipients of the report, the purpose of the evaluation, and the absence of the proffer of treatment or health care (Anfang et al. 2005). Signed releases of information should be obtained when contacting collateral sources. If the evaluee refuses to disclose information, then the refusal should be documented in the report. The examiner should also note the impact of the absence of the requested information about the answers to the health care organization's questions. Releases of an individual's protected health care information to the examiner must be compliant with Health Insurance Portability and Accountability Act (HIPAA) regulations. The examinee's consent to release the report to the peer review agency should also conform to this statutory requirement. As noted in the APA Guidelines, even in the absence

of a treatment relationship, an evaluator has responsibility under federal and/or state privacy laws for the secure storage and disposal of the protected health information and records which have been gathered (Anfang et al. 2005).

However, the APA Guidelines also remind examiners and examinees that, "Licensing board complaints, investigations, findings, and actions may be publicly disclosed, depending on the situation or jurisdiction. While some modification of the report may be appropriate in states where there is extensive public access, it must be recognized that being granted a license to practice medicine is a privilege, not an inherent right. The laws that govern the ability of a licensing board to order an evaluation are known (or should be known) to the physician at the time of licensure and renewal (since these are delineated in the medical practices act of each state and are typically included with the licensing packet)" (Anfang et al. 2005). As an example, in Nevada the statute governing licensure provides that by applying for licensure, the physician "shall be deemed to have given consent to submit to a mental or physical examination or an examination testing his or her competence to practice medicine when ordered to do so in writing by the Board or an investigative committee of the Board." In addition, the testimony or reports of the examining physicians are not considered to be privileged communications (NRS 630.318).

The APA Guidelines allow for more flexibility regarding the disclosure of personal information when dealing with referral sources other than State Medical Boards. This is because evaluations for medical staff organizations, practice groups, and hospital disciplinary committees are more likely to be reviewed by persons who may have personally interacted with the evaluee and who may have conflicts of interests. These other agencies that have oversight of physicians may have varying policies with regard to dissemination of the information contained in the report (Anfang et al. 2005).

Sources of Information

Evaluators require information about previous peer review problems, performance problems, incident reports, sanctions by hospital or organizations, any attempt at rehabilitation, quality improvement and risk management data, previous complaints to the State Licensing Boards and complaints by patients and staff members and relevant depositions (Anfang et al. 2005; Janofsky 2011). Retainer agreements between the health care agency and the evaluation can include a sentence tasking the agency to provide the evaluator with this documentation. Typically, FFD reports contain a section titled, "Sources of Information," in which the date, length of each interview, and type and location of interview with the physician evaluee or collateral source, and all written records reviewed are documented. It is also helpful to note the party providing written records.

Written documentation from the referral source about the specific behavior/complaints is essential. Treatment records, telephone interviews with treatment

providers and workplace supervisors and colleagues, are all valuable sources of information. Pharmacy records may prove very informative to document adherence to prescribed medication or addiction or abuse. The physician's job description including the specific duties of the evaluee may clarify essential job functions on which rest this physician's fitness for duty.

The mental health examiner may conduct collateral interviews with the referral source, witnesses to the events in question, a spouse or significant other, and supervisors in the physician's workplace. Collateral source information is helpful to clarify if misconduct is isolated and in response to a known stressor as in the first vignette or whether there is a pattern of repeated misconduct as in the second. At times information can be solicited that would confirm the examinee's version and would be very relevant to the assessment of fitness to practice.

In Dr. Smith's case, he maintained that allegations of disruptive conduct were promoted by other physicians who were jealous of his large surgical volume and were supported by the nursing staff because he was a whistleblower and they were hospital partisans. However, even those colleagues whom Dr. Smith had determined would be supportive had also witnessed his disruptive behavior. His explanations could not be supported by objective collateral evidence.

Janofsky (2011) has advised caution in considering obtaining information about the evaluee's behavior from the physician's economic competitors. The information provided may be biased and disclosure that the physician is being investigated can be misused. The evaluator should generally avoid contacting a patient complainant. Patient complainants are already aggrieved and the information they provide typically will be limited to that which they believe will support their positions and allegations. However, the evaluator should be provided with the written complaint and a transcript or summary of any interviews, other investigation conducted by the referral agency and any previous independent evaluations (Janofsky 2011).

In the second vignette, Dr. Smith contacted a psychiatrist who had never performed an IME of a physician. That psychiatrist may not be aware of the interstices of this arena of administrative law. Inexperienced evaluators may fall victim to defendant physicians and their attorneys who desire an expert ready to offer a favorable opinion, perhaps without access to the full range of information to which an evaluator could and should have access. Dr. Smith's attorney may have been attempting to obtain a more positive assessment by limiting the evaluating doctor's access to all of the relevant information. For example, Dr. Smith knowingly or unwittingly failed to disclose that there had been numerous complaints and that his behavior had persisted despite warnings and attempts at remediation. In the assessment of a physician accused of misconduct, it is essential that the evaluator have access to all the complaints possessed by the agency and not rely solely on the self-report of the physician examinee. In the case example, the Board had been provided with extensive documentation of the complaints made by 20 different staff members including other surgeons, anesthesiologists, and nurses.

However, evaluees should be given the opportunity to provide additional information supportive of their position and to provide the names of colleagues

who can be interviewed and may be able to provide another perspective on the allegations of misconduct. Intra-institutional conflicts and retribution against whistleblowers have sometimes been rebranded into unfounded allegations of physician misconduct.

Scheduling the Interview with the Evaluee and Obtaining Information About the Circumstances Leading to the Referral

Independent mental health evaluators may differ in their practice of scheduling the interviews. Some evaluators plan to conduct two interviews with the physician examinee, one prior to a thorough review of the referral complaints and then the other after an opportunity to examine all available documentation. This approach allows the physician examinees to provide their own account of the events in an open-ended manner. Examinees should be asked to describe the complaints fully even when the facts are disputed and the allegations are considered groundless. Examinees are generally appreciative of having an opportunity to explain the discrepancies between their report and that of the complainants. This approach is recommended "to mitigate some of the anxiety and adversarial feeling that often precedes the examination and fosters a more collaborative attitude for the interview" (Meyer and Price 2006). At the second interview, the discrepancies between the physician's self-report and the referral concerns can be addressed more fully.

Other mental health evaluators will conduct a single comprehensive interview after the referral information has already been reviewed. However, a similar approach can be used, with the first half of the interview being utilized as an opportunity for the examinee to provide information about the complaints from his or her perspective. Having just a single interview may be advantageous and more efficient in situations in which the evaluee does not live locally and will need to travel to the interview site and may also need to separately schedule the psychological or neuropsychological testing (Meyer and Price 2006). Since collateral sources will be contacted after the interview, there may need to be a follow-up session if new unexpected information is obtained. Interviews of three to four hours are anticipated, though further time may be necessary in complex cases.

The evaluator should obtain and document the physician examinee's explanation of events related to the allegations. The evaluator should inquire about discrepancies between the physician's report and that of the collateral sources and about work-related stressors and conflicts with members of the staff. If the evaluee disputes the allegations, data should be gathered concerning alternative explanations.

Prior to scheduling the FFD evaluation, payment for the evaluation should be discussed. As noted above, FFD evaluations are not reimbursed by third-party health insurers. Some malpractice carriers may pay for independent exams if there

are also allegations of patient harm. At times payment may be received through an attorney. Regardless of payment source, whether the evaluee or some third party, payment in advance for the estimated cost of the evaluation is recommended so as to avoid the appearance that payment was for a desired opinion (Anfang et al. 2005; Meyer and Price 2006) and to guard against non-payment for negative opinions.

Background Information and the Mental Status Exam

The FFD evaluation includes a complete mental health evaluation and mental status examination documented in the report. Assessment of cognitive functioning including frontal lobe and executive function is essential (Anfang et al. 2006). Disinhibited behavior may be secondary to unsuspected early dementia or other frontal lobe impairments.

In addition to an inquiry into the events in question, the examination includes inquiries into the examinee's educational and employment history, the basis for changes in either and the history of any workplace or training discipline. Credentialing information submitted by the evaluee that chronicles educational and employment history and the examinee's own curriculum vitae are each helpful to ensure the educational/work history obtained is complete. The evaluee can explain identified gaps in training or work history, peer review sanctions, hospital actions resulting in privilege changes, malpractice history, complaints, or sanctions by oversight agencies such as the state licensing or specialty boards or professional society ethics committees and previous periods of disability. A physician's prior accomplishments, such as academic awards, special achievements, and leadership positions, are relevant to assessment of physician capacity and are important data that should be integrated into the overall assessment of the evaluee.

The FFD assessment should include a detailed psychiatric history and substance abuse history and how impairment, if any, was manifested in the workplace. Did impairment result in any direct patient harm? The longitudinal course of a psychiatric or alcohol and substance abuse disorder including severity over time, need for inpatient or partial hospitalization, type of treatment, response to treatment, and treatment compliance is particularly helpful in establishing a foundation for opinions proffered about the examinee's future: prognosis, required treatment, required supervision, and required limitation of practice.

Evaluees should routinely be asked about arrests, convictions, restraining orders, and prior involvement with police or in a legal matter of any kind. Evaluees who have served in the military may have histories of non-judicial punishment such as a "captain's mast" or "Article 15." Although charges may have been dismissed or continued without a finding, the legally unsanctioned conduct is still relevant to an assessment of the physician's professional capacity. A detailed sexual history is indicated when there had been allegations of sexual misconduct and/or harassment (Janofsky 2011).

Typically, the interview will also address personal and family history, developmental history, relationship history, and medical history (Anfang et al. 2005; Meyer and Price 2006). The evaluator should ascertain whether the evaluee has been seeing a physician for either routine care or for treatment of a specific medical problem; is being treated and prescribed medication; or is self-prescribing (Janofsky 2011). The evaluator should seek information about current stressors and assess whether there are supportive relationships to aid the physician during recovery.

Psychological Testing

The authors routinely utilize a personality inventory such as the Minnesota Multiphasic Personality Inventory II (MMPI-II) and/or the Personality Assessment Inventory (PAI) to confirm impressions formed during the interview and review of collateral information (see Chap. 5). If the testing is inconsistent with the other data, then further evaluation may be needed. In some situations projective testing (e.g., the Rorschach), while not used routinely, is reliable to demonstrate a subtle psychotic process (Meyer and Price 2006). Roback et al. (2007) noted that sexual boundary violators had a similar percentage of profiles identifying character pathology as compared to disruptive physician and a group with other types of misconduct.

Many examiners will routinely include a neuropsychological screening test in a physician FFD evaluation. A full neuropsychological battery should be administered if the screening is positive, or the nature of the complaint or the findings of mental status examination suggest cognitive deficits. Consultation with a neurologist and the use of neuroimaging may be indicated for some examinees. Neuropsychological testing as opposed to imaging remains the most sensitive and specific testing to evaluate aspects of cognitive function. Depending on the circumstances, other medical and laboratory testing may be indicated. Urine screening and other laboratory tests for substance abuse may have been performed prior to the IME by the referring agency and these results should be obtained (Meyer and Price 2006).

Opinions Regarding Fitness and Treatment and Monitoring Recommendations

FFD evaluators should state that the opinions are limited to psychiatric contributions and causes of impairment and that an assessment of the examinee's requisite medical or surgical knowledge and skill was not performed. They should note that their opinions are based on the sources of information listed in the report. Examiners should state they retain the option to revise their opinions in light of review of newly accessed information.

Oversight agencies have different goals which may be reflected in their having somewhat different referral concerns and questions for the FFD examiner. When provided with specific referral questions, the examiner's opinions are presented as responses to those questions. Evaluators should be mindful that they are educationally assisting the agency. The agency and not the evaluator defines the arena with which it needs assistance. In criminal and civil law, experts assist the trier of fact. In administrative law, the expert is an educator to the agency about issues beyond its expertise.

Evaluators should begin with a diagnostic assessment based on the identification of symptoms/signs of the illness, and then describe a connection, if any, between symptoms of the diagnosed disorder and impairment affecting fitness to practice of medicine. These lead to ultimately offering prospective recommendations for treatment and workplace supervision (Anfang et al. 2005; Federation of State Medical Boards 2011; Meyer and Price 2006).

The following illustrative questions demonstrate an internal logical sequence which the FFD evaluator can use in formulating opinions: (Anfang et al. 2005; Federation of State Medical Boards 2011; Meyer and Price 2006).

1. Does the physician examinee suffer from a psychiatric illness or alcohol or substance abuse disorder?

   An examiner's response includes a DSM-IV diagnosis with documentation of the symptoms and signs that serve as the foundation of the diagnosis. The same standard should be applied to Axis II Personality Disorders or maladaptive personality traits. The language of the report should be jargon free and accessible to a college level reader without mental health training.

2. If a psychiatric illness or substance abuse/dependence is present:

   (a) Did the disorder(s) interfere in the past with the physician-examinee's ability to practice with reasonable skill and safety?
   (b) Does this disorder(s) interfere with the physician's current ability to practice medicine with reasonable skill and safety? If the physician is currently unfit, what is the prognosis for recovery?
   (c) Will the disorder(s) foreseeably interfere in the future with the physician-examinee's ability to practice with reasonable skill and safety?
   (d) What, if any, treatment of the physician and/or supervision of the physician's practice are required to maintain fitness? Please provide specific recommendations to mitigate risk.

It is essential that the report clearly correlate signs and symptoms of illness to professional impairment in workplace. The FFD examiner provides recommendations for acute and intermediate phase mental health treatment. Risk factors for relapse and premonitory signs and symptoms should be identified. Evaluators should be specific when making recommendations for treatment monitoring and expect these suggestions to be directly incorporated into a consent decree or into a monitoring contract. Typically, PHP contracts will identify the frequency and type

of treatment for stabilization. This may include outpatient, residential, or partial hospitalization treatment, participation in a 12-step recovery program as indicated, psychotherapy, weekly group meetings with other professionals in recovery, and random urine testing (Merlo and Greene 2010). The FFD evaluator should have knowledge of the standard provisions of contracts by oversight agencies.

FSMB's Policy on Physician Impairment has guidelines for discharge planning and PHP continuing care that would begin after the initial phases of intervention, evaluation, and acute treatment. Other oversight agencies often incorporate similar provisions as part of the monitoring contract. In many situations, the FFD evaluator may have recommendations for more intensive treatment or monitoring which may lead to modification of the standard contract. This is especially likely when the physician is undergoing evaluation following relapse.

The FSMB recommends that physicians enrolled in a PHP to support recovery from addictive illness should be monitored for a minimum of 5 years while physicians recovering from substance abuse may be monitored for a shorter period of time, typically 1 to 2 years. "Physicians in a PHP to support recovery from mental illness should be monitored for a period to time commensurate with the mental illness as determined by the treatment providers who are approved by the PHP, typically between one and five years" (FSMB 2011). For physicians under contract for disruptive behavior, the suggested monitoring period is for 1–5 years. The status of recovery would be verified with workplace reports, treatment reports and records, forensic screening as indicated, and contract compliance (FSMB 2011).

The FSMB's policy specifies that as part of continuing care treatment, recovering physicians establish a relationship with a personal primary care physician (PCP), inform their PCPs of the monitoring contract, have the PCPs provide reports to the PHP, and supply medical treatment records when requested. There are prohibitions regarding self-prescribing (FSMB 2011). For persons recovering from an addiction there can be provisions for regular attendance at Alcoholics Anonymous or Narcotics Anonymous programs or their equivalents. PHP participants may be required to attend weekly self-help groups, so-called "Caduceus meetings." Contracts may specify treatment with a therapist, psychologist or psychiatrist, the type of treatment, and the frequency of visits. Continuing medical education in the areas of addictive or mental illness may be required. The FSMB (2011) recommends that recovering physicians treated for mental illness should abstain from use of drugs. They may also be required to abstain from alcohol as well when indicated. Confirmation by forensic laboratory testing when warranted may be required.

The FSMB policy requires that contracts for physicians with disruptive behavior contain provisions similar to the above-stated requirements: a personal PCP, treatment with a therapist, psychologist or psychiatrist as clinically indicated, abstinence from drugs and abstinence from alcohol when clinically indicated, and appropriate support group attendance when available. Continuing medical education may be mandated (FSMB 2011). Additional recommendations for the disruptive physician may include courses in sensitivity training, anger management, individual coaching, or counseling.

Agencies responsible for public safety and physician fitness for duty often institute workplace monitoring for physicians who have been identified as impaired. Evaluators may suggest appropriate worksite monitoring conditions. For physicians recovering from an addictive illness or mental illness, the supervising physician often will be enlisted to fulfill the role of worksite monitor. The supervisor is already responsible for monitoring the quality of the physician's work and the new responsibilities would expand the role. If the physician practices in a setting in which there is no supervising physician, then another physician may be assigned following approval by the PHP or other oversight agency. The monitor would be expected to file regular status reports regarding any performance problems (FSMB 2011).

In the case of a disruptive physician, multiple worksite monitors in addition to the supervising physician may be selected based upon the capacity to observe recurrence of the disruptive behavior. A monitor may be an administrator, a physician, a colleague, a nursing staff member, or a subordinate (FSMB 2011). At times the monitor may be an employee of an agency that provides monitoring services to oversight agencies. Monitors must have the confidence of the examinee and not just the institution.

Evaluators should provide in the report those observable premonitory signs and symptoms of illness that could presage future psychiatric deterioration and behavioral misconduct. The monitors need to be apprised of this information to assist their early detection of examinee decompensation. Evaluators may recommend administrative and therapeutic responses that workplace monitors should initiate if there has been evidence of relapse (Meyer and Price 2006). The agency should be given guidance in understanding the risk of relapse.

For physicians who are evaluated for cognitive decline, the practice of medicine may need to be modified or even discontinued (FSMB 2011). "Less severe cases of cognitive decline [may] allow the physician to continue to practice with or without formal or informal practice restrictions" (FSMB 2011). If the physician continues to practice, then there will need to be a treatment monitoring contract, a worksite monitor, and strict provisions for evaluation of health and practice performance on an ongoing basis. The physician may be referred for a separate assessment of competency to practice with skill and safety in his or her specialty in light of the cognitive decline.

Case Vignettes: Outcome

The PHP provided Dr. Brown with a list of approved evaluators. Dr. Brown was examined by a psychiatrist with extensive experience in evaluating physicians with both depression and alcohol and substance use disorders. The evaluator discovered that Dr. Brown had been abusing both alcohol and benzodiazepines which he was self-prescribing. The evaluator recommended that Dr. Brown enter an inpatient alcohol and substance abuse treatment program that was designed to treat

physicians and other professionals and which could also provide treatment for his depression.

The PHP helped Dr. Brown arrange for coverage of his practice. Dr. Brown successfully completed the inpatient program, signed a 5-year contract with the standard provisions. Dr. Brown began treatment with the psychiatrist in the community. While initially conflicted about the reporting requirements of Dr Brown's contract, the psychiatrist was impressed by the motivation and determination of Dr. Brown. For Dr. Brown, a contract with the PHP ensured confidential treatment and the avoidance of a disciplinary investigation or sanction. Dr. Brown successfully returned to work while being monitored closely.

Dr. Smith had approached a psychiatrist who had never performed an independent psychiatric examination for the Medical Board. This psychiatrist consulted a colleague who had provided independent medical examinations for the Board. The psychiatrist called Dr. Smith and informed him that he had learned that Board would require that he choose an evaluator from the list provided to him. Dr. Smith consulted an attorney and agreed to undergo an evaluation with the Board vetted psychiatrist. The Board-approved psychiatrist arranged for psychological testing. Testing demonstrated no signs or symptoms of an Axis I Disorder but was consistent with maladaptive personality traits. Dr. Smith's explanation that the allegations were in retaliation for being a whistleblower could not be substantiated.

The evaluator recommended individual psychotherapy, sensitivity training, and workplace monitoring. Dr. Smith was required by Board order to have treatment and supervision overseen by the state PHP. Because of the Board involvement, Dr. Smith was motivated to re-examine his behaviors, committed to treatment, and made the changes necessary to ensure proper communication with other health care professionals. Unfortunately, Dr. Smith had not responded to early interventions. It is possible that an early independent psychiatric evaluation as part of the hospital's response to disruptive behavior may have led to changes that would have interrupted the path towards discipline.

Conclusion

The fitness of a physician or other medical professional affects the quality and safety of medical care. In performing independent mental health evaluations of medical professionals, examiners offer an objective opinion not only about the examinee's present fitness for duty but also about future professional fitness for duty and what treatment or oversight, if any, may be needed to ensure that fitness for duty (Meyer and Price 2006). An independent psychiatric evaluation can provide the agencies responsible for the oversight of health care recommendations for protecting the public through rehabilitation of impaired physicians.

Key Points

1. Obtain specific questions in written form from the referral in advance of the evaluation so that they can be addressed in the report.
2. Obtain written information from the referral source regarding the complaints. Offer the physician examinee the opportunity to supply documentation or suggest third parties who can confirm the examinee's version of events. Compare the evaluee's version of events with those of the agency and those of the collateral sources.
3. Consider using psychological testing to confirm the impressions from the exam. Assess cognitive capacity, utilizing, if indicated, a full neuropsychological battery, medical evaluation, laboratory and image testing, and appropriate substance use testing as indicated.
4. Provide specific recommendations for treatment and supervision. Include the type and frequency and concrete suggestions for monitoring treatment compliance and for workplace monitoring. Make the language accessible to non-mental health readers.
5. Provide suggestions on how to identify early signs of a recurrence of psychiatric illness or relapse of substance use.

References

Alexander, B.H., Checkoway, H., Nagahama, S.I., et al.: Cause–specific mortality risks of anesthesiologists. Anesthesiology **93**, 922–930 (2000)

American Board of Medical Specialties: Board Certification Editorial Background. http://www.abms.org/news_and_events/media_newsroom/pdf/abms_editorialbackground.pdf. Accessed 12 Dec 2011

American Medical Association. Model medical staff code of conduct: https//www.ama-assn.org/resources/doc/omssama-medical-staff-code-of-conduct.pdf. Accessed 12 Dec 2011, Revised 24 May 2010

American Medical Association Opinion E-9.0305 Physician Health and Wellness: American Medical Association. http://www.ama-assn.org/resources/doc/physician-health/policies-physicain-health.pdf, Accessed 2 Feb 2012, Issued June 2004

American Medical Association Opinion on Professional Rights and Responsibilities E-9.045 Physicians with Disruptive Behavior: American Medical Association. http://www.ama-assn.org/resources/doc/physician-health/policies-physicain-health.pdf. Accessed 2 Feb 2012, Issued Dec 2000

American Medical Association: Physician Characteristics and Distribution in the U.S. AMA Press, Chicago (2002–2003)

American Psychiatric Association: The Diagnostic and Statistical Manual of Mental Disorder, 4th edn. (Text revision). American Psychiatric Association, Washington, DC (2000)

Anfang, S.A., Faulkner, L.R., Fromson, J.A., et al.: The American Psychiatric Association's resource document on guidelines for fitness-for-duty evaluations of physicians. J. Am. Acad. Psychiatry Law **33**(1), 85–88 (2005)

Buhl, A., Oreskovich, M.R., Meredith, C.W., et al.: Prognosis for the recovery of surgeons from chemical dependency, a 5 year outcome study. Arch. Surg. **146**(11), 1286–1291 (2011)

Bryson, E.A.: Should anesthesia residents with a history of substance abuse be allowed to continue training in clinical anesthesia? The results of a survey of anesthesia residency program directors. J. Clin. Anesth. **21**, 508–513 (2009)
Collins, C.B.: Chemical dependency treatment outcomes of residents in anesthesiology: Results of a survey. Anesth. Analg. **101**, 1457–1462 (2005)
Cummings, S.M., Merlo, L., Cottler, L.: Mechanisms of prescription drug diversion among impaired physicians. J. Addict. Dis. **30**(3), 195–202 (2011)
DesRoches, C.M., Rao, S.R., Fromson, J.A., et al.: Physicians' perceptions, preparedness for reporting, and experiences related to impaired and incompetent colleagues. JAMA **304**(2), 187–193 (2010)
Domino, K.B., Hornbeim, T.F., Polissar, N.L.: Risk factors for relapse in health care professionals with substance abuse disorders. JAMA **293**(12), 1453–1460 (2005)
Dupont, R.L., McLellan, A.T., White, W.L., et al.: Setting a standard for recovery: Physicians' health programs. J. Subst. Abuse Treat. **36**, 159–171 (2009a)
DuPont, R.L., McLellan, A.T., Carr, G., et al.: How are addicted physicians treated? A national survey of Physician Health Programs. J. Subst. Abuse Treat. **37**(1), 1–7 (2009b)
Epstein, R.H., Gratch, D.M., Grunwald, A.: Development of a scheduled drug diversion surveillance system based on an analysis of atypical drug interactions. Anesth. Analg. **105**, 1053–1060 (2007)
Farber, N.G., Gilbert, S.G., Aboff, B.M., et al.: Physicians' willingness to report unimpaired colleagues. Soc. Sci. Med. **61**(8), 1772–1775 (2005)
Federation of State Medical Boards of the United States, Inc.: A Guide to the Essentials of the Modern Medical and Osteopathic Practice Act. http://fsmb/org/pdf/GRPOL_essentials.pdf (2009). Accessed 12 Dec 2011
Federation of State Medical Boards of the United States, Inc.: Addressing Sexual Boundaries: Guidelines for State Medical Boards. http://fsmb/org/pdf/GRPOL_Sexual%20Boundaries.pdf (2006). Accessed 12 Dec 2011
Federation of State Medical Boards of the United States: Policy on Physician Impairment. Accessed Apr 2011
Federation of State Medical Boards of the United States: Summary of 2011 Board Activities. www.fsmb.org/pdf/2011-survey-of-board-actions-pdf. Accessed 17 Mar 2012
Federation of State Physician Health Programs: Physician Health Program Guidelines http://www.fsphp.org/2005FSPHP_Guidelines.pdf (2005). Accessed 12 Dec 2011
Flaherty, J.A., Richman, J.A.: Substance use and addiction among medical students, residents, and physicians. Psychiatr. Clin. N. Am. **16**(1), 189–197 (1993)
Gabbard, G.O.: Psychotherapists who transgress boundaries with patients. Bulletin of the Menninger Clinic **58**, 124–135 (1994)
Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**(4), S3–S50 (2008)
Gold, M.S., Graham, N.A., Goldberger, B.A.: Second-hand and third-hand drug exposures in the operating room: A factor in anesthesiologists' dependency on fentanyl. J. Addict. Dis. **29**, 280–281 (2010)
Grant, D., Alford, K.: Sanction and recidivism: An evaluation of physician discipline by State Medical Boards. J. Health Polit. Policy Law **35**(1), 867–855 (2007)
Heath Care Quality Improvement Act, 42 U.S.C. 11101 ct seq (1986)
Hickson, G.B., Federspeil, C.F., Pichert, J.W., et al.: Patient complaints and malpractice risks. J. Am. Med. Assoc. **287**(22), 2951–2957 (2001)
Hilliard, J.T.: The threat worse than malpractice. Med. Econ. **80**, 38 (2003)
Hughes, P.H., Brandenburg, N., Baldwin, D.C., et al.: Prevalence of substance use among US physicians. JAMA **267**(17), 2333–2339 (1992)
Irons, R.: The behaviorally disruptive professional. Paradigm Summer, 6–7 (2001)
Janofsky, J.S.: Competency to practice and licensing. In: Buchanan, A., Norko, M.A. (eds.) The Psychiatric Report, Principals and Practice of Forensic Writing, pp. 145–157. Cambridge University Press, Cambridge (2011)

Jesilow, P., Ohlander, J.: The impact of the National Practitioner Data Bank on licensing actions by state medical licensing boards. J. Health Hum. Serv. Adm. **33**(1), 94–126 (2010)
Jost, T.S.: Legal issues in quality of care oversight in the United States: Recent developments. Eur. J. Health Law **10**, 11–25 (2003)
The Joint Commission: Issue 40: Behaviors that undermine a culture of safety issued 9 July 2008. www.jointcommission.org/assets/1/18/SEA_40PDF (2008). Accessed 2 Feb 2012
The Joint Commission: Leadership in healthcare organization. A guide to Joint Commission leadership standards: A governance institute white paper, Winter 2009 Governance Institute San Diego. www.jointcommission.org/assets/1/18/WP_leadership_standards.pdf (2009). Accessed 2 Feb 2012
Knight, J.R., Sanchez, L.T., Sherritt, L., et al.: Outcomes of a monitoring program for physicians with mental and behavioral health problems. J. Psychiat. Pract. **13**(1), 25–32 (2007)
Kohatsu, N.D., Gould, D., Ross, L.K., et al.: Characteristics associated with physician discipline: A case control study. Arch. Intern. Med. **164**, 653–658 (2004)
Kissoon, N., Lapenta, S., Armstrong, G.: Diagnosis and therapy for the disruptive physician. Physician Exec. **28**, 54–58 (2002)
Krizek, T.J.: The impaired surgical resident. Surg. Clin. N. Am. **84**(6), 1587–1604 (2004)
Kuerer, H.M., Eberlein, T.J., Pollock, R.E., et al.: Career satisfaction, practice patterns and burnout among surgical oncologists: Report on the quality of life of members of the Society of Surgical Oncology. Ann. Surg. Oncol. **14**(11), 3043–3053 (2007)
Leape, L.L., Fromson, J.A.: Problem doctors: Is there a system-level solution? Ann. Int. Med. **144**, 107–115 (2006)
Mass. Gen. Laws Ann. ch. 112 § 5f (Westlaw, Current through Chapter 102 of the 2012 2nd Annual Session)
McLellan, A.T., Skipper, G.S., Campbell, M., et al.: Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. BMJ **337**, 1–6 (2008)
Merlo, L.J., Greene, W.M.: Physician views regarding substance use-related participation in a state physician health committee. Am. J. Addict. Psychiatry **19**, 529–533 (2010)
Meyer, D.J., Price, M.: Forensic psychiatric assessments of behaviorally disruptive physicians. J. Am. Acad. Psychiatry Law **34**(1), 72–81 (2006)
Meyer, D.J., Price, M.: Peer review committees and state licensing boards: Responding to allegations of physician misconduct. J. Am. Acad. Psychiatry Law **40**, 193–201 (2012)
National Practitioner Data Bank, 42 U.S.C. 11101 ct seq (1986)
North Carolina Medical Board: Survey of the effect of disciplinary actions on board certification. http://www.ncmedboard.org/images/uploads/minutes_uploads/Investigative_Disciplinary_Committee.pdf. Accessed 12 Dec 2011
Patel, P., Robinson, B.S., Novicoff, W.M., et al.: The disruptive orthopedic surgeon: Implications for patient safety and malpractice liability. J. Bone. Joint Surg. Am. **93**, e126(1–6). http://dx.dol.org/10.2106/JBJSJ.01933 (2011)
Pelton, C., Lang, D.A., Nye, G.S., et al.: Physician diversion program experience with successful graduates. J. Psychoact. Drugs **25**(2), 159–164 (1993)
Pfifferling, J.H.: Physicians' disruptive behavior: Consequences for medical quality and safety. Am. J. Med. Qual. **203**, 96–105 (2008)
Piper, L.E.: Addressing the phenomenon of disruptive physician behavior. Health Care Manag. **22**, 335–337 (2003)
Roback, H.B., Strassberg, D., Iannelli, R.J., et al.: Problematic physicians: A comparison of personality profiles by offense type. Can. J. Psychiatry **52**(5), 315–322 (2007)
Roberts, L.W., Warner, T.D., Rogers, M., et al.: Medical student illness and impairment: A vignette-based survey study involving 955 students at 9 medical schools. Compr. Psychiatry **46**(3), 229–237 (2005)
Rose, G.L., Brown, R.E.: The impaired anesthesiologist: Not just about drugs and alcohol anymore. J. Clin. Anesth. **22**, 179–384 (2010)
Rosenstein, A.H., Russell, H., Lauve, R.: Disruptive physician behavior contributes to nursing shortage. Physician Exec. **28**(6), 8–11 (2002)

Rosenstein, A.H.: Nurse-physician relationship: Impact on nurse satisfaction and retention. Am. J. Nurs. **102**(6), 26–34 (2002)

Rosenstein, A.H., O'Daniel, M.: A survey of the impact of disruptive behaviors and communication defects on patient safety. Jt. Comm. J. Qual. Patient Saf. **34**(8), 464–471 (2008a)

Rosenstein, A.H., O'Daniel, M.: Managing disruptive physician behavior: Impact on staff relationships and patient care. Neurology **70**(17), 1564–1570 (2008b)

Rosenstein, A.H.: The quality and economic impact of disruptive behaviors on clinical outcomes of patient care. Am. J. Med. Qual. **26**(5), 372–379 (2011)

Rosenstein, A.H., Naylor, B.: Incidence and impact of physician and nurse disruptive behaviors in the emergency room. J. Emerg. Med. (March 19 published online ahead of print, 2011)

Schwenk, T.L., Gorenflo, D.W., Leja, L.M.: A survey on the impact of being depressed on the professional status and mental health care of physicians. J. Clin. Psychiatry **69**(4), 617–620 (2008)

Shore, J.H.: The Oregon experience with impaired physicians on probation: An eight-year follow-up. JAMA **257**(21), 2931–2934 (1987)

Stelfox, H.T., Ghandi, T.K., Orav, J., et al.: The relation of patient satisfaction with complaints against physicians, risk management episodes and malpractice lawsuits. Am. J. Med. **118**(10), 1126–1133 (2005)

Substance Abuse and Mental Health Services Administration. Results from the 2009 National Survey on Drug Use and Health: Summary of National Findings, vol. 1. http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9ResultsP.pdf. Accessed 20 Dec 2011

Wall, B.W.: Commentary: The clinical implications of doctors evaluating doctors. J. Am. Acad. Psychiatry Law **33**, 89–9 (2005)

Waters, T.M., Parsons, J., Warnecke, R., et al.: How useful is the information provided by the National Practitioner Data Bank? Jt. Comm. J. Qual. Saf. **29**, 416–4 (2003)

Wettstein, R.M.: Commentary: Quality improvement and psychiatric fitness-for-duty evaluations of physicians. J. Am. Acad. Psychiatry Law **33**, 92–94 (2005)

Chapter 14
Fitness-for-Duty of Law Enforcement Officers

Debra A. Pinals and Marilyn Price

Case Examples

The following fictionalized case examples are being used for illustrative purposes. This chapter will address the issues raised by these examples as they relate to the psychiatric treatment of police officers and related fitness-for-duty (FFD) evaluations. The cases will be discussed again at the end of the chapter.

Officer Jose Perez

Officer Jose Perez has been working as a law enforcement officer for the past 5 years. His performance reports have been solid with no notable difficulties with co-workers, supervisors, or work assignments. His usual assignment is in community policing where he covers a neighborhood known for its high crime rate, gang activities, and rampant drug dealing. In the last year, he had witnessed increased violence and he had to make some difficult arrests. After an incident in which he witnessed and was the first responder to the gang-related shooting of a 16-year-old male, Officer Perez's behavior and demeanor changed. For the following few weeks, he was noted by colleagues to be more irritable, yelling for

D. A. Pinals (✉)
Forensic Education, Law and Psychiatry Program UMass Medical School,
55 Lake Avenue North, Worcester, MA 01655, USA
e-mail: dspinals@pol.net

M. Price
Law and Psychiatry Service Massachusetts General Hospital, Harvard Medical School,
15 Parkman St WAC 812, Boston, MA 02114, USA
e-mail: mprice3@partners.org

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2_14,

no apparent reason, and at times appeared tremulous. He got into a physical fight with another officer with whom he did his patrol duty.

When Officer Perez's Chief called Officer Perez into the office to discuss growing concerns, Officer Perez became angry and began yelling about some perceived slights from other officers. His Chief had Officer Perez's service weapon removed, asked him to take some time off work, and recommended that Officer Perez seek professional help. Officer Perez began seeing a treating psychiatrist. After about 3 months, Officer Perez wanted to return to work and asked his psychiatrist for a letter saying he was able to return and to regain access to his firearm.

Officer Melinda Rhodes

Officer Melinda Rhodes is 24-years old and has been an officer for the past 2 years. Her usual duties involve working with schools as a resource officer and assisting with police training activities. She was recently assigned an additional project that required several late nights. In the last year, she has faced some personal and family problems, including the suicide of a brother after he returned from a military tour of duty in Iraq. In addition, she recently broke up with a boyfriend.

Officer Rhodes began to go out at night and drink alcohol. At work, she was noted to become increasingly flamboyant in her mannerisms and dress. She appeared to have increased energy and went to her police chief asking for additional assignments, though she could not generally complete them. She spoke about wanting to help the Department craft a policy related to "the Forever Safe Program" that involved a complex system of phone check-ins to fellow officers at all hours to ensure that they were feeling well enough to work the following day. Officer Rhodes began to work late evenings and spoke obsessively about the Forever Safe Program. Because of her extreme behaviors, her Chief put her on leave. He requested she enter mental health treatment and requested that she comply with a FFD evaluation.

Detective Sergeant Green

Detective Sergeant Green is a 40-year-old married male who has been a member of the town's police department for 16 years. He was a valued member of the department, had received numerous commendations over the years, and had no history of disciplinary action. Detective Sergeant Green began to show behavioral and emotional changes after the death of his parents in a car accident while they were vacationing out of the state. He began coming to work late more days than not. On two occasions he did not show up for work at all and did not call in advance. Detective Sergeant Green's hygiene deteriorated. He was irritable with the officers whom he supervised and with members of the public. There had been

several letters from members of the public who complained that he had been rude and insensitive. He had not properly reviewed a junior officer's police report, which had omitted certain elements substantiating the charges. This created a problem in the prosecution of the case.

The Chief had spoken to Detective Sergeant Green about his behavior. Detective Sergeant Green admitted to the Chief that he had been depressed since the death of his parents and had not been functioning well at work. He said that he was having difficulty concentrating, had a "short fuse," and needed time off. Detective Sergeant Green asked to take a medical leave so that he could undergo appropriate treatment. Detective Sergeant Green did not suggest at that time that his symptoms were due to any work-related incidents. A formal fitness for duty evaluation was not requested because Detective Sergeant Green agreed to seek treatment voluntarily. Detective Sergeant Green was told that his physician would need to clear him before he could return to work.

After Detective Sergeant Green had been on medical leave for 6 weeks, the Chief received a note from the treating psychiatrist, Dr. Smith, indicating that Detective Sergeant Green was suffering from Posttraumatic Stress Disorder and recommending that Detective Sergeant Green be placed on "injured on duty" status. Dr. Smith opined that Detective Sergeant Green had been exposed to several critical incidents in the past 3 years, which were the cause of his current difficulties and that he could not return to work for a period of at least 8 weeks. The Department then requested an evaluation of Detective Sergeant Green's current fitness for duty and whether any work impairment, if present, was related to his employment as a police officer.

Law Enforcement: Basic Job Requirements

Law enforcement work is a unique type of activity that requires a specialized knowledge of the rules and regulations to which an officer is subject, people skills, and technical expertise related to high-risk activities associated with maintaining public safety. This technical expertise includes knowledge of tactical strategies, understanding of policies and laws, as well as technical abilities and skills required to operate equipment ranging from computers to motor vehicles and weapons.

Officers may have a variety of job duties, but many of these present with unique stressors, including exposure to violence or traumatic incidents that may place the officers at increased risk of psychological sequelae from their work. In providing psychiatric treatment for police officers or assessing any officer in a FFD evaluation, mental health professionals should have a good understanding of job duties as well as the social network and peer relations that can contribute to both the stress and the resiliency that affect officer well-being. Given the multiple stressors that an officer may face, and ready access to firearms, inquires regarding suicidal thoughts or behaviors are particularly critical to keep in the forefront of

assessments. In addition, FFD examinations must also focus on firearm access and the balancing of risks and responsibilities required of their use in the law enforcement context.

Legal and Procedural Context of the Assessments

Referral for FFD Evaluation

Treating mental health professionals should generally work with law enforcement officer-patients to identify etiology behind symptoms and work toward symptom reduction as they would with any patient. The most effective treatment provides an officer-patient the greatest chance for improving occupational capacity if that has been impaired.

The role of the treating clinician is to work with the patient toward a common goal of symptom improvement and recovery. Police departments may not accept a treatment provider's opinion that an officer is able to return to work especially when there has been a need for firearm removal. The department may order an independent FFD evaluation. There are many reasons for this, including the complexities of a dual role since the treatment provider works for the patient, while the FFD evaluator typically undertakes an assessment at the request of the employer. The treating clinician generally relies on the self-report of the patient while an independent evaluator would additionally gather information from collateral sources.

In addition, the FFD evaluation may become a point of litigation, and thus could interfere with the therapeutic alliance established in the treatment relationship. An officer may already be in treatment with a mental health professional, or an officer could have been referred for emergency psychiatric treatment when there is evidence of imminent danger to self and others. The Employee Assistance Program (EAP) or treating mental health professional may aid the department in arranging for emergency treatment including psychiatric hospitalization, supporting law enforcement patients through what is typically a very stressful and difficult process. Even if asked to provide a FFD for one's own patient, the treating clinician may wish to consider declining, and referring the patient or requesting agency to an independent mental health evaluator with the recognition that the goal of a FFD evaluation is different from that of treatment.

When referring a case for independent evaluation of fitness for duty, there is a certain expertise that is well suited for these types of evaluations. For example, an independent evaluator should ideally have some background and experience doing disability- and FFD-related assessments. Referrals to mental health professionals who also have experience with police matters should also be considered. Forensic training can be very helpful in sorting through complex legal and regulatory nuances in this specialized job-related type of evaluation, as well as in understanding the application of risk assessment, report writing, and testimony.

In contrast with treating clinicians, mental health fitness for duty evaluators have a specific and limited role, within which evaluators have an allegiance to the retaining party (e.g. the police department), to try to answer concrete questions concerning occupational ability/capacity. Treating clinicians should, however, have a working understanding of the requirements of the FFD evaluations, as their officer-patients may be subject to a FFD evaluation, and treatment providers may be contacted by an evaluator to provide information regarding treatment progress and diagnostic assessments.

According to the International Association of the Chiefs of Police (IACP) Police Psychological Services Section (IACP 2009), a fitness-for-duty evaluation (FFDE) should be requested when there is "objective evidence that the employee may be unable to safely or effectively perform a defined job" and there is a "reasonable basis for believing that the cause may be attributable to a psychological condition or impairment." Further, "the central purpose of a FFDE is to determine whether the employee is able to safely and effectively perform his or her essential job functions" (IACP 2009). In determining the appropriateness of a referral for a psychiatric/psychological fitness for duty evaluation, Chiefs of Police may rely not only on their direct observations but also on reliable observations of other department members and members of the public (Collins 2011). Fischler and colleagues (Fischler et al. 2011) report that red flags signaling the need for a FFD evaluation can include "threats to self or others, suicide attempts, psychiatric hospitalizations, or observed symptoms" such as "frequent crying, uncharacteristic irritability, and excessive suspiciousness."

Fischler and colleagues (2011) also point out that the Occupational Safety and Health Act of 1970 (OSHA 1970) requires employers to provide workplaces free from known hazards that can cause death or serious harm, and in this way FFD evaluations provide a vehicle for the law enforcement agencies to demonstrate their compliance with this requirement. According to *Brownfield v. City of Yakima* (2010), a United States Court of Appeals case that upheld a mandatory FFD evaluation of a police officer, "Undisputed facts show that the officer exhibited highly emotional responses on a numerous occasions in 2005, four occurring in a single month immediately prior to the referral. Police officers are likely to encounter extremely stressful and dangerous situations during the course of their work" (*Brownfield v. City of Yakima* 2010).

The IACP guidelines also recommend that given the intrusive nature of the FFD evaluation and the need to obtain personal and private information about the employee, that FFD evaluations would most appropriately be conducted, "when the employer has determined that other options are inappropriate or inadequate in light of the facts of a particular case. The FFD evaluation is not to be used as a substitute for disciplinary actions" (IACP 2009). Collins (2011) also cautions that the request must be supported and must not be used as a mechanism for retaliation or based on other inappropriate motivations. Complaints or harassment or Americans with Disabilities Act (ADA) claims may arise in response to a request for a fitness-for-duty evaluation (Collins 2011).

Treating mental health professionals may need to understand some of the contexts in which FFD evaluations may be requested and the legal complexities involved. Collins (2011) notes that the courts have supported the request for a FFD evaluation after an officer was accused of abusing a citizen with the officer's firearm (*Conte v. Harcher* 1977), in response to "rapid variations in mood, excessive absenteeism, high use of sick leave, [and] excessive tardiness" (*Wuertz v. Wilson* 1996) and following an officer making "threats of physical harm" (*Flynn v. Sandahl* 1995). However, courts have also failed to find adequate cause under other circumstances such as for a FFD evaluation request when an officer used obscene language when speaking to another police employee (Maplewood and Law Enf Labor Service 1996). The Court also rejected disciplinary action and a FFD evaluation request that appeared to stem from retaliation against a Captain who had filed a grievance protesting his Chief's order banning a cartoon in the fire station (*Watts v. Alfred* 1992).

In addition to obligations to refer officers for FFD evaluations appropriately, legal cases have upheld that, depending on circumstances, police employers have an obligation to continually ensure that employees (i.e. the officers) are mentally fit to function in their role as law enforcement officers. In one case, *Bonsignore v. City of New York* (1982), a case that involved an officer who shot his wife and then killed himself, the City was found negligent for failing to identify one of their officers as having emotional problems despite multiple warning signs. This case identified that police departments have been held to have a duty to monitor the psychological fitness of officers and take reasonable precautions to avoid hiring and retaining officers who are psychologically disturbed.

Several legal cases have revolved around factual patterns wherein police departments and towns were questioned vis-a-vis their responsibilities when weapons used in violent or suicide incidents involved the police officer's use of a personal firearm or a service firearm (*Johnson v. Mers* 1996) or whether actions taken occurred on or off duty (*Mendoza v. City of Los Angeles* 1998; *People v. McRae* 2004). These nuances would not enter into a treatment dialogue in most treatment contexts. However, it is important for the treating psychiatrist to realize whether their police officer-patient has access to weapons, and it would be important to ask specifically both about service-issued firearms and personal firearms. Also, a treating psychiatrist might want to engage in dialogue with a law enforcement officer-patient related to whether the patient is still working and if so in what capacity.

In a 1991 case against the City of New York, the court did not accept plaintiff's argument that a policy of restoring or retiring officers within 1 year of being placed on restrictive duty played a role in an officer's suicide (*Cygan v. City of New York* 1991). In this case, the decedent had been on restricted duty for several months, and after a variety of evaluations, he was determined to be appropriate for a return to full duty with guns. He committed suicide while off duty about 4 months later. This case illustrates that a determination of when an individual is ready to return to full duty can be at issue, and a FFD evaluation may be used to determine this, but a

treating psychiatrist's work with a patient and the patient's progress may also be factored into the return-to-work analysis.

Although case law and professional guidelines emphasize the importance of FFD evaluations, supervisors have discretion in ordering the FFD evaluation, and law enforcement agencies often recognize the importance and need for programs that help police officers deal with the stress they face during the course of employment. Thus, the ability to obtain a FFD evaluation should not serve as a replacement for a comprehensive policy for providing mental health interventions for at risk officers and a means for confidential referrals (Pinals and Price 2010).

In fact, depending on the presentation of the officer, many departments will seek to have an officer obtain voluntary treatment services prior to proceeding to a formal fitness-for-duty evaluation. Employee Assistance Programs (EAPs) generally are available either in-house or through an outsourced agency that allows for confidential referral, brief counseling, and linkage to a variety of treatment programs and providers. Self-referral and referral by peer counselors is also utilized as a vehicle for EAP program access (Finn and Esselman-Tomz 1996, 1998). In this way, a supervisor can recommend services or contact at any point for an officer exhibiting signs or symptoms of emotional difficulties in the context of their work.

Some departments have special provisions for officers exposed to a critical incident including a requirement to see a mental health professional (Pinals and Price 2010). Critical incidents can be defined as any event that has a stressful impact that proves sufficient to overwhelm the usually effective coping skills of an individual (Kureczka 1996). Examples of critical incidents for law enforcement personnel include line of duty shootings; death, suicide, or serious injury of co-workers; homicides; and hostage situations (McNally and Solomon 1999).

Clinical Context of the Evaluations

As stated above, law enforcement officers have complex roles and responsibilities that require intact capacities to function. Law enforcement is often viewed as a profession that comes with tremendous stress and exposure to potential dangers. Law enforcement officers face increased risks of accidents, physical injury, homicide, as well as psychological harm (Violanti et al. 1996). Valentino (2000) pointed out that psychological harm in particular can stem from exposure to death, human misery, inconsistencies in the criminal justice system, and aspects of the job that involve negative public image. Line of duty shootings, deaths on the scene, particularly those involving a child, suicide or serious injury of co-workers, homicides, and hostage situations, among others can be considered among the critical incidents that may lead to psychological symptomatology and the need for subsequent evaluation (Gold et al. 2008; Miller 2006).

Specific potential sequelae have been described that relate to the stresses officers face. For example, problems that have been documented related to officer physical and emotional health include increased risk of alcohol/drug abuse,

ischemic heart disease, marital problems, excessively aggressive conduct, premature retirement, disability, and possibly an elevated suicide risk (Davey et al. 2000; Hem et al. 2001; Kapusta et al. 2010; Marzuk et al. 2002; Neylan et al. 2002; North et al. 2002; Pinals and Price 2010; Richmond et al. 1998; Tüchsen et al. 1996).

Stuart (2008) noted that there are conflicting data with respect to whether law enforcement officers are at increased risk of suicide. He pointed out that the increased risks of PTSD and job burnout have received attention but personality factors and coping styles have not been systematically studied as contributing causes. Violanti has questioned the validity of police suicide rates because of misclassification (Violanti 2010) and problems with the methodology of related studies (Violanti 2008). Regarding misclassification of deaths, Violanti (2010) noted that male police officers had a 17 % increased risk of being misclassified as undetermined. The risk of misclassification was also increased for female and African-American officers. The risk of misclassification for police officers was higher even when compared to military or firefighters. In terms of other data examining law enforcement stressors and risks, Violanti (2007) reviewed 29 cases of homicide/suicide in police families occurring in 2007. A total of 89 % of the homicide victims were women but five men were killed by a female officer. In 90 % of the incidents, the police service weapon was used.

Repeated exposure to incidents of a critical and potentially life-threatening nature also place officers at risk for the onset of Acute Stress Disorder and Posttraumatic Stress Disorder (Carlier et al. 1997; Kopel and Friedman 1997; Rivard et al. 2002; Sims and Sims 1998; Stephens and Miller 1998).

Although at any given point an officer may become impaired due to personal, medical, and/or work-related factors, the stressful nature of a law enforcement officer's job may place them at particular risk for work-related dysfunction. For example, exposure to critical incidents can also lead to potential career threatening reactions including overreaction to perceived threats or alternatively underreaction to clearly dangerous situations (Pinals and Price 2010). Decker (2002) points out that officers who are exposed to critical incidents may, in addition to developing stress-related illnesses, have disciplinary problems or develop burnout or substance abuse difficulties. Early retirements or resignations may also be seen as a result of exposure to these highly stressful encounters. In the 1970's, one report noted that about 70 % of officers who used fatal force left law enforcement within 5 years (McNally and Solomon 1999).

As noted above, officers may be referred by their departments to critical incident stress management programs (Carlier et al. 1997). FFD evaluations (Miller 2007) are separate from these interventions. The FBI's Critical Incident Stress Management Program includes interventions such as defusing and debriefing, peer support, family outreach, manager support, referral for therapy, and post-critical-incident seminars (McNally and Solomon 1999; Pinals and Price 2010).

Considerations for FFD Evaluators and Treating Clinicians

1. Requests for Assessments of Ability to Work

Prior to meeting with the law enforcement officer, the FFD mental health evaluator should establish the terms of the engagement with the retaining party. Generally speaking, these examinations will be funded directly through the Police Department or the relevant city, and thus retainers are not generally necessary. Individual officers at times contact mental health professionals to conduct FFD assessments so that they can be "cleared for work." Mental health professionals who undertake to provide FFD evaluations should do so via a third-party referral source, (e.g. police departments, attorneys representing an individual officer) rather than working directly with the police officer. This approach can minimize the potential for confusion related to serving dual roles as both independent evaluator and treatment provider, especially should the evaluation become the subject of litigation.

The IACP 2009 guidelines for FFD evaluations specifically address dual relationships noting that,

> examiners should decline to accept an FFDE referral when personal, professional, legal financial or other competing interests or relationship could reasonably be expected to: 6.1.1. impair their objectivity, competence or effectiveness in performing their functions; or 6.1.2 expose the person or agency with whom the professional relationship exists to harm or exploitation (e.g. conducting an FFDE on an employee who had previously been a client in counseling or therapy, evaluating an employee with whom there has been a business or significant social relationship, etc.). Similarly, an FFDE examiner should be mindful of potential conflicts of interest related to recommendations or the provision of services following the evaluation (e.g. referring an examinee to oneself for subsequent treatment). If such conflicts are unavoidable or deemed to be of minimal impact, the examiner should nevertheless disclose the potential conflict to all affected parties. (IACP 2009)

As seen in the case of Officer Perez, treatment providers may be asked at times to write letters regarding readiness to return to work on behalf of law enforcement officer-patients. Information contained in such letters should be authorized for disclosure by the officer-patient. In addition, in this treatment context, conclusory opinions such as "fit for duty" should be offered with caution. In some cases a treatment provider may wish to seek consultation from colleagues and from malpractice carriers to review what should or should not be documented in such a letter. In these instances, treatment providers should consider offering factual information related to engagement in treatment and presence of symptoms.

For example, a letter from a treating mental health professional might delineate that the patient has been in treatment, the frequency and duration of the treatment, and a statement related to whether the officer-patient reports his or her own adherence with treatment recommendations. Observations of mental status examination shifts (e.g. "Mr. Jones has described fewer depressive symptoms," or "Mr. Jones has appeared more engaged in treatment and has shown improved

concentration") may also be useful statements. It is important, however, for treating clinicians to recognize that their data is "one-sided" in that it generally involves observations and the patient's self-report of symptoms, and thus would not include the comprehensive analysis of numerous sources of information as would an independent evaluator's FFD assessment.

2. Review of Collateral Records

Job Description

In most cases, a treating clinician would not be in a position to review collateral records (such as job-related documents about work performance or work duties) for a law enforcement officer-patient. The treating clinician would rely upon information and descriptions provided by their law enforcement patient. Nevertheless, it is useful to understand how these sources of information are examined in the context of independent FFD assessments. The FFD evaluation of a law enforcement officer requires that mental health clinicians familiarize themselves with the specific functions of the particular officer (Finn and Esselman-Tomz 1996; Gold et al. 2008; Pinals and Price 2010) and the nature of police work in general (Gold et al. 2008; Miller 2007). Evaluators should also be familiar with conducting independent assessments related to work functioning (see e.g. Gold et al. 2008).

It is generally desirable for the referring agency to provide documentation of the objective evidence that forms the basis for seeking the FFD examination (Gold et al. 2008; IACP 2009). Although at times information will be supplied to the examiner in advance, should that not be the case it is also recommended that the evaluator request that the department supply information about the officer's history within the department including work performance, conduct, commendations, citizen letters of appreciation or complaint, disciplinary and civil claims history, remediation efforts, internal affair investigations, involvement in critical incidents and use of force incidents, incident reports of any triggering events, earlier periods of disability, previous referral to EAP, and available treatment records (Anfang and Wall 2006; Gold et al. 2008; IACP 2009; Pinals and Price 2010).

Clinical Records

In conducting a FFD evaluation, records of medical, psychological, and substance use treatment should be gathered, preferably in advance of the evaluation if they are available, or after a first meeting with the officer during which time appropriate releases of information can be obtained. Collins (2011) notes with respect to records,

> The Chief may order the employee to either obtain these records or to sign a form authorizing the employer to obtain copies. However, it is best if the evaluator convinces the employee to sign a release for this information so that the employer is not in possession of unrestricted private information.

Given that a FFD evaluation will generally include a request to obtain treatment records, treating clinicians should be mindful that their own records may become part of the information used in a FFD evaluation. Regardless, treating clinicians

should document any relevant clinical information just as they would in the course of any treatment. As noted, the police officer-patient who is required to undergo a formal fitness for duty evaluation would also be asked to sign appropriate releases of information. Given that the information may end up in an employer's file, it is important for the treating clinician to ensure that release of information requests are completed in full and that the patient is aware that medical record information has been requested and is being shared based on an adequate release.

Additional Collateral Data

It is typically helpful in conducting the FFD evaluations to seek information from collateral sources of information as needed to address the questions at hand (see e.g. IACP 2009 Guideline 9,1,4). In terms of collateral sources of information, consideration of speaking to individuals who can comment on the officer's functioning overall may be useful. This may include conversations with the mental health professional providing treatment to help gather information that may not be gleaned from the written records. The signed release of information should include permission to speak to the treating clinician as well as obtain written treatment records.

3. Interview of the Officer

Once the terms of engagement have been established, the examiner should schedule a time to meet with the law enforcement officer. Since officers may have access to service weapons, the referring agency should be told to advise the officer not to bring the service weapon to the interview. Generally, a single interview of 3–4 hours can be sufficient to obtain the data needed in complex cases, but it may be necessary to see the officer more than once. Clinicians performing FFD evaluations should be aware that these evaluations can be very stressful for the officer. Officers may present as anxious, or they may minimize impairments or problems because of a desire not to be taken off duty or not to be placed on light duty.

Informed Consent and Confidentiality

In a treatment context, the officer can retain the right to keep confidential information from being utilized in court contexts, and the mental health clinician has the obligation to hold information shared in confidence. With the appropriate signed authorization to release information for an employment evaluation, much of these confidences fall away because the officer has granted the permission for the information to be utilized in the work-related context. Once the information is shared with the employer, it likely would not be protected in the same way.

With the appropriate release of information, mental health treatment providers can reveal information and should convey facts as requested. If treatment providers are uncertain that the patient would truly want information shared, they might wish to contact the officer-patient prior to sharing the information to discuss and ensure that the officer-patient understands what information may be shared. This type of conversation, if held, would best be documented in the medical record

as an indication of the patient's views about sharing information in these employment contexts (in addition to any signed release).

For the FFD evaluator, informed consent is obtained at the outset of the officer's clinical interview. With regard to obtaining informed consent in a FFD context, the 2009 IACP Guideline 8.3 includes the following comment: "In obtaining informed consent, it is recommended that the examiner obtain written authorization from the employee to release the examiner's findings and opinions to the employer. If such authorization is denied, or if it is withdrawn once the examination commences, the examiner should be aware of any legal restrictions in the information that may be disclosed to the employer without valid authorization" (IACP 2009).

Collins (2011) notes that "While some examiners require the employee to sign a form indicating they are voluntarily agreeing to be examined, this is mostly for the examiner's personal liability purposes. Employees should be ordered by the employer to sign a release authorizing the examiner to share all relevant information with the employer and to make a report on the officer's fitness for duty." In a FFD context, if the officer is unwilling to specifically authorize the evaluation and the release of information back to the employer or retaining party, it generally would be prudent to stop proceeding and refer the issue back to the referring police department, encouraging the officer being evaluated to consult with his or her attorney or union representative.

Generally speaking, courts do not recognize information as privileged when an officer knew that the information obtained would be shared with a superior (Broun 2004). In *Scott v. Edinburg* (2000), the court concluded that no psychotherapist–patient privilege existed where a police officer was informed at the outset that an evaluation and testing would be reviewed by the police chief and the related reports could be subject to subpoena. Similarly, unlike mental health treatment records, specific records related to employment evaluations were considered to not be privileged in the case of *Estate of Turnbow v. Ogden City* (2008).

Although the examiner indicates at the outset that there may be some expectation of limited disclosure (to the referring body and the workplace, but not to the public at large), there are still exceptions regarding even limited disclosure. For example, further disclosure of reports could ensue if the officer has a pending law suit, arbitration, grievance, or disability claim or challenge. Given how courts have generally viewed this issue when it has been raised, as noted above, it is important to disclose at the outset of an evaluation of the limits of confidentiality of the information to be obtained.

Psychiatric Assessment Interview

Following the informed consent process, the FFD evaluator performs a detailed mental health interview. Psychological testing and possible consultation with other experts may be helpful depending on the particular case and has been recommended as component parts that may frequently be included in FFD evaluations (IACP 2009). The decision to obtain additional testing and consultation is generally at the discretion of the mental health evaluator who should have a rationale

for why specific components of the assessment are or are not utilized. Typical mental health interviews for FFD evaluations might consist of:

1. Personal and family background and development
2. School history (including any early conduct disorder issues)
3. Employment history (including financial background details such as current income, disability income if any, income prior to leaving work duty)
4. Relationship history
5. Psychiatric history
6. Family history of mental illness
7. Substance use history
8. Medical history
9. Legal history (including any criminal charges and civil litigation)
10. Mental Status evaluation
11. Specific FFD focused questions
    (a) Work-related stressors (burnout, conflict with peers or supervisors, exposure to critical incidents, etc.)
    (b) Violence and suicide-specific questions (with inquiry related to thought of harming self or others with own weapons or service authorized weapons)
    (c) Present medical leave status and motivation to return to work and active treatment
    (d) Current activities (social functioning, outside employment activities, etc.)
    (e) Current financial circumstances (e.g. current income and source of income, timing of remaining disability income, etc.)

FFD evaluations conducted by mental health professionals should elicit whether psychiatric disorders impair the officer's ability to function in his or her role at work and examine any contributing variables, such as substance use, that may be a focus for intervention. In addition, it will be important to elicit the officer's perspectives of current relationships with co-workers, especially given the need to work closely with colleagues and the tight social network among police (Pinals and Price 2010).

In addition to the aspects of assessment noted above, a FFD of a law enforcement officer should include a comprehensive suicide and homicide risk assessment. Janik and Kravitz (1994) reviewed the records of 134 police officers at the time of their first fitness-for-duty evaluation and found that 55 % of officers admitted to previous suicide attempts. Among those at highest risk were officers reporting marital problems, who were 4.8 times more likely to have attempted suicide and officers who had been suspended who were 6.7 times more likely to have attempted suicide than those who had never been subject to a suspension. A recent study of 115 police officers found that certain types of traumatic work exposures increased the risk for severe symptoms of Posttraumatic Stress Disorder (PTSD). These symptoms were associated with an increase in alcohol use and

suicidal ideation. Violanti (2004) found that the combination of a high level of PTSD symptoms associated with increased alcohol use resulted in a tenfold increase in suicidal ideation. Stuart (2008) noted that exposure to workplace trauma and organizational stress contributed to police suicide risk, but also commented on the need to examine personality factors and coping styles as a contributing factor. Thus, consideration of the above would be important in a comprehensive FFD interview.

4. Opinions Related to Fitness for Duty

The ultimate decisions as to whether an officer is "fit" or "unfit" generally falls under the purview of the referring police department. To help inform this decision, it is recommended that opinions of FFD mental health evaluators provide a clear description and opinion as to whether an officer's symptoms create impediments to working. As discussed above, treating clinicians would do best to avoid being placed in such a position that would require these types of complex decisions. A treating clinician would generally provide data related to treatment progress as noted above (but might obtain or refer the officer for additional forensic consultation or avoid formal opinions to the police department about readiness to return to work or specifics related to fitness to carry a firearm).

For the FFD evaluator, there is some debate about the specific language that should be used to form the opinion. Although some experts appropriately choose to avoid the words "fit" or "unfit," the IACP guidelines (2009) Sect. 10.1 specifically recommend that the FFE examiner provide, when possible, "a clearly articulated opinion that the examinee is presently fit or unfit for restricted duty." In terms of articulating impairments, the IACP Sect. 10.2 guidelines advise, "When an examinee is found unfit for unrestricted duty, it is advisable that the report contain, at a minimum, a description of the employee's functional impairments or job relevant limitations unless prohibited [by legal or related restrictions]" (IACP 2009). The guidelines go on to delineate that opinions are offered based on the information available at the time of the evaluation (and many examiners include this statement in their report). It is recognized that if new information comes to light there may be a request or need for an updated evaluation. Many evaluators will include a statement to that effect in their report.

Expanding somewhat on the aforementioned recommendations, in the Agency for Healthcare Research and Quality (AHRQ) guidelines clearinghouse of the Department of Health and Human Services, it is suggested that in fitness-for-work evaluations, evaluators utilize six possible judgments: "fit, temporarily fit, fit subject to work modifications, temporarily fit subject to work modifications, temporarily unfit, and permanently unfit" (Work Loss Data Institute 2010). If the evaluation includes issues related to the Americans with Disabilities Act, then the evaluation should include opinions as to whether there is a permanent impairment that substantially limits one or more major life activities (see Chap. 10). This is in addition to assessing work capacity, workplace demands, and the evaluee's ability to perform the essential functions of the job with or without accommodations.

The referring agency will often request an opinion regarding prognosis with or without treatment. In determining the prognosis, the evaluator should consider the officer's amenability to treatment intervention. The evaluating mental health professional should take into account the potential side effects of treatment on the functional capacity of an officer especially in terms of the safe use of firearms. Impairment due to the underlying condition as well as impairment due to medication side effects can impact judgment, reaction time, memory, and fine motor skills. If psychological testing has been used, the impairments found should be summarized and related to deficits in occupational functioning (Anfang and Wall 2006; Decker 2002; Rostow and Davis 2002, 2004).

When forming an opinion regarding a police officer's fitness for duty, the mental health evaluator should take into account the unique job requirements. The AHRQ guidelines emphasize the need to appreciate the specific tasks and work demands of a particular position. They recommend that the evaluating mental health professional assess the completeness and validity of the medical information available, potential impairments, permanency of impairments, as well as identify impairments that "may result in a sudden or gradual adverse consequence or a 'direct threat' (i.e. significant risk of substantial harm to the health or safety of self, co-workers, or the public that cannot be eliminated by reasonable accommodation") (Work Loss Data Institute 2010). The FFD assessment related to firearm access is discussed further below.

5. Assessment Related to Carrying a Firearm

Police officers generally must be able to carry firearms and they may be placed in a position in which they are required to make on the spot life and death decisions (Decker 2002). Police officers may need to defend their conduct in court and their mental state may become a focus of the litigation. There can be accusations that an officer acted irresponsibly by shooting a suspect without justification or alternatively failing to act because of immobilization or fear. Reaction times and tendency toward over- or under-reaction could affect the ability of an officer to make the needed quick decisions that could be of life and death proportions (Decker 2002; Gold et al. 2008). Use of a weapon also requires appropriate fine motor skills and processing speed. Side effects of medications can contribute to difficulties in fine motor coordination, processing speed, somnolence, etc.

Access to a firearm could be a serious concern when an officer may be at increased risk of suicide or homicide. There is a distinction, however, between emergency removal of a firearm and the issue of the police department making a decision to return a firearm to the officer after weapon removal. Often a firearm will already have been removed prior to the FFD evaluation. The department in such a circumstance may remove the service firearm as well as personal firearms. The officer will have been referred for emergency psychiatric treatment when there is evidence of imminent danger to self and others. The EAP or treating mental health professional may aid the department in arranging for emergency treatment including psychiatric hospitalization.

Mohandie and Hatcher (1999) recommend that after an officer's weapon has been removed, instituting a 30–60 day period during which the officer is precluded from carrying a weapon would allow sufficient time for addressing the precipitating factors and current circumstances. The issue of whether the firearm can be safely returned to the officer then often becomes an important consideration in the FFD evaluation.

A FFD examiner must therefore, assess whether there is a psychiatric condition that may impair the functions needed to operate a firearm safely. Opinions from a FFD examiner must be individualized and relevant to the particular circumstances and police officer. In addition, in some cases the FFD examiner may wish to alert the police department if specific issues related to loss of the ability to carry a firearm are raised in the context of the evaluation (e.g. such as increased hopelessness and worthlessness). The mental health evaluator's report should be careful about spelling out in clear terminology the issues that might impact the officer's abilities relevant to firearm usage, to facilitate the police department in making what can be a difficult decision. Thus, recommendations that delineate relevant clinical factors and individualized issues will assist the police department most since in FFDs, and the mental health evaluator does not make the ultimate decision related to service weapon removal.

Given the complex nature of this type of assessment and their role as treatment providers rather than objective evaluators, treating mental health clinicians would likely not be in the best position, nor have sufficient information, to make such a judgment regarding firearm usage with such high stakes consequences. As noted above relevant to more general fitness questions for an officer, if asked by police-patients to offer an opinion related to firearm access, a treating clinician may wish to refer the officer or obtain consultation from forensic evaluators on the relevant issues. Although in the FFD examination an examiner may be asked specifically about issues relevant to carrying a service weapon, as noted above officers may have personal weapons available to them. Therefore, when assessing an officer and when addressing suicide and homicide risk, as previously described, access to non-service connected weapons should be explored and considered. Mental health treatment providers and independent mental health fitness for duty evaluators alike should be cautious in doing risk assessments. They should not assume that if a service weapon is removed, the officer no longer has access to weapons.

An officer's full unrestricted duty usually includes carrying and being prepared to use a weapon. An officer whose service-issued weapon is removed because of concerns regarding the officer's mental health often experiences or perceives social stigma from peers, loss of self-esteem, and embarrassment. Moreover, if the FFD evaluator indicates that safety is compromised if a particular officer continues to have access to a weapon, there can be profound job implications, ranging from removal from full duty at a minimum, to being taken out of the workplace altogether. Thus, weapon removal or non-return can also precipitate further despondent feelings for officers whose identities may be tied to the sense of pride in their work and sense of trust that being afforded the opportunity to remain armed conveys. In these contexts, additional mental health treatment supports and

services may be needed for the officer who may have a secondary emotional reaction to the sudden loss of employment status and function.

6. Formulating FFD Report Content

FFD reports are produced to facilitate the police department's ability to determine whether an officer is fit to return to work. Although in many cases, the officer being evaluated is eager to return to work, it is recognized that others may be litigious or in search of secondary gain through the fitness-for-duty situation (Anfang and Wall 2006; Decker 2002; Gold et al. 2008). Thus the report framework should keep that in mind and indications related to malingering, symptom minimization, or other matters should be addressed if they arise.

As noted above, in formulating the report contents, mental health evaluators should consider the workplace demands, the officer's unique background, and current impairments. The AHRQ guidelines (Work Loss Data Institute 2010) recommend avoiding the term "disability" since it encompasses both impairments and other factors as they relate to workplace function. Instead, they recommend utilizing the term "impairment" to describe the limitations of the evaluee.

Disclosure of report contents and related information will be governed by agency policy and relevant laws related to the extent personal information is revealed in the report (Anfang and Wall 2006; Gold et al. 2008; Rostow and Davis 2002). A report provided to the department will generally become part of the confidential personnel record, although mental health evaluators cannot assume that there is a guarantee that it will remain confidential (Pinals and Price 2010). Mental health evaluators would not know who in the department (and beyond) may have access to the personnel files, and departmental policies related to access may shift over time.

Thus, a FFD report should contain only the information necessary to document the presence or absence of job-related personality traits, characteristics, disorders, propensities, or condition that would interfere with the performance of essential job functions (Fischler et al. 2011). The amount of information given to supervisors should be limited to issues related to addressing referral questions (Pinals and Price 2010; Rostow and Davis 2002). (See Chap. 2 for additional discussion of the release of information in FFD evaluations.) In some jurisdictions, more detailed reports will be expected to address the questions, especially when there is a need to delineate causation related to the impairments. It is important to review with the retaining department or agency the expectations for typical report content.

7. Recommendations for Treatment and Potential Accommodations

A retaining police department may specify that it does not want any opinion related to the adequacy of the current treatment. However, after a full examination and review of the data, the mental health evaluator is at times asked to consider whether the treatment the officer is getting is sufficient and appropriate, and if not, to provide additional treatment recommendations. Typically, a mental health FFD will focus on general psychiatric and psychological treatments.

Some law enforcement services consist of "first responders" to violence and terror situations, and mental health services for these unique workforces may also include treatments that focus on suicide prevention (Levenson et al. 2010) and PTSD. In those services, having a "peer component" (i.e. a specialized treatment intervention where many first responders get help and therefore can share their experiences and personal stories for mutual support) can be viewed as helpful. Medication treatment for specific symptom presentations may be indicated, as well as psychosocial treatments. Interestingly, there is minimal data available related to the benefits of psychosocial interventions provided to police officers for physical and psychological symptoms such as anxiety, depression, PTSD, sleep difficulties, anger, cynicism, marital problems, and distress (Peñalba et al. 2008). Further research is needed in this area.

Treatment recommendations made by the mental health FFD evaluator may or may not be shared with the treating mental health clinician by the department or agency which receives the report. When they are shared, treating clinicians will hopefully view the FFD evaluation as similar to an outside consultant's recommendations, even though the original purpose was meant to help the police department make job-related decisions. The treating clinician may or may not agree with the recommendations of the FFD evaluators.

Whether the treating mental health clinician agrees or disagrees with the independent evaluator's recommendations, it may be useful for the treating clinician to discuss with the law enforcement officer-patient the current treatment plan, and the FFD evaluator's recommended treatment plan. This discussion can include the risks and benefits of both courses of treatment (if different), and can provide reassurance if the recommendations are similar. When the recommendations are different, then a careful analysis of the best course of action and treatment focus, with engagement of the patient and informed consent practices can help foster a sense of trust in the treatment relationship and help move the treatment forward.

When a law enforcement officer is felt to be fit but only if subject to work modifications, according to the AHRQ guidelines, the mental health evaluator is essentially making and communicating the judgment that the employee would be a hazard to himself or herself or others if employed without such modifications. Thus, necessary modifications should be described as clearly as possible (Work Loss Data Institute 2010). Also, if the employee is thought to be unable to work safely even with modifications, then there should be some discussion as to whether this impairment appears permanent or temporary.

Mental health evaluators should familiarize themselves with the accommodations and work modifications (such as light duty) that may be available to the officer (see Chap. 4). Departments may not be required to create "light duty" or other positions as a form of reasonable accommodation. Furthermore, "light duty" may not be clearly defined and should not be recommended without a clear description of what is intended as the modification. The development of a plan for altered functions, including something the police department might refer to as "light duty" would be up to managerial discretion. Recommendations regarding

modifications will be viewed related to their apparent reasonableness for the department to provide without jeopardizing the department's functions. However, most departments consider some type of light duty preferable to having the officer out on sick leave receiving benefits (McNaught and Schofield 1998).

In writing the FFD report, the mental health evaluator should indicate whether specific further treatment is warranted so that the appropriate representatives or supervisors will be able to initiate a plan, such as referral for treatment that had not already been offered. In some cases, situations may be more acute, requiring more timely referrals for treatment or more intensive services (e.g. inpatient or partial hospitalization) to avoid further crises.

Case Discussions

Officer Perez was exhibiting an abrupt behavioral change, marked by overt signs of irritability, impulsive temper outburst, and some shifts in fine motor skills as was seen by his intermittent visible tremor. Thus, the Police Chief had a justifiable reason to pull him off duty and to ask him to seek treatment prior to his return. On examination, the treating psychiatrist identified Acute Stress Disorder as a leading diagnosis. Other than the incident at work, there were no family stressors or other factors that seemed to be contributing to Officer Perez's symptoms. The prognosis, given his lack of prior mental health history, seemed fairly good, but the fact that the events were recent and the change in behavior created ongoing concern about allowing sufficient time for resolution of symptoms.

The psychiatrist recommended a Selective Serotonin Reuptake Inhibitor (SSRI) to treat Officer Perez's anxiety. It was recommended that he continue to work with a specialist in PTSD. After the 3 months of treatment, the psychiatrist indicated to Officer Perez that he could not write a letter specifically indicating that Officer Perez was fit to return to work and carry a firearm, but the psychiatrist was willing to write a letter indicating the frequency and duration of the treatments and describing that Officer Perez reported adherence to the recommendations and reported decreased symptoms. The police department received the letter and determined that after a further 3 month waiting period, if Officer Perez's symptoms appeared improved, a return to work to lighter training and administrative duties for an additional period of time would be permissible to allow for a gradual re-integration.

There were additional concerns about returning Officer Perez to such a high crime area, but the police department decided they would re-assess that assignment after he demonstrated an ability to function back at work in this lighter duty role. Throughout the period of time when Officer Perez was out of work, his firearm had been removed based on concerns about his tendency toward irritability, temper outbursts, and fine motor disruption. The police department determined that they would not return the service weapon to Officer Perez without a formal FFD evaluation to help guide their decision making.

Officer Rhodes was also similarly appropriately referred for a FFD evaluation and to a treating psychiatrist based on observation of her behavior at work, including expressing bizarre ideas, increased goal-directed activity, intrusive calling of fellow officers, and other exaggerated behaviors. The Police Chief was also concerned about the emotional effects of the loss of her brother.

On examination during the FFD evaluation, Officer Rhodes appeared dishevelled and overly made up, wearing provocative street clothes. She spoke of her Forever Safe Program without interruption. She described feeling that she had been authorized by the mayor of the town to assist with getting this project off the ground and seemed irritated that her Chief had taken her offline, since she felt this would make it harder for her to accomplish her duties. She told the examiner that she had not slept or eaten in days since there was so much she needed to accomplish. She also revealed that in driving to the appointment she had hit another car in her rush to be on time and had driven away from the scene. She said her service weapon had been removed from her possession but that she owned a personal firearm.

The examiner concluded that Officer Rhodes was acutely manic and might require emergent hospitalization, voluntarily or if necessary, involuntarily. Even if the mental health professional enters the examination as an independent evaluator for the retaining party, not a treatment provider, emergency situations may require that the mental health professional make the evaluee's treatment needs a priority. If there is a treating psychiatrist, the FFD evaluator may wish to contact him or her immediately to gain assistance in facilitating the hospitalization while securing the continuity of care and information sharing with the treatment provider. Alternatively, the examiner could arrange the hospitalization independently. Evaluators should be prepared to take steps toward emergency involuntary hospitalization if needed. Clearly Officer Rhodes will require time off work, and the prognosis related to a full return to work and access to a firearm would require subsequent evaluations and careful consideration given the risk of recurrent manic episodes.

The case of Detective Sergeant Green demonstrates that the referral question is often not simply whether an officer is or is not fit for duty but rather whether the impairment is related to his employment. This can affect whether or not the officer will qualify for injured on duty status and receive full pay or be placed on medical leave with finite benefits. During the FFD evaluation, Detective Sergeant Green disclosed that he had been exposed to a number of critical incidents prior to the death of his parents. There had been two closely spaced incidents for which he had sought treatment.

While still a patrol officer about 5 years ago, Detective Sergeant Green had been the first responder to the fatal shooting of two teens. These young people had just been innocent bystanders. Just a month later, he had responded to a car accident in which a drunk driver had hit a van resulting in the death of a woman and her 5-year-old daughter. He stated that he began having nightmares and became much more irritable with his family shortly after the car accident incident. He noticed that he was drinking more and he sought the advice of a peer counselor.

The counselor advised him to seek treatment. He had discontinued treatment about a year prior to the death of his parents.

Detective Sergeant Green stated that the death of his parents had resulted in a relapse and he had been having nightmares of these earlier incidents. He tended to minimize the effect of having lost his parents in a tragic accident and the contribution to his current symptoms. Depending on whether an evaluator needs to include an analysis of causation, an evaluator may find it necessary to disclose more detailed personal information than typically provided to support an opinion limited only to fitness for duty.

Conclusion

Mental health treatment providers may be contacted by FFD examiners or they may be asked by their police officer-patients to help provide information to their employers related to fitness to work. Treatment providers should be cautious in providing conclusory opinions about FFD to employers especially given the understanding that a FFD evaluation would encompass collateral information that is generally not available to the treating clinician. The distinction of roles, working for the police officer-patient versus working for the police department to conduct a work-related assessment, also places the treatment provider in a different role with different inherent agencies, limitations, and responsibilities.

Independent mental health clinicians conducting FFD evaluations should objectively assess an officer's abilities and impairments, relying on a variety of sources of information to inform the assessment. In addition, evaluators should remain aware that officers face some extreme life and death situations, where reaction time and judgment are critical, and deviations in the ability to manage these situations cannot be taken lightly. As such, there have been evolving trends in case law and operational practice related to securing and utilizing FFD evaluations as a key component to maximizing the ability to maintain a healthy police department. FFD evaluations for law enforcement officers can involve a basic review of psychiatric symptoms that impact functioning. However, they also involve questions such as whether the impairments are or are not related to work, an officer's prognosis, and any factors related to access to weapons, which can make the FFD evaluation for law enforcement officers particularly challenging.

Key Points

1. In their role of monitoring the psychological well-being of officers, police departments may find signs that warrant taking an officer off duty and not allowing them to return until they have had a mental health FFD evaluation.

2. If the officer appears to have signs or symptoms that compromise their ability to work, a FFD evaluator should explain in lay terminology how the symptoms are linked to functional impairment, and in some cases offer information that may be helpful toward establishing accommodations for any return to work.
3. If possible, treating clinicians should avoid conducting FFD evaluations for their own patients. Their roles should be limited to providing factual information related to mental status observations, history, frequency and duration of treatment contacts, treatment adherence, and support.
4. Independent FFD mental health evaluators should have specialized expertise both in conducting FFD evaluations and FFD evaluations in law enforcement personnel.
5. FFD evaluations of law enforcement personnel require risk assessment generally but also specifically in regard to access to personal and service weapons and an assessment of the need to carry a weapon as part of the job duty.

References

Americans with Disabilities Act of 1990, 42 U.S.C. § 12112(d)(4)(A)

Anfang, S.A., Wall, B.W.: Psychiatric fitness-for-duty evaluations. Psychiatr. Clin. N. Am. **29**, 675–693 (2006)

Bonsignore v. City of New York, 683 F.2d 635 (2d Cir. 1982)

Broun, K.S.: The medical privilege in the federal courts—should it matter whether your ego or your elbow hurts? Loyola Los Angel. Law Rev. **38**, 657–705 (2004)

Brownfield v. City of Yakima, 612 F.3d 1140 (9th Cir. 2010)

Carlier, I.V., Lamberts, R.D., Gersons, B.P.: Risk factors for posttraumatic stress symptomology in police officers: A prospective analysis. J. Nerv. Ment. Dis. **195**, 498–506 (1997)

Collins, J.M.: Selections of professionals for fitness-for-duty evaluations, Chief's counsel. The Police Chief (August), 12–13, 2011

Conte v. Harcher, 365 N.E.2d 567 (Ill. App. 1977)

Cygan v. City of New York, 165 A.D.2d 58 (N.Y.A.D. 1991)

Davey, J.D., Obst, P.L., Sheehan, M.C.: Work demographics and officers' perception of the work environment, which add to the prediction of at risk alcohol consumption within an Australian police sample. Polic. Int. J. Police Strateg. Manag. **23**, 69–81 (2000)

Decker, K.P.: Fitness for duty evaluation in law enforcement personnel: Theory and practice. Presented at 33rd Annual Meeting of the American Academy of Psychiatry and the Law, Newport Beach, California, Oct 2002

Estate of Turnbow v. Ogden City, 254 F.R.D. 434 (D. Utah 2008)

Finn, P., Esselman-Tomz, J.: Developing a Law Enforcement Stress Program for Officers and their Families, Issues and Practices in Criminal Justice. National Institute of Justice, Washington, DC (1996)

Finn, P., Esselman-Tomz, J.: Using peer supporters to help address law enforcement stress. FBI Law Enforc. Bull. **67**(5), 10–18 (1998)

Fischler, G.L., McElroy, H.K., Miller, L. et al.: The role of psychological fitness-for-duty evaluations in law enforcement. Police Chief, **78**, 72–78, (2011)

Flynn v. Sandahl, 58 F.3d 283 (7th Cir. 1995)

Gold, L.H., Anfang, S.A., Drukteinis, A.M., et al.: AAPL practice guideline for the forensic evaluation of psychiatric disability. J. Am. Acad. Psychiatry Law **36**(Suppl 4), S3–S50 (2008)

Hem, E., Berg, A.M., Ekberg, O.: Suicide in police—A critical review. Suicide Life Threat. Behav. **31**, 224–233 (2001)
Indiana Code, Title 35, Article 47, Chapter 14 (IC 35-47-14), Proceedings for the Seizure and Retention of a Firearm. www.in.gov/legislative/ic/code/title35/ar47/ch14.html
International Association of Chiefs of Police (IACP) Police Psychological Services Section: Fitness-for-Duty Guidelines. Denver, Colorado. http://www.theiacp.org/psych_services_section/pdfs/Psych-FitnessforDutyEvaluation.pdf (2009). Accessed 21 Jan 2012
Janik, J., Kravitz, H.M.: Linking work and domestic problems with police suicide. Suicide Life Threat. Behav. **24**, 267–274 (1994)
Johnson v. Mers, 664 N.E.2d 668 (Ill.App. 2 Dist., 1996)
Kapusta, N.D., Voracek, M., Etzerdorfer, E., et al.: Characteristics of police officer suicides in the Federal Austrian Police Corps. Crisis: J. Crisis Interv. Suicide Prev. **31**, 265–271 (2010)
Kopel, H., Friedman, M.: Posttraumatic symptoms in South African police exposed to violence. J. Trauma. Stress **10**, 307–317 (1997)
Kureczka, A.W.: Critical incident stress in law enforcement. FBI Law Enforc. Bull. **65**(3), 1–10 (1996)
Levenson Jr, R.L., O'Hara, A.F., Clark Sr, R.: The badge of life psychological survival for police officers program. Int. J. Emerg. Ment. Health **12**, 95–101 (2010)
Maplewood and Law Enforcement Labor Service, 108 LA (BNA) 572 (Daly 1996)
Marzuk, P.M., Nock, M.K., Leon, A.C., et al.: Suicide among New York City police officers, 1977–1996. Am. J. Psychiatry **159**, 2069–2071 (2002)
McNally, V.J., Solomon, R.M.: The FBI's critical incident stress management program. FBI Law Enforc. Bull. **68**(2), 20–26 (1999)
Mendoza v. City of Los Angeles, 66 Cal. App. 4th 1333 (1998)
Miller, L.: Officer-involved shooting: Reaction patterns, response protocols, and psychological intervention strategies. Int. J. Emerg. Ment. Health **8**, 239–254 (2006)
Miller, L.: The psychological fitness-for-duty evaluation. FBI Law Enforc. Bull. **76**(8), 10–22 (2007)
Mohandie, K., Hatcher, C.: Suicide and violence risk in law enforcement: Practical guidelines for risk assessment, prevention and intervention. Behav. Sci. Law **17**, 357–376 (1999)
Neylan, T.C., Metzler, T.J., Best, S.R., et al.: Critical incident exposure and sleep quality in police officers. Psychosom. Med. **64**, 345–352 (2002)
North, C.S., Tivis, L., McMillen, J.C., et al.: Psychiatric disorders in rescue workers after the Oklahoma city bombing. Am. J. Psychiatry **159**, 857–859 (2002)
Occupational Safety and Health Act of 1970, Pub. L. No. 91-596, 84 Stat. 1590 (amended through January 1, 2004), http://www.osha.gov/law-regs.html. Accessed 21 Jan 2012
Peñalba, V., McGuire, H., Leite, J.R.: Psychosocial interventions for prevention of psychological disorders in law enforcement officers. Cochrane Database Syst. Rev. **16**(3), CD005601 (2008)
People v. McRae, 469 Mich. 704 (2004)
Pinals, D.A., Price, M.: Forensic psychiatry and law enforcement. In: Simon, R., Gold, L. (eds.) The American Psychiatric Publishing Textbook of Forensic Psychiatry, 2nd edn. American Psychiatric Publishing, Washington, DC (2010)
Richmond, R.L., Wodak, A., Kehoe, L., et al.: How healthy are police? A survey of life style factors. Addiction **93**, 1729–1737 (1998)
Rivard, J.M., Dietz, P., Martell, D., et al.: Acute dissociative responses in law enforcement officers involved in critical shooting incidents: The clinical and forensic implications. J. Forensic Sci. **47**, 1093–1100 (2002)
Rostow, C.D., Davis, R.D.: Psychological fitness for duty evaluations in law enforcement. Police Chief **69**(9), 58–66 (2002)
Rostow, C.D., Davis, R.D.: A Handbook for Psychological Fitness-for-Duty Evaluations in Law Enforcement. Haworth Clinical Practice Press, New York (2004)
Scott v. Edinburg, 101 F.Supp.2d 1017 (N.D. Ill. 2000)
Sims, A., Sims, D.: The phenomenology of posttraumatic stress disorder: A symptomatic study of 70 victims of psychological trauma. Psychopathology **31**, 96–112 (1998)

Stephens, C., Miller, I.: Traumatic experiences and posttraumatic stress disorder in the New Zealand police. Polic. Int. J. Police Strateg. Manag. **21**, 178–191 (1998)
Stuart, H.: Suicidality among police. Curr. Opin. Psychiatry **21**, 505–509 (2008)
Tüchsen, F., Andersen, O., Costa, G., et al.: Occupational and ischemic heart disease in the European Community: A comparative study of occupations at high risk. Am. J. Ind. Med. **30**, 407–414 (1996)
Valentino, A.M.: Police trauma: Psychological aftermath of civilian combat. Policing: Int. J. Police Strateg. Manag. **23**, 268–272 (2000)
Violanti, J.M.: Predictors of police suicide ideation. Suicide Life Threat. Behav. **34**(3), 277–283 (2004)
Violanti, J.M.: Homicide-suicide in police families: Aggression full circle. Int. J. Emerg. Ment. Health **9**, 97–104 (2007)
Violanti, J.M.: Police suicide research: Conflict and consensus. Int. J. Emerg. Ment. Health **10**, 299–307 (2008)
Violanti, J.M.: Suicide or undetermined? A national assessment of police suicide death classification. Int. J. Emerg. Ment. Health **12**, 89–94 (2010)
Violanti, J.M., Vena, J.E., Marshall, J.R.: Suicides, homicides and accidental deaths: A comparative risk assessment of police officer and municipal workers. Am. J. Ind. Med. **30**, 99–104 (1996)
Watts v. Alfred, 794 F. Supp. 431 (D.D.C. 1992)
Work Loss Data Institute. Fitness for duty. Encinitas (CA): Work Loss Data Institute: Various p. http://www.guidelines.gov/content.aspx?id=25689#Section420 (2010). Accessed 22 Dec 2011
Wuertz v. Wilson, 922 S.W.2d 268 (Tex. App. 1996)

Index

L. H. Gold and D. L. Vanderpool (eds.), *Clinical Guide to Mental Disability Evaluations*,
DOI: 10.1007/978-1-4614-5447-2, © Springer Science+Business Media New York 2013