AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability

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Statement of Intent and Development Process

This document is intended to be a review of legal and psychiatric factors and to give practical guidance and assistance in the performance of psychiatric disability evaluations. It was developed by forensic psychiatrists who routinely conduct disability evaluations and have expertise in this area. Some contributors are actively involved in related academic endeavors. The process of developing the Practice Guideline incorporated opportunities for review by members and integration of feedback and revisions into the final draft. The final draft of the Guideline was approved by the Council of the American Academy of Psychiatry and The Law in March, 2008. The contents thus reflect a consensus of opinion among members and experts about the principles and practice applicable to the conduct of psychiatric disability evaluations. As with any Practice Guideline, this one is not binding, nor should it be construed as setting a standard of care. The Guideline does not present all acceptable current ways of performing forensic evaluations of persons with psychiatric disability, and following it does not lead to a guaranteed outcome. Fact patterns, clinical factors, relevant statutes, administrative and case law, and the forensic psychiatrist's judgment determine how to proceed in a forensic evaluation.

Although treating clinicians may find this Guideline useful, it is directed toward psychiatrists and other clinicians who work in a forensic role in conducting evaluations and providing opinions related to psychiatric disability. It is expected that any clinician who agrees to perform forensic evaluations in this domain has the appropriate qualifications.

Efforts were made to minimize the potential for bias among the authors due to conflicts of interest. Participating psychiatrists were selected on the basis of their expertise and recognition of their work by their peers. Any participating author or reviewer who had a potential conflict of interest that could bias (or appear to bias) his or her work was asked to disclose the conflict and to resolve it as a prerequisite for acceptance of commentary or participation. The development of this Practice Guideline was not financially supported by any commercial organization.

Format

In Sections I and II, general aspects of disability evaluations are covered, including practical and ethics-related considerations and definition of terms. Section III provides general guidelines for disability evaluations. Sections IV and V address the different types of disability evaluations more specifically, utilizing a general organizational approach to distinguish between the types of disability evaluations. Suggestions are made for adapting the general guidelines to these specific types of evaluation.

The first general category of disability claims, reviewed in Section IV, represents the most common sources of referrals for disability evaluations. These include, but are not limited to, evaluations for Social Security Disability Insurance (SSDI), workers' or personal injury compensation, private disability insurance, and other specialized compensation and pension programs (e.g., military veterans' benefits). It also covers disability evaluations related to litigation in which plaintiffs claim that they are disabled as a result of psychiatric illness or injury and are seeking

compensation for damages. Such claims generally must be accompanied by psychiatric documentation to meet the requirements for compensation.

Section V is a review of a new category of disability evaluation that has emerged during 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 for an employee to continue or resume working and are related to the Americans With Disabilities Act (ADA), fitness for duty, and return to work. These assessments may be precipitated when individuals want to maintain employment but claim that they need accommodations to do so. They may also be requested when an employer believes that an employee is unable to work despite accommodations. A difference of opinion regarding the employee's ability to work can precipitate the request for one of these evaluations and usually signals the presence of an employment conflict.

These two general categories may overlap to some degree, since 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 between an ADA evaluation and a fitness-for-duty evaluation. Despite the overlap, the goals of evaluations designed to determine impairment that precludes work and evaluations that define skills and abilities that allow work function differ enough that there are distinctions in approach to these two broad categories.

I. Psychiatry and Disability Evaluations

A. The Disability Evaluation: The Psychiatrist as Consultant

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

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, often referred to as an independent psychiatric examination or independent medical evaluation (IME), may be requested by an insurance carrier, either party in a litigation, or an employer. The report should clearly indicate the purpose of the evaluation, the basis of the opinions, and whether the opinions are predicated on a record review alone or on a personal examination of the evaluee.

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

The disability evaluation is the most common psychiatric evaluation requested for nontherapeutic reasons. Each year, mental disorders affect approximately 20 percent (23.5 million) of Americans between the ages of 18 and 54.[1] Of individuals with any mental illness, 48 to 66 percent are employed, and 32 to 61 percent with serious mental illness are employed, compared with the percentage of all adults employed (76%–87%).[2] In 2000, an estimated 30.7 percent of individuals between the ages of 16 and 64 who reported having a mental disability (i.e., 2 million people) were employed.[3] These individuals work in a range of occupational categories, similar to those of people with no mental illness. Among those with mental illness, as in the general population, educational attainment is the strongest predictor of employment in high-level occupations.[2]

Psychiatrists and their patients are all too aware that many mental disorders are chronic or episodic and may wax and wane. During acute exacerbations, individuals may exhibit symptoms that impair work function to a varying degree. Such episodes may precipitate withdrawal from the workplace or requests for accommodations. During periods of relative stability, many individuals, even those who have some symptoms, may still function without impairment or be only mildly impaired.

The frequency with which problems regarding work function, mental disorder, and disability or accommodation arise is such that most psychiatrists report having some experience with requests for disability evaluation or documentation. Employers, third-party private or public agencies, or workers themselves may request evaluations to meet the administrative requirements of the social and legal contracts that are the structure for paid employment. Personal injury litigation often involves the evaluation of disability as part of claims for damages. Indi-

viduals may need a report for SSDI that justifies a request for benefits. Patients may require some type of documentation for a private employer that authorizes leave from work. Psychiatric opinions may be solicited 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.

Conversely, an individual who has disclosed a psychiatric condition or whose employer may have discovered or may suspect a psychiatric condition may undergo an evaluation intended to document the lack of impairment or the ability to work despite symptoms. For example, an individual who wants to resume employment after claiming a psychiatric disability may request a return-to-work evaluation. The employee who wants to continue to work despite a documented or suspected psychiatric disorder may be required to undergo a fitness-for-duty evaluation. Some of these evaluations may represent an employer's pre-emptive attempt to avoid a premature resumption of work that may exacerbate the employee's illness or an attempt to detect instability in an employee who may pose a risk to self or others in the workplace. An employer may request a fitness-for-duty evaluation in response to disruptive behavior of an employee in the workplace or because of concerns regarding the potential for violent behavior or the ability to operate machinery or handle firearms safely.

Individuals with mental disorders often have access to public or private disability benefits through their employment. In 1999, mental or emotional problems represented one of the top 10 causes of disability among adults overall, at a rate higher than disability caused by diabetes or stroke.[4] The National Health Survey Interview (1998–2000) found that, in young adults 18 to 44 years of age, mental illness was the second most frequently reported cause of limitation of activities (10.4 per 1000 people), exceeded only by musculoskeletal conditions. For midlife adults 45 to 64 years of age, mental illness ranked as the third most frequently mentioned cause of activity limitation (18.6 per 1000).[2] The World Health Organization reports that depression is the fifth leading cause of disability worldwide and predicts that it will be the second leading cause of disability after heart disease by 2020.[5]

Disability benefits are administered through public and private programs. In 2004, 146.7 million workers were insured through public programs in the event of disability. This number has been steadily growing since the 1980s, when only 100 million workers had such insurance.[6] In 2003, SSDI paid $70.9 billion in benefits to 5.9 million disabled workers.[7] Mental disorder that prevents substantial gainful employment is the leading reason why individuals receive SSDI. Mental disorders also form the largest single diagnostic category among SSDI recipients. In addition, persons with mental disorders have the longest entitlement periods and are the fastest growing segment of SSDI recipients. In 2001, 28 percent of SSDI recipients received payment based on mental disorders (not including mental retardation).[2,8]

Disability insurance is also available through workers' compensation and private insurers. In 2004, short-term disability (STD) benefits were available to 39 percent of workers and long-term disability (LTD) benefits were available to 30 percent of workers in private industry; nearly all individuals who had access chose to participate in these programs.[9]

Statistics regarding the number and cost of mental health-based disability claims submitted to workers' compensation and private insurance programs are difficult to obtain. However, indications are that mental health-based claims also represent a significant percentage of private insurance claims. UnumProvident Corporation, the leading provider of private income protection insurance, reported that each year, approximately four to five percent of both short- and long-term disability claims are for depression (UnumProvident Corporate Communications, personal communication. October 4, 2005). Another major company reported that among private insurers, claims for stress and mental disorders are now 20 percent of all claims and are one of the fastest rising categories of claims.[10]

C. Forensic Psychiatry and Disability Evaluations

Clinicians who are not comfortable performing disability evaluations may refer the evaluations to forensic psychiatrists. Certain types of disability evaluations, however, may not require forensic training or experience. Moreover, circumstances sometimes compel a practitioner to assume the dual role of treatment provider and forensic psychiatrist.[11] For example, an application for SSDI benefits requires an extensive report from the clinical treatment provider.

Forensic psychiatrists tend to be more cognizant of and comfortable with the goals, obligations, and constraints of the more complex disability evaluations, especially those that are requested within the context of litigation or that may result in litigation. Clinicians may find moving from the therapeutic to the forensic role in such evaluations difficult due to the often irreconcilable conflict presented by the differences between clinical and forensic methodology, ethics, alliances, and goals.[11–13] In addition, even seasoned clinicians may find the terms, requirements, and legal or administrative processes involved in disability evaluations unfamiliar.

Many disability evaluations require that an IME be performed. IMEs differ from evaluations conducted for therapeutic purposes in many respects, including lack of confidentiality, involvement of third parties, and potential legal ramifications. Even seemingly straightforward evaluations regarding work ability or disability can become the subject of administrative or legal dispute. In these cases, the evaluator should be prepared to defend his or her opinions in deposition or in court, a situation with which forensic psychiatrists are familiar.

The clinician who performs a disability assessment should be aware that if questions arise, he or she is likely to be held to the standards of the forensic specialist. For example, in a court case involving questioning of a child custody evaluation, the court stated that although the child psychiatrist who performed the evaluation was not a member of the American Academy of Psychiatry and the Law (AAPL), she should have been familiar with AAPL guidelines because she had undertaken a forensic evaluation.[14]

II. General Aspects of Disability Evaluations

A. Definitions of Disability and Factors Relating to the Definitions

1. Disability and Impairment

Disability is a legal concept, defined by language in statutes, case law, and insurance policies. The term has more than one legal definition. The Americans With Disabilities Act, the Social Security disability program, and private insurance plans all define it differently. (See Appendix I for a summary of definitions and salient factors in specific disability evaluations.) In performing an evaluation, the psychiatrist faces the challenge of understanding the relevant definition and translating it into a clinically meaningful concept. A disability evaluation is similar to a competency evaluation. Competency is also a legal rather than a clinical construct. Psychiatrists tend to translate competency into capacity and examine specific functional capacities (e.g., to stand trial, to execute a will, or to make treatment decisions). They generally translate disability into the clinical concept of functional impairment as it applies to vocational and occupational skills.

Many DSM diagnoses include a criterion requiring that the symptoms cause clinically significant distress or impairment in social, occupational, or other crucial areas of functioning.[15] Unfortunately, the current DSM provides no simple definition or explanation of what constitutes psychiatric impairment. Clinicians are directed to use the Global Assessment of Functioning (GAF) scale or other such scales as a practical (albeit imperfect) way of quantifying the severity of functional impairment. Although these scales enable quantification by arriving at scores, they are not specifically designed to measure occupational function. In addition, the scores assigned have an element of subjectivity and may vary depending on the psychiatrist's experience and perspective.

Where definitions of disability exist, they differ depending on the specific context. Nevertheless, these definitions can help guide clinical assessment of functional impairment. The World Health Organization defines impairments as "problems in body function or structure such as a significant deviation or loss" (Ref. 16, p 10). 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 of disability, depending on the terms and nature of the specific policy (e.g., group or individual, long-term versus short-term disability). Typically, these definitions are framed as the inability to perform occupational duties due to injury or

sickness. Examples may include any occupation (e.g., inability to engage in any gainful occupation for which one is reasonably fit by education, training, or experience), present occupation (e.g., inability to perform the material and substantial duties of the individual's current occupation), and other partial or modified definitions. Of note, these public and private insurers are less specific in their definitions of impairment.

The definitions of impairment and disability found in the *American Medical Association Guides to the Evaluation of Permanent Impairment*[18] are among the most useful in clarifying the difference between these two related concepts. The *Guides* defines *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). This alteration of an individual's health status is assessed by medical means. In contrast, a *disability* is an "activity limitation and/or participation restriction in an individual with a health condition, disorder or disease" (Ref. 18, p 5). The latter is considered a nonmedical assessment, and the AMA definitions clearly indicate that impairments may or may not result in a disability.

Despite these definitional distinctions, the terms impairment and disability are often used interchangeably. In addition, medical opinions are routinely offered in a disability claim, including both the degree of severity and the expected duration. This Practice Guideline endorses the use of the AMA definitions unless an alternate definition is specifically stipulated. Thus, the Guideline is focused on the assessment of impairment relevant to disability but not on the determination of disability, unless specific types of evaluations expressly include requests for opinions on disability.

Medical opinions on disability are not necessarily inappropriate and may be requested, despite the fact that the final determination of disability may be made by a fact-finder such as a court, a governmental agency, or an insurance company panel. However, psychiatrists should bear in mind that the determination of disability is ultimately an administrative or legal decision. An opinion offered about disability is more than a purely medical opinion. In such cases, the psychiatrist should be prepared to identify how and why the capacity to meet an occupational demand is altered.

2. Restrictions and Limitations

In a disability evaluation, the psychiatrist is often asked to consider whether an evaluee's psychiatric signs and symptoms are severe enough to limit or restrict ability to perform occupational functions generally (i.e., any substantial gainful activity) or specifically (i.e., the occupational tasks of a neurosurgeon for a current-occupation private disability policy). Restrictions are most easily understood as what an individual should not do. In contrast, limitations can be described as what the individual cannot do because of the severity of psychiatric symptoms. For example, an employee with bipolar disorder may be restricted from excessive irregular night hours because of the potential of triggering a manic episode. In contrast, the worker 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 an illness or diagnosis does not necessarily indicate that an individual has significant functional impairment. In a competency assessment, the presence of a psychiatric illness does not provide the information necessary to address decision-making capacity. Similarly, determining the presence of significant functional impairment in the event of psychiatric illness requires further exploration of the severity and impact of active psychiatric signs and symptoms.

Moreover, psychiatric impairment in one area does not indicate impaired capacity to perform specific occupational tasks and functions in others. Extending the example just given, an individual with bipolar disorder may be restricted from working excessive irregular night hours. Such a restriction could be disabling for a solo practitioner obstetrician, but may not represent a significant problem for an office-based dermatologist. A claimant with an orthopedic injury may be unable to lift weight beyond 20 pounds, but if the claimant has a sedentary job, this limitation would not create an occupational impairment. In addition, for disability insurance coverage (as noted in more detail later), sustained duration of significant occupational impairment is often key for the receipt of monetary benefits.

4. Impairment Versus Illegal Behavior

The association of impairment due to psychiatric illness with illegal or unethical behavior can create confusion in disability evaluations, particularly in

cases involving private disability insurance and fitness-for-duty evaluations of professionals. An individual sometimes claims that illegal or unethical behavior was caused by a psychiatric illness. Such claims often involve professional or financial misconduct, such as sexually inappropriate behavior by a physician or embezzlement by an employee.

The relationship between impairment due to psychiatric illness and illegal or unethical behavior has not been extensively addressed. Nevertheless, several professional organizations have attempted to clarify the challenges presented by the evaluation of claims in which both alleged psychiatric illness and illegal behavior are present. An American Psychiatric Association (APA) Resource Document notes:

> 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 [Ref. 19, p 85].

Similarly, the United States Federation of State Medical Boards (FSMB) adopted as policy a 1996 report that concluded:

> In addressing the issue of whether sexual misconduct is a form of impairment, the committee does not view it as such, but instead, as a violation of the public's trust. It should be noted that although a mental disorder may be a basis for sexual misconduct, the committee finds that sexual misconduct usually is not caused by physical/mental impairment.[20]

These policies provide a model for the assessment of unethical or illegal behavior in the context of a claim of psychiatric impairment. The analysis of such claims should be case-specific and should include a detailed examination of the relationship between mental illness and the individual's troublesome behavior. If, for example, an individual has a long history of bipolar disorder and behaves in a sexually inappropriate manner 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, if the individual has serial affairs with selected patients or a pattern of financial misconduct over a 20-year period, but has no documented psychiatric history, a claim of psychiatric impairment is likelier to be without merit.

A related topic is often referred to as legal disability: the inability of a person to perform prior occupational tasks because of a legal barrier such as incarceration, loss of professional license, or suspension from insurance programs. The psychiatrist should determine the sequence of legal events, the claimant's clinical status, and the timeframe for seeking treatment and filing a disability claim. The specific facts and context of the case are critical to the analysis of disability based on psychiatric impairments, as opposed to disability due to legal problems. There is considerable case law rejecting recovery of disability benefits when the claimant's legal disability arose before the alleged medical disability (for example, *Bertram v. Secretary of HEW*,[21] *Goomar v. Centennial Life Ins. Co.*,[22] *Massachusetts Mutual Life Ins. Co. v. Millstein*,[23] *Pierce v. Gardner*,[24] and *Waldron v. Secretary of HEW*[25]).

B. Ethics and Disability Evaluations

There are no uniform standards of ethics that apply to all forms of disability evaluations. However, AAPL has published ethics guidelines that apply to all types of forensic evaluations.[26] The AMA and the APA have also addressed the ethics-based requirements of third-party evaluations and expert testimony. This section is intended to supplement these guidelines, specifically in regard to disability evaluations.

The core concern underlying all the ethics-related precepts is the relationship between the psychiatrist and the evaluee. Although a traditional treatment relationship does not exist, a limited doctor-patient relationship is established by a third-party evaluation.[27,28] This relationship is best understood as one in which the psychiatrist has a duty to the referral source to provide a complete and thorough evaluation as well as certain duties to the evaluee, similar to but more limited than those in a traditional doctor-patient relationship.[28–30]

This limited doctor-patient relationship is based on evolving precepts of ethics that have become clearer as the subspecialty of forensic psychiatry has evolved. The APA's publication, "Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry,"[31] states that psychiatrists must comply with the same principles of ethics in performing third-party evaluations as within a treatment relationship. The AMA states explicitly that "a limited patient-physician relationship should be considered to exist during isolated assessments of an individual's health or disability for an employer, business or insurer."[32]

The AMA's *Guides* advises physicians performing independent evaluations that they have responsibilities similar to those of physicians providing treatment, with respect to providing objective evaluations, maintaining confidentiality to the extent possible, and fully disclosing potential or perceived conflicts of interest.

Evolving case law regarding third-party evaluations in psychiatry and other fields of medicine has also defined the legal duties psychiatrists owe to evaluees. 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 disclose significant findings, and not to cause harm to the individual.[27,28]

The legal and ethics-related obligations attendant on a psychiatrist's relationship with an evaluee in third-party evaluations should be considered in 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.[27,28,33]

1. Role Conflict

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. . . ."[26] Although most psychiatrists concur with this guideline, a similar position regarding disability evaluations is more difficult to delineate clearly. For example, SSDI applications request that the treating clinician provide an extensive disability evaluation. Employers may require that their 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 is common in workers' compensation cases.

The goals of forensic disability assessment and clinical treatment are not always antithetical and may at times even be congruent. Circumstances sometimes compel a practitioner to assume the dual role of treatment provider and forensic psychiatrist or expert witness,[11] especially in disability cases. Nevertheless, the psychiatrist who is asked to perform both roles should carefully consider whether the circumstances of a particular case might lead to a conflict of ethics. The problems that arise from the assumption of both roles may create compelling ethics-related and practical reasons for its avoidance whenever possible, especially in the context of actual litigation or circumstances that hold the potential for litigation. In such cases, treating physicians may suggest that a forensic expert be retained for the disability evaluation.

2. Honesty and Objectivity

The endeavor to be honest and objective involves complex practical considerations. The ethics-based imperative to strive for honesty and objectivity in the forensic practice of psychiatry has been discussed extensively.[12,13,34–38] Psychiatrists are aware of the many ways in which the various types of bias can influence opinions. Of these, advocacy bias related to the psychiatrist's employment or source of income may present unique pressures in disability assessments.

Requests for evaluations of psychiatric disability come most often from third-party referral sources, such as insurance companies, government agencies, and attorneys. Some psychiatrists have formal, contractual arrangements with organizations or systems. The potential bias in relying for employment on an agency that often requests forensic opinions should be consciously considered. Such employment does not preclude the ability to provide comprehensive, competent, and fair disability assessments. It may, however, create pressures that must be dealt with on an ongoing basis.

Some psychiatrists may have a less formal subcontractor relationship with disability insurers or companies that arrange independent psychiatric evaluations for insurers or employers. Large companies, insurers, and administrative systems often generate multiple referrals. The desire for such referrals and repeat business can create pressure to generate opinions that are favorable to the referral source.

The psychiatrist who conducts disability evaluations should not allow opinions to be compromised by these or other pressures and should not feel reticent to voice an opinion that does not support the referral source's desired outcome. In disability evaluations, this obligation extends to recognizing that expressing an opinion in the interest of pleasing the referral source, either to maintain employment or garner future referrals, is unethical.

3. Confidentiality

The purpose of a disability evaluation is the collection of information about an individual that will be communicated to a third party. Therefore, as is usually the case with forensic evaluations, disability evaluations are not confidential. The psychiatrist may be required to write reports or provide courtroom testimony that will reveal material to an employer or insurance company that in a clinical context would never be discussed outside the treatment setting. The individual who raises his or her own mental status as part of a claim in litigation has waived the privilege of confidentiality. An individual is also required to reveal the nature of his or her psychiatric problems to obtain disability benefits or accommodations for mental disability.

The psychiatrist has an affirmative obligation to make certain that the limits of confidentiality are communicated clearly before beginning the evaluation. A *pro forma* description, such as a boilerplate written statement that does not specify the circumstances of the evaluation and that does not include adequate explanation and discussion, is not sufficient to fulfill this obligation. The psychiatrist should obtain a signed release that indicates that these points have been explained and that the evaluee consents to the release of information as meets present state and federal statutes, including HIPAA (Health Insurance Portability and Accountability Act of 1996), if the psychiatrist is a HIPAA-covered health care provider.

Despite the lack of confidentiality inherent in disability evaluations, psychiatrists are ethically obligated to maintain confidentiality as much as possible. This necessity should also be explained to evaluees in the context of discussing the limits of confidentiality. Information obtained should be released only to the party who has been authorized to receive it. In addition, information that is not relevant to the disability evaluation should be considered confidential. Consent to release information in disability evaluations does not give a psychiatrist *carte blanche* to reveal all information obtained during the evaluation to anyone who is interested in it. Moreover, within the specific legal or administrative parameters of the disability evaluation, the psychiatrist should restrict disclosures of information obtained during the performance of the evaluation.

Inevitably, situations arise in which the psychiatrist and the evaluee disagree on what information is relevant. The evaluee should be advised that although his or her opinion may differ, the ultimate determination of what information is relevant is made by the psychiatrist. In addition, the evaluee should be advised that any information communicated to the psychiatrist, even if not determined to be relevant and included in a written report, may become public in the event of litigation and in the process of discovery.

All material reviewed by the psychiatrist is considered confidential and under control of the court, the attorney, or the referral source providing it, and should not be disclosed or discussed without the referral source's consent or other legally appropriate order.[26] In the event that litigation occurs after an evaluation has been conducted, the psychiatrist should not disclose information obtained in the course of the evaluation that did not become public knowledge through courtroom or deposition testimony. Such disclosures are ethically inappropriate and may expose the psychiatrist to legal liability.[28,29,33,39]

An important exception to confidentiality may arise if the evaluee threatens his or her own safety or the safety of others. If an evaluee discloses suicidal ideation or intent or threatens to harm a coworker, supervisor, or employer, the psychiatrist is ethically and perhaps legally obligated to take appropriate steps to ensure the safety of the evaluee or potential victims. Courts have ruled that the duty to disclose is fulfilled by making direct disclosure to the evaluee with instructions to seek treatment, by reporting findings to the evaluee's treating physician, or by communicating the existence of the problem to the evaluee's attorney.[28]

4. Forced Employee Evaluations

An employer may attempt to force an employee to undergo a psychiatric examination for nonpsychiatric reasons. In the event of workplace conflict, an employer may attempt to discredit or even terminate an employee by claiming that the employee is mentally unstable. In the course of such a conflict, the employee who poses a problem for reasons other than mental health may be forced to undergo a fitness-for-duty evaluation. A retaliatory referral for psychiatric evaluation is occasionally made after the employee lodges a complaint of harassment or discrimination. The stigma attached to a psychiatric evaluation may itself be used to discredit the employee.

Such employer practices are potentially damaging to the employee and represent a misuse of psychiatry. Psychiatrists should be sensitive to the possibility that their expertise may be misused in this way.[40,41] The use of a psychiatric examination as retaliation or as a deterrent against complaints is inappropriate. An individual may feel stigmatized and narcissistically wounded by having to undergo a psychiatric evaluation. The nature of such an evaluation is often intrusive and distressing. Moreover, such referrals raise questions of ethics that are not easily answered, given that assessments under these circumstances may be inherently unethical, analogous in many respects to the performance of unnecessary surgery.

There is no single and ethically clear way of responding to referrals that arise for reasons other than legitimate concerns regarding the employee's mental health and its effect on job performance. The psychiatrist who identifies a forced evaluation arising from an employment conflict or an attempt to discredit an employee should consider refusing the referral. Alternatively, the psychiatrist could conduct the evaluation and note the nonpsychiatric nature of the referral, stating, "This referral appears to have been generated by an unresolved workplace conflict rather than any change in the evaluee's psychiatric or mental status," in addition to offering an opinion regarding the employee's fitness for duty. Although this statement may discomfit the referral source, the psychiatrist cannot ethically justify ignoring the context of the evaluation.

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

HIPAA[42] is an extensive federal law covering many different concerns, including the privacy and security of health data. The Privacy Rule,[43] promulgated by HIPAA provisions, created standards regarding the use and disclosure of an individual's health information by "covered entities." The Privacy Rule gives the patient a statutory right to knowledge about and control over what information is shared, with whom, and for what purposes.

Providers are responsible for determining their status as entities covered or not covered by HIPAA.[44] Nevertheless, even if not covered, the psychiatrist may want to consider following the HIPAA guidelines in regard to third-party evaluations. The Privacy Rule sets forth practices that represent a minimum in regard to privacy and confidentiality. Most psychiatrists are already familiar with the Privacy Rule, and indeed, with often more stringent state laws regarding privacy and confidentiality. Many if not most psychiatrists have already integrated these rules and obligations into their standard practices. Thus, the integration of HIPAA's requirements should not present a significant hardship. In addition, should the Privacy Rule's requirements come to be considered a national standard of care, a possibility that has not yet been addressed by case law, integration of these practices would provide some protection from liability that can arise in third-party evaluations from allegations of breach of confidentiality.[28]

The psychiatrist should be familiar with the regulations regarding third-party evaluations, such as employment-related or disability evaluations.[45] The Privacy Rule permits covered health care providers to release an individual's protected health information to an employer or a disability insurance company, with that individual's authorization. It allows disclosure without authorization in only limited circumstances.[46] Although the Privacy Rule states that medical treatment of an individual cannot be conditional on the individual's signing an authorization for the disclosure of information, it expressly allows the physician, as a condition of performing the IME, to require the evaluee to sign an authorization for the release of protected health information to the third party requesting the IME.[47]

Disclosure of evaluations conducted in the context of litigation is subject to the rules of discovery of the jurisdiction. However, the individual has a right to receive, upon request, an accounting of disclosures of protected health information made by a covered entity. This accounting includes disclosures made in litigation or in proceedings in which the covered entity is not a party, when such disclosures are made in response to a subpoena, discovery request, or other lawful process.[48]

Disclosure in workers' compensation continues to be governed by state law. "[T]he 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. . . ."[49] Providers are still required to limit the amount of protected health information disclosed to

the minimum necessary to accomplish the workers' compensation purpose.

The 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[50] and treatment.[51] The SSA has indicated that the psychiatrist who is a covered entity under HIPAA is required by the Privacy Rule to provide evaluees with a notice of patient's rights and the psychiatrist's privacy practices,[52] and that the psychiatrist must receive a written acknowledgment of the receipt of the notice or documentation of a good-faith effort to obtain such an acknowledgment. Covered entities must still comply with all of SSA's rules regarding disclosure of information and access to information gathered and maintained while performing work for SSA. Some of these regulations limit disclosure of information.[53]

See Appendix II for resources regarding HIPAA regulations and medical practice and other topics related to third-party evaluations.

D. Safety of the Evaluator

The psychiatrist conducting a disability evaluation should be concerned about personal safety. Emotions associated with employment conflict can be as extreme as those in interpersonal conflicts such as divorce and custody battles. The outcome of a disability evaluation can result in lawsuits and the loss of monetary benefits, employment, or a career. An employee who is irate about undergoing a psychiatric examination or who is angered by a psychiatrist's report may become aggressive toward the psychiatrist. An individual referred because of an anger-management problem, substance use, or paranoid delusions may become overtly threatening.

The psychiatrist should be aware of the setting and context in which the evaluation is conducted. An interview should not be undertaken when the psychiatrist feels threatened in any way. He or she should be clear about setting limits around evaluation interviews. For example, the psychiatrist evaluating a law enforcement officer should consider it routine to ask whether the officer's firearm has been returned to the employer pending evaluation. If not, the psychiatrist may request that the evaluee refrain from carrying a firearm in the office. If any evaluee becomes threatening, the psychiatrist should consider terminating the interview. Threats made after the evaluation should be reported to the referral source and, if appropriate, to the local law enforcement agency.

III. General Guidelines for the Psychiatric Disability Evaluation

The goal of the psychiatric disability evaluation is to correlate symptoms of mental disorder with occupational impairment. This process consists of several steps. The following are general guidelines for conducting the evaluation.

A. Clarify the Type of Referral With the Referral Source

The psychiatrist should clarify the type of referral and the role he or she is expected to play in an evaluation. Although this can be done by phone, a written referral documenting the referral source's expectations and the questions to be answered by the evaluation is preferable. The referral contact is the optimal time to make certain that the referral source understands the evaluating psychiatrist's function and role. For example, the psychiatrist can use the initial contact to advise the referral source that no treatment will be provided directly to the evaluee.

At the initial contact, the psychiatrist may want to clarify with the referral source his or her position regarding communicating results of the assessment directly to the evaluee, to avoid a misunderstanding on this important point at the conclusion of the assessment. The referral source may expect or ask the psychiatrist to discuss findings and opinions with the evaluee, especially if the evaluee is a difficult employee whom the referral source does not want to confront or whom the referral source has already confronted without effecting a change in behavior.

Some psychiatrists are comfortable with the general practice of advising the evaluee of the results of an assessment. An evaluee may be better prepared for the likely consequences (positive or negative) if the psychiatrist reveals the opinions that will be conveyed to the employer. However, the psychiatrist may be more comfortable not discussing opinions or results with the evaluee and allowing the referral source to convey the information. The personal interview is only one source of data on which opinions should be based. Although an evaluee often asks for the psychiatrist's opinion at the end of the interview, the psychiatrist may not have reviewed all information necessary to formulate an opinion. In addition, the psychiatrist who advises an evaluee of an unfavor-

able opinion runs the risk of precipitating an angry confrontation for which the clinician may be unprepared.

Finally, the psychiatrist should bear in mind that offering opinions directly to the evaluee may create a doctor-patient relationship and impose certain duties on the psychiatrist.[27,28] Exceptions to this rule are based on the ethics-based and legally prescribed duties to the evaluee discussed earlier and arise only in circumstances that represent an immediate and identifiable danger or threat of danger to the evaluee or others.

B. Review Records and Collateral Information

Collateral information is an essential component of a comprehensive disability evaluation. Objective evidence of a psychiatric disorder and actual impairment is necessary to reach a conclusion that a psychiatric impairment is present. Some disability claims may encompass unique circumstances in which no collateral information is necessary. Generally, however, if the psychiatrist has no access to such information, subsequent revelation of inconsistent or contradictory facts can seriously undermine the conclusions and impeach his or her credibility.

Collateral information in disability evaluations generally falls into two categories: formal written records obtained in the course of usual professional and business operations and third-party information obtained through personal interviews, witness statements, and depositions. No single source of information is mandatory in conducting a disability evaluation.

The amount of collateral information available depends on the circumstances of the claim. For example, in personal injury litigation, discovery may result in the provision of all 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 may be limited or difficult to obtain.

The referral source usually gathers and provides collateral information to the psychiatrist. If the psychiatrist identifies additional information that may be available, access to this information should be requested. 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. The records reviewed and the source of these records may become significant factors should litigation arise. However, with the approval of the referral source, the psychiatrist can request a records release from the evaluee or permission to speak to a third party directly.

The psychiatrist should personally review collateral information and should not rely solely on summaries from the referral source. Summaries can be of value, but they can omit important information or create distortions that reflect the referral source's biases. In addition, the person preparing the summary may not recognize the psychiatric importance of some of the information and thus may not include all aspects of submissions from the original sources.

The following delineates specific types of collateral information that are useful or necessary for disability evaluations.

1. Written Records

a. Job Description. The psychiatrist should always request a written job description if one has not been provided. Assessment of impairment requires an understanding of the work skills required for a particular job. Without this understanding, determining the impact of a mental disorder on the ability to perform specific job requirements is difficult.

b. Psychiatric, Substance Use, Medical, and Pharmacy Records. These records may help the psychiatrist understand an individual's psychiatric symptom history and make a more accurate diagnosis of a disorder that could cause impairment in occupational functioning. Pharmacy records may be helpful in corroborating claims regarding doctors seen for treatment, medications and prescribed dosages, and possible substance use. Treatment records also frequently contain useful background information about sources of conflict or stress, evidence of personality trait disturbance, and motivational factors that can affect occupational functioning. Medical treatment records may reveal a disorder with psychiatric symptomatology or may help rule out such disorders if diagnostic laboratory or imaging tests such as EEG, PET, and 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 in work performance, but they may also provide evidence of workplace factors that could influence or precipitate a claim of disability.

For example, good evaluations and the absence of performance problems can reduce concerns about the influence of workplace factors on a claim. In contrast, employment records that contain documentation of adverse events that precede a claim of disability may raise concerns that the claim represents an attempt to address workplace conflict rather than work impairment resulting from psychiatric symptoms. Records may include disciplinary or personnel actions that have threatened the claimant's job stability, perhaps leading to disability claims. Personnel records from prior employers are often a valuable source of collateral information for similar reasons.

d. Academic Records. Although they 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 accommodation. The records may also indicate whether an individual has a history of behavioral problems, an important indication of conditions including personality disorders.

e. Other Experts' Evaluations. Evaluations performed by other mental health experts as well as those from other 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 be helpful in establishing the validity of self-reports, clinical symptom patterns, and personality features of the individual.

f. Personal Records. A variety of other personal records may be helpful, depending on the circumstances, as a source of collateral information. Prior and recent disability claims, criminal records, military records, and financial records, including tax returns, can provide information relevant to the evaluation of a claim of current disability. An individual's diaries or journals may also be useful, if contemporaneous and not kept for self-serving purposes to validate a claim of disability.

2. Third-Party Information

Information from third parties can be useful in corroborating an evaluee's self-reports of history, symptoms, and functioning. The reliability of all sources of collateral information should be taken into account, the inherent bias of all informants should be considered, and the consistency of reported information should be scrutinized.

a. Family Members and Friends. These individuals often have first-hand knowledge of a claimant's symptoms, evolution of disorders, and functional abilities. However, family members may be as invested in a disability claim as claimants themselves and may distort or exaggerate reports of mental symptoms in support of claims.

b. Treatment Providers. Conversations with treatment providers, with the evaluee's consent and when legally permissible, can be helpful. Physicians and therapists, particularly those who are aware that a legal or administrative disability claim is being made, may be circumspect in written documentation. They may be more forthcoming about their opinions if delivered in the course of a personal conversation.

c. Written Statements. Written statements, depositions, or affidavits provided by third parties may be informative. However, the psychiatrist should be aware that such statements may be incomplete or biased. An employer or other party may be biased against the claimant, especially in adversarial situations, such as personal injury litigation or workers' compensation claims, and may minimize symptoms or provide misleading information. Multiple witness statements that seem to corroborate each other may be more reliable and credible.

d. Surveillance. Surveillance at times is a powerful source of collateral information. Nevertheless, such information can be of limited value. A surveillance camera cannot capture an internal emotional state. Even in cases of alleged physical injury, surveillance pictures or tapes capture only discrete periods of time and may not accurately reflect the individual's overall functional ability. With psychiatric disorders, a discrete period of surveillance is even less likely to be representative of total functional ability. However, if the evaluee claims that certain activities are impossible for him or that he never engaged in them, surveil-

lance may disprove the assertion. Information gleaned from surveillance can also point out areas that bear further exploration with the evaluee.

C. Conduct a Standard Psychiatric Examination

1. Obtain Informed Consent

As in all forensic evaluations, the psychiatrist is required to inform the evaluee of the nature and purpose of the examination and to obtain consent to proceed. The consent should be in hand before the interview and examination begin. The evaluee should be clearly informed that:

> The evaluation is not for treatment purposes and the evaluee is not and will not become the psychiatrist's patient.
>
> The purpose of the evaluation is to provide an opinion about the evaluee's mental state and level of impairment or disability.
>
> The information and results obtained from the evaluation are not confidential, in that they will be shared with the referral source and may be disclosed to the court, administrative body, or agency that makes the final determination of disability.

Although these points form the core of an informed consent discussion, other items may also be discussed that clarify the purpose and nature of the relationship. For example, the psychiatrist may disclose or discuss who is paying for the evaluation. The payer is often the referring agency, which reinforces the lack of the traditional doctor-patient relationship in which the patient is responsible for payment, either directly or through an insurance company.

The evaluee should also be informed that the evaluation is voluntary and that breaks are allowed and encouraged when needed. Finally, the evaluee should be advised of the right not to answer questions, but that refusal to answer specific questions may influence the results of the evaluation and will be reported to the referral source. If an evaluee does not agree to the conditions, the evaluation should not be undertaken. The evaluee should be advised that refusal to proceed will be noted in the psychiatrist's report or testimony or reported to the referral source.

The evaluee should be told that although the psychiatrist renders an opinion, the regulatory agency, employer, or a jury will make the ultimate determination of disability. Also, the evaluee should be told that a written report will be produced and will be turned over to the retaining third party. Once the report is released to the third party, the psychiatrist does not control it or determine who has access to it.

2. Conduct a Standard Psychiatric Examination, Including a Mental Status Examination, and Obtain Additional Relevant Information

The psychiatrist should conduct a standard psychiatric examination, including a mental status examination, in all disability evaluations. The elements used to diagnose the presence or absence of a mental disorder follow the general principles elucidated in the APA's *Practice Guideline for Psychiatric Evaluation of Adults*, Section III.[27] During the interview process, it is better to begin exploration of symptoms and impairment with open-ended questions and only later to make inquiries based on checklists or criteria within categories of function.

Disability evaluations place greater emphasis on occupational and functional history than evaluations conducted for treatment purposes. Clinicians who treat patients often make assessments relative to disability based on the diagnosis of a sufficiently severe mental disorder and their intuition about the credibility of self-reports of impairment. Minimal information about vocational abilities is usually obtained or correlated with psychiatric symptoms. However, a patient's self-report of impairment may not be reliable because of the difficulty in quantifying such reports and the patient's investment in gaining disability status.

Using standard, systematic examination methods can help the psychiatrist to improve the accuracy of the disability assessment. All assessments of disability involve extrapolation, because it is impossible to know everything about actual functioning without observing the evaluee's everyday life closely and monitoring all activities. Nevertheless, extrapolation can be made more reliable by probing categories of function in detail, seeking clear examples of impairment, obtaining reliable corroboration, understanding the nature of the evaluee's work, and considering alternative explanations for disability claims.[54]

D. Correlate the Mental Disorder With Occupational Impairment

Most disability referrals require that the psychiatrist correlate the psychiatric disorder with specific occupational impairment.

1. Assess Categories of Function

Assessing specific areas of functioning is a starting point in the assessment of impairment and helps define the relevant disability factors in each case. Which categories of function are used may depend on the nature of the disability evaluation and the setting that defines disability criteria. Several different systems of classification of impairment are used in the United States and in other countries. These include the AMA's *Guides to the Evaluation of Permanent Impairment*, Fifth Edition[18]; the World Health Organization's *International Classification of Functioning, Disability, and Health* (ICF)[55]; Social Security Administration regulations[56]; DSM-IV-TR Global Assessment of Functioning Scale (GAF)[15]; and private disability insurance classification systems, among others.

If a referral source does not request that a specific classification system be used, the psychiatrist should consider utilizing the categories of functioning provided by the *AMA Guides*.[18] Using these categories and their components may help the psychiatrist to avoid making vague or overgeneralized conclusions about an individual's impairment and disability. The *Guides*' categories are: activities of daily living; social functioning; concentration, persistence, and pace; and deterioration or decompensation in a complex or work-like setting.

2. Seek Descriptions and Clear Examples of Impairment

The psychiatrist should explore all claimed impairments in detail, seeking specific behavioral examples and/or clear descriptions of how the claimed mental problems have affected functioning. Evaluees who do not want their assertions questioned may become uncomfortable or angry at detailed questioning. Nevertheless, this part of the evaluation is essential to an objective assessment of impairment.

3. Assess Complaints of Impairment for Internal Consistency

The internal consistency of a claimant's report of impairments must be examined. In providing an accurate history, the employee should be able to describe the development, course, areas, and severity of impairment with little self-contradiction. Similarly, an evaluee's denial of impairment—for example, in a fitness-for-duty evaluation—should also be internally consistent.

One way to assess the internal consistency of the self-report is to ask for a detailed account of the evaluee's actions on a typical day, a typical best day, and a typical worst day, and/or the days immediately before the interview. Asking for an hour-by-hour description of activities can counteract the tendency of some evaluees to provide only sweeping descriptions of impairment. Such an approach can also sometimes reveal areas of preserved functioning that demonstrate the potential for work or rehabilitation. In addition, the person's hobbies, recreation, and social interactions can be a rich source of functional information.

4. Correlate the Requirements of the Job With the Claimed Impairments

Employment documents, including job descriptions, performance reviews, and other work assessments, should provide the basis for a review of the nature of the job with the claimant. His or her description of the job may not match the written description in every detail, but should be consistent with the written description. In addition, a detailed inquiry into the actual work duties, the organizational structure of the workplace and work area, and the specific demands of the work provides a framework for assessing impairment.

The psychiatrist should correlate claimed or demonstrated impairments with specific job skills or requirements and may find speaking with the evaluee's supervisor (when permissible) to be helpful in making this correlation. An individual with mild or moderate symptoms of mental disorder may have significant impairment if the job is particularly hazardous or demanding. For example, as mentioned earlier, an individual with a desk job that requires no heavy lifting may experience only mild impairment from chronic back pain that results in a restriction against lifting more than 20 pounds. A dockworker may be disabled by such a limitation. Similarly, an inability to maintain persistence and pace due to severe depression could be a lesser impairment to an individual with flexible work demands, but a disabling impairment to one who has to meet daily deadlines.

5. Assess Functional History and Correlate It With the Current Level Of Impairment

The psychiatrist often assumes that an evaluee's functional impairment began with the illness for which the evaluation has been requested. However, much can be learned regarding an individual's current degree of functional impairment and its relationship, if any, to psychiatric illness, from a detailed review of the individual's functional history. Such a

review requires knowledge of the evaluee's academic, military, social, and occupational functioning and an assessment of this functioning in a longitudinal context.

6. Use Rating Scales Whenever Appropriate or Requested

Rating scales may be helpful in quantifying impairment, although the use of one usually is not required. The psychiatrist should bear in mind when using rating scales that most available 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 that the Social Security Administration uses to determine disability.[56]

Several rating scales are available for use in assessing psychiatric disability and for inclusion in psychiatric disability reports. If the referral source wants the psychiatrist to utilize a rating scale, the referral source generally will identify the preferred rating scale.

Guides to the Evaluation of Permanent Impairment[18] provides a rating system based on the combined scores of three self-report rating scales. This guideline, originally adapted in part from the Social Security Administration regulations, is 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[55] as a logical extension of the International Classification of Diseases, 10th revision.[57]

The rating scale that is generally most familiar to psychiatrists is the DSM Global Assessment of Functioning (GAF) Scale,[15] a standard component in multiaxial diagnostic assessment and commonly used both clinically and in disability evaluations. The GAF Scale considers psychological, social, and occupational functioning on a hypothetical continuum of mental health and illness and assigns a numerical value from 1 to 100 to rate degree of functioning. Instructions for the use of the GAF Scale specifically state that impairment in functioning due to nonpsychiatric limitations, such as physical illness or environmental problems, should not be considered in determining a GAF score.

Although the GAF Scale is a valid measure of adaptive functioning, it is limited to some degree by the fact that it assesses functioning from the standpoint of mental impairment alone. Practically speaking, it may be impossible to disentangle the combined limitations imposed by mental and physical impairments. Another limitation arises from the GAF Scale's single score, which combines the evaluation of psychological symptoms with academic, social, interpersonal, and occupational functioning. Applying a single common numerical value as a global measure for these distinct domains of functioning may be misleading in cases in which an evaluee's psychological, social, and occupational functioning do not correlate neatly.[58]

The Social and Occupational Functioning Assessment Scale (SOFAS), contained in Appendix B of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV),[59] was developed to assess social and occupational dysfunction independent of the severity of psychological symptoms. This scale is more specific to the assessment of work-related impairment and disability than is the GAF Scale.[60] Although the SOFAS is still considered investigational, the separation of psychiatric symptoms from the rating of social and occupational functioning in the scale may increase reliability and reduce confusion regarding the ratings of these domains. Both the GAF Scale and SOFAS have exhibited excellent reliability.[61]

7. Utilize Psychological Testing When Indicated

Psychological and neuropsychological testing can be useful in psychiatric disability evaluations, especially when an individual's reliability or diagnosis is in question. Cognitive testing, such as the Wechsler Adult Intelligence Scale-III (WAIS-III), can provide quantifiable and reproducible evidence of impairment of memory or other cognitive functions due to psychiatric symptoms. The MMPI-2 can provide corroborating data regarding psychiatric diagnoses, and its validity scales may also be of assistance in an evaluation. Comprehensive neurological tests such as the Halstead-Reitan Battery or the Luria-Nebraska Battery can be useful in assessing cognitive functioning in disability cases involving dementia, stroke, head injury, and neurologic disorders with additional psychiatric symptoms.[62] The tests cited herein are just examples of the many psychological tests available, and their uses.

Although psychological and neuropsychological tests can be useful in the evaluation of psychiatric

impairment, they should not be used as the sole basis for judging impairment. No psychological or neuropsychological test can take the place of a thorough psychiatric examination. However, psychological and neuropsychological tests can be valuable sources of information when conducted in conjunction with the psychiatric interview, examination of records, and review of information from collateral sources.

E. Consider Alternatives That May Account for Claims of Disability

1. Alternative Explanations

Alternate explanations for an individual's disability claim should be considered. An evaluee whose poorly supported claims have arisen during an employment conflict may be in considerable distress, but may be choosing not to work rather than experiencing a psychiatric impairment that results in work disability. Claimants sometimes do not understand the difference between being too upset to work and having a psychiatric impairment. In some cases, both dynamics may be operative, resulting in an exaggeration of symptoms or poor motivation despite minor impairment.

The psychiatrist may be confronted with the difficult task of assessing which element is the more substantial factor in a disability claim. The evaluee's circumstances should be explored both inside and outside the workplace, and the psychiatrist should expect to find factors related to real gain and/or psychological gain in any evaluation. The presence of such factors does not discount or invalidate the presence of true psychiatric symptoms and impairments related to these symptoms. However, failure to consider such factors may result in an inaccurate or incomplete assessment of psychiatric disability.

A detailed longitudinal history tracing the evolution of the claimed impairment in relationship to the individual's work history is an essential element in this assessment. Did the claimant first become depressed and then unable to work? If so, was there a time when he or she could work despite depression? Did treatment fail to improve symptoms, and if so, why? Are there reasons why the claimant would no longer want to work irrespective of depression? Did the employee have plans to leave work arising from personal preference before the depression became more severe? Does the claimant's age suggest an interest in early retirement?

The job history can also provide insight into this difficult determination. Broadly speaking, an individual with a consistent and productive job history may be less likely to choose not to work, sometimes despite relatively severe symptoms. Conversely, the individual who has demonstrated less of a commitment to gainful employment over the course of his or her life may be more likely to seek means of financial support outside employment. In such individuals, even a minor impairment may result in a claim of permanent, full disability. Examination of the circumstances of each case will indicate whether this broad generalization applies.

Motivation is also a key factor in this determination and should be considered. Noncompliance with rehabilitation, medication, and other treatment, along with an early decision by the claimant that he or she will never work again, should raise suspicion about the role of choice versus impairment in the claim. The psychiatrist 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. Exaggeration of symptoms or the potential for financial or psychological gain may be present when an individual makes little or no effort to seek treatment or rehabilitation. Conversely, a person who demonstrates vigorous attempts to obtain treatment and rehabilitation may be less likely to make the choice not to work.

Evaluation of alternative explanations for disability claims should take into account the possible contribution of workplace and personal dynamics. For example, disability claims not uncommonly arise when an employee faces negative personnel action due to deficient work performance, a personality change, lack of motivation, employment instability, or misbehavior.[63] Such a context may signal the possibility that the employee is using a disability claim as protection against untoward consequences of workplace performance or behavior or against a personnel action.

Outside the work setting, the claimant may face a personal life crisis that would be resolved by quitting work and claiming disability. The timing of the claimed disability or manifestation of symptoms disproportionate to the claimed impairment, along with evidence of exaggeration and malingering, may be clues to the presence of personal problems.

2. The Possibility of Malingering

The psychiatrist performing a disability evaluation is frequently asked either directly or by implication to determine whether a claimant is malingering. Although it is not possible to determine precisely how frequently disability claimants feign or exaggerate mental problems, studies and estimates over the past 25 years have suggested that the incidence may be as high as 30 percent.[64,65] When conducting a disability evaluation, therefore, the psychiatrist should always consider the possibility that the claimant is malingering. Exaggeration or magnification of symptoms is often more common than complete faking of illness or injury and can make the objective assessment of true impairment and symptoms more challenging.

The incentives for malingering may range from trying to obtain several paid months off from work to effecting temporary or permanent withdrawal from the workplace with monthly disability payments or a large settlement check. The claimant may fake the initial injury that produced the supposed psychological symptoms or may exaggerate the severity or duration of an actual injury to obtain additional sick time or financial compensation. A disgruntled employee may feign mental illness to effect removal from the workplace while obtaining monetary compensation.

An implication of malingering can have serious consequences for the claimant, and the determination should therefore be based on convincing objective evidence. Collateral information is essential in the detection of malingering. Inconsistency of symptoms across situations and contexts may be apparent only after information from several sources is reviewed. Comparing an employee's job performance before and after the claimed injury or onset of the illness can provide an assessment of baseline functioning and elucidate motives for malingering.

Other evidence suggestive of malingering includes discrepancies in an individual's report of illness and the history of the injury or illness. The claimant's legal and work histories may reveal repeated disability claims against a succession of employers. Such a history alerts the psychiatrist to the claimant's knowledge of the disability system and possible motives for malingering. The individual's history of substance use may also be helpful and may reveal inconsistencies between self-reports and collateral information.

The mental status examination is essential in the detection of malingering in a disability claim. The psychiatrist may compare mood, affect, speech, and thought processes during the evaluation to the individual's reported symptoms. For example, a malingerer may show marked discrepancies in mood, affect, and behavior. An employee claiming major depression may report feeling depressed and unable to concentrate, yet may have a pleasant affect for most of the interview and demonstrate no impairment in concentration. Evasive or hostile behavior during the interview (in the absence of psychosis) may also be suggestive of malingering.

F. Formulate Well-Reasoned Opinions That Are Supported by Clinical and Psychiatric Data

An opinion regarding the presence of work impairment due to psychiatric illness should be based on clearly identified changes or limitations in functioning. If the psychiatrist is unable to form an opinion regarding impairment to a reasonable degree of certainty, the reason for the failure should be clearly articulated. If information that is critical to the formulation of an opinion is missing, the psychiatrist should inform the referral source that the information must be obtained and reviewed for an opinion to be reached.

All psychiatric opinions should be held to a "reasonable degree of medical certainty" or a "reasonable degree of medical probability" (the choice of terminology depends on the jurisdiction).[66,67] An opinion held to a reasonable degree of medical certainty indicates that the psychiatrist believes that the opinion is more likely than not to be true or accurate, sometimes described as at least a 51 percent certainty. The claimant or the circumstances of the claim should demonstrate with specific and convincing evidence that an impairment is more likely than not to be present or absent.

In most disability evaluations, no specific mental disorder is required or excluded as a potential source of impairment. However, the psychiatrist should not base an opinion solely on the presence of a psychiatric disorder. The presence of a disorder does not automatically indicate impairment, and even less so, disability, since the latter determination in particular involves nonmedical and vocational considerations.

Certain disorders are more likely to result in work impairment than others. Psychotic conditions such as schizophrenia or severe bipolar disorder routinely

cause major impairment in social and occupational functioning. Certain chronic anxiety and depressive disorders that do not respond to treatment can be disabling, if not for all types of work, then perhaps for the type of work an employee was formerly capable of doing. Nevertheless, even a person with a severe psychiatric disorder can often work in a limited capacity or in a sheltered setting.

Therefore, unless a psychiatric disorder is so severe that it results in global impairment of functioning, and work impairment is inevitable from the manifested symptoms alone, conclusions about impairment should include specific factual reference to limitations or restrictions in areas of functioning. Descriptions of an employee's functioning should include compelling anecdotal examples provided by the evaluee as well as examples derived from sources of collateral information. Corroborating accounts of the employee's current life activities may also be useful in demonstrating an impairment or the lack thereof.

Psychiatric opinions regarding impairment (and, if requested, regarding disability) should demonstrate that the psychiatrist appreciates the requirements of the particular job and how the impairment may affect the ability to fulfill job responsibilities. The psychiatrist may be asked to provide an opinion about whether an employee is impaired or disabled with respect to only one type of work or to all types, to a particular setting or similar settings, or to specific work conditions. Again, the psychiatrist should clearly articulate a factual basis for such opinions.

Opinions regarding impairment should take into consideration the natural course of the psychiatric disorder, whether the employee is receiving appropriate treatment, the response to treatment, and the prognosis. When requested to do so, the psychiatrist should provide opinions regarding the limitations imposed by the claimant's mental impairment, the projected length of time that the limitations will continue, and the employee's remaining abilities or residual functioning.

G. Write a Comprehensive Report That Addresses Referral Questions

In certain situations, such as litigation concerning alleged personal injury, the referral source instructs the psychiatrist to submit only a brief written report or no report at all. In these cases, the findings and opinions are likely to be disclosed through abbreviated expert disclosure statements and oral testimony. In most other evaluation contexts, however, the referral source asks the psychiatrist to produce a written report that more fully describes the findings and opinions on disability.

Reports should provide enough information to support the opinions for which the psychiatrist is being consulted. Many referral sources ask specific, written questions. In these cases, the psychiatrist should focus on answering these questions, in addition to providing any data supporting conclusions, unless otherwise specified. When specific questions are asked, the psychiatrist should limit the response to providing opinions that answer only those questions, unless it appears that a relevant or significant aspect of the case is being overlooked.

Some referral sources request a full evaluation report without limitations on the scope or depth of the assessment. In such cases, the report should conform to standard suggested forensic psychiatric report formats unless otherwise indicated by the referral source. Several possible formats have been suggested,[62,68–70] but there is no single correct style or format for writing a disability evaluation report. It may be helpful for the psychiatrist to communicate orally with the referral source about impressions or opinions after an initial review of the sources of information and/or after the personal interview, to ensure that the report fulfills the referral source's needs. The psychiatrist should be aware that in the event of litigation, all such oral communications are potentially subject to discovery.

Regardless of the format used for preparing the written report, the psychiatrist should remember that most final arbiters of disability decisions have not had medical or psychiatric training. The report should therefore convey information and opinions in nontechnical language that can be easily understood. The following elements should be included in all types of disability reports (unless otherwise specified as noted above).

1. Identifying information.
2. Referral source.
3. Questions posed by the referral source.
4. Informed consent. The consent should document that the evaluee understands the reason for the evaluation, the absence of a treatment relationship, and the nonconfidential nature of the

evaluation and, in light of that understanding, agrees to proceed with the evaluation.

5. Sources of information:
   a. All records and other materials reviewed.
   b. Dates and duration of interviews of the evaluee.
   c. Collateral sources, including dates, duration, and type (telephone or in person) of interviews.
   d. Assessment of the reliability of sources of information if relevant or significant.
   e. Psychological tests or evaluation instruments used.
6. 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 use or trauma, criminal history.
   h. Medical history and current medications.
   i. Family history.
   j. Educational and occupational histories, including the 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. Sexual, marital, and relationship histories.
   l. Current social situation: living arrangement, financial status, and legal status.
7. Mental status examination.
8. Relevant physical examination findings obtained from medical records.
9. Relevant imaging, diagnostic, and psychological test findings.
10. Opinions, either as responses to specific questions posed by the referral source, or as answers to the two broad core questions: the determination of the presence of a psychiatric disorder, and the relationship between the psychiatric disorder and any impairment and/or disability. As discussed earlier, opinions should be well reasoned and include supporting data.

When specific referral questions have been provided, the psychiatrist should organize the responses by showing each question, followed by the response. The implication that opinions about impairment or disability hold for the specific reason for the referral should be addressed. As mentioned earlier, some referral sources expressly direct the evaluating psychiatrist not to give an opinion about disability. The psychiatrist may be instructed to provide opinions only on impairment and other relevant factors that may influence a disability determination.

If no questions have been provided, the psychiatrist should include all findings and opinions relevant to disability in the case. These may include (but are not limited to):

Multiaxial diagnosis, including GAF score. Diagnoses should adhere to current DSM categories. They should, at a minimum, include Axes I, II, and III, and may include all five DSM axes when appropriate and indicated. Reasons for any differential diagnoses should be given. In cases in which a diagnosis is contingent on a factual determination, adequate explanation should be provided on how the disputed fact could change the diagnosis.

Impairments in work function and the relationship to psychiatric symptoms.

Adequacy of and response to past treatment.

Treatment recommendations, including recommendations for medical consultations or psychological testing.

Prognosis, including the expected course of the evaluee's disorder(s), likelihood of chronicity, and expected duration of the impairment.

Opinions on restrictions or limitations imposed by the claimant's mental impairment(s), if the referral source requests them. The projected length of time that the restrictions will be in force and remaining abilities or residual functioning of the employee should be included.

IV. Specialized Disability Evaluations: Entitlement to Compensation for Work Impairment

Many types of disability evaluations share common elements, as described in Section III. However, specific types encompass distinct areas, and the psy-

chiatrist may have to adapt evaluation procedures to the context and facts of each case. This section is a review of how types of disability evaluations differ, with suggested guidelines specific to each. Some of the more important points are summarized in table format in Appendix I.

Disability evaluations fall into two general categories: those for entitlement to compensation for work impairment and those to gain approval to continue or resume working, with or without request for accommodations. Each of these categories could easily encompass an entire set of guidelines. In addition, they may overlap to some degree. The following sections are not intended to provide comprehensive descriptions of every type of evaluation. Rather, a brief description is offered of common disability evaluations, their specific goals and legal bases (statutory, administrative, or employment), their qualitative differences, and the unique challenges generated by these features.

A. Government Disability Programs: Social Security Disability Insurance and Supplemental Security Income

1. Public Disability Insurance

The Social Security Administration (SSA) administers two programs that provide disability benefits: 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 coverage in the form of cash benefits for those disabled workers and their dependents who have contributed to the Social Security trust fund through the Federal Insurance Compensation Act (FICA) tax on their earnings. Eligibility for SSDI benefits is not means-tested (that is, based on other sources of income or current assets), but does require at least 5 years of contributions over the 10-year period preceding the disability.

SSI is a social welfare program that differs from SSDI in several ways. SSI provides a minimum income level for low-income, aged, visually impaired, and disabled persons. Financial need, which is statutorily defined, determines eligibility for SSI benefits. Neither insured status nor any previous attachment to the work force is required. The benefits reflect a flat-rate, subsistence payment that is lower than average SSDI payments.

Despite these differences, the definition of a disability under SSI and SSDI is the same, and an individual can be eligible for benefits under both programs. In addition, both SSDI and SSI link up to other support and compensation systems. For example, after a two-year waiting period, recipients of SSDI benefits who are disabled and under the age of 65 are eligible for Medicare; in most states, disabled SSI recipients are automatically eligible for Medicaid.

Psychiatrists with active clinical practices generally have some familiarity with Social Security disability claims. Patients may file claims for public disability insurance when they feel they can no longer work because of psychiatric illness, thereby beginning a process that relies heavily on information provided by the treating psychiatrist. Clinicians may not be aware, however, that the SSA's disability determination process, definition of disability, and criteria for determining disability generally differ from those of other government and private disability programs.

The process and definitions used by the SSA in determining eligibility for psychiatric disability benefits are highly specific and statutorily defined. In addition, a person considered disabled under another program, such as workers' compensation, is not necessarily deemed disabled under the Social Security program because, unlike many other public or private programs, there is no partial disability under SSI or SSDI. Under the rules governing eligibility for SSI or SSDI benefits, a person is either disabled or not.[71]

2. Filing a Claim

Applications for benefits and preliminary screening are made at SSA district offices. After verification of legal eligibility, the claim is referred to the state Disability Determination Services (DDS). This is a federally funded state agency responsible for developing medical evidence and rendering the initial determination of disability, utilizing federal regulations and SSA procedures and guidelines. Medical and vocational evaluations are obtained and used to determine eligibility. Most determinations are made by the state DDS at the initial and reconsideration levels.

The SSA disability determination consists of a five-step sequential evaluation[72] in which the following questions are asked:

> Is the claimant engaged in substantial gainful activity (SGA)? A claimant who is working and

earning over the prescribed level is considered to be performing substantial gainful activity, and, no matter how serious the medical condition, the employee is not deemed eligible and the claim is denied.

If a claimant is not engaging in SGA, does he or she have a severe impairment? A medically determinable severe impairment is one that has more than a minimal impact on an individual's ability to engage in basic work activities, such as understanding, remembering, and carrying out instructions and responding appropriately to supervision, coworkers, and work pressure in a work setting. If a medical impairment or combination of impairments is not severe, the disability claim is denied.

If it is severe, does the claimant's impairment meet or equal a listed impairment? The SSA has developed a set of medical evaluation criteria called the "Listing of Impairments," or the "Listing." If a claimant's medical impairments meet the criteria of one of the listed impairments (or is medically equivalent to a listed impairment) and the claimant is not engaged in substantial gainful activity, he or she is deemed to be disabled, and the claim is allowed.

If the impairment does not meet or equal a listing criterion, does the impairment prevent the claimant from doing past relevant work? At this stage, the SSA determines whether the claimant has the residual functional capacity (RFC) to do the type of work that he or she has done in the past. If the claimant can still perform relevant work as in the past, the disability claim is denied.

If the claimant is not able to do past relevant work, does the impairment prevent the claimant from doing any other work? At this final step of the sequential evaluation, the SSA determines whether the claimant has the RFC to do other work that is appropriate to age, education, and work experience. The claimant who is unable to perform any other work is deemed disabled. If the claimant is able to perform other jobs that are widely available in the national economy, the claim is denied.

Medical evidence is the cornerstone of a determination of eligibility for Social Security disability. Individuals who file a disability claim are responsible for providing medical evidence showing the presence of one or more impairments and the severity of the impairment(s), and case law has established that a claimant has the burden of proof on the first four steps of the five-step sequential process. The SSA, with the claimant's permission, will help in obtaining medical reports and records from the health care providers who have treated or evaluated the claimant. The state DDS requests copies of medical records from physicians, psychologists, and other health care professionals and from hospitals, clinics, and other facilities that the claimant has attended.

The claimant's health care providers and consultative examiners are not expected to make the determination of disability. The medical evidence furnished by the claimant's providers is reviewed by an adjudicative team that makes the determination. This 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 record 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. Claimants who are deemed ineligible may file a request for reconsideration at any field office or by calling the SSA. If benefits are again denied at the DDS level, claimants may request a hearing before an Administrative Law Judge at the SSA. Further appeals options include a request for review of the denial decision by SSA's Appeals Council, and then review in the federal courts.[73] Although nearly all claims are adjudicated at the lower levels of the agency, Social Security cases are among the most commonly litigated federal appellate cases.[74]

3. The Role of the Psychiatrist

In contrast to many other types of disability evaluations, treatment providers are the primary sources of information for Social Security disability claims. Often decisions regarding eligibility for disability benefits are made using the information provided by the treating psychiatrist alone. The SSA may also ask the psychiatrist to provide a consultative examination (CE) as an independent clinical examiner in some cases. The psychiatrist may participate in the SSA process in other ways, such as through employment by the SSA or a state DDS, or by providing

expert evidence at an appeal hearing. These roles require additional forensic or administrative experience.[71]

SSDI and SSI have identical requirements concerning the information sought from physicians. As in other disability evaluations, documentation of the existence of an impairment and how it interferes with an individual's functioning is required. Three basic concepts underlie the determination of psychiatric disability by the SSA: the claimant must have a medically determinable impairment, referred to as a listed mental disorder; the mental disorder must result in an inability to work; and the inability to work resulting from the mental disorder must last or be expected to last for at least 12 months.

Therefore, an SSA disability report should state whether a mental disorder is present, and if so, whether the disorder has interfered with the individual's ability to work over a period of time. The SSA form or referral letter uses or suggests a reporting format that allows for a relatively straightforward application of the relevant legal SSA criteria to the clinical data obtained by the examining physician.[75] The psychiatrist is discouraged from discussing ability to work, because this determination is within the sole purview of the state DDS.[76]

4. Providing Information as a Treating Psychiatrist

The process of determining psychiatric disability emphasizes medical evidence provided by the claimant's treating psychiatrist or psychologist. Many disability claims are decided solely by reviewing the medical evidence from treating sources. Information provided by both psychiatrists and psychologists is considered medical evidence for purposes of the SSA. SSA regulations place special emphasis on evidence from treating sources for two primary reasons. The SSA considers those sources to be the medical professionals most able to provide a detailed, longitudinal picture of the claimant's impairments, and treating clinicians are considered to bring a unique perspective to the medical evidence that is not obtainable from medical findings alone, from reports of an individual examination, or from records of a brief hospitalization.[71]

The SSA asks the treating physician to complete a standardized form focusing on clinical observations and evaluation. The request for medical information from the state DDS usually specifies the level of detail required, based on explicit SSA medical eligibility criteria. The SSA may approve additional diagnostic testing to establish conclusively the extent and severity of an illness. The SSA regards a mental status examination as providing the 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 or expect to be disabled for a period of not less than 12 months to be eligible for benefits. It attempts to determine whether the claimant is not expected to be able to function in a 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 for a continuous period of at least 12 months.[74] Providers should also provide specific details of the claimant's condition over time, including the nature, duration, and frequency of exacerbations and remissions of the claimant's mental disorder.[75]

5. Consultative Examinations

If the adjudicative team needs additional information beyond that provided by the treating clinician, a CE may be obtained on a fee-for-service basis. These examinations require specialized expertise. The psychiatrist performing a CE must have an active license in the state assigning the evaluation and must have training and experience administering the type of examination or test that the SSA requests. Fees for CEs are set by each state and may vary from state to state. Each state agency is responsible for overseeing and managing its CE program.

The claimant's treatment provider is the preferred provider of the CE if that physician is qualified, equipped, and willing to perform the examination for the authorized fee. The SSA's rules also provide for using an independent examiner (other than the treating source) for a CE or diagnostic study if one of the following is true:

- The treating psychiatrist prefers not to perform the examination.
- The treating psychiatrist does not have the equipment to provide the specific data needed.
- There are conflicts or inconsistencies in the file that cannot be resolved by going back to the treating psychiatrist.

The claimant prefers and can show good reason for preferring another examiner.

Prior experience indicates that the treating psychiatrist 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 review, analysis, and interpretation of the clinical findings, test results, and other evidence in the case record. The independent examiner also may be asked to provide additional detailed medical findings about the claimant's impairment or to provide technical or specialized medical evidence not available in the claimant's current medical file.

A CE report has many elements in common with a treatment provider's disability report. In addition, consultative examiners should describe the claimant's mental restrictions and provide an opinion concerning what the claimant can do despite the impairment. CE reports should specifically include detailed information concerning functional limitations relative to activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. Opinions about a claimant's residual capabilities despite the impairment should describe the ability to understand, remember, and carry out instructions and to respond appropriately to supervision, coworkers, and work pressures in a work setting. The assessment of capabilities should also include whether the individual can manage the awarded benefits responsibly.

Consultants should obtain information concerning a claimant's functioning from both the claimant and other sources, including community mental health centers, sheltered workshops, family members, and friends. The consultative examiner should request medical records from the DDS to determine their availability before the examination.

Depending on the nature and scope of the CE, a general or focused physical examination may be indicated to determine whether the claimant's signs and symptoms are due to a mental or physical impairment or to determine whether the claimant has physical findings attributable to the adverse effects of psychotropic medications. Blood and urine testing, imaging studies, and psychological testing may also be requested. Psychological test results are considered in the context of all the evidence, and decisions regarding disability are not based on test results alone.

Problems arise when the CE report fails 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 conclusions may reduce the credibility of a report, particularly if the report does not include specific data to support its conclusions. Reports may also fail to make a connection between the functional restrictions and the existence of a mental disorder. Since functional restrictions may result from circumstances other than a mental disorder, the report should indicate whether restrictions in functioning arise from a mental disorder or other factors.[76]

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."[77] As mentioned earlier, substantial gainful activity (SGA) is any work generally performed for remuneration or profit, involving the performance of significant physical or mental tasks, or a combination of both.[70] This definition includes part-time work, regardless of pay or similarity to an individual's former work.[78] If jobs within the claimant's capability are available in substantial quantity elsewhere in the country, then the claimant is not eligible for disability benefits.[79]

In addition, to qualify for benefits, an individual must have a medically determinable impairment that causes disability. The SSA has established eight categories of mental disorders (based on DSM-III-R criteria) that can result in a finding of disability caused by a medically determinable impairment. The "Listing of Impairments" is so constructed that an individual meeting or equaling the criteria of the Listing cannot reasonably be expected to engage in gainful work. Each category or diagnostic group except mental retardation, autism, and substance addiction disorders consists of a set of clinical findings (Paragraph A criteria), one or more of which must be satisfied.

The SSA's nine categories of listed impairments are: organic mental disorders; schizophrenic, paranoid, and other psychotic disorders; affective disor-

ders; mental retardation; anxiety-related disorders; somatoform disorders; personality disorders; substance addiction disorders; and autistic disorder and other pervasive developmental disorders.

An individual who is disabled by mental illness should have a recognized or listed disorder to meet the definition of a medical impairment. However, the SSA recognizes that the nine categories do not encompass all types of clinical findings that may result in impairments severe enough to preclude working. The effect of a combination of impairments is also considered and 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 considered severe by itself. The state DDS may also find a claimant to be disabled based on reports indicating the presence of medically equivalent impairments that are comparable with the criteria of the listings for mental disorders.[75,80]

If Paragraph A criteria are satisfied, criteria assessing functional restrictions (Paragraph B and C criteria) are considered. The criteria in Paragraphs B and C of the Listing are based on functional areas thought to be relevant to work, and these criteria establish the severity of the disorder. Paragraph C criteria, which were added to the schizophrenia, paranoia, and other psychoses and the anxiety-related disorders, essentially recognize the significant impact of impairments related to certain chronic mental illnesses, even when such impairments are decreased by the use of medication or psychosocial factors such as placement in a structured environment.[74]

The restrictions listed in Paragraphs B and C must be the result of a mental disorder that is manifested by the clinical findings outlined in Paragraph A. At least two or three of the Paragraph B criteria must be met for a claimant to demonstrate functional restrictions. A person who is severely limited in the areas defined by Paragraphs B and C because of an impairment identified in Paragraph A is generally presumed to be unable to work.[62,74,75]

Paragraph B criteria include:

> Marked restriction of activities of daily living, including cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, attending to grooming and hygiene, using telephones and directories, and using a post office. The examiner should assess the independence, appropriateness, effectiveness, and consistency with which the claimant can perform these activities.
>
> Marked difficulties in maintaining social functioning, defined as the claimant's ability to interact independently, appropriately, effectively, and consistently with other individuals. Social functioning includes the ability to get along with other persons, including family members, friends, neighbors, grocery clerks, landlords, and bus drivers. The claimant may demonstrate limitations in social functioning by having a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. The psychiatrist should appraise the claimant's cooperative behaviors, consideration of others, awareness of others' feelings, and social maturity. Social functioning in work situations may involve interactions with the public, coworkers, and persons in authority (e.g., supervisors).
>
> Deficiencies in concentration, persistence, or working pace that result in frequent failures to complete tasks, defined as the ability to pay attention and concentrate well enough to complete the tasks commonly involved in the job in a timely and appropriate manner. Limitations in concentration, persistence, or pace are best observed in work settings, but can also often be assessed through clinical examinations, including mental status examination or psychological testing. Strengths and weaknesses in areas of concentration and attention can be discussed in terms of the claimant's ability to work at a consistent pace for an acceptable length of time and until a task is completed and the ability to repeat sequences of action to achieve a goal or an objective. The psychiatrist should evaluate the claimant's ability or inability to complete tasks under the stresses of employment during a normal workday or workweek (i.e., 8-hour day, 40-hour week, or similar schedule). The psychiatrist should make note of limitations in the claimant's ability to complete tasks without extra supervision or assistance; in accordance with quality and accuracy standards; at a consistent pace without an unreasonable number and length of rest periods; and without undue interruptions or distractions.

Repeated episodes of deterioration or decompensation in work or work-like settings that cause the individual to withdraw from the situation or to experience exacerbation of signs and symptoms (which may include deterioration of adapted behaviors). This criterion refers to exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be manifested in worsening symptoms or signs that would ordinarily require increased treatment, a less stressful situation, or a combination of the two interventions. Episodes of decompensation may also be inferred from the history of present illness, psychiatric history, or medical records that show significant changes in medication; documentation of the need for a more structured psychological support system (e.g., hospitalizations, placement in a halfway house, or a highly structured and directing household); or other relevant information in the record about the existence, severity, and duration of the episode.

b. Residual Functional Capacity. When a claimant has an impairment that is not sufficiently severe to justify benefits on the basis of medical evidence alone, the reviewing medical consultant is asked to assess the claimant's residual functional capacity (RFC). The assessment of RFC is defined as "a multidimensional description of work-related abilities which an individual retains despite medical impairments."[72] RFC is a description of what the claimant can still do in the work setting despite the limitations caused by impairments.

The elements of an RFC assessment are derivatives of the criteria in Paragraphs B and C of the "Listing of Impairments" and describe an expanded list of work-related capacities that may be impaired by mental disorder. These qualities are assessed in the context of the individual's capacity to sustain the listed activity over a normal workday and workweek on an ongoing basis. They are:

Understanding and memory: the ability to understand and remember procedures related to work; short, simple instructions; and detailed instructions.

Sustained concentration and persistence: the ability to carry out short and simple or detailed instructions; maintain attention and concentration for extended periods; perform activities within a given schedule; maintain regular attendance and be punctual within customary tolerances; sustain an ordinary routine without special supervision; work with or near others without being distracted; make simple work-related decisions; complete a normal workday and workweek without interruptions from psychologically based symptoms; and perform at a consistent pace without an unreasonable number of and unreasonably long rest periods.

Social interaction: the ability to interact appropriately with the general public; ask simple questions or request assistance; accept instructions from supervisors and respond appropriately to criticism; get along with coworkers and peers without distracting them or exhibiting behavioral extremes; maintain socially appropriate behavior; and adhere to basic standards of neatness and cleanliness.

Adaptation: the ability to respond appropriately to changes in the work setting; be aware of normal hazards and take appropriate precautions; use public transportation and travel to and within unfamiliar places; set realistic goals; and make plans independent of others.[18]

The determination of mental RFC is critical to evaluating the capacity to engage in substantial gainful work activity in cases in which the claimant's impairment, although severe, does not meet the criteria in the Listing. A claimant who has an impairment that is not listed by the SSA and is not equivalent to any listed disorder, may, in some instances, be found disabled if the demands of a job that the person would be expected to fulfill, based on age, education, and work experience, exceed the remaining capacity to perform.[75,79]

When the claimant's RFC is not sufficient for him or her to perform the previous job, other factors are considered in assessing whether other types of work are possible. These factors include the claimant's age, education, and work experience and the jobs that are available in the national economy.[74,79]

7. Key Points in Conducting SSA Disability Evaluations

Understand and use the relevant definitions and criteria used by the SSA.

Avoid providing opinions on disability.

Rely on and follow the format of the forms and referral questions supplied by the SSA, as they ask for specific information that is directly linked to the medical criteria that the SSA uses to make disability determinations.

Provide specific support for and examples of psychiatric disorders, symptoms, and diagnoses and how these interfere with functioning.

B. Workers' Compensation

1. Disability Insurance in Lieu of Liability

Workers' compensation is a no-fault program that is designed to provide medical treatment, disability benefits, and necessary rehabilitation services for workers who have sustained a work-related injury or illness. In contrast with tort law, in which liability for a person's injury arises only after it is established that a second party caused that injury, workers' compensation is more akin to an injury insurance program. It does not require that employer fault be established, but instead provides compensation for any injury that arises out of a worker's employment.

Although details of systems vary, workers' compensation laws in all 50 states are similar in that they reflect a compromise of sorts between employees and employers. The injured employee can count on receiving a certain percentage of wages during the period of disability and medical care at the employer's or the insurer's expense, regardless 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 prohibits the injured employee from suing the employer for anything other than limited, statutory damages. Thus, unlike tort law, which may provide awards for any and all losses associated with an injury, an injured employee receives payments intended only to compensate for lost wages and associated medical costs due to disability.

To receive compensation, the worker must demonstrate that he or she experienced an unanticipated or accidental occurrence that resulted in injury or disability and that arose from and occurred during the course of employment. If the employee can prove the claims, guaranteed benefits are awarded that are specified by statute and case law and are based on a fixed schedule. However, certain types of injuries that might be compensable in tort law, such as pain and suffering, are noncompensable under workers' compensation law.

All states have workers' compensation statutes, and under the Federal Employee Compensation Act (FECA), most federal employees are similarly covered through the United States Department of Labor, Office of Workers' Compensation Programs.[81] FECA allows compensation if an injury or disease occurred in the performance of the claimant's duties and was causally related to factors of employment. Specifically, the federal occupational exposure must have contributed to the development of the diagnosed condition by direct cause, aggravation, acceleration, or precipitation. The disability questions are generally analogous to state workers' compensation law and to the general matters related to impairment and disability. However, each state has its own workers' compensation laws, and the rules governing eligibility for benefits vary across jurisdictions. Therefore, psychiatrists who perform evaluations for workers' compensation programs should review applicable laws and definitions in their jurisdictions before conducting evaluations or providing opinions about disability

2. No-Fault Does Not Mean No Dispute

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 a prerequisite for an award of benefits. All other aspects of a workers' compensation claim may be and often are disputed and litigated.

Causation is often highly contested in workers' compensation claims and frequently is the central question in related litigation. Most workers' compensation statutes require, as a part of their coverage formula, that the injury claimed be a personal injury by accident or an accidental injury arising out of and in the course of employment. Causation is ultimately determined by a jurisdiction's workers' compensation board. A complete discussion of causation in workers' compensation claims is beyond the scope of the Guideline. To prevail in such disputes, the employee must establish a link between employment and the injury. The extent of injury (degree of damage) is also subject to dispute.

3. Psychiatric Claims in Workers' Compensation

Compensation usually requires medical documentation of the claimant's injury or illness and its effects. If any part of the claim alleges emotional stress or the presence of a mental disorder, the employee is referred to a mental health professional for evaluation. Workers' compensation tribunals, like other administrative and legal systems, historically have been skeptical of emotional injury or psychiatric claims because of their perception of such claims as primarily subjective in nature.

One 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 presume a connection between the employment and an accidental injury if it occurred within the time and place of employment. When a mental disorder is claimed, however, the causal relationship between the psychiatric disorder and the workplace may be more aggressively questioned. An employer may argue that the worker's emotional condition was not caused or aggravated by the work but rather was the result of events outside the workplace or a pre-existing psychiatric disorder unrelated to the job.

Another significant obstacle encountered in claims of psychological injury in the workers' compensation system is the requirement that there be objective evidence of injury. In many jurisdictions, this stipulation has led to a requirement that a physical connection be established between a claimed mental injury and the job.[82] Workers' compensation claims for mental injury are divided into three categories, two of which demonstrate this connection.

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 of major depression filed by a laborer who falls off scaffolding, injures his back, and then develops major depression, which he claims is due to physical limitations caused by the back injury. Another example might be a firefighter who is burned in the course of duty, but whose disability is primarily from post-traumatic stress disorder.

In a mental-physical claim, an emotional problem, such as stress, is claimed to have led to an objectively measured physical disorder, such as a heart attack.[83] Originally in such claims, mental injury had to arise from a discrete and clearly identified nervous shock, such as witnessing a disaster at work and subsequently having a heart attack. Mental-physical claims have expanded the realm of compensable emotional injury to include prolonged or cumulative work stress, and there has been a trend toward compensation 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: mental trauma or stress that causes a psychiatric disturbance. In these claims, psychiatrists 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 building fire or a bank robbery. 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 perspectives of the worker and the employer differ widely. Nevertheless, despite the subjectivity inherent in such claims, these types of stress claims are expanding rapidly. Stress-related claims that are based on an aggravation of a pre-existing condition, using the "eggshell skull" principle in tort law,[84] 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 has 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 recovery for claims of physical injury are not. 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.[85,86] Thus, in some states, a workers' claim must meet an objective test and is not allowed if it is based on a misperception or an overreaction to a work environment (e.g., *Fox v. Alascom, Inc.*[87] and *Green v. City of Albuquerque*[88]). In other states, a claimant must show that job stress is something other than the ordinary stresses of employment that all workers experience (see, for example, *Romanies v. Workmen's Comp. App. Bd.*[89]). In yet other states, the nature of the stress must be either a sudden stimulus or an unusual event (see, for example, *Hercules Inc. v. Gunther*[90]).

A problem commonly encountered in analyzing stress-related claims occurs when an employee has a pre-existing emotional disorder that manifests itself in the workplace. Understandably, such an employee may have difficulty performing the job or relating to others at work. This inevitably creates stress for the employee, but that stress is not necessarily the cause of the disorder. In addressing this problem, for example, a New Hampshire court ruled that when there is a pre-existing weakness, the workplace conditions must contribute substantially to the stress for the claim to be compensable (*New Hampshire Supply Company v. Steinberg*[91]).

Administrative or personnel actions by employers create some of the thornier problems in workers' compensation stress claims.[63] For example, an employee who receives a warning or reprimand for poor performance understandably experiences stress. Stress is also undoubtedly caused by a layoff or termination, with or without cause. Tribunals have been divided on whether these events should be considered employment stressors for the purpose of workers' compensation claims. Many state systems and the federal government's workers' compensation regimen now have exceptions for stress that results from personnel action, if the action was undertaken in good faith.

4. Degree of Impairment

Jurisdictions differ as to the levels of impairment that may be compensable. Four subcategories of disability are frequently used in workers' compensation claims to project loss and financial remuneration: 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 might 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 reasonable, but only if formed from a complete understanding of the specific nature of the individual's work duties.

In workers' compensation claims, adjudication of impairment and disability relies most often on the AMA *Guides.*[18] The *Guides'* utility in the rating of degree of impairment in psychiatric disorders has always been ambiguous in contrast to determinations of physical disabilities. The *Guides* is organized into chapters on physical systems (e.g., "The Digestive System," "The Endocrine System"). Each chapter identifies "Principles of Assessment" and offers disability ratings in terms of percentages. The chapter on psychiatric disability, "Mental and Behavior Disorders," does not offer a percentage scale. Rather, it suggests that impairment be rated by calculating the median value of three psychiatric ratings scales, the Brief Psychiatric Rating Scale, the GAF scales, and the Psychiatric Impairment Rating Scale (Ref. 18, pp 355–360). This application is cumbersome, and its utility has yet to be demonstrated.

The use of percentages in psychiatric disorders has always been problematic. As the 5th edition of the *Guides* pointed out, the use of percentages in rating impairment due to psychiatric disorders "implies a certainty that does not exist" (Ref. 92, p 361). Nevertheless, some states' disability determinations require a percentage rating of impairment regardless of whether the impairment is physical or mental. Here, a state may rely on its own percentage rating system for mental disorders fashioned from the general categories of function adopted by the SSA.[93] Alternatively, a state may require a percentage rating for mental impairment but not specify how that should be determined.[94]

5. Key Points in Conducting Workers' Compensation Evaluations

Determine whether a DSM-defined mental disorder is present.

If the referral source asks for an opinion regarding causation, assess whether the mental disorder arose from and during the course of employ-

ment. If the psychiatrist believes it did, the report should include specific facts or bases of the judgment.

If offering opinions on causation, be familiar with the applicable particular terminology regarding causation in the state or federal statutes and address inquiries and opinions to the standards articulated by this terminology.

Assess whether the mental disorder leads to impairment and, if requested, to disability.

Assess the degree of impairment, using the scale (or percentage rating system) specified by the relevant jurisdiction. If requested, use the specified disability categories of temporary-partial, temporary-total, permanent-partial, and permanent-total.

Address other specific referral questions, which may include: whether the worker is impaired or disabled from performing the duties of the job where the injury occurred; what restrictions may be necessary to allow the worker to perform the job; whether the worker can perform another job; whether the worker can perform any job at all; whether an individual has reached maximum medical improvement, defined as the medical end result; whether there is a need for treatment before and after the settlement of the claim; and whether that treatment is necessary for a work-related mental disorder.

C. Private Disability Insurance Claims

1. The Role of Psychiatrists in Private Disability Insurance Claims

Psychiatrists can become involved in claims of persons who hold private disability insurance policies in two 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 on the claimant's eligibility to receive or to continue benefits.

Carriers handle most private disability insurance claims through internal review processes, by having their own staff members examine the materials submitted by claimants and their treating clinicians. If a carrier has further questions about disability status, it may request an IME, that is, an evaluation by a nontreating clinician. IMEs, often performed by forensically trained clinicians, are thus the second route by which psychiatrists become involved in private insurance disability claims. Also, if benefits end before a claimant believes he or she can return to work or when the carrier denies the claim outright, a legal dispute may arise between the carrier and claimant. In such situations, the claimant's attorney may request an IME from a psychiatrist (or a rebuttal or narrative from a treating clinician) to help resolve the dispute.

When treating an individual who has filed a private disability insurance claim or when conducting private disability IMEs, the psychiatrist should be aware of important distinctions between private disability insurance and social insurance programs such as SSDI and workers' compensation. Individuals may be covered by private disability insurance policies as part of their employment benefits. However, they may also purchase private disability insurance themselves. In the latter case, the policy holder is usually well educated and is often a self-employed professional. Historically, higher socioeconomic status is associated with fewer claims and shorter duration of claims, although in recent years, especially among physicians, the trend has been toward an increase in the number of claims.[95]

The carrier seeking to determine eligibility for benefits or whether to continue paying benefits may ask for only a review of records from an independent psychiatrist, rather than an in-person examination. In such cases, the carrier asks the psychiatrist specific questions that the independent reviewer must answer and establishes a record to support a claim determination. Often, at least one question in such referrals is whether the records support the degree of disability claimed. The psychiatric opinion reached through record review alone is obviously limited by the lack of a personal interview with the claimant. In addition, it may be limited by the lack of other relevant or necessary information. The psychiatrist should be certain to specify that the opinion offered is based only on the records provided.

2. Treatment and Forensic Roles: Conflict of Ethics

Sections I and IIIC of this Guideline provide a general discussion of the ethics-related concerns and potential role conflicts if the same clinician provides both treatment and forensic services. A patient often asks the treating clinician to become involved in a private disability claim. Like social security or work-

ers' compensation claims, in which treatment providers often play primary or exclusive roles in providing information and evaluations, the clinician may simply have to provide clinical information to support the patient's disability claims. However, the patient's requests in connection with a private disability insurance claim often require an opinion that necessitates evaluation beyond the evaluation that has been conducted for treatment purposes. Clinicians and patients are often unaware that providing such opinions without adequate collateral or employment information may cross the boundary separating the two roles of clinician and forensic expert, and may create a conflict of ethics.

A physician is obligated to provide information regarding diagnosis, treatment, and prognosis in support of the disability claim if a patient requests it and provides appropriate authorization for release of the information. However, a treating psychiatrist should advise the patient, to the extent possible, of the consequences of releasing medical records. For example, the psychiatrist should discuss whether the patient's interests regarding the disability claims would be better served and the person's privacy safeguarded by sending a summary report or letter, rather than copies of the records in their entirety. A cogent, readable summary of a patient's record is more likely to assist in making the claim than are handwritten chart notes. Although some carriers may not accept a summary in lieu of records, it is often worth exploring this option when the patient's privacy is at stake.

Releasing information gathered in the course of clinical care differs from attempting to conduct an IME or serving as an expert witness for one's own patients' private disability claims. First of all, treating psychiatrists are not independent and therefore cannot, by definition, provide independent medical evaluations of their patients. Moreover, the treating psychiatrist who offers disability opinions may adversely affect the therapeutic relationship in several ways. For example, conducting third-party interviews after the treatment relationship is established may result in a patient's perception that the treating psychiatrist is challenging the patient's credibility.[96]

3. Definitions and Factors in Evaluations

In contrast to the highly structured and universal definitions of disability found in Social Security statutes, the definitions of disability and the manner and duration in which benefits are paid in private insurance programs are based on the terms of the individual policy and vary widely. Underwriting practices and competitiveness within the insurance industry periodically cause surges in disability claims.[94] In addition, there is no comprehensive or integrated system for filing or processing private psychiatric disability claims. Each claim may take on an administrative life of its own, particularly because psychiatric illnesses often lack standardized treatment plans for specific conditions. Often, the claimant's treating psychiatrist informs the carrier that revoking reimbursement will cause a relapse of the claimant's psychiatric condition, resulting in further administrative complications.

From an economic perspective, the carrier's concerns about the difficulty in quantifying psychiatric claims can affect the decision to provide benefits. These matters should be understood and taken into account by the psychiatrist when conducting the evaluation and preparing the report. For example, in response to these concerns, the carrier sometimes places time limits on the amount or duration of the psychiatric claimant's benefits. Also, when the carrier finds no objective evidence to support a disability claim submitted as a medical disability (e.g., chronic fatigue syndrome), it may instead suggest that the disability stems from an untreated psychiatric disorder (e.g., depression), which would limit the duration of benefits. Newer policies may restrict benefits for subjective or self-reported syndromes, which can limit the duration of benefits without raising the question of a psychiatric disorder.

Private disability claims referred for independent psychiatric or forensic evaluation often encompass some of the most difficult clinical problems in psychiatry. For example, such referrals frequently involve disability related to poorly understood symptoms that lack objective medical evidence, such as chronic pain syndromes or chronic fatigue syndrome, and the role of psychiatric illness in such claims. Other difficulties may involve the relationship between claimants and their work. For example, the question of whether a physician despises working in a managed care environment and has become depressed or has developed depression and cannot work can be challenging. Similarly, resolving the question of whether a depressed doctor who feels well enough to engage in nonprofessional activities such as golf or travel can work may not be straightforward. Even though this individual is not completely disabled, he

or she could endanger patients through fatigue and poor concentration.

The ambiguous nature of such claims requires that psychiatrists conduct IMEs or records reviews with the most careful adherence to the general guidelines suggested herein.[97,98] Knowing the conditions of the claimant's disability policy and the policy's definition of disability can help the psychiatrist identify potential areas that may distort the opinion.

4. Conducting Independent Evaluations in Private Disability Insurance Claims

In addition to the usual elements of a comprehensive psychiatric assessment, the independent psychiatrist should give special attention to learning how the claimant functioned before the alleged disability began, what contributed to the disability, and what has changed in the individual's ability to function. The psychiatrist should review efforts and results of any attempts to return to work during or after treatment. A complete work history should be obtained, including the claimant's account of the current disability, past episodes of disability and the reasons for them, and work performance problems. Also useful are the claimant's descriptions of typical activities before and after the onset of disability, self-assessment, self-prognosis, and future plans. Although the claimant may volunteer information about work performance problems, he or she can also be asked about relationships with peers and supervisors, reprimands, or concerns voiced by others in the work environment.

The psychiatrist should also be certain to have knowledge of the claimant's pre- and post-disability income, disability benefits, and policy terms, as these may indicate the significance of financial factors in the motivation to return to work. Exploring these may also help clarify if filing a disability claim represents the claimant's conscious or unconscious efforts to resolve nonemployment problems, such as family or marital disputes.[95,99] The psychiatrist should be aware that such questions raise the ethics-based concerns involved in functioning essentially as an investigator. The referring insurers may use such information to deny payment to the claimant. Thus, the psychiatrist should be cautious in coming to conclusions.

The referring agency should provide collateral information for the psychiatrist to review. This information may include medical records, a description of the employee's job responsibilities, and surveillance. If possible and relevant, the psychiatrist should obtain reports about the person's functioning by speaking with a spouse or significant other, work colleagues or supervisors, and treatment providers. It is prudent to have the claimant sign a consent form or to document consent to make these contacts. In cases in which the individual refuses to allow the necessary collateral contacts, the psychiatrist should note in the report the refusal and the stated reason for refusal. The psychiatrist should also indicate that the report's conclusions may be limited by the lack of potentially relevant information or that no valid conclusions can be drawn without certain critical collateral information.

Requests for opinions and findings will vary from case to case and among referral sources. Most specify the areas that should be covered in the IME. The referral source usually requires a comprehensive IME report, with a full DSM multiaxial diagnosis, plus detailed findings and treatment recommendations. Some referral sources may not want the independent psychiatrist to offer an opinion on the "ultimate issue" of whether a disability exists. Instead, the psychiatrist may be asked to discuss the claimant's overall functional capacities, so as to allow the referral source to make a determination of disability status. When asked to provide an opinion regarding disability status, the psychiatrist should state whether the individual has a psychiatric illness, whether that illness (if present) impairs ability to work, and the specific reasons for and areas of impairment.

Regardless of whether an opinion about disability is requested, the IME report should address the specific functional tasks of the particular claimant's duties. A comprehensive and objective report should make it easy for the reader to comprehend the clinical connection of an illness with the impairing symptoms and how those symptoms affect the person's ability to work.[19]

The psychiatrist is often asked a variety of questions regarding treatment. Many referral sources ask for an assessment of current treatment and recommendations for additional treatment. The psychiatrist may be asked whether current treatment meets the standard of care. The referral source sometimes asks the psychiatrist to link treatment recommendations to relevant practice guidelines promulgated by the American Psychiatric Association. If current treatment is not adequate for the condition, the IME report should say so. It may be important to com-

ment on several related matters, including the limitations of prior evaluation and treatment, the reasons for those limitations, potential barriers to care due to the claimant's health insurance policy, and the claimant's attitude and resistance, if any, toward treatment and recovery.[100–102]

The psychiatrist may also be asked for an opinion regarding limitations or restrictions, whether the employee can return to work at the current occupation or some other occupation, or whether the employee can work under specific conditions. Again, opinions regarding limitations, restrictions, and return to work should be supported by objective evidence, including history of the illness and its relationship to impairment and ability to work, current symptoms, whether treatment is organized to facilitate a return to work, and the motivation of the claimant. The IME report should outline in detail the psychiatrist's opinions regarding restrictions, limitations, and ability to return to work with prescribed or modified workplace conditions.

An employee's illegal behavior or maladaptive personality traits may prompt a request for an IME. The psychiatrist should recognize that such behavior and traits do not necessarily result from disability or impairment caused by a psychiatric illness. If no psychiatric impairment is found, the psychiatrist should clearly articulate this opinion and provide data to support the conclusion.

Motivation and possible malingering should also be assessed. The person's defensiveness or symptom exaggeration, if present, should be described and evaluated. The psychiatrist should consider a variety of interpretations of such presentations. Defensiveness may reflect feelings about having to undergo evaluation of the disability claim, a way of articulating the level of distress and impairment, or a knowing exaggeration or misrepresentation of symptoms or functioning.[103]

5. The Written Report

The written report is often the only final work product of the private disability IME. Many times, the referring agency does not provide feedback to the psychiatrist after the report is submitted, as the case is processed internally. It is not unusual, however, for referral sources to ask for clarification, pose follow-up questions, or forward a newly received record and ask the psychiatrist whether the new information changes any of the opinions. Because the report is often the only input that the psychiatrist will provide, it is important to be thorough and to link the observed symptoms to the functional impairments observed. In addition, if litigation is taking place or should ensue, clearly articulated and substantiated positions presented at the outset may prevent the problems that could arise with the adding of opinions or facts at a later time, such as in deposition or trial testimony.

Sometimes, the psychiatrist cannot obtain enough information to answer the questions posed by the referral source. This problem arises most often when only a review of records is conducted. In such cases, the psychiatrist should not hesitate to inform the referral source that sufficient data are not available to formulate an opinion within a reasonable degree of certainty.

The information that has been provided may indicate the existence of additional records that could be obtained. When this occurs, the psychiatrist should advise the referral source of the existence of the records and recommend that they be obtained. In addition, it may become evident from a review of the records or an interview of the claimant that additional testing is indicated. If so, the psychiatrist should suggest to the referral source that the person undergo psychological, neuropsychological, or medical testing; urine screening or other laboratory tests; or other examinations.

6. Key Points in Conducting Private Disability Evaluations

Clarify the referral source's questions in writing.

Understand the claimant's policy terms and definition of disability.

Obtain a thorough work history.

Inform the referral source if questions cannot be answered because of lack information and indicate what additional information could or should be provided.

State whether opinions were reached solely through a review of records.

Provide a well-substantiated report.

Provide specific answers to the referral source's questions.

V. Specialized Areas of Disability Evaluation: Evaluations for Ability to Continue Working, With or Without Request for Accommodations

A. Americans With Disabilities Act (ADA) Evaluations

1. Intent of the ADA

The Americans with Disabilities Act (ADA)[104] of 1990 was designed to protect the civil rights of disabled individuals, including their employment rights.[105] The Act requires an employer to make "reasonable accommodations" for a disabled but qualified worker to enable that individual to perform essential job functions, unless the accommodation would impose an "undue hardship" on the employer. Thus, in contrast with employment claims in which individuals seek compensation because they cannot work, individuals who raise ADA claims seek to return to or remain in the work force.

Employers often face difficult decisions when attempting to make reasonable accommodations for individuals with psychiatric disorders. Whereas providing a ramp for wheelchair-bound employees is a relatively straightforward construction process, providing a less stressful environment for an employee with a psychiatric disorder can be an ambiguous undertaking that is difficult to operationalize. Moreover, unlike many physical disabilities, identifying a mental disability itself may be difficult. The employer may be hard pressed to distinguish whether an individual's behavior is due to a psychiatric illness, which must be accommodated, or to poor work and interpersonal skills, which require disciplinary action.

Many common workplace situations raise ADA-related questions and therefore result in requests for disability evaluations. For instance, once an employee makes a request for accommodation, the employer is legally required to engage in an interactive process in which the employer and employee must clarify what the disabled individual needs and identify the appropriate reasonable accommodation as quickly as possible. Any unnecessary delay in addressing the request for accommodation may cause the employer to be held liable.

A common situation that leads to a request for a disability evaluation occurs when an employee presents an employer with information about a psychiatric disorder without a direct request for evaluation or accommodation. Such a situation arises, for example, when an employee justifies taking sick days by providing a note from a psychiatrist citing depression as the reason for absence from work. The transmission of such information thus makes the employer aware of the employee's potential disability and can create a duty for the employer to follow ADA regulations with respect to the employee.

The occurrence of a troubling event in the workplace often prompts a request for a disability evaluation under the ADA. The event may be as simple as having an employee with known depression miss a week of work or as complicated as having an employee whose display of bizarre behavior is frightening coworkers but is not overtly dangerous or threatening. An evaluation may also be necessary before an employee's return to the workplace following a psychiatric hospitalization.

An employer may refer an employee for psychiatric evaluation concerning the employee's fitness for duty and for clarification of the employer's legal obligations under the ADA. 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 the employer and employee decide what is in their mutual best interest as they negotiate arrangements for reasonable accommodations. Although the psychiatrist is generally asked to offer opinions within a reasonable degree of medical certainty concerning disability under the ADA, a court makes the final decision on disability if the case goes to litigation. However, most ADA matters do not proceed to litigation. In these cases, the psychiatrist's opinion may be dispositive for both the employer and employee.

Take, for example, a work situation involving an employee who has post-traumatic stress disorder (PTSD). The psychiatrist would not make an ultimate legal determination that the employee's condition meets the ADA's definition of disability. This determination is a complex legal process that requires a multistep analysis. Although a diagnosis of PTSD made according to DSM[16] criteria by a qualified mental health professional can meet the definition of a mental impairment under the ADA, some courts have found that PTSD is not substantially limiting for purposes of the ADA.[106] Yet an employer may allow an employee with a diagnosis of PTSD an accommodation based on a psychiatric opinion. For

example, an employer may allow a productive employee who has been the victim of a rape to take leave each year on the anniversary of the attack, if a psychiatrist so suggests.

Other matters related to whether a person has a legitimate disability or what accommodations are reasonable are subject to legal dispute. Although an employer often asks a psychiatrist to evaluate whether a limitation is substantial or a requested accommodation is reasonable, disagreements on these questions may not be settled by psychiatric opinions. Indeed, such questions form the basis of ADA-related litigation, which must be settled by the courts.

Nevertheless, psychiatric opinions can provide valuable information in ADA-related assessments. In a best-case scenario, a well-done ADA evaluation may allow an employee who might otherwise have to assume disability status to remain in the work force, while providing suggestions that may improve the mental health of the employee. An evaluation may also contain suggestions that help the employer by facilitating the continued employment of a valuable worker. At a minimum, an ADA evaluation may help avert a confrontation that could lead to a claim of discrimination and costly litigation.

2. The ADA and the Definition of Disability

The ADA and subsequent related case law have delineated a definition of disability that is distinctly different from all other disability determinations, and this makes ADA evaluations unique among psychiatric disability evaluations. The ADA defines disability as "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."[107] In other words, in addition to those individuals suffering from an actual disability, the ADA is designed to protect individuals with a history of mental illness and those whom others regard as having a mental illness. The ADA applies its definition throughout its laws and is not confined to the employment sector. If a person satisfies the ADA's legal definition, he or she obtains protection under all sections of the ADA, including protection against discrimination in restaurants, stores, private schools, professional offices, etc.

This definition of disability under the ADA has been interpreted by the courts so narrowly that employees prevailed in only 3% of cases brought under the ADA from 2002–2004.[108] This statistic underscores the need for forensic psychiatrists to understand the ADA's definition of disability so that they can conduct evaluations that address the ADA regulations and use the ADA's language.

The determination that an individual has a psychiatric disability under the ADA first requires that the individual have a diagnosable mental illness. However, the ADA specifically excludes certain conditions and behaviors as grounds for disability. V codes, which describe stressful events and relationship problems, do not qualify as disabilities under the ADA. As was noted earlier in the Guideline, courts may not always recognize certain DSM diagnoses as disabling. Statutory language in the ADA legislation itself specifically excludes the following conditions from ADA protection: compulsive gambling, kleptomania, pyromania, transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, and other sexual behavior disorders.

Individuals with substance use disorders caused by the current use of illegal drugs are also excluded from ADA protection.[109] However, individuals who have used illegal drugs in the past but are not current users are covered by the ADA. Finally, the sexual orientations of bisexuality and homosexuality, neither of which are DSM diagnoses, cannot be used as a qualifying diagnosis leading to disability under the ADA.[109]

The second requirement for psychiatric disability under the ADA is that the identified mental illness must "substantially limit one or more of the major life activities."[109] A major life activity is an activity or function that the average person engages in most days with little effort and that is important to his or her overall functioning. The performance of the major life activity must be greatly impaired compared with the ability of the average person for an individual to be considered disabled under the ADA (*Burch v. Coca-Cola Co.*[110]). Sleeping, eating, and learning are examples of major life activities. Other activities such as working, thinking, and interacting with others have been considered major life activities by some courts, but not by others.[111] Courts usually require evidence that the mental illness and substantial limitations in ability to perform a life activity have persisted for more than a few months (*Sanders v. Arneson Products*[112]).

3. Functional Evaluation and Essential Job Functions

The ADA does not necessarily entitle the disabled individual to continue working at the current job. The individual who is disabled under the ADA is entitled to continue to work at the current job only if he or she has the required training to perform the essential job functions and can carry them out with or without an accommodation. The individual who wants a promotion or transfer to a job for which he or she is not qualified by training or experience is not entitled to such a job simply because of the presence of a recognized disability.

Essential job functions are those parts of the job that are crucial, not secondary, to the function of the position. For instance, an essential job function for a letter handler at a 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.

The psychiatrist therefore must determine whether the disabled individual can perform essential job functions. To gain an understanding of a claimant's essential job functions, the psychiatrist should obtain a written or verbal job description from the employer as well as information from the worker. The psychiatrist should not assume an understanding of the essential job functions, because these may change from employer to employer, even if the job title is the same.

The psychiatrist should then try to determine if the evaluee can perform the essential functions of the job with or without accommodation. To return to the letter handler example, the psychiatrist would attempt to learn whether the post office employee could sort mail efficiently and correctly if accommodated by not being required to do an occasional overtime shift until 3 a.m.

The psychiatrist should seek to determine whether the person could perform the essential functions of the job if no psychiatric illness were present. Clearly, psychiatrists are not experts in the training needed for every type of employment and cannot be the final arbiters of whether individuals are qualified for the jobs they hold or seek. Information regarding this assessment should be obtained from both the employer and the worker. Most employers already have a clear opinion about whether an employee is trained to perform essential job functions and do not need psychiatric opinions to substantiate their assessments.

This area of evaluation is most relevant in a case in which the employee has misrepresented his or her training or has been promoted to a position that is beyond the level of training. Generally, in these cases the individual has demonstrated poor work performance that predates a claim of psychiatric disability, though he or she asserts that the poor performance was due to a psychiatric disability. If the employee does not have the necessary training for the job position, even if he or she is defined as disabled under the ADA, the ADA does not entitle the employee to keep the job.

An individual who is considered disabled under the ADA and meets the criteria for maintaining the job may still be discharged if he or she presents a direct threat to self or others. The ADA considers the term direct threat to mean a substantial risk to the safety of the individual or others that cannot be eliminated without accommodation. Generally, a perception by another employee or supervisor that an individual is dangerous is not adequate for an individual to be considered a direct threat. Recent violent behavior or a plan to commit violence is evidence of direct threat under the ADA.

Psychiatric ADA evaluations that involve the presence of danger and direct threat require additional attention to risk factors for violence and violent behavior. In these cases, collateral information provided by the employer about the employee's threatening behavior in the workplace is essential. The psychiatrist should consider the duration of the risk and the severity, imminence, and likelihood of potential harm.

4. Assessment of Reasonable Accommodation

The mental health professional performing an ADA evaluation is often asked to comment on accommodations that an employee needs to perform a job or essential job functions. The ADA regulations define reasonable accommodations as "modifications or adjustments" to the work environment, to the way a position is performed, or that allow a disabled employee "to enjoy equal benefits and privileges of employment" when compared with nondisabled employees.[113]

Suggesting 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[114] that involve improved communication, schedule changes, or changes in the physical environment. When accommodations are more complicated, the psychiatrist can make a recommendation to involve a job coach or mental health rehabilitator. These professionals identify problems and provide possible solutions, generally after a visit to the workplace.

Under the ADA, although employers are required to provide reasonable accommodations, they are not required to provide accommodations that cause undue hardship, including those that are expensive, difficult, or disruptive. A difference of opinion between employee and employer on whether specific accommodations are reasonable, like other potentially disputed elements of ADA interactions, may become the subject of litigation.

Based on case law, reasonable accommodations for persons with mental disabilities have included job restructuring, part-time or modified work schedules, acquiring or modifying equipment, changing test or training materials, reassignment to a vacant position, or unpaid leave. Other suggestions that may enable a psychiatrically disabled individual to retain employment have not been considered reasonable. For example, an employer usually is not obligated under the ADA to create a day-shift-only position for an employee with a disability that precludes working on a schedule of rotating shifts.[106]

The psychiatrist should make any suggestions regarding accommodations that may assist in maintaining the evaluee's employment without regard to the legal arguments that might accompany them. The psychiatrist is not in a position to determine whether a suggested accommodation would be considered reasonable or an undue hardship for an employer. He or she should be aware, nevertheless, that an employer is more likely to implement suggestions for reasonably simple, inexpensive accommodations than those for more complex accommodations, especially when the suggestions are based on clinical judgment regarding the symptoms and severity of the employee's disorder and are informed by an understanding of the individual's work situation. The psychiatrist should therefore strive to provide simple suggestions when possible. Whether such accommodations are implemented is up to the employer, or, if a case goes to litigation, the court.

5. Key Points in Conducting ADA Evaluations

Determine whether the employee meets criteria for a recognized psychiatric disorder.

Assess for substantial impairment of major life activities related to the disorder.

Determine the duration of impairment of major life activities.

Include in the disability evaluation report all of the major life activities that are impaired and the duration of the impairment of each activity.

Be familiar with the essential functions and training necessary for the employee's job.

Assess the employee's capacity related to essential and nonessential job functions.

Assess whether the employee can perform these functions with or without accommodations.

Suggest accommodations that may enable the employee to perform essential job functions for which he or she is qualified.

Assess whether the employee poses a direct threat of danger to self or others.

B. General Evaluations of Fitness for Duty

1. Referrals

Fitness-for-duty (FFD) examinations usually are requested by employers through employee assistance programs or through the company's human resources department. The referral occurs after an employee has displayed behavior that creates concerns that a psychiatric illness is present that will adversely affect the employee's job performance.

FFD referrals often involve the question of potential dangerousness to others, especially to the public or others in the workplace. For example, a schoolteacher who appears depressed may be referred because of angry and inappropriate outbursts in the classroom. A police officer may be referred after demonstrating excessive irritability while on duty or following the officer's involvement in an off-duty disturbance that creates concern about mental stability, even if the episode did not lead to the officer's arrest.

Thus, referrals for FFD evaluations frequently arise in the context of crisis for both employer and employee. Consequently, the referral source often asks the psychiatrist to complete an FFD assessment quickly, on an urgent or even emergent basis. Both the employee and the referral source feel pressure to

complete an FFD evaluation as quickly as possible. The potential evaluee may be suspended or placed on administrative leave and at risk of losing the job pending the outcome of the FFD evaluation. The employer often finds 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 assume the employee's responsibilities and may cause disruptions of normal workplace activity or productivity.

Nevertheless, psychiatrists should approach requests for expedited FFD evaluations cautiously. These assessments generally cannot be completed in less than one week for a variety of reasons, including the complexity of the factors involved, the time necessary to obtain collateral data, and the need to have more than one interview with the employee. In addition, FFD examinations often involve questions of safety for the psychiatrist that are related to the employee's degree of anxiety and distress, another reason that conducting these examinations within a constricted timeframe is inadvisable.

The psychiatrist should therefore carefully evaluate the appropriateness of the FFD evaluation referral. Since it may arise in the context of a mental health or employment crisis, the psychiatrist should make a triage determination regarding the most appropriate intervention. The employee may need an emergency clinical assessment, often conducted in a psychiatric emergency room for safety purposes. Such interventions should take place before beginning the FFD evaluation itself. The question of fitness for duty can be revisited and rescheduled if still indicated following completion of an urgent clinical assessment for treatment purposes.

The psychiatrist should obtain a significant amount of information at the time of referral to determine whether the FFD referral is appropriate and timely, including:

> Detailed information concerning the reason for the referral, which may include the nature of the behavior that led to the referral and documentation from supervisors, coworkers, and customers concerning the behavior. Interviewing the employee's supervisor before interviewing the evaluee often helps to clarify the events that led to the referral and can help the psychiatrist formulate areas for inquiry during interviews with the employee.
>
> The employee's job description.
>
> Copies of job performance evaluations.
>
> Copies of relevant medical/psychiatric records. (The evaluee is often responsible for supplying these records.)
>
> Current job status—that is, whether the employee is on medical or administrative leave or is suspended, working, or in danger of being terminated.
>
> The employee's reaction to being referred for the FFD examination.[74]

The matter of confidentiality is particularly relevant because of the relationship between FFD examinations and the workplace. For example, it is often unnecessary for FFD reports to describe an evaluee's background (e.g., family and social histories) except to the extent that such information is directly related to the specific referral questions. In addition, an agreement should be reached regarding the nature of the report that will be generated and who will have access to the report. The psychiatrist, the referral source, and the evaluee should understand this agreement and the limitations of confidentiality before the examination.

The psychiatrist should request a written document from the referral source specifically stating the questions that should be addressed. Obtaining the questions in writing will help minimize miscommunication between the referral source and the psychiatrist. These questions often involve concerns related to work limitations, suggested modifications in work assignments, diagnosis, treatment, prognosis, and safety.

2. Forced FFD Evaluations

FFD evaluations lend themselves to misuse by employers, as noted previously in the discussion regarding ethics (Section IIB4). In the context of a workplace conflict, an employer may try to discredit or even terminate an employee by raising the question of mental instability. During such conflicts, an employee who poses problems for reasons other than mental health may be referred for forced FFD evaluations. The psychiatrist should therefore be alert for possible misuse of the FFD evaluation process[40,41] and should decline to undertake evaluations when it appears that psychiatric expertise is being used for

reasons other than obtaining an accurate opinion about an employee's functioning.

3. Key Points in Conducting FFD Evaluations

Assess the appropriateness of the evaluation at the time of the referral. If it appears that a clinical evaluation for treatment should precede an FFD evaluation, the psychiatrist should so advise the referral source.

Ask the referral source to provide specific, written questions for the evaluation.

Before interviewing the employee, obtain information about relevant behavior and conflicts in the workplace.

Advise the employee of the evaluation and limits of confidentiality before conducting the interview.

Carefully evaluate any differences or omissions between the employee's report of events and reports from the referral source.

Perform a standard psychiatric examination with a focus on the evaluee's ability to perform relevant work functions as explained in the job description and on other relevant referral questions. Obtain psychological testing if clinical information indicates a need for such data for the psychiatrist to reach or support a conclusion.

Limit reports to information relevant to the referral.

C. Evaluations of Fitness for Duty for Physicians and Police Officers

Performance of certain occupations may involve public safety concerns. Individuals in these occupations therefore are often subject to special scrutiny if they display poor judgment, signs of cognitive impairment, or disruptive behavior. The following sections cover FFD evaluations specific to two such groups: physicians and public safety 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 pose a risk to the public. Other types of workers, including bus drivers, truck drivers, chemical plant employees, and other persons who operate heavy machinery have unique safety-related responsibilities that may lead to their undergoing FFD evaluations.

Nevertheless, physicians and individuals whose duties involve carrying firearms have a low threshold for referral when possible psychiatric impairment occurs. Some procedures for evaluating these groups apply to persons in other occupations when possible psychiatric impairment generates concerns about public safety.

1. Evaluations of Fitness for Duty of Physicians

a. Agency Referrals. A formal, independent psychiatric examination may be requested when a physician's behavior raises questions of fitness to practice. Usually, the observations and concerns about the physician's conduct have been reported to an agency responsible for oversight of physicians such as a hospital administrative board, a hospital physician health committee, a state physician health committee, or a state licensing board. Any of these agencies may intervene and order a physician to undergo an assessment.[19,115–117] A request for an IME may also originate from the physician or from an attorney representing a defendant physician.

The psychiatrist is asked to perform a comprehensive evaluation of the physician and provide a full report of the findings. The psychiatrist who conducts a physician FFD evaluation should consider how a psychiatric condition, a medical condition, or a medication side effect might affect the evaluee's ability to practice. The psychiatrist is also asked to offer opinions about past professional conduct, current health, and future capacity to function safely as a physician and is likely to be asked for recommendations about treatment and professional supervision or oversight, if indicated.[19,115]

Physicians are often referred for evaluation when there is a suspicion of impairment, even absent any known direct harm to a patient. Justifying the need for such referrals is the AMA's position that, when a physician's health or wellness is compromised, the safety and effectiveness of medical care may also be compromised.[118] The AMA defines physician impairment as "the inability to practice medicine with reasonable skill and safety as a result of illness or injury."[118] The definition encompasses impairment due to psychiatric disorder, substance use, dementia, or other disorders.

Physician FFD evaluators are also frequently requested to assess troublesome or disruptive behav-

ior.[115,119] The AMA defines disruptive behavior as "[c]onduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care,"[120] including but 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 pages within a health care institution).[121] Physicians may also be referred for evaluation because of accusations of sexual harassment, arrest for a felony, and boundary violations.[19,115] Disruptive or illegal behavior may not be due to an Axis I disorder, but could reflect longstanding problematic personality traits or a personality disorder.[19,115,121]

The ability to practice safely may be compromised by factors unrelated to psychiatric impairment, such as deficient knowledge, skill, or experience. The task of assessing a physician's competence in a specialty is outside the scope of FFD evaluations.[19] If a psychiatrist suspects that incompetence is a factor in impaired performance, the physician should be referred elsewhere for assessment. In such cases, a state medical society's physician competency committee can act as a resource. The psychiatrist should consider noting in the report that the expressed opinions are limited to assessment of the relevant psychiatric factors.[115]

All referral sources ask for an opinion about the fitness to practice medicine.[117] However, more specific questions are generated by the focus, mission, concerns, or agendas of referring agencies. For example, when a hospital department, group practice, or administrative board refers a physician for assessment, it 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.[115]

Psychiatrists who provide physician FFD evaluations should be familiar with the objectives of each of the agencies that monitor physician conduct, since these are typically sources of physician FFD referrals. These agencies include: hospital-based physician health committees,[122,123] state physician health programs that operate independently of the state medical licensing board and are not involved in the disciplinary process, and state medical licensing boards.[19,115]

Physician health programs at both the state and hospital level in addition to their primary interest in the physician's health are also concerned with the preservation, if possible, of a physician's ability to practice safely. Their referral questions center on the identification of psychiatric disorders that affect the physician's ability to practice. In addition to Axis I and II disorders, a physician health committee is concerned about personality traits or stressors (e.g., divorce or other personal or family problem) that may help to explain the reported misconduct.[19,115]

Physician health committees often ask for opinions that go beyond diagnosis of a psychiatric disorder. If a treatable disorder is identified, the committee asks for suggestions for treatment and monitoring compliance. The psychiatrist is asked for opinions about the need for oversight in the work environment. If the psychiatrist believes that the physician cannot continue to work safely, the committee will inquire about a strategy for rehabilitation. Many physician health programs have a standard contract that is modified based on the psychiatrist'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.[115]

In contrast to physician health committees, the state medical licensing boards are primarily concerned with protecting the public, and the referral questions generated by the boards reflect this mandate. State boards have the authority to order FFD evaluations in a variety of circumstances in which they consider the public to be at risk. During the licensing process, a physician may disclose information that raises questions about current fitness or the 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 of such evalua-

tions are generally borne by the physician rather than the state.

The results of the FFD evaluation can affect a board's licensure decision. Many physicians do not realize that a license to practice medicine is a privilege that is regulated.[19,115] A license can be suspended or revoked as the result of an administrative hearing. Although there are provisions for appeals to civil court, state medical licensing boards are afforded wide authority and discretion to protect the public. They provide defendant physicians with certain legal rights, such as the right to cross-examine witnesses and present evidence. However, the protections available to defendant physicians are substantially narrower than those afforded to criminal defendants.[115]

The medical licensing board may decide to divert the physician to the state physician health committee. The 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.[116,124]

b. Important Aspects. The APA has developed a Resource Document containing 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 violation of professional boundaries, a detailed sexual history should be obtained.

The psychiatrist should offer opinions about the presence of a mental illness and the extent, if any, to which the mental illness has interfered with the physician's ability to practice with skill and safety in the specific work setting. The psychiatrist should provide a description of how the mental illness affects job-related capacities and thus fitness for duty.[19] 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 usually necessitate an assessment of short- and long-term risk and suggestions for risk management and mitigation.

The administration of a full neuropsychological battery should be considered when there is suspicion of cognitive impairment. Some psychiatrists use a screening neuropsychological examination that includes tests of executive functioning, to detect more subtle impairment. When there is suspicion of a substance use disorder, appropriate testing can be obtained by the referring agency.[19] If indicated, the physician should be referred for a medical evaluation and for laboratory and imaging tests.

The psychiatrist should provide recommendations for treatment, including specifications about the type and frequency of treatment. He or she will be expected to provide, if appropriate, concrete suggestions for monitoring and supervision of the physician in the workplace. Such suggestions may include regular reports from treatment providers or random urine screening of a substance user. These suggestions may be incorporated into the provisions of a consent decree or a monitoring contract.[115]

Boards often ask for guidance in understanding the risk of relapse and request strategies for decreasing the risk. When requested, the psychiatrist should provide guidance on how to identify early signs of relapse. An understanding of the physician's long-term vulnerabilities will help supervisors to intervene promptly when necessary. The psychiatrist may suggest specific administrative and therapeutic steps that the workplace monitors can take in the event of a relapse.[115]

Opinions should be well supported by data, and the foundation of the opinions should be discussed in detail in the report. For example, the psychiatrist may conclude that an evaluee has no major psychiatric disorder but has become impaired and unable to practice safely in response to a severe stressor.[19] The stressor should be described in the report along with recommendations for treatment and oversight. The psychiatrist should also comment about the individual's customary interpersonal style.[115,119] The physician's conscious awareness of his or her psychological status and behavioral demeanor is an important consideration as the agency develops an oversight plan.[115]

In contrast to other types of FFD reports, which, as noted, should be limited to the specific work-related function and impairment, a physician's FFD evaluation report should be comprehensive. The state medical licensing board generally expects a full report that allows independent evaluation of the psychiatrist's opinion. The APA guidelines recommend that sensitive personal information be omitted or summarized in a report for the medical licensing board only if such information does not bear directly on the referral concerns.[19]

Before conducting an evaluation, the psychiatrist may want to consider clarifying with the referral source the degree of personal information to be disclosed to avoid problems that may be caused by withholding information. The withholding of information may raise concerns that the report is biased toward the evaluee, particularly if the report is favorable.[19] However, it may be appropriate to withhold personal information in reports submitted to practice groups, hospitals, or HMOs because the recipients of the report may personally know or have conflicts of interest with the physician. If the information is withheld, the report should document that the sensitive information (personal, medical, or social) was obtained and that a more detailed report can be provided on request.[19]

c. Key Points in Conducting Evaluations of Fitness for Duty of Physicians:

Obtain detailed information relevant to contradictions and omissions between the evaluee's version of events and the versions of collateral sources. Detail may include an extensive employment history, history of complaints or malpractice suits, and a sexual history.

Assess cognitive capacity, utilizing, if indicated, a full neuropsychological battery, medical evaluation, laboratory and image testing, and appropriate substance use testing.

Provide a comprehensive report, but consider and if possible clarify before the evaluation the degree to which personal information should be revealed. Assess whether the referral context suggests that a limited report may be more appropriate.

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 a recurrence of psychiatric illness or relapse of substance use.

Provide recommendations for treatment including provisions for type and frequency of treatment, means for monitoring compliance, and concrete suggestions for oversight and supervision of the evaluee in the workplace.

2. Evaluations of Fitness for Duty of Law Enforcement Officers

Evaluation of the fitness for duty of a law enforcement officer is requested when the officer exhibits behavior that calls into question his or her ability to perform the essential duties of the job safely and effectively.[40,41] Public safety concerns generally center on the officer's ability to handle firearms safely. This Guideline is not intended to cover every possible scenario in relation to such concerns, and common sense should be used within the parameters of the Guideline.

The psychiatrist will be asked to perform a thorough psychiatric evaluation, to provide an opinion about fitness for duty, and to assess whether the officer poses a risk to self, the department, or the public.[40] To formulate opinions about these matters, the psychiatrist must know about the demands of police work and the specific responsibilities of the officer undergoing evaluation.[40,125]

a. Agency Referrals. The actual referral process for FFD evaluations is frequently subject to agency guidelines and the provisions of union contracts. The model policy recommended by the California Peace Officers Association[126] 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."[127]

A law enforcement agency may order an IME if it is job-related and consistent with business necessity. The departmental policy often lists behaviors that suggest that the person's ability to perform the essential functions of an armed peace officer may be compromised. Thus, a referral for an FFD evaluation includes descriptions of recent problematic behavior and specific concerns about job performance.[40]

Usually supervisors, fellow officers, or civilians in the community have observed and reported the unusual behavior.[40] The model policy of the California Peace Officer's Association recommends that supervisors be alert for evidence that an individual may not be psychologically fit, especially when there has been a sudden or dramatic change in the officer's behavior. The policy supplies numerous indicators of possible impairment that may adversely affect job performance, including the use of unnecessary or excessive force, inappropriate verbal or behavioral conduct indicating problems with impulse control, abrupt and negative changes in conduct, and a variety of psychiatric symptoms, such as irrational speech or conduct, delusions, hallucinations, and suicidal statements or behaviors.[127]

Some departments require that an officer see a mental health professional after involvement in a critical incident, which is defined as any event that has a stressful effect sufficient to overwhelm the usually effective coping skills of the officer. Such incidents include shooting in the line of duty; a death, particularly of a child; suicide or serious injury of coworkers; homicides; and hostage situations.[128,129] An officer exposed to a critical incident may resign or retire prematurely or his or her behavior may result in disciplinary problems. The officer may experience burn out, stress-related illnesses, post-traumatic stress disorder, or a substance use disorder.[130] If an intervention is unsuccessful, an FFD examination may be ordered.

In addition, departments have concerns that after exposure to a critical incident, an officer may have difficulty judging the level of response that would be appropriate in a future threatening situation unless an intervention is made. Overreacting could lead to inappropriate use of force. Hesitating or failing to use the necessary degree of intervention in critical situations could place officers and the public at risk.[35,36,121] However, as noted earlier in the Guideline, the psychiatrist should be alert for circumstances that raise suspicions of misuse of the FFD evaluation process.[40,41]

b. Important Aspects. Before beginning the assessment, the psychiatrist should understand the referral questions, know who will receive the report, and clarify the nature of the information and opinions that the report will disclose. These matters vary from referral to referral and may change depending on the referral questions, agency policies and procedures, and provisions of the union and/or employment contract.

The law enforcement agency should provide written documentation concerning the agency's response to the officer's questionable behavior, including efforts, if any, at remediation. Remediation may consist of meeting to discuss the behavior, supervision, further training opportunities, mentoring by another officer, or reassignment to other duties. The history of referral to an employee assistance program (EAP) and/or treatment and disciplinary action taken or pending regarding the current situation should also be provided to the psychiatrist.[41,126]

The psychiatrist should also review medical and treatment records before beginning the interview and should have access to available written documents concerning job performance, including evaluations, complete disciplinary records, awards and commendations, complaints and suits initiated by the general public, testimonials, and previous periods of impairment and disability.[126] The agency should 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). It is helpful to have a detailed job description listing the officer's specific responsibilities. The psychiatrist should become familiar with the accommodations and work modifications (such as light duty or restricted duty) that may be available to the officer.

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

Interviews with collateral sources are an integral part of the assessment. The evaluee should be encouraged to identify individuals who have knowledge about the events that precipitated the evaluation. Input from others is especially important in cases in which the officer denies misconduct and maintains that the evaluation has arisen because of conflicts with supervisors or is retaliatory. Information may be obtained from supervisors who can provide further context for understanding the unusual conduct. The psychiatrist often can learn from col-

lateral 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.[126]

Other sources of collateral information may also prove helpful. Prior or current treatment providers can add information about response to treatment, treatment compliance, and the role, if any, of substance use.[41,130] Family members can often provide observations about the officer's level of functioning. Their statements are especially important in the evaluation of an officer who may be suicidal. The psychiatrist should also record in the report any information that has been requested but withheld and offer a disclaimer stating that opinions offered are limited by the refusal.[126]

The psychiatrist should explore in detail any discrepancies between the evaluee's description of events and the versions of collateral sources. In addition to the standard elements of a comprehensive psychiatric evaluation, the examination should include questions about any recent or past stressors, such as exposure to critical incidents.[40,41] The administration of a neuropsychological battery should be considered when there is suspicion of cognitive impairment. Psychological testing may be helpful in the overall assessment. When indicated, the individual 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 testing, if allowed by law and by contract, may be useful.

If an officer is not fit for duty, the department may request an opinion about whether the impairment is the direct result of a job-related injury. The psychiatrist should understand the implications of such circumstances, which may go beyond those of the typical FFD evaluation. An opinion that an impairment is the direct result of a job-related injury may have a bearing on the officer's employment status with and financial compensation from the agency. In addition, if the officer has a pending lawsuit, arbitration, or grievance, information obtained from the evaluation could be included in discovery.[126]

c. Fitness for Duty and Access to Firearms. When assessing the fitness for duty of an officer who carries a firearm, the psychiatrist usually must state whether there are contraindications to the officer's continuing to have access to a weapon. An officer who carries a firearm must be able to make on-the-spot, life-and-death decisions. With regard to the proper use of firearms, the psychiatrist should take into account not only the effects of the mental illness but also the potential side effects of treatment.[41,130] The psychiatrist should consider whether psychiatric illness, medical illness, or the effects of medication may have effects on the officer's judgment, reaction time, memory, and fine motor skills.[130]

The risks of suicide and homicide should be carefully assessed, given the officer's ready access to a firearm. One study found that 55 percent of officers undergoing FFD examinations admitted to previous suicide attempts.[131] The question of whether officers have a higher risk of suicide than the general population remains controversial. However, it is clear that most officers who attempt or commit suicide use a firearm to do so.[132,133] When a high-risk situation has been identified, weapon removal and referral for emergency psychiatric assessment may be indicated. A 30- to 60-day period before considering restoring the officer's access to a firearm has been recommended to ensure that the precipitating and risk factors have been successfully managed.[134]

State and federal statutes, agency procedures, and the employment contract may dictate the extent of information and opinions that the FFD report can contain. The International Association of Police Chiefs Police Psychological Services Section recommends that unless otherwise prohibited, the psychiatrist 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 basis for the estimate.[126]

The psychiatrist could find that the evaluee is fit for duty and able to return to work without restriction or that the officer is unfit with little likelihood of remediation. An examination could reveal that the individual is temporarily unfit for duty, but that there is a good possibility of resolution with treatment. The psychiatrist may believe that the officer's return to work should be conditional on undergoing treatment. In such a case, the psychiatrist may suggest specific treatment modalities and provide indicators of improvement and treatment compliance. The psychiatrist may find that the misconduct is not related to an Axis I disorder, but is a reflection of a personality disorder. At times, a lack of cooperation by the evaluee may leave the psychiatrist unable to

provide an opinion about fitness for duty. The agency may then decide to take disciplinary or administration action.[40]

In some cases, an officer who has undergone evaluation can return to work with accommodations or modification of duties.[40] Recommendations may include reassignment to light duty, part-time employment, mentoring, or retraining.[126] The creation of a light-duty position as a form of reasonable accommodation is a function of managerial discretion.[135] Although the psychiatrist can make recommendations about accommodations and restrictions, the agency must determine whether the recommendations are reasonable.[126]

d. Key Points in Conducting Evaluations of Fitness for Duty of Law Enforcement Officers:

Become familiar with the context and limitations of the law enforcement FFD referral as provided by the source. Evaluations may be limited by contract or union agreement.

Obtain sufficient history and collateral information to make a critical assessment of dangerousness to self or others and to determine whether the results indicate restriction of access to firearms.

If requested, offer opinions about treatment, specific workplace monitoring, and access to firearms.

Know the options for accommodation, including recommendations for light duty, supervision, and monitoring. Make specific recommendations if requested.

D. Evaluations for Return to Work

The return-to-work evaluation is similar to the fitness-for-duty evaluation, except that the former usually occurs after completion of an employment-related process. This process often involves a psychiatric FFD or disability examination that led to the decision that the employee not be allowed to return to work or that he or she work at a modified job. During the time that the employee was not working or was working at a modified job, he or she may have undertaken or completed treatment that has provided enough stabilization or symptom resolution to allow resumption of workplace responsibilities.

1. Important Aspects

The psychiatrist should focus return-to-work evaluations on whether the impairment that led to leaving work or changing job responsibilities has been remedied. Presumably, an employee undergoing a return-to-work evaluation desires to re-enter the workplace. If the work-related impairments that led to withdrawal from the workplace are unchanged, it is unlikely that the return will be successful. However, if the impairment is no longer present, the psychiatrist should recommend that the employee return without restriction, or with appropriate short-term or long-term accommodations.

Opinions regarding the ability to return to work should clearly reflect an understanding of the original reason that led to withdrawal from or modification of the employee's job and a detailed description of what has changed. The psychiatrist should review documents relevant to the administrative decision to grant disability or leave. The referral source should provide written documentation concerning the decision. The psychiatrist should examine the documentation, the length of time absent from work, and activities engaged in since leaving the job.

The psychiatrist should also review medical and mental health records, especially those generated during the period when the employee was unable to work. The records should include the treatment process, response to treatment, current treatment if any, and current mental and functional status. If impairments have not resolved to the extent that a full return to work is possible, the psychiatrist should provide recommendations regarding treatment or accommodation that may facilitate the process.

2. Key Points in Conducting Evaluations for Return to Work

Establish a clear understanding of the reasons for the initial withdrawal from the workplace or change in responsibilities through documentation and a standard psychiatric interview.

Base opinions concerning the ability to return to work on documented changes in psychiatric symptoms or levels of impairment.

Specifically address the problems that resulted in the change in employment status with concrete data and examples.

If requested, provide suggestions for continued treatment, workplace monitoring, and other

ways to ensure adequate functioning and prevention of relapse of mental illness.

VI. Conclusions

This Guideline represents a consensus about best practices in conducting disability and other work-related evaluations. It is provided to assist psychiatrists in the challenging task of meeting the needs of the systems that call on them to help resolve difficult situations that arise in the workplace. The Guideline may be read by attorneys and judges and, like other published professional guidelines, may be used in legal arenas to challenge experts or to try to establish standards of care. It has not been formulated for these legal uses or purposes.

Practice Guidelines, although useful for the reasons reviewed earlier, are not considered binding. They vary in both usefulness and applicability on a case-by-case basis. In addition, even with the use of Practice Guidelines, experts can and will 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 Guideline is to help psychiatrists who provide various types of disability evaluations to formulate well-reasoned opinions that represent honest assessments of the available information.

Appendix I

Table A1 Summary of Types of Disability Evaluations, Similarities and Differences

	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

Appendix II: Additional Information Regarding HIPAA and Employment Evaluations

For additional information regarding HIPAA and third party evaluations, see the following web sites:

1. Social Security disability evaluations: http://www.ssa.gov/disability/professionals/hipaa-cefactsheet.htm/.
2. The official HHS information source for the HIPAA Privacy Rule is www.hhs.gov/ocr/hipaa/. It provides links to other HIPAA information, including HHS December 2003 guidance—an easy-to-read discussion of some of the key concerns.
3. The American Medical Association (AMA) also provides useful HIPAA information at www.ama-assn.org/ama/pub/category/4234.html/.

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