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PRACTICE RESOURCE

Forensic Evaluation of Psychiatric Disability

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AAPL Practice Resource for the Forensic Evaluation of Psychiatric Disability

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Introduction

Statement of Intent and Development Process

This updated Practice Resource is a review of legal and psychiatric factors to give practical guidance and assistance in the performance of psychiatric impairment and disability evaluations. It was developed by a Task Force of forensic psychiatrists who routinely conduct evaluations of psychiatric impairment and disability and who have expertise in this area. Some members are actively involved in related academic endeavors. The process involved a thorough review of the original AAPL guideline¹ and current practice, with integration of feedback and revisions into the final draft. (In May 2017 the AAPL Council voted to title all of AAPL's educational products as AAPL Practice Resources. This Practice Resource is a revision of the 2008 AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability.) The text was distributed for review by the Council of the American Academy of Psychiatry and the Law (AAPL) and was approved in May 2016. Thus, it reflects a consensus among experts about the principles and practices applicable to the conduct of psychiatric impairment and disability evaluations.

This Practice Resource should not be construed as dictating a standard for forensic disability and im-

pairment evaluations, nor does it present all acceptable ways of performing them. Following it does not lead to a guaranteed outcome. Differing fact patterns, clinical factors, relevant statutes, administrative and case law, and the psychiatrist's judgment determine how to proceed in each evaluation. Adherence to the approaches and methods set forth in this document will not assist in drawing conclusions about a person's psychiatric impairment or disability. It is expected that any clinician who agrees to perform forensic evaluations in this domain has the appropriate qualifications.

Format

Sections I and II discuss disability evaluations in general, including practical consideration, definitions, and ethics. Section III provides general concepts for disability evaluations. Sections IV and V address the different types of disability evaluations more specifically, using a general organizational principle to distinguish between the types of disability evaluations. Suggestions for adapting the general concepts for each type of evaluation are provided.

The first general category of disability claims, reviewed in Section IV, represents the most common source of referrals for disability evaluations, including, but not limited to, Social Security Disability Insurance (SSDI), Workers' Compensation or personal injury, and private disability insurance claims and other specialized compensation and pension programs (e.g., VA benefits), which includes disability evaluations related to litigation in which plaintiffs claim they are disabled as a result of psychiatric illness or injury and are seeking compensation for damages. Such claims generally must be accompanied by psy-

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chiatric documentation to meet requirements for compensation.

Section V reviews a new category of disability evaluations that has emerged over the years following legislation and case law governing civil rights and the increasing responsibilities of employers toward their employees. Broadly speaking, these evaluations are designed to meet requirements to continue working. These include evaluations related to the Americans with Disabilities Act (ADA), as well as fitness-for-duty evaluations and return to work evaluations. Any of these assessments may be precipitated when individuals want to maintain employment but claim they need accommodations to do so. They may also arise when an employer believes that an employee is unable to work despite accommodations. Requests for one of these evaluations often indicate a difference of opinion regarding the employee's ability to work and usually indicate the presence of employment conflict.

These two general categories may overlap to some degree, because both are related to the concept of disability and work impairment. For example, there may be a substantial overlap between a disability evaluation for insurance purposes and a return-to-work evaluation or an ADA evaluation and a fitness-for-duty evaluation. Despite the overlap, the goals of evaluations designed to determine impairments that preclude work and evaluations that define skills and abilities that allow work differ sufficiently to necessitate distinctions in approach to these two broad categories.

Section I. Psychiatry and Disability Evaluations

A. The Disability Evaluation: The Psychiatrist as Consultant

The purpose of disability-related evaluations is to gather information that an organization or system can translate into a specific course of action, such as providing workplace accommodations, authorizing health care benefits, arranging for medical care, making changes in employment status, and awarding damages or disability benefits. Psychiatrists providing such evaluations are generally required to answer specific questions and should do so in language that facilitates the process of fair decision-making on the part of the report's recipients.

Opinions may be offered based on a review of records alone or on a review of records in conjunction with a direct evaluation of the individual in question. Such an evaluation is often referred to as an independent psychiatric examination or independent medical evaluation (IME). It may be requested by an insurance carrier, either party in a litigation proceeding, or an employer. Reports should clearly indicate the purpose of the evaluation and the basis of opinions (i.e., whether opinions are based on record review alone or whether a personal examination of the evaluatee has been conducted).

B. The Increasing Need for Expertise in the Provision of Disability Evaluations

Disability evaluations are among the most common psychiatric evaluations requested for nontherapeutic reasons. Each year, mental disorders affect approximately 20 percent or one in five Americans between the ages of 18 and 54.² Neuropsychiatric disorders are the leading cause of disability in the United States, followed by cardiovascular and circulatory diseases and neoplasms; major depressive disorder is the single most common cause of neuropsychiatric disability.² Compared with the percentage of all adults employed (76–86%), only 48 to 66 percent of adults with any mental illness and 32–61 percent of adults with serious mental illness are reported to be successfully employed.³ In 2000, an estimated 30.7 percent of the 6.7 million individuals between the ages of 16 and 64 who reported having a mental disability were employed.⁴

Many mental disorders are chronic or episodic and may wax and wane. During periods of relative stability, many individuals, even those who have some symptoms, may still function without impairment or be only mildly impaired. During acute exacerbations, individuals may develop symptoms that more significantly impair their work function and may precipitate withdrawal from the workplace or requests for accommodations.

Mental health clinicians are frequently asked to opine about their patients' work function, mental disorder, disability, and workplace accommodations. Employers, private or public agencies, or workers themselves may request evaluations to meet the administrative requirements of the social and legal contracts that form the structure of employment. Personal injury litigation often involves the evaluation of disability as part of claims for damages. Individuals

may need a report supporting a claim for Social Security Disability Insurance (SSDI) benefits. Patients may require documentation of an illness or impairment to obtain a leave from work from a private employer. Psychiatric opinions regarding necessary accommodations for purposes of compliance with the Americans with Disabilities Act (ADA) or completion of a Family and Medical Leave Act (FMLA) certification form may be requested.

Employees who disclose a psychiatric condition or whose employers suspect a psychiatric condition may request evaluation to document capacity to perform essential job functions, despite the presence of symptoms of mental illness. Employees wishing to resume employment after a medical leave due to a psychiatric illness may be required to undergo a return-to-work evaluation. Those who wish to continue to work despite a documented or suspected psychiatric disorder may be required to undergo a fitness-for-duty evaluation or evaluation for requested accommodations.

Employers may seek to avoid premature resumption of employment. Employers are also legally required to maintain safety in the workplace, which includes identification of unstable employees who pose a risk to themselves or others and referral of these employees for psychiatric evaluations. Employers may also seek psychiatric assessment of an employee who is disruptive in the workplace to identify the employer's responsibility under the ADA and any restriction an employee's illness may impose on the employer's administrative authority. Depending on the specific job description, employers may ask for the assessment of psychiatric factors affecting the ability to operate machinery or handle firearms safely.

Individuals with mental disorders often have access to either public or private disability benefits through their employment. In the United States in 2010, mental illness was the second most frequently reported cause of years lived with disability (YLD), exceeded only by musculoskeletal conditions.⁵ The World Health Organization reports that depression is the third leading cause of disability worldwide (2004) and predicts that it will be the top leading cause of disability (exceeding heart disease) by 2030.⁶

Disability benefits are administered through both public and private programs. Ninety percent of all U.S. workers aged 21 to 64 are protected by SSDI, more than 160 million workers. This number has been steadily growing since the 1980s when only 100 million workers had such insurance.⁷ In 2013, SSDI

paid out more than 120 billion dollars in benefits to 8.9 million disabled workers.⁸ Mental disorders preventing substantial gainful employment are among the leading reasons that people receive SSDI. Disabled mentally ill individuals have the longest entitlement periods and represent one of the fastest growing segments of SSDI recipients. In 2013, 27 percent of SSDI recipients received payment based on a mental disorder (not including intellectual disability).

Disability insurance is also available through Workers' Compensation and private insurers. The U.S. Bureau of Labor Statistics reports (2014) that 39% of workers in U.S. private industry have access to employer-provided short-term disability (STD) insurance, and 33 percent are offered long-term disability (LTD) insurance.⁹

Statistics regarding the number and cost of mental health-based disability claims for Workers' Compensation are difficult to obtain. Private mental health disability claims are significant. The Council for Disability Awareness reports that in 2012, \$9.4 billion was paid in private disability insurance benefits to more than 660,000 recipients; mental disorders account for 8 to 9 percent of all LTD claims.¹⁰

C. Forensic Psychiatry and Disability Evaluations

Treating clinicians who choose not to perform disability evaluations may wish to consider referring these evaluations to forensically trained colleagues. However, circumstances sometimes compel a practitioner to assume the dual role of treatment provider and forensic evaluator.¹¹ For example, an application for SSDI benefits may require an extensive report from the clinical treatment provider.

Forensic psychiatrists tend to be more cognizant of and comfortable with the obligations and constraints associated with more complex disability evaluations, especially those that occur within the context of litigation or may result in litigation. Clinicians may find moving from the therapeutic to the forensic role in such evaluations difficult because of some of the irreconcilable conflicts between clinical and forensic methodology, ethics, alliances, and goals.^{11,12} Clinicians may also be unfamiliar with the legal and administrative processes involved in disability evaluations.

Many disability evaluations require an Independent Medical Examination (IME). IMEs differ from evaluations conducted for therapeutic purposes in many respects, including differing terms of confiden-

tiality, involvement of third parties, and the potential of discovery and use in future litigation. Even seemingly straightforward evaluations regarding work ability or disability can become the subject of administrative or legal dispute. In these cases, evaluators must be prepared to defend their opinions in deposition or in court, a situation that some clinicians may find disconcerting. In general, nonspecialist clinicians who offer a specialty service are held to that specialty standard of care, differences in training and experience notwithstanding.

Section II. General Factors in Disability Evaluations

A. Definitions and Related Matters

1. Disability and Impairment

Disability is a legal term of art, defined by statute, case law, administrative regulation, or insurance policy contents, with more than one legal definition. The Americans with Disabilities Act, the Social Security disability program, and private insurance plans all define the word differently. (See Appendix I for a summary comparison of definitions and salient topics in specific disability evaluations). Evaluating psychiatrists face the challenge of understanding the relevant definition and translating it into a clinically meaningful concept.

Psychiatrists most typically translate disability into the clinical concept of “functional impairment” as it applies to vocational and occupational skills.

Disorders described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) include the criterion that symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The DSM, Fifth Edition (DSM-5)¹³ provides no definition of psychiatric impairment, nor does it include a recommended scale or rating system¹⁴ for assessment of functional impairment related to psychiatric disorders. In DSM, Fourth Edition, Revised,¹⁵ clinicians were directed to use the Global Assessment of Functioning (GAF) scale to quantify the severity of an individual’s symptoms or functional impairment. DSM-5 no longer recommends any specific functional assessment scale, but it includes the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0),¹⁴ for clinicians to consider as a possible rating scale in Section III, Emerging Measures and Models.

Familiarity with general definitions of impairment and disability can help guide clinical assessment, especially when a specific definition relative to a specific case is not provided. For example, the terms impairment and disability are often incorrectly used interchangeably. Although they describe related concepts, these terms have different meanings regardless of the source of the definition. In a specific case, the applicable definition of disability is context driven and specified by the legal arena from which the assessment has arisen. The definition of disability for Workers’ Compensation will differ from the definition arising from private disability contracts.

The World Health Organization defines disability as “an umbrella term for impairments, activity limitations and participation restrictions”; impairments as “problems in body function or structure such as a significant deviation or loss”; and functioning as “all body functions, activities and participation.”¹⁶ Under the Social Security Act (SSA), disability is defined as “the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment(s) 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.” An impairment “results from anatomical, physiological or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques.”¹⁷

Private disability insurers offer a variety of definitions depending on the terms and nature of the specific policy (e.g., group or individual or long-term versus short-term disability). Typically, these are framed as the inability to perform occupational duties because of injury or sickness. Examples include “any occupation” (e.g., unable to engage in any gainful occupation for which an individual is reasonably fitted by education, training, or experience), “your occupation” (e.g., unable to perform the important, or material and substantial, duties of the individual’s regular occupation), and other partial or modified definitions. Moreover, public and private insurers are less specific in their definition of “impairment.”

The definitions of impairment and disability found in the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 6th Edition,¹⁸ are among the most useful in clarifying the difference between these two related concepts. The *Guides* define impairment 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” (Ref. 18, p 5). The definition does not presume any causal relationship. This alteration of an individual’s health status is assessed by medical means. In contrast, disability is “activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease” (Ref. 18, p 5). The latter is considered a nonmedical assessment, and both the AMA definitions and WHO definitions clearly indicate that impairments may or may not result in a disability.

Medical opinions are routinely offered on disability, including both its degree and its expected duration. This Practice Resource endorse the use of the AMA definitions unless an alternate definition is specifically requested or required. This Practice Resource will focus on the assessment of impairment relevant to disability, but not on the determination of disability, *per se*, unless specific types of evaluations include requests for opinions specifically on disability.

Medical opinions on disability are not necessarily inappropriate and may be requested, despite the fact that the final determination of disability rests with a fact-finder, such as a court, a governmental agency, or an insurance company panel. Disability evaluators opine, but do not decide. The determination of disability is ultimately an administrative or legal decision. Once an opinion is offered about disability, more than a purely medical opinion has been offered. In such cases, psychiatrists should be prepared to identify facts and reasoning supporting their view of how and why the capacity to meet an occupational demand has been altered.

2. Restrictions and Limitations

Disability evaluators are also often asked to consider whether evaluatees’ psychiatric signs and symptoms are severe enough to limit or restrict their ability to perform occupational functions generally (i.e., any substantial gainful activity) or specifically (i.e., the specific occupational tasks of a neurosurgeon for a “your occupation” private disability policy). Restrictions are most easily understood as what a claimant “should not do.” In contrast, limitations can be described as what a claimant “cannot do,” because of the severity of psychiatric symptoms. For example, an evaluatee with bipolar disorder may be restricted from excessive irregular night hours because of the potential of triggering a manic episode. In contrast,

the evaluatee may be limited in the ability to sustain concentration beyond one hour because of racing thoughts and diminished attention.

3. The Relationship Between Illness and Impairment

The presence of a psychiatric illness or diagnosis does not necessarily indicate that an individual has significant functional impairment. A conclusion of significant functional impairment related to psychiatric illness requires evidence of the severity and impact of active psychiatric signs and symptoms. The presence of psychiatric impairment alone does not necessarily indicate impaired capacity to perform job specific tasks and functions. If impairment is present, the diagnosis does not indicate the duration of the impairment. Extending the example above, an individual with bipolar disorder may be restricted from working excessive irregular night hours, a limitation that could be disabling for an obstetrician in solo practice, but may not represent a significant problem for an office-based dermatologist. The duration of identified impairments found at the time of an examination may be predicated on the effectiveness of treatment, such as a changing medication regimen. The duration may or may not be foreseeable within reasonable medical certainty at the time of examination. The effect and duration of a psychiatric symptom on a specific aspect of job function are key questions for compensability from private, job-specific insurance policies.

4. Impairment Versus Illegal Behavior

The interrelationship between psychiatric illness, functional impairment, and illegal or unethical conduct can be particularly challenging in a disability evaluation. These cases typically involve physicians, attorneys, or other professionals whose licenses have been suspended or lost because of professional or financial misconduct. These claimants assert that their illegal or unethical behavior resulted from a psychiatric illness and file a claim for disability benefits based on the purported psychiatric diagnosis. The alleged misconduct could include, for example, disruptive behavior, sexual harassment, illicit substance use, or fraud.

Such claims raise the question of whether a legal barrier (e.g., loss of license or incarceration) is preventing the insured from performing usual professional tasks, a situation sometimes referred to as a “legal disability.” Whether the insured’s inability to practice is caused by a psychiatric condition or by an

administrative or legal barrier to professional practice is the ultimate issue in these cases.

Several professional organizations have offered positions on the evaluation of disability claims in which, allegedly, both psychiatric illness and unethical or illegal behavior are present. An American Psychiatric Association (APA) resource document states, "Under certain circumstances, a physician's problematic behavior leads to questions about fitness for duty. Boundary violations (such as sexual misconduct), unethical or illegal behavior, or maladaptive personality traits may precipitate an evaluation, but do not necessarily result from disability or impairment due to a psychiatric illness."¹⁹

Similarly, the Federation of State Medical Boards (FSMB), specifically in regard to physician sexual misconduct, has indicated:

... regardless of whether sexual misconduct is viewed as emanating from an underlying form of impairment, it is unarguably a violation of the public's trust. It should be noted that although an addictive disorder, mental disorder, sexual disorder, phase of life crisis may be a contributory circumstance, boards are still charged with taking appropriate steps to see that the public is protected.²⁰

In general, if the medical condition for which coverage is sought came before the legal action against the evaluatee, courts will find for the insured's having access to disability insurance benefits. In contrast, considerable case law rejects recovery of disability benefits when the claimant's legal barrier arose before the alleged medical disability. Courts have been more divided in cases involving professionals who have practiced for some time, despite the behavior that arguably has a medical cause, but that they now claim has resulted in loss of licensure.^{21,22}

In cases involving illegal or unethical conduct that has resulted in loss of licensure or incarceration, evaluators should determine the timeline of both medical and legal events, the claimant's clinical status, and the timeframe for seeking treatment and filing a disability claim. The analysis of such claims should include a detailed examination of the relationship between any mental illness and the individual's problematic behavior. If, for example, an individual has a long history of bipolar disorder and commits sexual misconduct or embezzles funds only during a well-documented manic episode while off mood-stabilizing medication, a claim of psychiatric impairment may well be valid. In contrast, for an individual with a sustained pattern of sexual or financial misconduct not correlated with exacerbations of a psychiatric ill-

ness, the misbehavior is unlikely to be related to psychiatric impairment.

B. Ethics

There are no uniform rules of ethics that are task specific to disability evaluations. AAPL was the first professional organization to provide a practice guideline for many types of common disability evaluations.¹ As in AAPL's other practice resources, the relationship between the psychiatrist and the evaluatee is a core concern of professional ethics.

Although a traditional treatment relationship does not exist in disability evaluations, a limited doctor-patient relationship is established by a third-party evaluation.^{23,24} This relationship is best understood as one in which the psychiatrist has both a duty to the referral source to provide a thorough, objective, probative evaluation and also certain doctor-patient duties to the evaluatee. Even in the absence of a proffer of treatment, those ethics-related duties include a respect for persons, informed consent, objectivity, abstinence from foreseeable harm to the evaluatee, and protection of the evaluatee and third parties in the event of foreseeable risks of harm.

The APA's publication, "Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry,"²⁵ states that psychiatrists must comply with the same ethics-based principles in performing third-party evaluations as within a treatment relationship. The AMA's Code of Medical Ethics states explicitly, "When a physician is responsible for performing an isolated assessment of an individual's health or disability for an employer, business, or insurer, a limited patient-physician relationship should be considered to exist."²⁶ This document advises physicians performing independent evaluations that their responsibilities to evaluatees are similar to those of physicians providing treatment in respect to providing objective evaluations, maintaining confidentiality to the extent possible, and fully disclosing potential or perceived conflicts of interest.

Evolving case law addressing third-party evaluations in psychiatry and other fields of medicine has also defined the legal duties evaluators owe to evaluatees. The recent trend is toward legal recognition of a limited doctor-patient relationship in such evaluations, which at a minimum includes duties to maintain limited confidentiality, to respond to a clinical

emergency (e.g., acute suicidality) and to not cause harm to an evaluatee.^{27–29}

The legal and ethical obligations attendant upon an evaluator's relationship with an evaluatee in third-party evaluations should be considered when providing disability and other employment-related evaluations. Lawsuits based on principles of medical malpractice and ordinary negligence, although significantly less common than in clinical practice, are arising more frequently than in the past. In addition, complaints of ethics violations can result in disciplinary actions by professional organizations or state medical boards.^{27–30}

1. Role Conflict

Although AAPL's ethics guidelines advise, "A treating psychiatrist should generally avoid agreeing to be an expert witness or to perform an evaluation of his patient for legal purposes," there are some settings in which this suggestion may not be observed.³¹ The SSA's request that the treating clinician provide an extensive disability evaluation is one of several exceptions. Another is an employer's requirement that the employee's treating clinician provide information regarding fitness for duty or for purposes of meeting ADA or FMLA requirements. Adopting both treatment and evaluation roles are common in Workers' Compensation cases. However, in civil litigation, the goals of forensic disability assessment and clinical treatment often present irreconcilable role conflicts for a single professional.¹¹ Clinicians are generally advised to refer the forensic function to an appropriate colleague.^{11,27–29}

2. Honesty and Striving for Objectivity

The endeavor to be honest and objective involves complex practical factors. The ethics of honesty and striving for objectivity in the forensic practice of psychiatry has been extensively discussed.^{32–37} Forensic assessments often expose the evaluator to various types of bias that can, in turn, influence opinions. In disability evaluations, the risk of bias flowing from the evaluator's own employment or source of income is of particular concern.

Requests for evaluations of psychiatric disability are most often from third parties, such as insurance companies, government agencies, or attorneys. Some psychiatrists may have an informal noncontractual relationship with disability insurers or subcontracting companies that arrange independent disability evaluations for insurers or employers. Some psychi-

atrists have formal contractual arrangements with or are employed by organizations requesting disability assessments. Either circumstance may foreseeably create pressures on an examiner to generate opinions that will be favorable to the referral source paying for the examination. The evaluator must maintain objectivity and needs to maintain continuing awareness of these potential pressures.

Psychiatrists should not compromise their opinions due to financial bias. They are ethically bound to be honest and objective and not be reticent to voice an opinion that does not support the referral source's desired outcome. Opinions expressed in the interest of pleasing the referral source, either to maintain employment or garner future referrals, are unethical.

3. Confidentiality

The purpose of a disability evaluation is to gather a probative database that then serves as the foundation for answers to questions posed about the evaluatee. The answers, which contain protected health information, are provided to a third party. The third party may then re-release the information to lawfully designated individuals. Although the evaluatee is not deprived of all confidentiality protections, this is not the level of confidentiality a person typically expects in health care. Evaluatees seeking disability benefits, workplace accommodations, or who have claimed disability as part of Workers' Compensation claims or in litigation proceedings based on claims of mental disability are required to reveal the nature of their problems if they are to obtain monetary compensation, workplace accommodations, or both.

Communicating the limits of confidentiality in a disability evaluation is part of the process of obtaining informed consent, the elements of which are discussed in detail below (see Section III.C.1). Psychiatrists conducting disability evaluations have an ethical and legal duty within the limited physician-patient relationship to limit disclosures of information to information that is relevant to the specific disability evaluation.^{1,25,28,29,38} Information that is not relevant to the disability evaluation should not be included in the report provided by the evaluator.

At times, the evaluating psychiatrist and the evaluatee will disagree on what information is relevant. The evaluating psychiatrist has the responsibility and discretion to determine what information is indeed relevant.

The Genetic Information Nondiscrimination Act of 2008 (GINA)³⁹ was passed to prevent employers from discriminating against a worker's present capacity to work based on genetic information. Title II of GINA prohibits covered entities, including employers and insurance companies, from using genetic information in their decision-making processes. Family medical history is statutorily included in the definition of genetic information. The Equal Employment Opportunity Commission (EEOC), which enforces Title II of GINA, has required employers and insurers to provide advance notice to health care providers to exclude genetic information, including family history, from their responses to requests for medical information. This includes employer or insurer requested disability evaluations.^{28,40,41} GINA does not limit the evaluator's access to family medical history as a source of data on which to base medical conclusions.

The EEOC has provided a model "safe harbor" statement for insurers, employers, and their attorneys to provide to physicians when requesting information or reports, including requests for IMEs and disability evaluations.⁴² Psychiatrists may need to avoid including family history of medical or psychiatric illness in disability reports that will be forwarded to insurance companies or employers.

Information obtained in the disability evaluation should be released only to authorized recipient(s). Absent a court order, all written materials reviewed by the evaluating psychiatrist, including medical and insurance records, may not be re-released by the psychiatrist. The parties who created the records and not the evaluator are responsible for the production and release of these original records. In the event of litigation occurring after an evaluation, psychiatrists may not publicly disclose information that they obtained in the course of their evaluation that did not become public knowledge through courtroom or deposition testimony or admission into evidence. Such disclosures are ethically inappropriate and can result in legal liability.^{28,41,43}

Similar to treatment providers, forensic evaluators have ethical and legal duties to act if the evaluatee threatens his or her own safety or the safety of others, actions that may breach confidentiality. Discussion of this potential should be included in the informed-consent process at the beginning of an examination. The type of action required of the evaluator is determined by clinical risk assessment of the case-specific

facts. Courts have found the duty to disclose may be fulfilled by direct disclosure to the evaluatee with instructions to seek treatment, by reporting findings to the evaluatee's treating physician, or by communicating the existence of the problem to the evaluatee's attorney.

4. Mandated Evaluations of Complainant Employees

Employers may require administratively or legally problematic employees to undergo fitness-for-duty (FFD) or psychiatric evaluations. Some employers may refer an employee for an FFD or psychiatric evaluation after the employee's "whistle blowing" or filing of a complaint of harassment or discrimination against the employer. The employee may allege the mandated assessment is retaliation for the complaint against the employer and an attempt to discredit or even terminate the employee through claims of mental instability. The employer may assert having legitimate concerns that the employee has a history of threats and instability.

The forensic evaluator's role in this situation, as in other adversarial conflicts, is to develop a database sufficient to answer the questions that have been asked. The evaluator should avoid becoming a partisan or advocate in a dispute. The psychiatrist is serving as an expert only about the employee's mental health and not as a decider in the employment dispute. If the evaluating psychiatrist concludes there is no evidence of a psychiatric disorder or occupational impairments related to a psychiatric disorder, the report should so indicate and not more.

C. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Confidentiality

HIPAA⁴⁴ is an extensive federal law covering many different facets of confidentiality, including the privacy and security of electronically stored health data. HIPAA's Privacy Rule,⁴⁵ created standards regarding the term of storage, use and disclosure of individuals' "protected health information" (PHI) by individuals and institutions to which HIPAA applies, otherwise known as "HIPAA-covered entities."⁴⁶ The Privacy Rule makes no distinction between PHI gathered for treatment and for disability evaluations.⁴⁷ This legislation also gives individuals a statutory right to knowledge about what medical information is shared, with whom, and for what purposes.

Providers are responsible for determining their status as covered or noncovered entities under HIPAA.⁴⁷ The Privacy Rule sets forth practices that represent a minimum in regard to the confidentiality and disclosure of PHI. States may have more stringent statutory, case law, and regulatory requirements. Psychiatrists not observing their jurisdictional requirements for confidentiality and disclosure of health care information are exposing themselves to liability under state and federal law.^{24,47}

The ethics guidelines of APA and AAPL do not require written consent for a third-party IME or written authorization for disclosure of the results of an evaluation to the third party. However, the AMA's Code of Ethics states that results of third-party evaluations for an employer, business, or insurer "should not be communicated to a third party without the individual's prior written consent, unless required by law."³⁸ Although legality and ethics require that the patient provide verbal informed consent, we recommend that psychiatrists obtain a signed acknowledgment of informed consent that includes specific text consenting to the disclosure of PHI.

The HIPAA Privacy Rule specifically allows IME physicians to require the evaluatee to sign an authorization for the release of PHI to the third party requesting the IME as a condition of performing the IME.⁴⁸ The rule also requires an individual's authorization to permit covered health care providers to release the information to an employer or a disability insurance company.⁴⁹ In addition to incorporating HIPAA and state confidentiality requirements, if appropriate, evaluators should adhere to the statutory federal required elements of the Confidentiality of Substance Abuse Treatment.^{28,50} Withdrawal of consent by an evaluatee must be communicated in writing.

Disclosure of evaluations conducted for litigation is also subject to the jurisdictional rules of discovery. HIPAA provides evaluatees rights to request and receive the disclosures of PHI made by the evaluator.⁵¹

Disclosure in Workers' Compensation is governed by state law. "[T]he HIPAA Privacy Rule explicitly permits a covered entity to disclose protected health information as authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law that provide benefits for work-related injuries or illness"⁵² Providers are still required to limit the

amount of protected health information disclosed to the minimum necessary for the Workers' Compensation assessment of the injured worker.

SSA has determined that consultative examinations (CEs) conducted for the SSA fall within the range of functions included in HIPAA definitions of "health care provider" and "treatment."^{53,54} SSA has indicated that evaluators who are covered entities under HIPAA are required by the Privacy Rule to provide evaluatees with a notice of the patient's rights and the psychiatrist's office privacy practices⁵⁵ and for the psychiatrist to receive a written acknowledgment of the receipt of the notice or documentation of good-faith effort to obtain such an acknowledgment. The HIPAA privacy rule governs disclosures to SSA by consultative examiners who are covered entities.

D. HIPAA and Disclosure of Information to the Evaluatee

Clinicians have traditionally referred evaluatees requesting copies of their disability or employment reports to the third party who solicited the evaluation. Evaluatees have rights of access to their IME report under HIPAA and by state and federal discovery. Reports are best written in accessible, objective, non-pejorative language. Psychiatrists conducting these evaluations may therefore include in their initial disclosures and informed consent to evaluatees the relevant aspects of the Privacy Rule and their own policies in regard to evaluatees obtaining copies of their medical records.

The HIPAA Privacy Rule states, "an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set."^{47,56}

The Privacy Rule defines the designated record set as "that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems."⁵⁴

The Office for Civil Rights (OCR) of the Department of Health and Human Services states on its "Enforcement Activities and Results" web page:

At the direction of an insurance company that had requested an independent medical exam of an individual, a

private medical practice denied the individual a copy of the medical records OCR determined that the private practice denied the individual access to records to which she was entitled by the Privacy Rule.

OCR required that the private practice revise its policies regarding access “to reflect the individual’s right of access regardless of payment source.”⁵⁷

Psychiatrists have also been advised, even when providing access to a report, to withhold access to treatment records created by other providers, on the basis that confidentiality concerns require that access to this information come directly from those providers. Disability evaluations typically include obtaining and reviewing records created by other health care providers. OCR has also affirmed that patients have access to their records held by covered entities, regardless of whether another treatment provider created information contained in the file.⁵⁷ In a subsequent case example, OCR indicated that if an individual’s medical records contain copies of other health care providers’ records, the individual is entitled to access these records as well. State confidentiality laws, however, may supersede this requirement, so evaluators must be familiar with their own jurisdictional standards.

Under HIPAA and the Privacy Rule, if the evaluating clinician believes that access to the information may be harmful to the evaluatee, the bar for denial of an individual’s request for records is high. Denial is justified only if “that access requested is reasonably likely to endanger the life or physical safety of the individual or another person.”⁵⁸ Under these circumstances, only those specific parts of the record that would put the individual into crisis can be withheld; the rest of the record must still be released. If the record is withheld, the individual has the right to have that decision reviewed. The covered entity would identify another mental health clinician to review the individual’s record to determine whether the denial of access was appropriate.⁵⁹

At the time of the writing of this Practice Resource (2016), SSA has taken a position that appears to contradict the aforementioned evaluatee right to access to PHI records articulated under the HIPAA Privacy Rule. SSA has advised its independent disability evaluators to refer claimant’s requests for records related to application for Social Security Disability benefits to their state Disability Determination Service (DDS).⁶⁰ SSA acknowledged that an independent examination for purposes of determining eligi-

bility for Social Security disability benefits is a covered health care function under HIPAA. Nevertheless, SSA’s regulations deny evaluatees direct access to reports; SSA has advised disability evaluators that they must comply with SSA’s regulations and not the Privacy Rule’s right of an individual to access their PHI. This contradiction has not yet been legally or administratively addressed.

The SSA notwithstanding, a HIPAA-covered entity is required by the Privacy Rule to disclose PHI when individuals make requests to access their PHI.⁶¹ HIPAA specifically delineates exceptions that constitute grounds for denial of access,⁶² such as risk of harm. In addition, an individual’s access may be denied if the protected health information was obtained from someone other than a health care provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information. However, none of these exceptions is based solely on the fact that the information was collected for disability or employment evaluations.

E. Safety Concerns for Evaluators

Psychiatrists conducting disability evaluations should assure their own safety before and during the course of the assessment. All disability evaluatees have significant monetary compensation at risk. They are already part of an adversarial process that has challenged their narrative and often their dignity. Some evaluatees have mental health and substance use disorders that confer an increased risk of perpetrating violence. Some may have a history of violence. The outcome of a disability or fitness-for-duty evaluation can result in lawsuits, financial insecurity, and loss of employment or career. Evaluatees who are angry about undergoing a psychiatric examination or who are angered by an evaluator’s report may express that anger toward the evaluator.

In addition to requesting photo identification, evaluators may reasonably ask evaluatees if they have weapons on their person and if so, may refuse to continue with the assessment. Both evaluator and evaluatee should have independent means of egress from the office. Evaluators should also be clear about setting limits on angry or inappropriate behavior in regard to safety concerns. If an evaluatee becomes unduly agitated, angry, or threatening, the evaluator should terminate the interview. The termination should be framed as the evaluator’s being uncomfort-

able and therefore unable to provide the full attention that the evaluatee deserves. The evaluator should make no reprimand of the evaluatee's conduct or comments. Threats made after the evaluation should be reported to the referral source and, if appropriate, to local law enforcement agencies.

Section III. General Concepts

The goal of the psychiatric disability evaluation is to correlate symptoms of mental disorders with occupational impairments and manifestation in the workplace. Psychiatric disability evaluators may be asked to answer questions about cause, prognosis, treatment, motivation, aggravating and mitigating factors, malingering, and secondary gain.

A. Clarification of Questions and Goals

Psychiatrists should clarify the specific questions and goals that are to be addressed in the assessment. Although the needed information can be obtained by phone, a written referral documenting the referral source's expectations and the specific questions that must be addressed in the evaluation is preferable. The moment of the referral contact is a good time to ensure that the referral source understands the nature of the services that will be provided. For example, psychiatrists can use the initial contact to make certain that referral sources understand that no treatment will be provided directly to the evaluatee. They can also clarify that the database will not be limited to meetings with the evaluatee and provide examples of collateral sources of information such as records, e-mails, memos, and psychological testing.

Psychiatrists and the referral source can clarify who will be responsible for providing the evaluatee a copy of a report, if any. A referral source may expect or request that an evaluator will discuss findings and recommendations with the evaluatee. Evaluatees may ultimately be privy to reports that contain and concern their PHI.

B. Review of Records and Collateral Information

Collateral information is an essential component of a disability evaluation. Objective evidence of a psychiatric disorder and actual impairment is necessary to find within reasonable medical certainty that a psychiatric impairment is present. The most obvious source of information is the direct observation and examination of the evaluatee. Written data are a second independent source of information. Inter-

views (telephone or in person) or written statements of witnesses to relevant events are a third independent source. Psychological testing can be a fourth important source. These different data bases enhance the evaluator's ability to confirm conclusions and identify inconsistent or contradictory assertions.

For example, in personal injury litigation, discovery may result in the provision of all past and recent treatment records, witness statements, depositions, and other background materials. In contrast, in cases such as an ordinary claim for Social Security disability benefits, collateral information is encouraged, but may be limited or difficult to obtain.

Typically, the referral source gathers and provides collateral information to the evaluating psychiatrist. If psychiatrists identify additional information that may be available, they should request access to this information. Requests for collateral information should be directed to the referral source to the extent possible to ensure that the referral source is aware of all the records that are being reviewed. Evaluatees sometimes supply additional collateral information. All data should be reviewed by the individual evaluator. Evaluators cannot rely on other's summaries and still maintain objectivity and independence. All sources of information should be clearly identified in the evaluator's report.

Interviews of third parties require notice and permission from the referral source and may require appropriate consent from the evaluatee. The possibly adversarial nature of a disability evaluation has the potential to make any individual a partisan in the claim. That includes treating clinicians who may have no personal stake in the outcome. Partisan feelings may lead to both intentional and unintentional editing by witnesses of their own narrative. No single narrative can be assumed to be reliable and complete, *per se*.

The following are examples of types of collateral information that may be part of a disability evaluation.

1. Written Records

a. Job Description

Psychiatrists should always request a written job description if one has not been provided. Assessment of impairment is job specific and requires that an evaluator understand the requisite job skills and tasks for each evaluatee.

b. Psychiatric, Substance Use, and Medical and Pharmacy Records

These assist an evaluator in findings of diagnosis, symptom history, and treatment response, all of which are essential to an opinion of the manifestations of an impairment in the workplace by mental illness. Pharmacy records may be helpful in corroborating claims regarding doctors seen for treatment, medications and dosages prescribed, and possible prescription drug misuse. Treatment records frequently contain useful background information about an individual, sources of conflict or stress, evidence of maladaptive personality traits, and motivational factors that can affect occupational functioning. Actual contemporaneous treatment notes are preferred; a summary narrative prepared by the treatment provider may reflect bias or advocacy in support of the patient's disability claim. Medical records may reveal a medical disorder with psychiatric symptoms or rule out such disorders if diagnostic laboratory or imaging tests, such as electroencephalogram (EEG), computed tomography (CT)/magnetic resonance imaging (MRI), positron emission tomography (PET), and single-photon emission computed tomography (SPECT) have been performed.

c. Employment Records

Employment or personnel records are an important source of collateral information, especially when impairment in functioning arises in the context of an individual's current or recent employment. Employment records may provide evidence of difficulties or resilience in work performance; they may clarify workplace factors that have positively or negatively influenced psychiatric symptoms and workplace performance.

For example, good job evaluations and the absence of performance problems can reduce concern that workplace factors influenced a claim. In contrast, employment records that contain documentation of disciplinary episodes that precede a claim of disability may raise concerns that it represents an attempt to avoid workplace consequences rather than work impairment based on psychiatric symptoms. Records may include personnel actions that have threatened the claimant's job stability and perhaps have led to disability claims in an attempt to avoid job termination. Personnel records from prior employers are also often a valuable source of collateral information for

similar reasons, in addition to providing a longitudinal perspective of occupational functioning.

d. Academic Records

Although these may also be difficult to obtain, academic records can shed light on an individual's intellectual abilities, earlier achievements or failures, limitations in functioning, or need for accommodations. They can also indicate whether an individual has a history of behavioral problems, an important factor in diagnosing whether a psychiatric problem is of longstanding duration or has arisen more recently.

e. Other Experts' Evaluations

Evaluations performed by other mental health experts as well as those by other psychiatrists or nonpsychiatric physicians can help determine the consistency of an individual's reports and allow comparison of diagnostic formulations. Evaluations that include psychological and neuropsychological testing can clarify the validity of self-reports, clinical symptom patterns, and personality features of the individual.

f. Personal Records

Prior and recent disability claims and criminal, military, and financial records can provide relevant information for the evaluation of a claim of current disability. An individual's diaries or journals may also be useful, if contemporaneously kept.

2. Third-Party Information

Information from third parties can be useful in corroborating evaluatees' accounts of their history, symptoms, and functioning. The reliability and potential partisan nature of all sources of collateral information should be taken into account. Interviews of third parties from the workplace may be essential to the evaluator's understanding of the workplace milieu. Evaluatee supervisors should be identified. Evaluatees may also identify individual witnesses to events in question to assure that the evaluator is getting a balanced rather than edited version of the workplace and the evaluatee's performance. The opportunity for the evaluatee to identify collateral sources also reasonably fosters the evaluatee's trust in the examination process.

a. Family Members and Friends

These individuals often have first-hand knowledge of an evaluatee's symptoms, the evolution of the

evaluee's disorder, and the evaluatee's functional abilities. As is true of the evaluatee, friends and family members may be invested in the success of a disability claim and may knowingly or unwittingly distort or exaggerate reports of the individual's symptoms.

b. Treatment Providers

Conversations with treatment providers, with evaluatee consent, can be helpful. Physicians and therapists, particularly those who are aware of their patient's disability claim, may be circumspect in their documentation. They may be more forthcoming about their opinions in the course of a personal conversation.

Treating clinicians may become unduly adversarialized in a patient's dispute with an employer. In the process of trying to protect their patient, a treating clinician may begin to criticize an employer, of whom the treating clinician in fact has no direct knowledge. Treating mental health clinicians may take their patient's narrative as simply true rather than true only according to the patient's subjective experience.

c. Written Statements

Written statements, depositions, or affidavits provided by third parties may be informative, but may also be incomplete or biased. Adversarial situations, such as personal-injury litigation or workers compensation claims, may influence third parties, leading them to either unwittingly or knowingly minimize or inflate symptoms or provide misleading information.

d. Surveillance

Surveillance of claimants in personal-injury litigation and contested disability claims is common. Although it may be a powerful source of collateral information, a video cannot capture an individual's mental state. However, surveillance may document an evaluatee's easily engaging in activities contrary to the evaluatee's own assertions and thus forcefully challenge the evaluatee's claim and reliability.

C. Standard Psychiatric Examination

1. Informed Consent

As in all forensic evaluations, evaluators are required to inform the evaluatee of the nature and purpose of the examination and obtain consent to proceed with the evaluation. After verbally reviewing

and making certain that the evaluatee understands all the elements of informed consent, the psychiatrist should ask the evaluatee to provide written acknowledgment that the core elements of informed consent have been explained and that the evaluatee agrees to go forward with the evaluation.

Some elements of informed consent regarding confidentiality and release of information may be specified by state law. As an example, general elements of informed consent in disability evaluations may include informing the evaluatee that:

- 1) The purpose of the evaluation is an independent, forensic psychiatric evaluation and not psychiatric treatment.
- 2) The purpose of the evaluation is not health care, and the evaluator is not serving as a treating doctor.
- 3) The evaluator has been retained by the party/ persons to perform the assessment and will be furnishing a verbal or a written evaluation, or both, to the requesting party. The evaluator could also be called to testify under oath to the findings.
- 4) The report will include the evaluatee's protected health information; the protected health information will then be under the authority of the person or agency who received it from the evaluator.
- 5) The evaluatee must agree to the release of the protected health information. The release is limited to information that is relevant to the questions posed by the retaining entity.
- 6) This authorization and release may apply to all information related to the evaluatee's mental health, history, and function. It may apply specifically to information from medical records, psychological testing, psychotherapy notes, laboratory studies, x-rays and scans, admission and discharge notes, progress notes, treatment plans, and consultations.
- 8) The evaluator must be objective and independent in his evaluation.
- 9) Although the evaluator will offer an opinion about specific questions, it is the regulatory agency, employer, or jury and not the evalu-

ator who will make the ultimate determination about the events or claim in question.

- 10) If the evaluator believes the evaluatee's or another person's safety is at serious risk, then the evaluator is ethically and legally required to take reasonable steps to protect that person's safety.
- 11) The evaluatee's participation must be voluntary and reflect the choice that the evaluatee has made.
- 12) The evaluatee can at any time refuse to answer questions, can terminate the evaluation, or can refuse to provide the evaluator with requested authorization, if needed, to speak to third parties. The evaluatee should be informed that such refusals can be communicated to the retaining party.
- 13) The release will remain valid for 180 days (or other reasonable period), but an evaluatee has the right to revoke this consent, and the revocation must be in writing. Revocation of consent covers only future actions, not prior releases.
- 14) The evaluatee may be offered a copy of the signed consent.

If an evaluatee does not agree to the conditions of the evaluation or refuses to provide written consent to proceed, the evaluation should not be undertaken. The evaluatee has the right to refuse, which will be communicated to the retaining party. The evaluator has the right and responsibility to delineate the conditions under which an evaluation will be undertaken (e.g., covert electronic recording of the meeting is expressly prohibited.)

2. Psychiatric Interview

The elements used to evaluate and diagnose the presence or absence of a mental disorder follow the general principles described in APA practice guidelines. Disability evaluations typically focus more on occupational and functional history than do treatment evaluations. Evaluators explore categories of function in detail, seek clear examples of impairment, obtain reliable corroboration, understand the nature of the evaluatee's work, and consider alternative explanations for disability claims.⁶³ Treating clinicians often make disability assessments of their own patients, relying on clinically observed signs and

symptoms and their patient's narrative. An uncorroborated self-report of impairment may not be reliable for a variety of reasons, including lack of insight, bias, and potential financial gain.

D. Correlation of a Mental Disorder With Occupational Impairment

The primary task of a disability evaluation is to correlate psychiatric symptoms with specific areas of occupational function and impairment.

1. Assessing Categories of Function

Evaluators should use the schema categorizing function and disability specified by the requesting party. If no schema of categories of function is specified, examining psychiatrists can use any one of several different classification systems for impairment. These include the *AMA Guides to the Evaluation of Permanent Impairment*, Sixth Edition¹⁸; World Health Organization, International Classification of Functioning, Disability and Health (ICF)⁶⁴; Social Security Administration guidelines⁶⁵; DSM-IV-TR Global Assessment of Functioning Scale (GAF)¹⁵; and private disability insurance classification systems, among others. In the sixth edition of the *AMA Guides*, the categories of impairment for mental and behavioral disorders were revised to be more congruent with the ICF definitions⁶⁴ and conceptual framework.⁶⁶

The categories include:

- 1) Self-care, personal hygiene, and activities of daily living
- 2) Role functioning and social and recreational activities
- 3) Travel
- 4) Interpersonal relationships
- 5) Concentration, persistence, and pace
- 6) Resilience and employability

2. Descriptions and Examples of Impairment

Specific behavioral examples and clear descriptions of the evaluatee's functioning and impairment are essential to an objective assessment of impairment. These examples can then be assessed for internal consistency.

An evaluatee can be asked to give a detailed account of actions on a typical day, a typical best and worst day, or the days immediately before the interview. Asking for an hour-by-hour description can prevent

an evaluatee from providing an over-generalized description of impairment. An evaluatee's narrative about hobbies, recreation, and social interactions may be a useful source of information about attention span, planning, persistence, and the capacity to experience pleasure.

3. Correlation of the Requirements of the Job With the Claimed Impairments

The actual work duties, the organizational structure of the workplace and work area, and the type of specific demands provide the functional framework for assessment of impairment. A job description, performance reviews and other work assessments and memos provide the basis for the review of the employer's perspective with the evaluatee. Evaluatees' descriptions of their jobs may match or differ from employer's written descriptions. Evaluatees may report aspects of job requirements or functioning not specified in a written job description. Discrepancies require clarification and corroboration.

Claimed or demonstrated impairments require correlation with specific job skills or requirements. When possible, speaking with the evaluatee's supervisor and other workplace third parties may assist in this process.

Individuals with mild or moderate symptoms of mental disorder may nevertheless have significant impairment, depending on the job's demands. An individual with a desk job that requires no heavy lifting may experience only mild impairment from chronic back pain with a restriction of lifting more than 20 pounds. A dockworker may be effectively disabled by such a limitation. Similarly, an inability to maintain persistence and pace due to severe depression could be less of an impairment for an individual with flexible work demands, but may represent a disabling impairment for an air traffic controller.

4. Correlation of Functional Work History With Current Levels of Impairment

Psychiatrists may incorrectly assume that an evaluatee's functional impairment began with the illness for which the evaluatee is undergoing evaluation. A longitudinal review of the individual's functional history in academic, military, social, and occupational settings can clarify the relationship between an individual's current degree of functional impairment and its relationship, if any, to psychiatric illness.

5. Rating Scales

Referral sources may request the use of a numerical rating scale of an evaluatee's degree of impairment. Most rating scales are not specific to psychiatric disability. They generally include mental illness as a category of impairment in the structure of the overall scale. For example, the Social Security Administration's "Blue Book," a rating scale used in Social Security disability evaluations, is not specific to psychiatric disability but rather to the criterion the Social Security Administration uses to determine disability.⁶⁵

The *Guides to the Evaluation of Permanent Impairment*¹⁸ provide a rating system based on the combined scores of three self-report rating scales. The *Guides*, originally adapted in part from the Social Security Administration regulations, are commonly used in Workers' Compensation cases in the United States. Another general rating scale is The International Classification of Functioning, Disability and Health (ICF), developed by the World Health Organization,⁶⁴ developed as an extension of the *International Classification of Diseases*, Tenth Revision.⁶⁷

Psychiatrists in the United States are most familiar with the Global Assessment of Functioning Scale (GAF) which has been widely used clinically and in disability evaluations.⁶⁸⁻⁷⁰ The GAF scale was a fundamental component in the multi-axial diagnostic assessment described by the Diagnostic and Statistical Manual of Mental Disorders in the editions published from 1980 until 2000.

However, DSM-5¹³ contains no endorsed rating scale for psychiatric dysfunction. Instead, it includes the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) as a rating instrument for further study.¹⁴ The WHODAS 2.0 is a self-report rating system, and its use in disability evaluations may therefore be limited. The challenges presented by the WHODAS 2.0 may create reluctance on the part of third party referral sources to adopt its use. As of the date of this Practice Resource, there is no indication that U.S. disability programs are adopting or planning to adopt WHODAS 2.0 in place of the GAF Scale. Those systems that have used the GAF Scale are likely to continue to request its use in psychiatric disability evaluations for the foreseeable future.

The GAF relies on clinician judgment to identify an individual's worst symptoms and function due to a psychiatric disorder and correlate those findings with descriptors on a 1-100 scale of increasing men-

tal health. The GAF is not an average of strengths and weaknesses. It scales psychological, social, and occupational functioning and excludes the effects of physical illness or the environment. Studies of the GAF have found good inter-rater reliability for the GAF, which can be further improved with training.⁶⁹

Although no longer included in DSM-5, the GAF scale remains a widely used measure of adaptive psychological functioning. It may be difficult with some evaluatees to disentangle the combined limitations imposed by mental and physical impairments.

6. Use of Psychological Testing

Psychological and neuropsychological testing may be helpful to assess an evaluatee's psychological capacity, diagnosis and reliability. Neuropsychological testing provides quantifiable and reproducible evidence of impairment of attention, memory, language, verbal and nonverbal reasoning, abstraction, and executive function.⁷¹

Personality profiles such as the Minnesota Multiphasic Personality Inventory (MMPI)-2⁷² and the Personality Assessment Inventory (PAI)⁷³ provide data regarding psychiatric diagnoses and the reliability of an examinee's self-report.

Psychological and neuropsychological tests often contain embedded validity scales to assess the consistency, reliability, and effort of the evaluatee. However, no single test can resolve a question of impairment.

E. Alternative Explanations for Alleged Disability

1. Alternative Explanations

Claimants may not understand the difference between "being too upset to work" and having a psychiatric disorder that causes work impairment. Symptom exaggeration or poor motivation may be factors in claims of impairment. Psychiatrists are asked to assess those elements that are substantial factors in a disability claim.

A detailed longitudinal history tracing the evolution of the claimed impairment in relation to the individual's work history is an essential element in this assessment. Did the evaluatee first become depressed and then unable to work? If so, was there a time when the evaluatee could work despite depression? Did treatment fail to improve symptoms, and if so, why? Are there reasons that the evaluatee would no longer want to pursue work irrespective of depression? Did the evaluatee have plans to leave work be-

cause of personal preference before the depression became more severe?

Noncompliance with efforts at rehabilitation, medication, and other treatment, along with an early decision that the person would never work again, should raise suspicion about the role of choice versus impairment in the claim. Evaluators should consider whether the decision to file a disability claim, especially a long-term disability claim, was made before maximum treatment effect had taken place. Symptom exaggeration or the possibility of financial or psychological gain may be a motivator when an individual makes little or no effort to accept or comply with treatment or rehabilitation.

The assessment of alternative explanations also includes the contribution of workplace events and dynamics. Did the employee face negative personnel action because of work performance problems, a personality disturbance, lack of motivation, employment instability, or even misconduct?⁷⁴ Is an evaluatee using a disability claim to avoid the consequences of poor workplace performance or misconduct?

Outside the work setting, individuals may face a variety of personal life crises that could be resolved by quitting work and claiming disability. The timing of a claimed disability or claimed symptoms disproportionate to the claimed impairment, along with evidence of exaggeration and malingering, may be clues to such problems.

2. Malingering

Psychiatric disability evaluators are often asked to form an opinion about whether the evaluatee is malingering. Research from the past 25 years suggests that the prevalence of malingering in disability evaluations may be as high as 20 to 30 percent.⁷⁵⁻⁷⁷ Malingering is the conscious feigning of illness, motivated by external incentives. The illness itself or the intensity of symptoms may be malingered. Incentives for malingering a psychiatric disability are often monetary. Sometimes the motivation is to be removed from a high-risk or otherwise undesired work setting. Malingering can be considered as partial or dimensional, rather than categorical (present or absent).⁷⁸

Symptom exaggeration or magnification can also be unwitting and unpremeditated. Magnification of true symptoms or impairment is much more common than outright malingering. An adversarial environment can have an effect on the narrative of

evaluatees. Many evaluatees may emphasize their self-reported impairment to counter what they perceive as their employer's minimization.

The diagnosis of malingering is serious, and it should be based on convincing, objective evidence. Collateral corroborating information is essential. The inconsistency of symptoms across settings, claimed impairments in excess of examination findings, or discrepancies between an individual's report of illness and the medical record may indicate a feigned psychiatric disorder. The use of standardized psychological testing with proven validity measures can often be helpful, as will other relevant collateral data (e.g., urine toxicology and pharmacy records to confirm medication compliance).

Evaluators may note a disparity between a claimed psychiatric disorder and observations of an examinee during an interview. An evaluatee may claim severe depression and inability to concentrate, but nevertheless attend to and appear euthymic during what is for most a stressful interview. Evasive or hostile behavior during the interview may be motivated by malingering.

F. Formulation of Opinions

Opinions that psychiatric illness has caused work impairment are founded, within reasonable medical certainty, on a probative database. Reasonable degree of medical certainty is a legal term of art, meaning more likely than not.⁷⁹ Some components of the assessment may not be conclusive and must be noted in the report. Some evaluators will identify missing information or additional studies that are essential to answering the assessment questions.

The diagnosis of a psychiatric disorder does not necessarily prove either the presence or the causation of impairment. Impairment by itself does not prove disability; disability is founded on both impairment and its effect on specific vocational demands.

Some psychiatric disorders are more likely to cause work impairment. Psychotic conditions routinely cause significant impairment in social and occupational functioning, as may treatment-resistant mood and anxiety disorders. However, even evaluatees with very severe psychiatric disorders may sometimes work in a limited capacity or in a supported setting.

Unless a psychiatric disorder causes global impairment of work function, conclusions about impairment should include specific factual reference to limitations or restrictions in identified areas of function.

Psychiatric opinions regarding impairment (and, if requested, regarding disability) should describe the effect of impairments on the requirements of the evaluatee's job-related tasks and responsibilities. Typically, psychiatrists are asked if an evaluatee is impaired or disabled from all work or a specific type of work or work setting.

Often, psychiatrists are also asked to opine about the natural history of a diagnosed disorder, the sufficiency of the evaluatee's treatment, and the evaluatee's prognosis. Psychiatrists are often asked to describe work restrictions or limitations caused by the diagnosed disorder, their duration or permanence, and any treatment recommendations.

G. Written Report

All reports must directly address the referral questions. Failure to respond is a fundamental failure of the assessment process. When specific questions are asked, psychiatrists should limit themselves to providing opinions that are responsive to the questions asked. In addition to responses to the referral questions, all reports should note the parties who requested the evaluation, the purpose of the assessment, the sources of information on which the evaluator's opinions are based, and the informed consent of the evaluatee.

Sometimes, the referring party (e.g., a personal injury attorney, plaintiff or defense) may instruct the evaluating psychiatrist to discuss conclusions before writing a report, to submit only a brief written report, or to submit no report at all. Attorneys in particular may have multiple reasons for these requests and need not disclose those rationales to the evaluator. Especially with brief reports, which may be requested by an attorney for preliminary negotiations, psychiatrists should be mindful not to offer conclusions that exceed the foundation of the data they have reviewed. They are also advised to include a statement reserving the right to revise opinions in the event of being presented with new information.

Most referring parties request a full evaluation report. Generally, the format of the report should conform to the forensic psychiatric standards available in several publications.^{71,80-83} Sometimes psychiatrists choose to communicate orally with the referral source before writing the report. In the event of litigation, all such oral communications may be discoverable, depending on the jurisdiction.

Regardless of the format chosen for a written report, the language should be objective, nonjudgmental, and accessible. The prospective readers, including the arbiters of disability decisions, usually have neither medical nor psychiatric training. Jargon should be avoided and technical language explained.

The following elements may be included in all types of disability reports:

- 1) Identifying information
- 2) Referral source
- 3) Reason for the evaluation: specific questions to be answered
- 4) Informed consent and authorized release of information. (Maintain any signed consent and disclosure authorization forms obtained as part of the file.)
- 5) Sources of information:
 - a) All records and other materials reviewed
 - b) Interviews, with date and duration of each one and whether conducted in person or remotely (telephone, computer, etc.)
 - c) Collateral sources (e.g. interviews by other parties; include date, duration, and whether conducted in person or remotely)
 - d) Special examinations (e.g., psychological tests or evaluation instruments)
- 6) The evaluator's well-reasoned responses to the referral source's questions, including supporting data.

The following additional sections may be included when the evaluator is asked for a full report. The extent of the information provided will be based on the evaluator's decision regarding its relevance to the purpose and findings of the report.

- 7) Detailed history
 - a) Onset and course of current symptoms
 - b) Review of systems
 - c) Claimed or observed impairments
 - d) Recent occupational status and relationship to impairments, if any
 - e) Workplace dynamics
 - f) Psychiatric and mental health treatment history
 - g) Social history: substance use, history of abuse or trauma, criminal history
 - h) Medical history and current medications
 - i) Family history (Note caveats about GINA, mentioned earlier, regarding what may actu-

ally be included in the written report, although relevant history should be obtained during the forensic interview.)

- j) Educational and occupational history, including highest level of education attained, job history, reasons for leaving a job, grievances, Workers' Compensation claims for work-related illnesses and injuries, and any previous public or private disability insurance claims, or employment-related litigation
- k) Relevant sexual, relationship, and marital history
 - l) Current social situation: living arrangement and financial and legal status
- 8) Mental status examination and a full review of psychiatric signs and symptoms at the time of the examination
- 9) Relevant physical examination findings obtained from medical records, if any
- 10) Relevant imaging, diagnostic, and psychological test findings
- 11) Opinions: When specific referral questions have been provided, psychiatrists should organize their responses by listing each question, followed by their response. Some referral sources will expressly direct the evaluating psychiatrist not to give an opinion about disability. Psychiatrists may be instructed only to provide opinions on impairment and other relevant factors that may influence a disability determination. Insurers typically reserve for themselves the right to decide the question of disability. Opinions may include (but are not limited to):
 - a) DSM psychiatric diagnosis: diagnoses should follow current DSM categories. They should, at a minimum, include the presence of any major psychiatric disorders, including personality disorders, where appropriate and indicated. Reasons for any differential diagnoses should be given.
 - b) Impairments in work function and the relationship to psychiatric symptoms
 - c) Adequacy of and response to past treatment
 - d) Treatment recommendations, including recommendations for medical consultations or psychological testing
 - e) Prognosis, including the expected course of the evaluatee's disorder(s), likelihood of chronicity, and expected duration of the impairment

- f) Response to requests for opinions on restrictions or limitations imposed by the claimant's mental impairment(s), including projected duration of restrictions and remaining abilities or residual functioning.
- g) If appropriate, opinions about the reliability of the data reviewed

Section IV. Evaluations for Entitlement to Compensation Benefits

This section includes a brief description of common types of disability evaluations, their specific goals and legal foundation (statutory, administrative, employment, tort), and how these individual features generate unique challenges for psychiatric disability assessment.

A. Government Disability Programs

1. Public Disability Insurance

The Social Security Administration (SSA) administers two different programs that provide benefits based on disability: the Social Security Disability Insurance Program (SSDI) (Title II of the Social Security Act) and Supplemental Security Income (SSI) (Title XVI of the Act). SSDI is a public disability insurance program that provides financial support to disabled workers and their dependents. Eligibility for SSDI benefits requires that the worker's earnings have been taxed by the Federal Insurance Compensation Act (FICA) for a statutorily defined minimum period of time. Eligibility is independent of other sources of income or assets.

In contrast to SSDI, SSI is a means-tested social safety net disability program, with eligibility tied to an individual's assets but independent of an individual's prior work history. SSI provides a minimum income level for those of low economic status and for the aged, blind, and disabled. Financial need is statutorily defined and determines a person's eligibility for SSI benefits. Eligibility does not require prior employment. The SSI benefit is a flat-rate, subsistence payment lower than average SSDI payments.

Despite their differences, SSDI and SSI share a definition of disability: the individual is currently unable to be gainfully employed. An individual can be eligible for benefits under both programs. In addition, both SSDI and SSI link to other support and compensation systems. For example, after a two-year waiting period, recipients of SSDI benefits are eligi-

ble for Medicare⁸⁴; in most states and the District of Columbia, disabled SSI recipients are automatically eligible for Medicaid.⁸⁵

Psychiatrists with active clinical practices often have some familiarity with Social Security disability claims, which rely heavily on information provided by the treating clinicians. SSA's disability determination process, definition of disability, and criteria for determining disability are set by statute and differ substantially from employment-provided and private disability programs. Unlike other public and private programs, SSI and SSDI do not provide benefits for "partial disability." Under the rules governing eligibility for SSI or SSDI benefits, a person is either disabled or not.⁸⁶

2. SSDI Claims

Applications for SSDI benefits and preliminary screening are made at SSA district offices. After verification of legal eligibility, the claim is referred to a state Disability Determination Service (DDS). DDSs are federally funded state agencies that review evidence using SSA rules. State DDSs may review medical records, IMEs and vocational evaluations. They determine the presence, if any, of disability in both initial and reconsideration phases of the SSA's adjudication.

The SSDI disability determination has a five-step "sequential evaluation"^{86,87} process that asks these questions:

- 1) Is the claimant currently engaging in substantial gainful activity (SGA)? SGA is statutorily defined as a level of work activity and earnings. If an individual earns more than a specific amount and is doing productive work, the SSA generally rules that the individual is engaging in SGA and is ineligible for SSDI benefits.
- 2) If a claimant is not engaging in SGA, does the claimant have a severe impairment? A medically determinable "severe" impairment is one that has more than a minimal impact on the claimant's ability to perform basic work activities, such as abilities to understand, remember, and carry out instructions and to respond appropriately to supervision, co-workers, and work pressure in a work setting. If a medical impairment or combination of impairments is not "severe," the disability claim is denied.

If the impairment is severe:

- 3) Does the claimant's impairment meet or equal a "listed" impairment? The SSA has developed a set of medical evaluation criteria called the "Listings of Impairments," or the "Listings."⁸⁶ If a claimant's medical impairments meet one of the listings (or are medically equivalent to a listed impairment) and the claimant is not engaging in substantial gainful activity, the claimant is deemed to be disabled, and the claim is allowed.

If the impairment does not meet or equal a listing:

- 4) Does the impairment prevent the claimant from doing past relevant work? At this stage, the SSA determines whether claimants have the residual functional capacity (RFC) to do the type of work they have done in the past. If the claimant can still perform past relevant work, the disability claim is denied.

If the claimant is not able to do past relevant work:

- 5) Does the impairment prevent the claimant from doing any other work, taking into account the claimant's residual functional capacity, age, education, and work experience? At this final step of the sequential evaluation, the SSA determines whether claimants have the RFC to do other work that is appropriate to their age, education, and work experience and that is readily available in the community.

Medical evidence is the cornerstone of a determination of Social Security disability. Individuals who file a disability claim are responsible for providing medical evidence showing that they have one or more impairments and the severity of those impairments. Case law has established that a claimant has the burden of proof of the first four steps of the five-step sequential process. Medical evidence generally comes from the claimant's health care providers. The State DDS requests copies of medical records from the sources identified by the claimant.

The claimant's health care providers are not asked to opine on the determination of disability. The medical evidence furnished by the claimant's providers is reviewed by an adjudicative team, which makes the disability determination. Their initial determination is subject to review by another disability examiner at one of the SSA's 10 regional offices or at SSA

headquarters. Both of these reviews are strictly paper reviews. The claimant is not examined or interviewed at either of these steps in the process.

To ensure that individuals are treated fairly and that their claims receive the maximum possible consideration, a multilevel appeals process is built into the law for claimants found not to be disabled. If an initial appeal is denied at the DDS level, claimants may request a hearing before an Administrative Law Judge at the SSA. Further appeal options include a request for review of the denial decision by SSA's Appeals Council and then review in the federal courts.⁸⁸ Although most claims are adjudicated at lower levels of the agency, Social Security cases can also be litigated in federal courts.

3. Role of Psychiatrists

In contrast to many other types of disability evaluations, for the SSA, treatment providers are the primary sources of information about the claimant's level of function. Often decisions are made using only the information provided by the treating psychiatrist. The SSA may also ask psychiatrists to provide consultative examinations (CEs) as an independent clinical examiner. Psychiatrists may also be retained as experts by the SSA, by a state DDS, or by either side at an appeals hearing.⁸⁶

SSDI and SSI have identical requirements concerning the information sought from health care providers: they require documentation of the existence of an impairment and how it interferes with an individual's functioning. Three basic concepts underlie the determination of psychiatric disability by the SSA:

- 1) The claimant must have a medically determinable impairment, referred to as a listed mental disorder.
- 2) The mental disorder must result in an inability to work.
- 3) The inability to work resulting from the mental disorder must last or be expected to last for at least 12 months.

SSA forms or referral letters provide a reporting format for a straightforward application of the relevant legal SSA criteria to the clinical data.⁸⁹ Psychiatrists are discouraged from opining about the claimant's ability to work because this determination is the sole purview of the state DDS.⁹⁰

4. Providing Information Regarding One's Own Patients

The process of determining psychiatric disability relies on the medical evidence provided by the claimant's treating clinician. Many disability claims are decided solely by a review of the medical evidence from treatment providers. They are considered most able to provide a detailed, longitudinal picture of the claimant's impairments unobtainable from a single examination or a brief hospitalization.⁸⁶

The SSA asks treating physicians to complete a form documenting clinical observations and evaluation. The SSA may approve additional diagnostic testing to establish conclusively the extent and severity of an illness. The SSA regards a formal mental status examination as the psychological equivalent of a physical examination. Each provides objective medical evidence needed by disability adjudicators to establish the existence of a mental impairment and the severity of the impairment.

The SSA requires that a claimant be disabled for a period of no less than 12 months to be eligible for benefits. The agency attempts to determine whether the claimant is not expected to be able to function in any work setting, even though there may be some periods during the 12 months when the claimant may function well. Providers should therefore address whether any limitations have lasted or are expected to last continuously for at least 12 months.⁹¹ Providers should also document 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 clinical exacerbations and remissions.⁸⁹

5. Consultative Examinations

If the SSA adjudicative team needs additional information beyond that provided by the treating clinician, a consultative examination (CE) may be obtained on a fee-for-service basis. These examinations require specialized expertise.⁹² All CE providers must have active licenses in the state in which they are performing their evaluations, and they must have the training and experience to perform the type of examination or test SSA requests. Each state agency manages its own CE program, including consultant training and compensation. SSA considers the claimant's treatment provider the preferred source for a CE if that physician is qualified, equipped, and willing to perform the examination for the authorized fee. SSA's rules also provide for using an independent

examiner (other than the treating source) for a CE or diagnostic study if:

- a) The treating source prefers not to perform the examination;
- b) The treating source does not have the equipment to provide the specific data needed;
- c) There are conflicts or inconsistencies in the file that cannot be resolved by going back to the treating source;
- d) The claimant prefers another source and has good reason for doing so; or,
- e) Prior experience indicates that the treating clinician may not be an adequate source of additional information.

The consultant's primary role is to make a judgment as to the severity of the impairment based on a review of the medical data, a personal examination of the claimant, and any relevant collateral information. The consultative examiner may also be asked to provide additional detailed medical findings about the claimant's impairment or to provide technical or specialized evidence not available in the claimant's current medical file.

Consultative examiners are asked to describe the claimant's mental restrictions and provide an opinion about the claimant's residual work capacity. CE reports include detailed information concerning functional limitations relative to activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. Opinions about the claimant's residual capabilities despite his impairments should describe 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. Assessment of capability includes assessment of the individual's capacity to manage benefits responsibly.

In addition to a direct examination of the evaluatee and medical records provided by the DDS, consultants may also consider data from collateral sources including community providers, family members, and friends. Collateral interviews often provide important additional data.

The consultant may also suggest a physical examination of the claimant, blood and urine testing, imaging studies, and psychological testing.

Problems arise when reports fail to provide the supporting data necessary to establish a mental disorder or offer a diagnosis using terms not found in the DSM. Generalizations or overly broad conclu-

sions reduce the credibility and utility of a report. Because functional restrictions may result from circumstances other than a mental disorder, reports should say whether restrictions in functioning arise from a mental disorder or other factors.⁹⁰ Failure to causally connect functional restrictions with a diagnosed mental disorder is a fundamental oversight.

6. Definitions

a. Disability

The SSA's statutory definition of disability is 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."⁹³ Substantial gainful activity (SGA) is any work of a nature generally performed for remuneration or profit involving the performance of significant physical or mental duties, or a combination of both, which are productive in nature.⁸⁶ This definition includes part-time work, regardless of pay or its similarity to an individual's former work.⁹⁴ If jobs within the claimant's capability are available in substantial quantity somewhere in the national economy, then the claimant is not eligible for disability benefits.⁹⁵

In addition, an individual must have a medically determinable impairment that is the cause of the disability. The SSA has nine listed categories⁹⁶ of mental disorders, still largely based on DSM, Third Edition-Revised (DSM-III-R) criteria,⁹⁷ which can result in a finding of disability based on a medically determinable impairment. The listings for mental disorders are so constructed that an individual meeting the A, B, and, if present, C criteria of the listings for mental disorders could not reasonably be expected to engage in gainful work.

The SSA's nine categories of mental disorder or "listed impairments" are:

- 1) Organic mental disorders
- 2) Schizophrenia, paranoia, and other psychotic disorders
- 3) Affective disorders
- 4) Intellectual disability
- 5) Anxiety-related disorders
- 6) Somatoform disorders

- 7) Personality disorders
- 8) Substance addiction disorders
- 9) Autistic disorder and other pervasive developmental disorders

Each category or diagnostic group except intellectual disability, autism, and substance addiction disorders consists of a set of clinical findings (paragraph A criteria), one or more of which must be satisfied. An individual who is disabled by a mental disability typically must have a listed disorder to meet the definition of a medical impairment. However, the SSA recognizes that their nine categories of mental disorders do not encompass all types of clinical findings that may result in impairments severe enough to preclude an individual from working. The effect of a combination of different mental impairments and a mental plus a physical impairment are also evaluated for severity in determining disability for work. If a combination of impairments precludes work, then the person would be considered disabled, even if no single impairment would be sufficient. The state DDS may also find claimants to be disabled based on reports indicating that they are experiencing medically equivalent impairments comparable with the criteria of the listings for mental disorders.^{89,98}

If paragraph A clinical criteria are satisfied, then paragraph B and C functional restrictions are assessed. The criteria in paragraphs B and C are based on functions relevant to work, and these criteria establish the severity of the impairment. Paragraph C criteria were added to certain listed disorders in recognition of the significant impact of these chronic mental illnesses on work impairment. An individual may be considered disabled even when such impairments are decreased by the use of medication or certain psychosocial factors such as placement in a structured environment.⁸⁹

The restrictions listed in paragraphs B and C must be the result of the identified mental disorder outlined in paragraph A. A minimum of two or three of the paragraph B criteria must be met for claimants to demonstrate functional restrictions. A person who is seriously limited in the areas defined by paragraphs B and C because of a disorder identified in paragraph A is generally presumed to be unable to work.^{87,89,91}

Paragraph B criteria include:

- 1) Marked restriction of activities of daily living. These include activities such as cleaning,

shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for grooming and hygiene, using telephones, and using a post office. The examiner assesses the independence, appropriateness, effectiveness, and sustainability with which the claimant can do these activities.

- 2) Marked difficulties in maintaining social functioning. Social functioning at work may involve varying degrees of interaction with the public, coworkers, and persons in authority (e.g., supervisors). Social functioning includes the claimant's ability to interact independently, appropriately, effectively, and on a sustained basis with other individuals. Social functioning includes the ability to get along with other persons, including, for example, family members, friends, neighbors, grocery clerks, landlords, or bus drivers. Limitations in social functioning may be documented by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. Examiners also document evidence of cooperative behaviors such as consideration for others and their perspectives, awareness of others' feelings, and social maturity.
- 3) Deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely fashion in work settings. This refers to the ability to sustain attention, concentration, and judgment and to complete work in a timely manner. Limitations in concentration, persistence, or pace are best observed in work settings, but can also often be assessed through clinical examination, including the mental status examination, and psychological or neuropsychological testing.

A claimant's capacity to sustain attention, concentration, and judgment can be reported in terms of history or observed duration of effort, resilience under stress, resistance to distraction, and performance with and without supervision. On its website, the SSA provides detailed and updated guidance for documenting categories of impairment.^{99,100}

- 4) Repeated episodes of deterioration or decompensation in work or worklike settings that cause the individual to withdraw from the situ-

ation or to experience exacerbation of signs and symptoms (which may include deterioration of adapted behaviors). Exacerbations of signs or symptoms accompanied by a loss of adaptive functioning may include difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodic decompensation may require additional treatment, a less stressful environment, or both.

A pattern of episodic decompensation may be documented in the history of present illness, psychiatric history, medication history, or history of reliance on more structured psychological support systems (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household).

b. Residual Functional Capacity

When a claimant's medical evidence of impairment is insufficient to meet benefit criteria, the reviewing medical consultant assesses the claimant's Residual Functional Capacity (RFC). RFC is defined as "a multidimensional description of work-related abilities which an individual retains despite medical impairments."⁸⁷ In other words, what can the claimant still do in a work setting, despite the limitations caused by the claimant's impairments?

The elements of an RFC assessment are derived from paragraph B and C criteria of the listings for mental disorders. The elements describe an expanded list of work-related capacities that may be impaired by mental disorder. Evaluators assess the individual's capacity to sustain the listed activity over a normal workday and workweek. The RFC elements are:

- 1) Understanding and memory: the individual's ability to understand and remember procedures related to work and both simple and detailed instructions.
- 2) Sustained concentration and persistence: the individual's ability to:
 - a) Carry out both simple and more detailed instructions
 - b) Maintain attention and concentration for extended periods
 - c) Perform activities within a given schedule
 - d) Maintain regular attendance and be punctual within customary tolerances
 - e) Sustain an ordinary routine without special supervision

- f) Work with or near others without being distracted
 - g) Make simple work-related decisions;
 - h) Complete a normal workday and workweek without interruptions from psychologically based symptoms
 - i) Perform at a consistent pace without an unreasonable number of and unreasonably long rest periods.
- 3) Social interaction: the individual's ability to
- a) Interact appropriately with the general public
 - b) Ask simple questions or request assistance
 - c) Accept instructions and respond appropriately to criticism from supervisors
 - d) Get along with coworkers and peers without distracting them or exhibiting behavioral extremes
 - e) Maintain socially appropriate behavior
 - f) Adhere to basic standards of neatness and cleanliness.
- 4) Adaptation: the ability to
- a) Respond appropriately to changes in the work setting
 - b) Be aware of normal hazards and take appropriate precautions
 - c) Use public transportation and travel to and within unfamiliar places
 - d) Set realistic goals
 - e) Make plans independent of others

When the claimant's impairment does not meet the A and B criteria in the listings for mental disorders, the claimant's RFC is critical to qualifying for disability benefits. A claimant who has an impairment not meeting one listed by the SSA and not equivalent to any listed disorder may nevertheless be found disabled if the demands of jobs in which the evaluatee might engage exceed the claimant's remaining capacity. When a claimant's RFC is insufficient to do the previous job, assessment of the claimant's capacity for other work will include the claimant's age, education, work experience, and what jobs are available in the national economy.^{89,95}

Key Points in Conducting SSA Disability Evaluations

- 1) Understand and use the SSA's statutory definitions and criteria.
- 2) Do not provide opinions on disability. That determination is the SSA's alone.

- 3) Rely on and follow the format of the forms and referral questions supplied by the SSA to ask for specific information directly linked to the SSA medical disability criteria.
- 4) Document how psychiatric disorders, signs, and symptoms interfere with the evaluatee's functioning.

B. Workers' Compensation

1. Disability Insurance in Lieu of Liability

Workers' Compensation was designed to provide benefits for medical treatment, lost income, and, if necessary, rehabilitation services for workers who have a work-related injury or illness, regardless of the party at fault for the injury. In contrast with tort law, where liability for a person's injury arises only upon establishing that a second party caused that injury, Workers' Compensation is a worker's injury insurance program.

Although details of Workers' Compensation systems vary by state, all Workers' Compensation provides access to benefits based on work-related injury, independent of fault and the tort system. Injured employees are guaranteed a percentage of wages (usually nontaxable) during the periods of disability, as well as medical care expenses. The cost is borne by their employer or the employer's insurance carrier, independent of the employee's fault in causing the injury or illness. In exchange for providing this guarantee, employers are protected by the "Workers' Compensation bar," which aims to preclude injured employees from suing their employer for anything other than the limited, statutorily set damages. Unlike tort law, which may provide compensatory (e.g., lost wages, pain, suffering, medical expenses) and punitive awards to a plaintiff, under Workers' Compensation, an injured employee receives compensation limited to a percentage of lost wages and to the associated medical costs due to disability.

To receive compensation, workers are required to demonstrate that they have an accidental injury or disability that arose out of and in the course of employment. An employee who proves this claim is guaranteed to receive benefits determined according to state statute and case law.

All U.S. states have Workers' Compensation statutes. Each state has its own Workers' Compensation laws, and the rules governing eligibility for benefits vary across jurisdictions. Evaluators for Workers'

Compensation programs should review applicable jurisdictional laws and definitions.

Most federal employees are similarly covered under the Federal Employee Compensation Act (FECA).¹⁰¹ FECA will allow compensation if an injury or disease occurred in the performance of the claimant's duties, and was causally related to factors of employment. FECA requires that the federal occupational exposure contributed to the diagnosed condition by direct cause, aggravation, acceleration, or precipitation. Federal disability questions are generally analogous to state Workers' Compensation law.

2. Causal Relation to Employment

Psychiatrists providing evaluations in Workers' Compensation cases should understand that the "no fault" component of such claims means only that a finding of fault or liability is not required as a prerequisite to awarding benefits. All other legal aspects of a Workers' Compensation claim may be and often are disputed and litigated. One of the most common disputes is whether there is a causal relation between the injury and employment.

Workers' Compensation requires that the injury claimed be an accidental personal injury arising out of and in the course of employment. Whether an injury was causally related to employment is ultimately determined by a Workers' Compensation board using definitions that may vary by jurisdiction. Causal relation to employment under Workers' Compensation is a legal term of art with jurisdictional differences, but is not the same as proximate cause, which applies in other litigation. To prevail under Workers' Compensation, the employee must establish a link between employment and the injury. Extent of injury (degree of damage) is also subject to dispute.

3. Psychiatric Claims in Workers' Compensation

Eligibility for compensation requires medical documentation of the claimant's injury or illness. Claims of mental injury are commonly evaluated by a mental health professional. Workers' compensation tribunals, like other administrative and legal systems, historically have been skeptical of emotional injury or psychiatric claims because of the perception of such claims as primarily subjective in nature.

One common obstacle to the success of a Workers' Compensation claim of mental or emotional injury is the question of whether the injury arose out of and in

the course of employment. Most tribunals will presume a causal connection between the employment and an accidental physical injury that occurred while working. However, a claim that a mental illness is causally connected to employment may be disputed. Employers may point to nonwork factors as causing the mental disorder and argue that the worker's employment was contemporaneous with but causally unrelated to the alleged emotional injury. Developmental factors, family psychiatric history, and workplace-independent stressors may all play a role in evaluating causation.

Another significant obstacle to a claim of psychological injury under Workers' Compensation is if there is a jurisdictional requirement of objective evidence of injury. Some jurisdictions require a physical connection to the mental injury. For example, post-traumatic stress syndrome (PTSD) arising from an employment-related physical injury may be compensable, whereas PTSD arising independent of the physical injury may not.¹⁰²

Mental injury claims in Workers' Compensation are typically divided into three categories, two of which demonstrate this connection.^{103,104}

a. Physical–Mental Claims and Mental–Physical Claims

In a physical–mental claim, a clear precipitating physical injury is alleged to have led to an emotional injury. An example of this category would be a claim for major depression filed by a laborer who falls off scaffolding and injures his back, then develops major depression that he now claims is due to limitations from his back injury. Another example would be a firefighter who is burned in the course of duty, but whose disability is primarily from PTSD.

In a mental–physical claim, stress or an emotional problem is claimed to have led to an objectively measured physical disorder, such as stress leading to heart attack.¹⁰² Originally in such claims, mental injury needed to arise from a discrete and clearly identified nervous shock, such as witnessing a disaster at work resulting in a heart attack.^{104,105} Mental–physical claims have expanded the realm of compensable emotional injury to include prolonged or cumulative work stress, and there has been a trend to compensate for many conditions (e.g., asthma and peptic ulcers) that are claimed to result from such stress. Although the stress-related illness or the stressful circumstances

may be subjective, the physical connection is thought to give these claims objective credibility.

b. Mental–Mental Claims

The third and most controversial type of Workers' Compensation claim is a mental–mental injury: a mental trauma or stress that causes a psychiatric disturbance. In these claims, evaluators face the challenge of defining a personal injury in which a psychological force has produced a psychological effect. The most straightforward mental–mental claims are psychiatric syndromes caused by an obvious traumatic event or limited sequence of events, such as a fire at a plant or a robbery in a bank. In such claims, the worker or other observers can describe, in a manner that can be independently scrutinized, the magnitude of the threat, the proximity of the threat to the worker, and the likely alarm created.

In contrast, attempts to evaluate the cumulative effects of exposure to some noxious aspect of the total work environment present a more difficult challenge, especially when the perspective of the worker and the employer widely differ. Nevertheless, despite the subjectivity inherent in such claims, these types of stress claims are expanding rapidly. Stress-related claims that are based only on aggravation of a pre-existing condition, according to the eggshell skull principle from tort law,¹⁰⁶ have added to the complexity of mental–mental claims. The notion that Workers' Compensation covers individuals with pre-existing emotional conditions that are exacerbated by a work-related stress opens the door to a multitude of potential claims. Individuals with emotional disorders who experience exacerbations or recurrences of symptoms can often claim plausibly that work-related stress at least contributed to worsening of the disorder.

Because these claims are more difficult to demonstrate convincingly, recovery for them is limited in ways that claims for physical injuries are not.¹⁰⁷ For example, many jurisdictions have attempted to limit these mental–mental claims by narrowing the scope of allowable claims or by using more restricted language.^{104,105} In some states, a workers' claim must meet an objective test of a reasonable person in similar circumstances and is barred if the claim is based on a misperception or an employee's overreaction to a work environment. In other states, a claimant must show that job stress is something other than the ordinary stresses of employment that all workers experience.

In yet other states, the nature of the stress must be either a sudden stimulus or an unusual event. When claimants have pre-existing disorders, it may be necessary for them to demonstrate that workplace conditions have substantially contributed to a recurrence or exacerbation of the disorder for the claim to be compensable.

Concurrent employer disciplinary administrative or personnel actions can complicate the question of causal relation to employment.⁷⁴ For example, as a result of a reprimand for poor performance, an employee may be stressed. Stress is also undoubtedly caused by a layoff or termination with or without cause. Workers' Compensation boards have been divided on whether these situations are properly considered employment stressors for the purpose of Workers' Compensation claims. Many state systems and the federal government's Workers' Compensation program now have exceptions for stress resulting from good-faith personnel actions.

4. Degree of Impairment

Workers' Compensation adjudication of impairment and disability most often relies on the *AMA Guides*.^{18,66} In the past, the *Guides* had not used the percentage rating system for psychiatric disorders applied to other organ and body systems. The current edition includes a percentage impairments rating system for certain psychiatric diagnoses in the categories of mood disorders, anxiety disorders, and psychotic disorders. The actual method of arriving at the *Guides'* psychiatric impairment rating scale (PIRS) value is based on a median value of percentages, derived from three other rating scales, including the GAF Scale. The *Guides* also lists other disorders such as personality disorders and dissociative disorders that are not ratable by percentage of impairments.¹⁷

Nevertheless, state Workers' Compensation statutes vary in regard to their use of rating systems or percentages.¹⁰⁸ Even when the use of the *Guides* is required, the edition statutorily identified may not be the most recent. Some states may rely on their own percentage rating system for mental disorders.¹⁰⁹ A state may require a percentage rating for mental impairment but not specify how that should be determined beyond referencing the *AMA Guides*.¹¹⁰ In general, percentage ratings of mental impairments should be used with caution.

As noted above, the *AMA Guides'* Sixth Edition, also revised the categories of impairment for mental

and behavioral disorders to be more congruent with the World Health Organization's International Classification of Functioning (ICF) definitions and conceptual framework.¹⁰⁸ These include (Ref. 18, p 352):

- 1) Self-care, personal hygiene, and activities of daily living
- 2) Role functioning and social and recreational activities
- 3) Travel
- 4) Interpersonal relationships
- 5) Concentration, persistence, and pace
- 6) Resilience and employability

States may differ in the level of impairment that is compensable. Four subcategories of disability are frequently used in Workers' Compensation claims to project financial loss and compensation: temporary-partial, temporary-total, permanent-partial, and permanent-total.

Depending on the type of mental disorder, a temporary disability may be understandable, but a permanent one may not be expected. Similarly, a given mental disorder may cause an individual to be disabled from one type of work but not another, or may prevent the individual from working full-time but not part-time. One of the most common opinions provided by clinicians is that an individual can work only part-time. Such opinions may be valid, but only if formed from a complete understanding of the specific nature of the individual's work duties.

Evaluators may be asked to comment about maximum medical improvement (MMI), which is not necessarily defined as complete resolution of symptoms or impairment, but is a plateau from which no further significant improvement is expected. Evaluators should consider duration and types of treatment received, response to prior treatment interventions, and prognosis if further treatment gains are expected with additional or different treatment interventions.

Key Points in Conducting Workers' Compensation Evaluations

- 1) Determine whether a mental disorder is present (using the relevant edition of the DSM, if required by the jurisdiction's statute).
- 2) If the referral source asks for an opinion regarding causation, assess whether the mental disorder arose out

of and in the course of employment. If the evaluator believes this is the case, the evaluator's report should include specific facts upon which these opinions are based.

- 3) If offering opinions on the causal relation of the injury to employment, use the applicable federal or state statutory definition.
- 4) Assess whether the mental disorder leads to impairment and, if requested, to disability.
- 5) Assess the degree of impairment, using the scale (or percentage rating system) specified by the relevant jurisdiction. If requested, use specified disability categories of temporary-partial, temporary-total, permanent-partial, and permanent-total.
- 6) Address other referral questions, which may include:
 - a) Whether the worker is impaired or disabled from performing the duties of the job where the injury occurred
 - b) Restrictions that may be necessary to allow the worker to perform his or her own job
 - c) Whether the worker can perform another job
 - d) Whether the worker can perform any job at all
 - e) Whether an individual has reached maximum medical improvement, typically defined as medical end result
 - f) The continuing need for treatment before and after settlement of a claim, and whether that treatment is needed to address work-related mental disorder

C. Private Disability Insurance Claims

1. The Role of Psychiatrists

Psychiatrists can become involved in claims of persons who hold private disability insurance policies in several ways. In the course of treatment, a private insurance company (the carrier) or the patient claiming disability (the claimant) may ask a treating psychiatrist to submit clinical information to the carrier. The carrier uses this and other information to decide whether the claimant is eligible for benefits or whether current benefits will be continued.

Carriers handle most private disability insurance claims through internal review processes using their own staff or consultants to examine materials submitted by claimants and the claimants' treating clinicians. If a carrier has further questions about disability status, it may request an "independent medical evaluation" (IME), that is, an evaluation by a nontreating clinician. IMEs, often performed by forensically trained clinicians, are a second route by which psychiatrists become involved in private insurance disability claims. Finally, if benefits end before claimants believe they can return to work, or

when carriers deny claims outright, legal disputes may arise between the carriers and claimants. In such situations, claimants' attorneys may request IMEs from forensic psychiatrists (or rebuttals or narratives from treating clinicians) to help resolve disputes.

When treating individuals who have private disability insurance claims or when conducting private disability IMEs, psychiatrists should be aware of important distinctions between private disability insurance and social insurance programs, such as SSDI and Workers' Compensation. Private disability policies are enforceable private contracts between the carrier and the covered individual. Coverage can be purchased as part of employment benefits or independently by an individual. In the latter case, policy holders are often highly trained, self-employed professionals who seek to insure their capacity to work in their specific occupation. Historically, higher socioeconomic status was associated with fewer claims and shorter duration of claims, although in recent years, especially among physicians, the trend has been toward an increasing number of claims.¹¹¹

Carriers seeking to determine initial or continued eligibility for benefits may seek only a review of records from an independent psychiatric evaluator. Carriers ask specific questions, to which they want independent reviewers to respond. Often, at least one question in such referrals is whether the records support the degree of disability claimed. Psychiatric opinions reached through record review alone are limited by the absence of direct examination of a claimant. Other testing or employment information may be absent. The reviewer should specify that the opinion offered is based solely on the records provided and reserve the right to amend opinions should additional information become available.

2. Ethics of Combined Treatment and Forensic Roles

Section IIB of this Practice Resource provides a general discussion of the ethics-related concerns and potential role conflicts if the same clinician provides both treatment and forensic services. Patients often ask their treating clinicians to become involved in their private disability claims. Like Social Security or Workers' Compensation claims, in which treatment providers often play primary or exclusive roles in providing information and evaluations, clinicians may simply have to provide clinical information to support their patients' disability claims. However, patients' requests in private disability insurance claims

often include requests for opinions that require evaluation of data beyond that which has been collected for treatment purposes. Clinicians and patients alike often are unaware that providing such opinions without adequate collateral or employment information may cross the boundary typically separating the roles of clinician and forensic expert and may create clinical and ethics-related difficulties.

Physicians are required to provide information regarding diagnosis, treatment, and prognosis to support disability claims if requested by a patient who has provided written authorization for release of the information. Treating psychiatrists should inform patients of possible consequences of the release of all of their medical records. Psychiatrists may offer to write a clinical summary in lieu of release of all records. Insurers usually reimburse clinicians for the time taken to write a summary. A cogent, readable summary of a patient's problems can assist a patient's claim and the insurer while providing privacy for clinical information that is not germane to the insurer's concerns. Nevertheless, some carriers may not accept a summary in lieu of records, and the patient claimant will then decide whether to agree to the insurer's request. Note that it is the patient (not the treating clinician) who has the right to authorize releasing (or to decline releasing) the actual medical records.

Providing opinions based on information gathered in the course of clinical care differs from opinions based on an IME or other forensic evaluation of the claimant. Treating psychiatrists are not independent of their clinical duties to their patients and therefore cannot provide truly independent medical evaluations. Moreover, treating psychiatrists' disability opinions may adversely affect the therapeutic relationship. Patients may want or expect advocacy, not assessment. The assessment of patient's veracity and reliability that is required in a disability IME may disrupt the treatment alliance.¹¹²

3. Definitions and Factors

In contrast to the uniform statutory definitions of disability found in SSI and SSDI, the definitions of disability and the manner and duration in which benefits are paid in private insurance programs are defined by contractual terms of the policy and vary widely. Policies offered as a benefit of employment or membership in a group usually are cancelable by the carrier at the end of a defined period and have rates

that are reassessed annually. Private policies purchased by an individual from a carrier typically have more specific language of the work capacity being insured. Typically, these policies have a set cost and cannot be canceled by the carrier regardless of the changing health of the insured.¹¹¹ Unlike disability programs created by statute, carriers have their own individual corporate process for assessment of their insured's claims of disability.

Carriers require objective, probative data about a claimant's incapacity and limitations. Carriers may sometimes place time limits on the benefit or duration for which a psychiatric claim will receive compensation. In the absence of objective evidence to support a medical disability claim (e.g., chronic fatigue syndrome), carriers may sometimes suggest that the disability stems from an untreated psychiatric disorder (e.g., depression), which may limit the duration of benefits depending on the terms of the contract. Newer policies may limit the duration of benefits for "subjective" or "self-reported" syndromes, which can limit the duration of benefits, even without raising psychiatric questions.¹¹³

As in other types of disability assessments, private disability claims may encompass the breadth of psychiatric disorders and their interface with comorbid medical disorders including chronic pain or chronic fatigue syndrome. Claimants and their treaters may inaccurately ascribe chronic job dissatisfaction to a psychiatric disorder that impairs function. Professionals whose policy is occupation specific may collect disability benefits for their former occupation, even if they are gainfully employed at a different professional task. A surgeon who is disabled due to a hand injury may be eligible for long-term benefits, even though that surgeon is gainfully employed providing nonsurgical health care in the clinic.

Knowing the conditions of the evaluatee's disability policy and the policy's definition of disability can help evaluators understand and anticipate potential areas for distortion of their opinions.¹¹³⁻¹¹⁵

4. Conducting Independent Evaluations

In addition to performing a comprehensive psychiatric examination, evaluators are asked to determine function before claims of disability, workplace, and other environmental disincentives to returning to work, claimant veracity, and claimant motivation.¹¹³ Evaluators inquire about circumstances of any prior periods of disability. Has the claimant been

the object of supervisory criticism or discipline? Have the claimant's workplace conditions changed substantially? Can the claimant's account of disability be corroborated by medical records or by third parties? What is the claimant's level of function outside the workplace? Is it congruent with the claimed workplace impairments?

An evaluatee's pre- and postdisability income, disability benefits, and financial status may clarify the potential significance of financial factors in the evaluatee's motivation to return to work.^{111,116}

The referral source or the carrier typically provides collateral information for the evaluating psychiatrist to review. This information may include medical records, the evaluatee's job description, and prior history of job performance and surveillance, if any. With appropriate releases from the claimant, evaluating psychiatrists can corroborate the claimant's self-report of function through contacts with third parties such as treating clinicians, workplace supervisors, colleagues, family, and friends. If evaluatees refuse to allow the necessary collateral contacts, evaluators should note both the refusal and evaluatees' stated reason for refusal in the report. The report's conclusions may be limited by the lack of relevant collateral information. In the absence of sufficient data, evaluators may opine that no conclusion is possible within reasonable medical certainty.

Most requests for assessment include specific questions to be answered by the evaluator. Evaluators typically are asked to document an objective foundation for the opinions proffered. Evaluators are commonly asked questions about adequacy of treatment, prognosis, alternate treatments, and the evaluatee's adherence, motivation, and residual function.¹¹⁷⁻¹¹⁹ Currently, a multiaxial DSM diagnosis may be requested by carriers. It remains unknown whether this practice will continue or yield to the nonmultiaxial system of DSM-5. Evaluators should not offer an ultimate opinion about whether the claimant is "disabled" unless specifically asked.

The report should address evaluatee's remaining capacity for specific functional tasks of the evaluatee's duties. A comprehensive and objective report should make it easy for a reader to comprehend the causal connection between the symptoms and consequences of a diagnosed illness and its direct effect on the evaluatee's capacity to work.^{113,120}

Evaluators may also be asked their opinions regarding limitations, restrictions, and accommoda-

tions; whether evaluatees could return to work at their own occupation or some other occupation; and whether they can work under specific conditions. Opinions regarding limitations, restrictions, accommodations, and ability to return to work should be supported by objective evidence that causally connects the diagnosed disorder with the workplace recommendations.

An evaluatee's illegal behavior or maladaptive personality traits may prompt a request for an IME. Illegal conduct may or may not be a consequence of an illness. Maladaptive personality traits that rise to the level of a disorder may be a basis of impairment. As with other opinions, the evaluator documents the data that indicate the presence or absence of a causal connection between a diagnosed disorder and the evaluatee's work capacities.

Evaluators are asked about the evaluatee's motivation and possible malingering. An evaluatee's defensiveness or symptom exaggeration, if present, should be assessed and documented. Defensiveness may reflect an evaluatee's feelings about having to undergo evaluation of their disability claim, their manner of articulating level of distress and impairment, or their knowing exaggeration or misrepresentation of symptoms or functioning.¹²¹

5. The Written Report

Often the written report is the only work product of the private disability IME.^{113,120} Many times, the referral source will not provide feedback to the IME evaluator after the report is submitted. It is not unusual, however, for referral sources to ask for clarification, pose follow-up questions, or forward a newly received record and ask an evaluator whether the new information changes any of the evaluator's opinions. Because the report is often the only input that the evaluator will provide, it is important for evaluators to be thorough and to link the observed symptoms to the functional impairments observed.

Sometimes, evaluating psychiatrists cannot obtain enough information to answer the questions posed by the referral source. This problem arises most often when psychiatrists are conducting reviews of records alone. In such cases, evaluating psychiatrists should not hesitate to inform the referral source that they do not have enough data to formulate an opinion within a reasonable degree of certainty.

The information that has been provided may indicate the existence of additional records that are

needed. Evaluators should recommend that these records be obtained. The need for additional testing may become evident from a review of records or an interview of the claimant. The evaluator can recommend that the claimant undergo psychological, neuropsychological, or medical testing; urine screening or other laboratory tests; or other examinations.

Key Points in Conducting Private Disability Evaluations

- 1) Clarify in writing the referral source's specific questions.
- 2) Understand the evaluatee's policy terms and definition of disability.
- 3) Obtain a thorough work history.
- 4) If the referral source's questions cannot be answered due to lack of information, inform the referral source and suggest what additional information could or should be provided.
- 5) Inform the referral source if opinions are reached through a review of records only.
- 6) Provide a clear, well-substantiated report.
- 7) Provide specific answers to the referral source's questions.

Section V. Evaluations for Ability to Continue Working, With or Without Requests for Accommodations

A. Americans with Disabilities Act and Americans with Disabilities Act Amendments Act Evaluations

1. Intent of the ADA

In contrast to employment claims in which individuals seek compensation because they cannot work, individuals who raise Americans with Disabilities Act (ADA) claims seek to return to or remain in the work force, avoiding the need to apply for financial disability benefits. Employees who are totally disabled and unable to work are not eligible for accommodation under the ADA. As in the case of SSDI, in most ADA cases, documentation is completed by the treating mental health provider and does not require forensic psychiatric evaluation.¹²²

The ADA, enacted in 1990, was designed to protect the civil rights of disabled individuals, including

their employment rights, and make it possible for them to continue working despite mental or physical disabilities. Title I of the ADA requires an employer to make “reasonable accommodations” for a “disabled” but qualified individual to enable that individual to perform “essential job functions,” unless the accommodation would impose an “undue hardship” on the employer.¹²³

The ADA defined disability as having a “physical or mental impairment” that “substantially limits” one or more “major life activities”; having a history of an impairment¹²⁴; or being regarded by others as having an impairment. In other words, in addition to those individuals with an actual disability, the ADA was designed to protect individuals with a history of disability and those whom others regard as having a disability. Beginning in 1999, the United States Supreme Court’s rulings and rulings in lower courts in ADA cases began to limit the class of persons entitled to protection under the ADA. These judicial decisions often focused on determining whether a plaintiff was “disabled” within the meaning of the statute. The Supreme Court and lower courts narrowly interpreted ADA’s definition of disability, so that employees prevailed in only 3 percent of cases brought under the ADA from 2002 to 2004.¹²⁵

A bipartisan group of stakeholders, increasingly frustrated by courts’ restrictive interpretations of the ADA, developed and passed the Americans with Disabilities Amendments Act (ADAAA) of 2008. The ADAAA explicitly rejected the judicial narrowing of ADA coverage, emphasized that the definition of disability should be construed in favor of broad coverage, and explicitly mentioned major psychiatric disorders as disabilities. The ADAAA and associated EEOC regulations additionally included less restrictive interpretations of the terms substantially limits and major life activities, which also had been narrowed by Supreme Court and lower court decisions.¹²⁶

The ADA does not override health and safety requirements established under other Federal laws, such as those of the U.S. Occupational Safety and Health Administration (OSHA), even if a standard adversely affects the employment of an individual with a disability. However, an employer still has the obligation under the ADA to consider whether there is a reasonable accommodation that will prevent exclusion of qualified individuals with disabilities who can perform jobs without violating the standards of

those laws. If an employer with 15 or more employees can comply with both the ADA and another Federal law, then the employer must do so.¹²⁷

The ADA and ADAAA do not supersede state or local laws that provide greater or equal protection for persons with disabilities, but do pre-empt laws that provide less protection.^{29,126} An employer cannot rely on a state or local law that conflicts with ADA requirements as a defense to a charge of discrimination.

Common workplace situations may raise ADA-related questions and may therefore result in requests for psychiatric disability evaluations. Once employees identify themselves as having a psychiatric diagnosis and make requests for accommodations, employers are legally required to engage in an “interactive process,” in which employers and employees must clarify what the disabled individual needs and identify the appropriate reasonable accommodation as quickly as possible. Any unnecessary delay in addressing requests for accommodations may lead to employer liability.

However, employers may face challenges when attempting to meet their legal obligations to make reasonable accommodations for individuals with psychiatric disorders. Whereas providing ramps for wheelchair-bound employees is a relatively straightforward accommodation, providing a less stressful environment for an employee with a psychiatric disorder, for example, can be difficult to operationalize. Moreover, unlike many physical disabilities, identifying a mental disability itself may be challenging, and employees with mental illnesses may be hesitant to identify themselves as such for a variety of reasons, including fear of stigmatization. Employers may find it difficult to distinguish whether an individual’s behavior or performance difficulties are due to a psychiatric illness that may require accommodation or to poor work and interpersonal skills that require disciplinary action.

A common situation that may give rise to a request for a disability evaluation occurs when an employee presents an employer with information about a psychiatric disorder, but does not make a direct request for evaluation or accommodation. This can occur, for example, when an employee presents a doctor’s note citing depression as the reason for work absence. This information technically notifies an employer of the employee’s potential disability under ADA/ADAAA, even though the employee did not directly request accommodations.

The occurrence of a troubling event in the workplace also often prompts a request for a disability evaluation under the ADA/ADAAA. The event may be as simple as an employee with known depression missing a week of work or as complicated as displaying bizarre behavior that is frightening coworkers but is not overtly dangerous or threatening. Requests for evaluations may also occur before an employee's return to the workplace after a psychiatric hospitalization.

An employer may also refer employees for psychiatric evaluation to clarify the employer's obligations under the ADA/ADAAA. Psychiatric assessment, including a diagnostic evaluation, assessment of functional impairment and disability, and recommendations for accommodations may be used in an "interactive process" that can help both employers and employees decide what is in the best interest of both parties as they negotiate arrangements for reasonable accommodations. If employees and employers cannot resolve disputes over application of the ADA/ADAAA, a court will make the final determination. Most of ADA-related circumstances, such as requests for accommodations or whether an individual has a disability, do not proceed to litigation. In these cases, the psychiatrist's opinion may be helpful and dispositive for both employers and employees.

A comprehensive ADA evaluation may allow an employee, who might otherwise have to withdraw from the workplace and claim disability status, to remain in the work force. The evaluation can also provide suggestions that help the employer by facilitating the continued employment of a valuable worker. An ADA evaluation may help avert a confrontation that could lead to a claim of discrimination and costly litigation.

2. The ADA and Definition of Disability

The ADA/ADAAA has delineated a definition of disability that is distinctly different from all other disability determinations, and this makes ADA/ADAAA evaluations unique. As noted above, the ADA/ADAAA defines disability as either "a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment."¹²⁸ The ADA definition is not confined to the employment sector. Persons who satisfy the ADA's legal definition obtain protection under all sections of the ADA, including protec-

tion against discrimination in restaurants, stores, private schools, professional offices, among others.

The determination that an individual has a psychiatric disability under the ADA first requires that the individual have a diagnosable mental impairment. Courts usually recognize most psychiatric disorders as "impairments," but not necessarily as "disabilities." Whether impairment rises to the level of a disability is case specific. In addition, the ADA/ADAAA specifically excludes certain conditions and behaviors as grounds for disability. DSM "V codes," which describe stressful events and relationship problems, do not qualify as disabilities under the ADA. Statutory language in the ADA legislation itself specifically excludes the following conditions from protection: compulsive gambling, kleptomania, pyromania, transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, and other sexual behavior disorders.¹²⁹

Substance use disorders caused by current use of illegal drugs are also excluded from ADA protection.¹³⁰ However, individuals who have used illegal drugs, but are not current users, are covered under the ADA. Finally, the sexual orientations of bisexuality and homosexuality, neither of which is a DSM diagnosis, cannot be used as a qualifying diagnosis leading to disability under the ADA.

The second requirement for psychiatric disability under the ADA is that the identified mental illness or psychiatric symptoms must "substantially limit one or more of the major life activities." The ADAAA widened the interpretation of the terms substantially limits and major life activities. The ADAAA included, and the EEOC adopted, a list of potential major life activities. This list includes, but is 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."¹³¹

The psychiatric assessment of the limitations of these major life activities should include and describe the "condition, manner, or duration" of each affected activity.¹³² If a dispute arises over these assessments, a court may ultimately resolve the conflict. Nevertheless, when providing an evaluation, psychiatrists should focus on the clinical aspects of an evaluatee's limitations.¹²⁶

An individual with impairment that limits a major life activity is still covered by the ADA/ADAAA when that impairment is in remission. The determination of whether an impairment substantially limits a major life activity will be made without regard to the effectiveness of mitigating measures, such as medication. An employer cannot require an employee to use a mitigating measure, but failure to do so may render the employee unqualified for the position or may support the contention that the employee presents “a direct threat,” each of which might disqualify the employee from the ADA’s protection.^{126,132}

3. Functional Evaluation and Essential Job Functions

Individuals who are disabled under the ADA are entitled to continue to work at their job positions only if they can perform the essential job functions, either with or without accommodation. “Essential functions” statutorily are those fundamental job duties of the employment position.¹³³ A job function may be considered essential for any of several reasons, including, but not limited to, the following:

- 1) The position exists to perform that specific function.
- 2) The number of employees among whom the performance of that job function can be distributed is limited.
- 3) The function may be highly specialized so that the incumbent in the position is hired for his or her expertise or ability to perform the particular function.¹³³

For example, an essential job function for a letter handler at the post office might be to sort letters and put them in the appropriate bin. A nonessential function might be to work an occasional overtime shift until 3 a.m.

Psychiatric evaluators therefore must determine whether the disabled individual can perform essential job functions.¹³⁴ To gain an understanding of an evaluatee’s essential job functions, evaluators should obtain a written or verbal job description from the employer as well as information from the evaluatee. They should not assume that they understand what essential job functions are, because these may change from employer to employer, even for the same job position.

The psychiatric evaluator then determines whether the evaluatee can carry out the essential functions of the job whether there is or is not a psychiatric illness, and with or without accommodation. Information regard-

ing this assessment should be obtained from both the employer and the evaluatee. Psychiatrists are not experts in the training needed for every type of employment and need not attempt to credential the evaluatee.

For a letter handler, the evaluator would assess whether the post office employee could perform the essential job function of sorting mail if there were no psychiatric illness and independent of the nonessential job function (night shifts).

This assessment is critical in cases of employees who have misrepresented their training or have been promoted to a position that is beyond their abilities. Often such employees have poor work performance that predates their claim of psychiatric disability, though they may assert that their poor performance was caused by a psychiatric illness. Individuals unable to perform essential job functions, with or without accommodation, cannot retain that specific job, even when deemed disabled under the ADA.

ADA protections do not apply if the employee presents a direct threat in the workplace. The ADA defines direct threat to be “a significant risk to the health and safety of others that cannot be eliminated by reasonable accommodations.”¹³⁵ The mere perception by another employee or supervisor that an individual is dangerous is often insufficient to satisfy statutory requirements. Recent violent behavior or a plan to commit violence are examples of objective evidence of direct threat under the ADA.^{29,126}

Psychiatric ADA evaluations addressing a direct threat require assessment of risk factors for violence. Collateral information from individuals in the workplace is essential. The duration of the risk and the severity, imminence, and likelihood of potential harm are key concerns for assessment.

Some employment, by its fiduciary nature to public safety, may have a lower level of acceptable risk. Professions such as law enforcement, pilots, health care workers, and intelligence and Department of Defense workers tolerate less workplace risk and often have their own written policies to guide psychiatric evaluators.^{29,126}

4. Assessment of Reasonable Accommodation

Mental health professionals performing ADA/ADAAA evaluations are often asked to identify possible accommodations that would permit a disabled evaluatee to perform essential job functions. The ADA/ADAAA regulations define reasonable accommodations as “modifications or adjustments to the work environment, or to the manner or circum-

stances under which the position held or desired is customarily performed, that enable an individual with a disability who is qualified to perform the essential functions of that position;” or “that enable [an] employee with a disability to enjoy equal benefits and privileges of employment as are enjoyed by its other similarly situated employees without disabilities.”¹³³

Identifying potential accommodations requires knowledge of the essential functions of the job. It may also involve a more detailed understanding of workplace surroundings, structure, and scheduling. Many of the accommodations needed by disabled employees can be arranged through simple, inexpensive, common-sense interventions or changes^{134,136} that involve increased communication, schedule changes, or changes in surroundings or the physical environment. The EEOC has provided examples of reasonable accommodations for persons with mental disabilities, including time off from work; a modified work schedule; physical changes in the workplace; moving work locations; access to additional equipment; increased supervision and guidance; changes in workplace policies such as more frequent breaks; provision of a job coach; and, when not an undue hardship for the employer, reassignment to a different position.¹²⁶

When accommodations are more complicated, psychiatrists can make a recommendation to involve a job coach or rehabilitation specialist. These professionals identify the problems and provide possible solutions, generally after a visit to the workplace.

Under the ADA/ADAAA, although employers are required to provide reasonable accommodations, they are not required to provide accommodations that cause themselves undue hardship, that is, accommodations that are expensive, difficult, or disruptive.^{128,133}

Differences of opinion between employee and employer on whether specific accommodations are reasonable, like other potentially disputed elements of ADA/ADAAA claims, may become the subject of litigation. Psychiatrists are asked to offer opinions about potential accommodations, but do not determine what would be considered reasonable or an undue hardship for an employer.

Employers are more likely to implement suggestions for relatively noncomplex, inexpensive accommodations, especially when the suggestions are based on clinical judgment regarding the symptoms and severity of the evaluatee’s disorder and are informed by an understanding of the individual’s work situation.

Key Points in Conducting ADA Evaluations

- 1) Assess whether the evaluatee meets criteria for a psychiatric disorder.
- 2) Assess for substantial impairment of major life activities related to the disorder.
- 3) Determine the duration of impairment of major life activities.
- 4) Identify in the report all of the major life activities that are impaired and the duration of the impairment of each activity.
- 5) Be familiar with the essential functions necessary for the evaluatee’s job.
- 6) Assess functional capacity related to essential and nonessential job functions.
- 7) Assess whether an evaluatee can perform these functions with or without accommodations.
- 8) Suggest accommodations that may enable individuals to perform essential job functions for which they are qualified.
- 9) Assess whether evaluatees pose a direct threat of danger to themselves or others.

B. General Fitness-for-Duty Examinations

I. Referral

Fitness-for-duty (FFD) examinations are initiated by an employer or workplace agency when an employee’s illness or workplace behavior has raised concerns about the employee’s workplace capacities or workplace risk to safety. Employers are responsible for prudent efforts to assure safety in the workplace. They are statutorily authorized by the ADA to require an FFD examination when they have a reasonable basis for concern. Continued employment may be conditional on the employee’s full cooperation.

Examples of circumstances that may trigger an FFD evaluation include the following scenarios: an industrial worker treated for a mental illness appears unduly sedated after a return from a medical leave; a worker hospitalized for psychosis, symptoms of which were observed in the workplace, wishes to return to work; a schoolteacher who appears hypomanic is referred because of angry and inappropriate outbursts in the classroom; and a security officer is referred after demonstrating excessive irritability while on duty or after the officer’s involvement in an off-duty disturbance that creates concern about mental stability.

Referrals for FFD evaluations frequently are urgent for both employer and employee. Both the evaluatee and the referral source feel pressure to complete an FFD evaluation as quickly as possible. Potential evaluatees may be suspended or on administrative leave and at risk of losing their jobs pending the outcome of an FFD evaluation. Employers also find these situations difficult, not least because an employee may not be allowed to work pending the examination. Such absences create a need to have other workers fulfill the employee's responsibilities, and may cause other disruptions of normal workplace activity or productivity. Evaluators are well advised to inform the referral source that, urgency notwithstanding, assessment includes a comprehensive psychiatric assessment, access to collateral documents and individuals to establish a database of the events in question, and a thorough risk assessment. Evaluatees may be angry at having to undergo an examination and fearful of the unwanted intrusion that any such an examination represents.

Psychiatrists may determine on the basis of the preliminary information provided by a referral source that emergency room mental health assessment or hospitalization or both may be required in lieu of an outpatient FFD evaluation. Urgent clinical interventions performed by a treatment provider may be needed before the FFD evaluation begins. FFD questions can be revisited and interviews rescheduled if still indicated after completion of an urgent clinical assessment for treatment purposes.

At the time of referral, psychiatrists should attempt to determine:

- 1) Detailed information concerning the reason for the referral at the present time, including the nature of the behavior that led to the referral and documentation from supervisors, co-workers, and customers concerning the behavior. (Interviewing or obtaining documentation from the employee's supervisor before interviewing the evaluatee may help clarify the nature of the events that led to the referral and can help the evaluator formulate areas of inquiry during interviews with the employee.)
- 2) The evaluatee's job description
- 3) Copies of job performance evaluations
- 4) Copies of relevant medical/psychiatric records (evaluatees are often responsible for supplying these records)

- 5) The evaluatee's current job status, whether the evaluatee is on medical or administrative leave, suspended, or working with or without restrictions
- 6) The names and contact information of workplace supervisors, witnesses, and complainants, if any, who may serve as collateral contacts for the FFD
- 7) How and by whom the employee will be informed of the required FFD (Sometimes the evaluator will be asked for advice about this process.)
- 8) That the referral source will provide the evaluator with a written statement of the questions to which the evaluator will respond.⁹¹

Statutorily mandated requirements about the confidentiality of protected health care information (PHI) apply to FFDs. Evaluators must safeguard PHI as they would for clinical assessments. Employers must have confidential storage for employee PHI. Evaluators disclose only PHI relevant to answering the employer's workplace questions. It may not be necessary to provide detail about an evaluatee's family and social history, except to the extent that such information is directly related to the specific referral questions, as discussed above. The evaluating psychiatrist, the referral source, and the evaluatee all should have notice and understanding of the limitations of confidentiality and the nature of the anticipated disclosures.

Psychiatrists should request a written document from the referral source indicating the questions that the psychiatric evaluation should address, thus helping to keep miscommunications between the referral source and the evaluating psychiatrist to a minimum. These questions often involve situations related to work limitations or restrictions, suggested modifications in work assignments, diagnosis, treatment, prognosis, and safety.

2. *Inappropriate Use of Evaluations*

Psychiatric FFD evaluations may be misused by an employer (see Section II.B.4). Employees who have become problematic for reasons other than their mental health may be referred for FFD evaluations in an effort to undermine the credibility of, or to retaliate against, employees who have filed formal complaints.

An employee may also incorrectly conclude that the mandated examination is retaliation, when in fact it is wholly appropriate. The employee's allega-

tion may be motivated by witting or unwitting denial of responsibility for poor performance or disruptive conduct. Evaluators should therefore be alert for possible misuse of the FFD evaluation process.^{137,138} The report should clearly indicate if an evaluation does not demonstrate a psychiatric disorder or symptom as the basis for problematic workplace behavior or for workplace conflict.

Key Points in Conducting Fitness-for-Duty Evaluations

- 1) Assess the appropriateness of the evaluation at the time of the referral. If it appears that a clinical evaluation for treatment purposes should precede an FFD evaluation, the psychiatrist should so advise the referral source.
- 2) Have the referral source provide specific written questions for the evaluation.
- 3) Before interviewing the employee, obtain information about relevant behaviors and conflicts in the workplace.
- 4) Advise evaluatees of the evaluation and limits of confidentiality before conducting the interview.
- 5) Carefully evaluate any differences or omissions between the evaluatee's report of events and reports from the referral source and the degree of the employee's insight into the nature of the FFD referral.
- 6) Perform a standard psychiatric examination with a focus on the evaluatee's ability to perform relevant work functions, as explained in the job description and other relevant referral questions. Obtain psychological testing if clinical information indicates a need for such data to reach or support a conclusion.
- 7) Limit reports to information relevant to the referral.

C. Fitness-for-Duty Evaluations of Physicians and Public Safety Officers

Performance of certain occupations raises questions of public safety. Individuals in these occupations therefore are often subject to special scrutiny if they display poor judgment, signs of cognitive impairment, or disruptive behavior. As noted above, the level of acceptable risk in these occupations is typically lower than in occupations that do not involve public safety. The following sections will discuss

FFD evaluations specific to two such groups: physicians and law enforcement officers who carry firearms.

The focus on these two occupations is not intended to imply that impairment of individuals in other occupations does not raise safety concerns. Health care workers other than physicians, such as nurses, dentists, and psychologists, may present similar public safety concerns. Other types of workers, including school bus drivers, tractor trailer drivers, chemical plant operators, aircraft pilots, and other persons who operate heavy machinery have unique safety-related responsibilities that may lead to FFD evaluations.

Nevertheless, there is a low threshold for FFD referral of physicians and armed law enforcement officers if they have exhibited possible psychiatric impairment. Some procedures for evaluating these groups will apply to persons in other occupations when possible psychiatric impairment generates concerns about risks to the public. This discussion is not intended to cover every possible scenario in relation to safety concerns for physicians or officers who carry firearms; common sense within the parameters of this Practice Resource should be used.

1. Fitness-for-Duty Evaluations of Physicians

a. Agency Referrals

A formal, independent psychiatric examination may be requested when problematic behavior raises questions about a physician's fitness to practice. Usually, the observations and concerns about the physician's conduct will have been reported to an agency responsible for oversight of physicians, such as a hospital administrative committee or department chair, a hospital physician health committee, a state physician health committee, or a state licensing board. Any of these agencies is statutorily mandated¹³⁹ to intervene in the presence of reasonable concerns and order a physician to undergo an assessment.^{18,140–142} A request for an IME may also originate from the physician who is the subject of a peer review or administrative law investigation, or from an attorney representing a defendant physician.⁴⁹

The evaluator will be asked to perform a comprehensive evaluation of the physician and provide a full report of the findings. Psychiatrists who conduct physician FFD evaluations should consider how a psychiatric condition, a medical condition, or a med-

ication side effect might affect the evaluatee's ability to practice his or her specific specialty. Evaluators will also be asked to offer opinions about past professional conduct, current health, and future capacity to function safely as a physician. The evaluator is likely to be asked for recommendations about treatment and professional supervision or oversight, if indicated.^{19,49,140}

Physicians are often referred for evaluation absent any known direct patient harm. The conduct in question may have occurred outside of the workplace. Justifying the need for such referral is the state board's concern that, when a physician's health or wellness is compromised, the safety and effectiveness of medical care may also be compromised.¹⁴³ The AMA defines physician impairment as "the inability to practice medicine with reasonable skill and safety as a result of illness or injury." The definition encompasses impairment related to psychiatric disorder, substance use, dementia, other medical disorders or medicines with cognitive or behavioral side effects.

Physician FFD evaluations are also frequently requested to evaluate troublesome or disruptive behavior.^{140,144,145} The AMA defines disruptive behavior as "conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care."¹⁴⁶ This includes, but is not limited to, conduct that interferes with the ability to work with other members of the health team.

Disruptive physicians may engage in a range of unprofessional actions. Examples include displays of inappropriate anger, intimidation of coworkers, unwillingness to take responsibility for adverse events, and failure to fulfill professional responsibilities (e.g., repeated failure to respond to calls).^{49,147} Physicians may also be referred for evaluation because of accusations of sexual harassment, other boundary violations, or an arrest.^{19,49,140} Disruptive or illegal behavior may or may not be caused by a major psychiatric disorder, but could reflect longstanding problematic maladaptive personality traits or a personality disorder.^{19,140,144,147}

The ability of a physician to practice safely may be compromised by factors unrelated to psychiatric impairment, such as deficient knowledge, skill, or experience. The task of assessing physicians' technical competence in their specialty is outside the scope of FFD evaluations.¹⁹ If an evaluating psychiatrist suspects that incompetent skills could be a factor in impaired performance, the evaluatee should be referred

for further assessment. In such cases, a state medical society physician competency committee can act as a resource.⁴⁹ Evaluators should consider noting in their reports that their expressed opinions are limited to assessment of the relevant psychiatric factors.^{140,145}

All referral sources will ask for an opinion about the fitness to practice medicine.^{142,145} However, more specific referral questions are generated by the focus, mission, concerns, or agendas of referring agencies. For example, when a hospital department, group practice, or an administrative board refers a physician for assessment, they may be concerned about the safety of the workplace and the physician's ability to meet the institution's expectations for acceptable conduct. Often there are written policies that describe these expectations. FFD examinations requested by residency training programs or medical schools may reflect concerns about fitness to complete training and fitness for learning. Referral questions from military and Department of Defense agencies may reflect features of their specific codes of conduct.^{140,145}

Psychiatrists providing physician FFD evaluations should be familiar with the objectives of each of the agencies that monitor physician conduct, given that these are frequent sources of physician FFD referrals. These agencies include:

- 1) hospital-based physician health committees^{49,148,149};
- 2) state physician health programs that operate independent of the state medical licensing board and are not involved in the disciplinary process; and state medical licensing boards.^{19,49,140,150}

Physician health programs at both the state and hospital level are primarily interested in physician health and the preservation, if possible, of a physician's ability to practice safely. Their referral questions will center on the identification of psychiatric disorders that affect the physician's ability to practice. In addition to major psychiatric disorders and personality disorders, a physician health program would be concerned about personality traits or stressors (e.g., divorce or other personal or family problem) that may help to explain the reported misconduct.^{19,49,140,150}

Physician health programs often ask for opinions that go beyond diagnosis of psychiatric disorder. If a

treatable disorder is identified, the physician health program will ask for suggestions for treatment and for monitoring compliance. The physician health program will ask psychiatric evaluators for opinions about the need for oversight in the work environment. If the evaluator believes that the physician cannot safely continue to work, there will be further questions about a strategy for rehabilitation. Many physician health programs have a standard contract that is modified based on the evaluator's recommendations. If the physician fails to complete the contract or violates one of the provisions of the contract, then the state medical board may be notified.^{49,140,150}

In contrast to a physician health program, a state medical licensing board is primarily concerned with protecting the public, and the referral questions generated by state licensing boards reflect this mandate. State boards have the authority to order FFD evaluations under a variety of circumstances in which they consider public safety to be at stake. During the licensing process, a physician may disclose information that raises questions about current fitness or need for monitoring (for example, if the physician was under a monitoring agreement in another state). The enforcement division of the state medical licensing board may request an evaluation after a complaint from a patient, a colleague, or a health care agency, or after an arrest. The costs for such evaluations are generally borne by the physician rather than the board.

The results of the FFD evaluation can affect a board's decision to grant licensure. A license to practice medicine is a privilege that is regulated by medical boards.^{19,140,145} A license can be suspended or revoked after an administrative hearing. Although there are provisions for appeals to civil courts, state medical licensing boards are afforded wide authority and discretion to protect the public. State medical licensing boards provide physician defendants with certain legal rights, such as the right to cross-examine witnesses and the right to present evidence. However, the protections available to physician defendants are substantially narrower than those afforded to criminal or civil defendants.¹⁴⁰

The state medical licensing board may decide to divert the physician to the state physician health committee. The state licensing board may also decide to discipline the physician, an action that can have lasting professional consequences. Official disciplinary actions such as public reprimand, suspension,

and revocation may be reported to the National Practitioner Data Bank. States vary in the degree of public disclosure of complaints, investigations, findings, and actions.¹⁹ Nevertheless, this information has increasingly become readily available online in the form of physician profiles.^{141,151}

b. The Evaluation

The APA has developed a resource document on guidelines for psychiatric fitness-for-duty evaluations for physicians.¹⁹ These guidelines recommend conducting a thorough psychiatric assessment, obtaining a detailed history, collecting collateral information (including indices of past performance), and ordering psychological testing as indicated. Questions about previous peer review allegations, disciplinary actions, malpractice history, and prior complaints to the state board or hospital committees can provide important information related to performance. When there are allegations of a professional boundary violation, a detailed sexual history should be obtained.

Psychiatric evaluators should offer opinions about the presence of a mental illness and the extent, if any, to which the mental illness has interfered with the evaluatee's ability to practice with skill and safety in the specific work setting. The evaluator should provide a description of how the mental illness affects job-related capacities and thus fitness for duty.^{19,49} These opinions should be supported by specific data obtained from the evaluation of the physician and information collected from collateral sources. Physician FFD evaluations also require an assessment of short- and long-term risk arising from a diagnosed mental disorder and suggestions for risk management and mitigation.

Some evaluators incorporate tests of frontal lobe function as part of the mental status examination to screen for deficiencies of memory, language, judgment, and executive function. The administration of a full neuropsychological battery may be needed if cognitive impairment is suspected. When a substance use disorder is suspected, appropriate serum, urine, and hair analyses can be obtained by the referring agency.¹⁹ If indicated, the evaluatee should be referred for a medical evaluation and for appropriate laboratory and imaging studies.

Evaluators usually provide specific recommendations for treatment, including modality, duration, and frequency. Evaluators may provide recommendations of the monitoring, scope of practice activi-

ties, and supervision of the evaluatee's clinical activities. Often an evaluatee will have a workplace supervisor-monitor who, like the evaluatee's treating clinicians, will document the evaluatee's adherence with treatment and workplace recommendations. Evaluatees with substance use disorders may need mandated random urine screening to document abstinence. The evaluator's recommendations are often incorporated into a consent decree or contract between the state board or state physician health service and the evaluatee.^{49,140,145}

Evaluators are often asked for opinions about the prognosis of the diagnosed disorder, the risk of relapse, and risk mitigation. Identification of observable premonitory signs of relapse is particularly helpful for both the treating clinicians and the workplace monitors. An understanding of the evaluatee's long-term vulnerabilities will help the evaluatee's monitors and supervisors intervene promptly when necessary. The evaluator may suggest specific administrative and therapeutic steps with which workplace monitors can respond if the evaluatee relapses.^{140,145}

Opinions should be well supported by data, and the foundation for opinions should be discussed in detail in the report. Evaluators should also comment about an evaluatee's customary interpersonal style.¹⁴⁴ The evaluatee's capacity for conscious awareness of psychological and behavioral problems and openness to treatment and supervision are both essential findings for developing a plan of oversight.^{140,145}

The state medical licensing boards expect a report that allows for the board personnel themselves to review the basis of the evaluator's opinion. The APA Guidelines recommend that sensitive personal information be omitted or summarized in a report for the medical licensing board when it does not directly bear on the referral concerns.¹⁹ It may be appropriate to edit personal information when reporting to practice groups, hospitals, or HMOs where the recipients of the report often personally know or have potential conflicts of interest with the evaluatee. If the information is withheld, the report should document that the sensitive information (personal, medical, or social) was obtained and considered.^{19,49}

Key Points in Conducting Fitness for Duty Evaluations of Physicians

- 1) Obtain detailed information relevant to contradictions and omissions between the evaluatee's version of events and the version from

collateral sources. This may include an extensive employment history, history of complaints or malpractice suits, and a sexual history.

- 2) Assess cognitive capacity, using, if indicated, a full neuropsychological battery, medical evaluation, laboratory and image testing, and appropriate substance use testing.
- 3) Provide a comprehensive report. Consider and clarify the degree to which details of the evaluatee's personal information must be revealed. Assess whether the referral context suggests that a more limited report may be more appropriate.
- 4) Assess and describe short- and long-term risk and suggestions for risk management and mitigation. Provide guidance, if requested, on how to identify early signs of an evaluatee's recurrence of psychiatric illness or relapse of substance use.
- 5) Provide recommendations for treatment including provisions for type and frequency of treatment, means for monitoring compliance, concrete suggestions for oversight, and supervision of the evaluatee in the workplace.

2. Fitness-for-Duty Evaluations of Law Enforcement Officers

Fitness for duty evaluations of law enforcement officers typically are requested when officers have exhibited behavior that has called into question their ability to perform the essential duties of their jobs safely and effectively or their ability to handle firearms safely.^{137,138,152} Law enforcement officers may own any number of firearms privately. However, when an agency provides a firearm to an employee, as in a law enforcement position, it is obligated to monitor both workplace and public safety in regard to the employment-issued firearm. It is also obligated to ask the officer to surrender the employment-issued firearms if safety concerns arise, even if the officer still has access to personally owned firearms.

The psychiatric evaluator will be asked to perform a thorough evaluation, to provide an opinion about fitness for duty, and to assess whether the officer poses a risk to self, the department, or the safety and welfare of the general public.^{137,138,152} Evaluators must understand the demands of police work in gen-

eral and the specific responsibilities of the officer undergoing evaluation.^{152,153}

a. Agency Referral

The actual referral process for FFD evaluations is frequently carried out according to agency guidelines and the provisions of union contracts. The International Association of Chiefs of Police (IACP) developed updated guidelines in 2013.¹⁵⁴ The model policy recommended by the California Peace Officers Association suggests that an FFD examination be ordered when an officer's "conduct, behavior or circumstances indicate to a reasonable person that continued service by the officer may be a threat to public safety, the safety of other employees, the safety of the particular officer, or potentially interfere with the agency's ability to deliver effective police services."¹⁵⁵

The departmental policy may list conduct that suggests that the officer's ability to perform the essential functions of an armed peace officer may be compromised. Typical FFD referrals include descriptions of allegedly problematic conduct and specific job performance concerns.^{137,152}

Often, supervisors, fellow officers, or civilians have made documented reports of the conduct in question.¹³⁷ The model policy of the California Peace Officers Association recommends that supervisors be alert for evidence that an employee may not be psychologically fit, especially when there has been a sudden or dramatic change in an officer's behavior. The model policy supplies numerous examples of possible impairment that may adversely affect job performance. These include the use of unnecessary or excessive force, inappropriate verbal or behavioral conduct, problems with impulse control, abrupt and negative changes in conduct, and a variety of psychiatric symptoms, such as irrational speech or conduct, delusions, hallucinations, threats to others and suicidal statements or conduct.^{154,155}

Some departments require that an officer see a mental health professional after involvement in a critical incident. A critical incident is any event that has a stressful impact sufficient to overwhelm the usually effective coping skills of an officer, such as line-of-duty shootings; deaths (particularly of a child), suicide or serious injury of coworkers, homicides, and hostage situations.^{152,156,157} After exposure to a critical incident, officers are at increased risk for misconduct, stress-related illness, substance

abuse, and claimed disability.¹⁵⁸ If initial departmental interventions are unsuccessful, the department may require an FFD examination.

Problematic conduct may include poor judgment, leading to delayed responding, excessive force, and endangerment of fellow officers and the public.^{147,152} FFD examinations may also be misused by departments to undermine the stature and credibility of the evaluatee. As with other mandated evaluations, evaluators are charged with collecting objective probative data that are not biased by stakeholders.^{137,138,152}

b. Important Aspects

Before meeting with an evaluatee, an evaluator should clarify the referral questions, who will receive the report, and any applicable departmental or union policies or procedures.

The law enforcement agency should provide written documentation of the agency's response to the alleged misconduct. Remediation efforts may consist of meeting to discuss problem behavior, supervision, further training opportunities, mentoring by another officer, or reassignment of duties. The history of referral to an employee-assistance program or treatment and disciplinary action taken or pending regarding the current situation should also be provided to evaluators.^{138,152,154}

Relevant written documentation typically includes medical records, reports of job performance, disciplinary records, awards, and commendations, written complaints and suits initiated by the general public, testimonials, and previous periods of impairment and disability.¹⁵⁴ The agency should also provide information about whether the officer has been exposed to a critical incident (e.g., a use of force incident or an officer involved shooting). Evaluators should inquire with the department about accommodations and work modifications (such as light duty or restricted duty) that may be available to the officer.

The evaluator may have access to earlier pre-employment psychological testing. Law enforcement officers are usually carefully screened before being offered a position on the force. Departments differ in the extent of tests they administer, but such testing is usually followed by an interview with a mental health professional. The results of these evaluations may help the evaluator understand aspects of the events that have led to the FFD referral.

Interviews with collateral sources are an integral part of the assessment. The evaluatee should be encouraged to identify individuals who would have knowledge about the events in question, especially in cases where the officer denies misconduct and maintains that the evaluation really has arisen because of conflicts with supervisors or is retaliatory in nature. Information may be obtained from supervisors and peers who can provide further context for understanding the problematic conduct. Evaluators often can learn from collateral sources whether the alleged incident is an isolated event, and perhaps represents a response to a specific stressor, or reflects an established pattern of misconduct.^{152,154}

Prior or current treatment providers can give information about past response to treatment, treatment compliance, and the role, if any, of substance use.^{138,152,158} Family members can often provide observations about the evaluatee's level of function outside of the workplace. This insight is especially important when evaluating an officer who may be suicidal. The evaluator should also record in the report the nature of any information that has been requested but withheld and offer a disclaimer stating that opinions offered are limited by the refusal.^{152,154} The evaluator should explore in detail significant discrepancies between the evaluatee's description of events and the versions of collateral sources. Independent of information provided by the department, evaluators should also ask the evaluatee about exposure to stressors at work and at home, including work-related critical incidents.^{137,138,152}

The administration of a neuropsychological battery may be needed to assess questions of cognitive impairment. Personality profiles such as the MMPI-2 and the PAI are useful. Many police officers will have had administrations of the MMPI-2 that can be used for comparison. When indicated, the evaluatee should be referred for a neurological or medical evaluation and for laboratory and imaging tests. If a substance use disorder is suspected, verification by urine or hair testing, if allowed by law and by contract, may prove useful.

If the officer is not fit for duty, the department typically will ask whether the impairment is the direct result of a job-related injury. Job-related injuries are usually compensable. If the officer has a pending lawsuit, arbitration, or grievance, information obtained from the evaluation could be discoverable.^{152,154}

c. Firearms

When assessing the fitness for duty of an armed officer, evaluators are asked if there are contraindications to the officer continuing to carry an employment-issued weapon. An officer who carries a firearm must be able to make on-the-spot, life-and-death decisions. Evaluators must consider both the effects of mental illness and treatment side effects, if any.^{137,152}

The risk of suicide must be considered. Studies indicate that law enforcement officers have a significantly elevated risk of suicide, regardless of race or gender.¹⁵⁹ More police officers in the United States die of self-inflicted injuries than are killed in the line of duty.¹⁶⁰ One study found that, during their FFD examinations, 55 percent of officers admitted to previous suicide attempts.¹⁶¹ Most officers who attempt or commit suicide use a firearm to do so.^{162,163} Weapon removal and referral for emergency psychiatric assessment is sometimes indicated so that the immediate risk can be assessed and managed.¹⁶⁴

State and federal statutes, agency procedures, and the employment contract may offer guidance about the information and opinions to be provided in the FFD report. The International Association of Police Chiefs Police Psychological Services Section recommends that, unless otherwise prohibited, the evaluator should provide a description of the officer's functional impairments or job-related limitations, an estimate of the likelihood of and time frame for a return to unrestricted duty, and the evaluator's basis for that estimate.¹⁵⁴

A psychiatric evaluator could find that the evaluatee is fit for duty and able to return to work without restriction or that the evaluatee is currently unfit, with little likelihood of remediation. An evaluatee may be temporarily unfit for duty but likely to recover with treatment. The evaluator may wish to suggest specific treatment modalities and provide indicators of improvement and treatment compliance. For law enforcement officers with substance use disorders, there is increasing awareness of effective treatment monitoring and the impact of specialized AA/NA groups for first responders.

Misconduct may be unrelated to a diagnosable disorder. Sometimes, the evaluatee's lack of cooperation may so impair the FFD process that no opinion about the evaluatee's fitness for duty can be proffered. The agency may then decide to take disciplinary or administration action against the officer.^{137,152}

In some cases, an officer who has undergone evaluation can return to work with accommodations or modification of duties.^{137,152} Recommendations may include reassigning the officer to light duty, part-time employment, mentoring, and training.¹⁵⁴ The creation of a light-duty position as a form of reasonable accommodation is a function of managerial discretion.¹⁶⁵ The agency determines whether proposed accommodations are reasonable or unduly burdensome.¹⁵⁴

Key Points in Conducting Fitness-for-Duty Evaluations for Law Enforcement Officers

- 1) Be familiar with the context and limitations of the law enforcement FFD. These may be limited by contract or union agreement.
- 2) Obtain sufficient psychiatric history and direct and collateral information about the events in question and prior job performance to respond to proffered questions that will include assessment of risk to self, coworkers, and the public at large, including the evaluatee's access to service firearms.
- 3) If requested, offer opinions about treatment, specific workplace monitoring, and the officer's access to firearms.
- 4) Identify options for accommodation, including recommendations for light duty, supervision, and monitoring. Make specific recommendations if requested.

D. Return-to-Work Evaluations

The requirements of return-to-work evaluations are similar to fitness-for-duty evaluations, but return-to-work evaluations are at the final stage of an employment-related process. This process often involves questions of both FFD, response to treatment, disability, and accommodation, if any.

Presumably, an employee undergoing a return-to-work evaluation desires to return to the workplace. Sometimes an employee may feign wellness in a premature effort to return to work. If the work-related impairments that led to withdrawal from the workplace are unchanged, a transition back to the workplace is unlikely to be successful. However, if the impairment is no longer present, the evaluator should recommend that the employee return to work without restriction.

Opinions regarding the ability to return to work should reflect an understanding of the problems that led to work withdrawal or modification and a de-

tailed description of what has changed. If impairments have not resolved to the extent that full return to work is possible, evaluators should provide recommendations regarding treatment or accommodation that may facilitate this process.

Psychiatrists should review documentation of the original decision granting disability or leave, including evaluations justifying withdrawal from the workplace, subsequent treatment and rehabilitation, and the examinee's functioning during the period of disability.

Key Points in Conducting Return-to-Work Evaluations

- 1) Establish a clear understanding of the basis for the workplace withdrawal or change in responsibilities.
- 2) Base opinions concerning ability to return to work on documented changes in psychiatric symptoms or levels of impairment.
- 3) Specifically identify the factors that resulted in change in workforce status with concrete data and examples.
- 4) If requested, provide suggestions for continued treatment, workplace monitoring or other ways to help ensure adequate functioning or prevention of relapse of illness.

Caution

This Practice Resource represents a consensus about best practices in forensic psychiatric assessments of disability and fitness for duty to assist psychiatric evaluators. This Resource may be read by attorneys and judges, and, like other published professional guidelines or educational resources, may be used in legal arenas to challenge experts or to establish standards of care. This Resource has not, however, been formulated for legal use.

This Practice Resource is not binding. Information provided may in utility and applicability on a case-by-case basis. Even with the use of this Practice Resource, experts can come to different conclusions based on an evaluation of the same data. Honest disagreement between experts should be expected and respected. The intent of this Practice Resource is to help psychiatrists who provide the various types of disability evaluations formulate well-reasoned opinions that represent honest assessments of the information obtained in disability evaluations.

Appendix I: Summary of Salient Points in Disability Evaluations

	Definition of Disability Provided	Causation Relevant	Degree of Impairment Relevant	Partial or Total Disability	Litigation Possible
SSDI	Disability statutorily defined	No	No	No	Yes
Workers' Compensation	No	Yes	Yes	Yes	Yes
Private disability insurance	Varies	No	Yes, depending on policy	Yes, depending on policy	Yes
ADA	Disability statutorily defined	No	Yes	N/A	Yes
Fitness for Duty	No	No	Yes	N/A	Yes
Return to Work	No	No	Yes	N/A	Yes

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