Evaluating Mental Health Disability in the Workplace

Liza H. Gold · Daniel W. Shuman

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Model, Process, and Analysis

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We dedicate this book to our friend and mentor, Robert I. Simon, MD.

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Introduction

To earn one's bread by the sweat of one's brow has always been the lot of mankind. At least, ever since Eden's slothful couple was served with an eviction notice. . . . No matter how demeaning the task, no matter how it dulls the sense and breaks the spirit, one *must* work. Or else (Studs Terkel: *Working: People Talk about What They do All Day and How They Feel about What They Do*, 1972, p. xii).

Workplace Conflict and Crisis

Studs Terkel, in his homage to workers and their work, teaches us that work is not a choice but an imperative. When personal, medical, or social problems threaten an individual's ability to function in the workplace, serious problems arise. These problems often result in an escalating series of crises, which can take over the individual's life, leading to disability, job loss, loss of relationships, career loss or change, conflict, litigation, and financial ruin. When the causes or consequences of these problems are psychiatric disorders, mental health professionals are asked to provide clinical treatment as well as evaluation of and guidance in managing issues relating to disability and the ability to work.

People have complicated relationships with their work, whether they are 9–5 blue-collar workers or 24/7 professionals. As one group of psychiatrists observed:

> At least one third of our lives is spent at work. It is the cause and cure of many of our ills. We feel loved through the admiration our work earns. We are empty and dejected when work fails. Goals we work toward define us; without them we lack purpose and direction. We discharge aggression when we attack our tasks, and our successes protect us from the debilitating stress of frustrated ambition. We feel masterful and strong in achievement, weak and impotent in failure. We earn our place in civilization through our work. We reduce guilt through hard labor and defy time with accomplishment. Work organizations structure our lives and, for many of us, the people we love, hate, fear, and need comes as importantly from our offices, factories, and shops as from our families and communities (Committee on Psychiatry in Industry 1994, p. xi).

Interpersonal relationships are widely recognized to encompass complicated and powerful psychological dynamics, requiring specialized training and expertise. Less attention has been paid to the dynamics of people's relationship with work. It appears axiomatic that people need to work to make money and ensure that basic material needs are met. On closer scrutiny, it quickly becomes evident that there is more to work than making money. People work to achieve psychological, emotional, and social satisfaction, and often work even if fortunate enough to be able to meet financial needs without working.

The price to be paid for underestimating the complexity of troubled relationships between people and their work can be catastrophic. The emotional fallout resulting from problems in the workplace can be as severe as those of disintegrating marriages or other important personal relationships. Psychiatric disorders that wax and wane due to their chronic or episodic nature may result in work impairments. During periods of relative stability, many individual may function without impairment or be only mildly impaired, even if they are experiencing symptoms. During acute exacerbations, individuals may develop symptoms that significantly impair their work function. Workplace problems may themselves result in the onset or exacerbation of psychiatric disorders. The overwhelming personal, social, and economic costs associated with these problems can include behavioral and interpersonal work conflicts, voluntary or involuntary withdrawal from the workplace, claims for disability, requests for accommodations, extended and expensive litigation, and sometimes, tragically, even workplace violence and death.

The Extent and Cost of Mental Health Disorders in the Workplace

Statistics relating to workplace psychiatric illness claims underline just how commonly psychiatric disorders and their associated problems burden individuals, employers, and society as a whole. Large numbers of individuals either enter the workplace with preexisting psychiatric disorders or develop psychiatric disorders during the course of their working lives. Depending on the study reviewed, between 20 and 25% of adults of working age suffer from a diagnosable psychiatric disorder in any given year. The Surgeon General's Report on Mental Health (United States Department of Health and Human Services, 1999) estimated that about one in five Americans experiences a psychiatric disorder in a given year. The National Institute of Mental Health has estimated that 26.2% of Americans aged 18 and older, about one in four adults suffer from a diagnosable psychiatric disorder in a given year (National Institute of Mental Health, 2007). When applied to the 2004 United States Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people (National Institute of Mental Health, 2007).

Statistical analyses have also found that large numbers of individual with psychiatric illness are employed. One study found that of individuals with any psychiatric illness, 48–73% are employed; 32–61% of individuals with serious psychiatric illness are employed. Of all adults, 76–87% are employed (Jans, Stoddard, & Kraus, 2004). In 2005, an estimated 29% of individuals (or 2,185,000 people) between the ages of 21 and 64 who reported having a mental disability were employed (Cornell University Disability Statistics, 2005).

The monetary costs of psychiatric disorder and disability due to psychiatric disorder are staggering. Annual income in those with psychiatric illness who work is reduced due to psychiatric illness between $3500 and $6000 on an individual basis, and between $100 and $170 billion collectively every year (Marcotte & Wilcox-Gok, 2001). The first national estimate of lost earnings associated with mental disorders in the United States was $44.1 billion in 1985 (Rice, Kelman, Miller, & Dunmeyer, 1990). Costs of reduced or lost productivity in 1990 were estimated to total $78.5 billion, including both lost earnings and productivity (Jans et al., 2004). In 1992, this estimate was updated to a loss of $77 billion (Harwood et al., 2000). The most recent estimate, for the year 2002, is $193.2 billion. Of this, 75.4% was due to reduced earnings among mentally ill persons with any earnings and the remaining 24.6% was due to reduced probability of having any earnings (Kessler et al., 2008). Comparative cost of illness studies have demonstrated that the magnitude of this association is high in relation to most physical disorders.

Statistics measuring employment rates and disability are challenging to collect. Definitions and conceptualizations of disability vary in scope and severity between studies and data collection systems. In addition, there are multiple data sources, including broad epidemiological surveys, some of which are better than others. Nevertheless, the scope of problems associated with psychiatric disorders in the workplace is clear.

- In 1999, mental or emotional problems represented one of the top 10 causes of disability among adults in the United States, at a rate higher than disability caused by diabetes or stroke (Centers for Disease Control and Prevention, 2007).
- Of individuals with psychiatric disorders in any given year, 30% (or approximately 6.1 million) report some form of work disability (Jans et al., 1996).
- Psychiatric disorders are the leading cause of disability in the United States and Canada for individuals aged 15–44 (National Institutes of Mental Health, 2007).
- The World Health Organization reports that depression, a condition characterized by episodic exacerbations, 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 (Murray & Lopez, 1996).
- The National Health Survey Interview (1998–2000) found that for younger adults, aged 18–44, psychiatric illness was the second most frequently reported cause of activity limitation (10.4 per 1,000 people), exceeded only

by musculoskeletal conditions. For mid-life adults, 45–64 years, psychiatric illness ranked as the third most frequently mentioned cause of activity limitation (18.6 per 1,000) (Centers for Disease Control and Prevention, 2007).

The costs of disability benefits paid out by private and public agencies are another way to assess the prevalence and extent of mental health disability issues. In 2004, SSDI paid out $78.2 billion dollars in total claims benefits to approximately 6.2 million disabled workers (Social Security Administration, 2006). Psychiatric disorders that prevent substantial gainful employment are the leading reason that people receive SSDI, represent the largest single diagnostic category, are associated with the longest entitlement periods, and are the fastest growing segment of SSDI recipients. In 2003, 28% of SSDI recipients received payment based on a psychiatric disorder (not including mental retardation) (International Center for Disability Information, 2005; Jans et al., 2004; JHA, 2006).

Disability insurance is also available through workers' compensation programs and private insurers. National statistics regarding the number and cost of mental health-based disability claims in workers compensation programs are difficult to obtain. However, the amount of money involved in workers' compensation claims is substantial. In 1996, total benefit payments had reached $42.5 billion (Larson & Larson, 2000). Indications are that mental health-based claims also represent a significant percentage of those made to workers' compensation boards.

National statistics regarding the number and cost of mental health-based disability claims in private insurance programs are also difficult to obtain, as they are compiled by private companies and often not made public. In 2004, short-term disability (STD) benefits were available to 39% of workers, long-term disability (LTD) benefits were available to 30% of workers in private industry, and nearly all participated (United States Department of Labor, 2005a). One research and consulting firm that serves the disability industry reported that in 2004, 6% of new LTD claims and 4% of STD claims submitted were for psychiatric disorders (JHA, 2006). This firm noted that the average LTD and STD duration for psychiatric disorders represented the second longest averages of 99 days for STD and 28 months for LTD, exceeded only by average duration of disability for claims of fibromyalgia (JHA, 2006).

Costs of employment litigation associated with mental health claims, which often include claims of disability or impaired work capacity, are also impressive. Mental and emotional injuries constitute the bulk of exposure in most employment litigation (Lindemann & Kadue, 1992; McDonald & Kulick, 2001). The Equal Employment Opportunity Commission (EEOC) reported that approximately 95,000 charges of employment discrimination were filed in 2008 alone resulting in almost 300 million dollars of monetary benefits paid out through settlement, conciliations, or resolutions (United States Equal Employment Opportunity Commission, 2008). Social Security cases occupy a significant

portion of the federal appellate case load (Metzner & Buck, 2003). Statistics on other types of litigation may be impossible to calculate, but are clearly high. Many law firms specialize in and employ multiple lawyers to deal with the number of state and federal cases related to various types of employment litigation. The American Bar Association Labor and Employment Law Section reports a membership in excess of 22,000 attorneys (American Bar Association, 2008).

Disability and Disability-Related Mental Health Evaluations: The Need for Expertise

Disability and disability-related mental health evaluations require specialized knowledge, training, and experience, just as do evaluations of competency to stand trial or criminal responsibility. The purpose of disability and disability-related mental health evaluations is to provide an administrative or legal system with relevant and reliable information it can translate into concrete actions, such as accommodations, award of benefits, or modification of job responsibilities (Brodsky, 1987b). Mental health professionals who undertake these evaluations should be familiar with the employment context that generated the evaluation and the legal or administrative regulations that apply to that context.

Employers, third-party private or public agencies, or workers themselves may request disability and disability-related evaluations in order to meet the administrative requirements of the social and legal contracts that structure paid employment. The need for such evaluations can arise in the context of claims for short-term or long-term psychiatric disability benefits, disability claims under the Social Security Act, or workers' compensation claims. Mental health evaluations may also be requested when employees make requests for accommodations under the Americans with Disabilities Act (ADA) or when employers have questions regarding an employee's fitness for duty or ability to return to work after disability absence or medical leave.

Litigation that arises from employment conflict covers a wide array of employment issues and can also result in mental health assessments. Claims against employers can be made under federal laws and regulations such as the ADA, the Occupational Safety and Health Act, the Equal Employment Opportunity Commission, public or private disability, workers' compensation, or torts such as premises liability, negligence, wrongful termination, negligent, or intentional infliction of emotional distress. Claims of psychiatric illness, disability, or injury in such cases often precipitate an attorney's request for a mental health evaluation to assist in proving causation, entitlement to benefits, or damages.

Providing thorough and competent evaluations based on standardized guidelines is critical to adjudication of such claims, not least because claims for benefits, damages, or entitlements based on mental or emotional problems

often elicit skepticism from observers. Judicial and administrative compensation systems have historically been and often remain hostile to claims of injury and disability due to psychiatric disorder. Reviewers, administrators, and the legal system often subject evaluations of psychiatric disorders to heightened scrutiny. For example, employers typically offer more limited coverage and benefits and voice greater suspicion about malingering when employees claim disability due to psychiatric illness. The legal system initially expressed its doubts by denying compensation in the absence of physical impact and more recently by imposing damage caps on intangible losses such as emotional damage.

Concerns regarding manipulation and abuse are epitomized by claims of work-related stress disorders. In the employment arena, concerns regarding the reality of disability and disability-related claims based on stress frequently lead to referrals for mental health evaluation (Bonnie, 1997b). Patients, employers, insurers, administrators, and attorneys believe mental health professionals have the necessary knowledge and experience to answer questions regarding the credibility of employment claims of disability, causation of injury, restrictions, limitations, and return-to-work potential.

Mental health professionals become involved in disability and disability-related evaluations when a problem related to psychiatric illness is claimed or identified and some employment action needs to be taken. Most psychiatrists and psychologists can report some experience with requests for disability evaluations or for documentation for employment purposes. Many clinicians fill out paperwork for their patients to obtain medical leave, disability, accommodations, or provide opinions regarding impairment or ability to function in the workplace. Indeed, some evaluations require treating clinicians to provide assessment and are straightforward enough to present no challenge beyond that addressed by general clinical training.

However, general clinical training does not encompass the education or experience needed to perform competent disability and disability-related evaluations in more complex situations involving crisis or conflict. Evaluations relating to fitness for duty or the ADA, for example, can be well outside a general clinician's expertise. Even relatively straightforward disability claims can result in litigation, drawing unsuspecting clinicians into court to defend diagnosis, treatment, and opinions on disability.

General clinicians without experience in medico-legal evaluations will as a matter of course refer mental health evaluations of individuals for criminal issues, such as competency to stand trial or criminal responsibility to a forensic specialist, even if the evaluee is the clinician's own patient. Yet, clinicians often will not hesitate to offer an opinion that an individual is fit for duty despite workplace problems or is disabled due to psychiatric illness and needs to withdraw from the workplace, unaware that such opinions might draw them into a complex labyrinth of legal and administrative adjudication that can sometimes rival that of criminal matters.

The difficulties and ambiguities that arise at the interface of psychiatry and psychology and the legal system have been extensively discussed (Appelbaum, 1997; Mossman, 1994; Stone, 1984). These challenges take on another dimension of complexity when mental health fields interact with the world of paid employment and the different bodies of law in the administrative and judicial systems charged with administering employment benefits and resolving employment conflicts. The law governing the employment relationship in the United States has undergone rapid change in recent years, and employment conflict and litigation covers complex legal, statutory, and administrative arenas. Even experienced forensic clinicians often find the integration of these disparate worlds challenging.

The medical model of disability conceptualizes disability as a problem whose locus resides in an individual. In this model, disability is assumed to be caused by disease, trauma, or some other health condition. A competing model, the social model of disability, posits that the cause of disability does not arise from within individuals alone but results from a combination of an environment that fails to accommodate persons with disabilities and negative attitudes toward individuals with disabilities.

For more than two decades, institutions concerned with disability have struggled to integrate these two models (Iezzoni & Freedman, 2008). This has resulted in varied definitions and roles for physicians in the assessment of disability. For example, Social Security disability programs are based almost exclusively on the medical model of disability, and in Social Security evaluations, the role of physicians is central. The role of physicians in the social model of disability, best typified perhaps in ADA evaluations, is less clear. Although physicians' expertise is required in assessing aspects of disability in the social model, medical education and training generally does not confer expertise in issues such as the evaluation of work environments and whether accommodations are reasonable.

The popularity of the medical model of disability has waxed and waned but seems to have outlasted the competition, assuring that physicians, and in the case of psychiatric disorders, psychiatrists and psychologists, will continue to be asked to provide opinions regarding these complex workplace problems. Therefore, mental health professionals providing disability and disability-related assessments need to understand both the definitions associated with disability and other work ability-related evaluations, as well as their own roles in these evaluations, regardless of the model or combination of models being utilized.

Formulating competent opinions regarding issues relating to disability and employment problems may appear to be matters of common sense or logical extensions of clinical practice. Unfortunately, in many situations, such is not the case. General clinicians often believe they know what is needed for the capacity to work, if only by virtue of experience. Everyone knows people who work. In contrast, not everyone knows someone who has been accused of a crime. Most clinicians typically do not assume they understand how to assess mental states in questions of criminal responsibility or competency to stand

trial. Nevertheless, common sense and personal experience are often not enough to address sometimes the complex concepts and problems relating to disability and associated employment issues.

Despite the central role of work in peoples' lives, relatively little clinical training has centered on this aspect of functioning and the problems that may occur. Few mental health professionals have had any formal training in performing disability and disability-related assessments during their clinical training. In contrast with diagnosis and treatment, most clinicians receive little or no training in how to evaluate their patients' ability to function in the workplace (Talmage & Melhorn, 2005a). As a result, the quality of disability and disability-related evaluations varies widely and often fails to meet the needs for which they have been solicited.

Forensic specialists are also often unprepared to respond to requests for many types of disability evaluations. Unless one specializes in a practice directed specifically at disability or occupational evaluations, a clinician may have little opportunity to learn how best to conduct an evaluation, obtain the necessary data, and effectively communicate results and relevant opinions. Moreover, unlike clinical practice, no consistent continuing education process in which clinicians who wish to improve their skills can engage exists. Relatively few continuing education programs offer training in conducting employment-related assessments.

"Peer review" for learning purposes, another common avenue for professional development, is almost nonexistent in regard to disability and disability-related evaluations. The exception to this is in litigation, where the opposing expert's in-depth review of one's opinions is inevitable but not necessarily constructive. In addition, unlike clinical practice where treatment outcome may provide some indication of quality of services, outcomes in disability-related evaluations rarely include an opportunity to review one's performance or skills. In the absence of litigation, once a report has been submitted, often no further contact regarding the quality of the report, the outcome of the case, or how relevant the evaluation was to that outcome occurs. (As in litigation, complaints should the opinions be contrary to the interests of the retaining party are not uncommon but are also rarely constructive.) Referral sources will simply avoid future referrals if examiners provide inadequate reports or poor quality evaluations.

Who Can Use the Information in This Book

This book will provide empirically based, legally grounded analysis as well as practical guidelines and suggestions regarding mental health evaluations associated with disability claims, ADA claims, and fitness-for-duty evaluations. It is intended for mental health practitioners varying in levels of experience, from the general clinician to the forensic expert, all of whom may be confronted with clinical, legal, or administrative situations that require specialized disability assessments. General practitioners will find much that is helpful regarding

some of the common types of disability evaluations they are asked to provide in the course of their clinical practice. More experienced forensic specialists will find the information and suggestions provided will increase their expertise and level of comfort in providing more complex disability-related evaluations.

Although this text will be helpful to general mental health practitioners, clinicians uncomfortable with performing disability and disability-related evaluations should consider referring them to forensic specialists. Circumstances sometimes compel a practitioner to assume the dual role of treatment provider and forensic evaluator (Strasburger, Gutheil, & Brodsky, 1997). For example, an application for Social Security Disability benefits requires an extensive report from the clinical treatment provider. Many forms of workers' compensation insurance require evaluation of treatment, progress, and prognosis from the treating clinician.

Nevertheless, circumstances may suggest referral for various reasons to those with more specialized forensic training. Many disability-related evaluations are essentially independent medical examinations, that is, clinical assessments by a provider, not otherwise involved in the care or treatment of the patient, at the request of a third party who is not the provider's employer. Such examinations differ significantly from clinical evaluations conducted for treatment purposes (American Medical Association, 2008), particularly in regard to issues of confidentiality and the involvement of third parties. In addition, in the event of a dispute, evaluators need to be prepared to defend their opinions in trial or hearing, a situation with which forensically trained specialists are familiar.

General clinicians may encounter other circumstances that suggest a referral to a forensic specialist. Clinicians may encounter difficulty in moving from the therapeutic to the forensic role due to the conflict presented by the differences between clinical and forensic methodology, ethics, alliances, and goals (Appelbaum, 1997; Shuman & Greenberg, 1998; Strasburger et al., 1997). The terms, requirements, and legal or administrative process involved in employment evaluations may be unfamiliar. In such cases, reliance on clinical skills alone may result in erroneous conclusions or irrelevant reports. Even where the issues in clinical and employment evaluation are similar, the consequences of different types of disability evaluations differ dramatically and cannot help but frame the opinions rendered.

Clinicians who provide disability and disability-related evaluations should also be aware that should questions arise, they are likely to be held to the standards of forensic specialists (*Sugarman v. Board of Registration in Medicine*, 1996). In a related vein, by statute or judicial determination, some states consider forensic diagnosis and testimony the practice of medicine and require compliance with the same rules that govern clinicians (Federation of State Medical Boards, 2007; Simon & Shuman, 1999).

Finally, this book will also be of use to other professionals such as attorneys, human resource specialists, and insurance administrators. These groups frequently call upon the services of mental health practitioners when conflicts or disputes arise in the workplace and either the employee or the employer raises

issues of disability or fitness for duty related to mental health. This book will familiarize them with what they can expect and reasonably ask of mental health practitioners whom they ask to provide evaluations that help them resolve or adjudicate difficult employment claims related to mental health.

Readers should be aware this text focuses on disability and disability-related evaluations that arise in paid employment contexts, that is, work for which one is receiving monetary compensation. There are many kinds of work and not all of them result in payment for the labor provided. For example, many women and some men provide household labor and childcare essential to their partners' successful functioning in the workplace but for which no monetary compensation is directly received.

In addition, this text addresses disability evaluations that arise due to disorders typically encountered in the workplace rather than disorders that prevent individuals from entering the workplace. Although serious psychiatric illness does not necessarily preclude competitive employment, labor force participation among people with serious psychiatric disorders is very low. Community surveys indicate that of those with schizophrenia and related illnesses, only 22–40% are employed (Jans et al., 2004). However, many of these individuals work in sheltered situations and 75–85% with these disorders do not hold any type of competitive employment (Bonnie, 1997a; Estroff, Zimmer, Lachicotte, Benoit, & Patrick, 1997; Kirsh, 2000; Yelin & Cisternas, 1997). Thus, for individuals with serious disorders such as developmental disabilities or schizophrenia, which arise during childhood, adolescence, or young adulthood, and therefore preexist opportunities for paid employment, the types of employment evaluations discussed here are not common.

This book will also not address areas the authors believe are adequately covered elsewhere or do not represent a significant number of evaluations. For example, preemployment evaluations conducted for various jobs outside any litigation or administrative process are common and may include a mental health evaluation, but will not be covered here. The overwhelming majority of evaluations, disputes, and complaints in the workplace come from those who are still employed or those who have quit or suffered a termination. Only a very small percentage of complaints come from individuals who claim they were improperly rejected for employment. In addition, certain highly regulated and specialized disability evaluations, such as those conducted within the military and Veterans Administration, are well covered in those administrative systems and so will also not be addressed here.

Further, this discussion will not address any of the professional fields associated with employment-related attempts to prevent illness or disability or return disabled individuals to the workplace. Although relevant to the ability to reenter the workplace and maintain employment, the literature and evaluations related to vocational rehabilitation, occupational illness, sheltered employment, employee assistance programs, and other employment-related fields are beyond the scope of this discussion. Finally, the issues addressed here are not intended to be a guide to occupational psychiatrists and

psychologists whose primary obligation is to their employer. For example, the challenges encountered by mental health professionals employed by insurance companies for claim review purposes will not be discussed.

This book will address the types of evaluations, conflict, and crisis related to mental health disability issues that commonly arise in the workplace. Such crises may result from an employee's wish to withdraw from the workforce due to psychiatric disorder. Such individuals generally require a mental health professional's evaluation to qualify them to receive benefits to which they may be entitled by administrative law or by private insurance contract. When individuals claim the psychiatric disorder from which they suffer was caused by the workplace, they may file a workers' compensation claim or a claim of discrimination under federal or state law, or one of many tort claims related to employment law. Again, such claims will typically require an evaluation by a mental health professional in order to result in monetary compensation or damage awards.

Disability-related assessment also includes individuals who already are employed and wish to remain in the workplace but who request or require accommodations to do so. If individuals request accommodations for a disability, as they are legally entitled to do under the ADA, they may be referred for a mental health evaluation to determine their ability to continue working and the types of accommodations necessary.

Sometimes employers question an employee's ability to meet the requirements of their job or their ability to do so without presenting a risk to themselves or others. In these cases, employees may be referred for evaluations for fitness-for-duty and/or risk assessment. Such evaluations may include concerns about the potential for workplace violence or the ability to safely manage an employment-issued firearm, or public safety concerns regarding an impaired physician or other medical care provider. Generally, as in ADA evaluations, the subjects of such evaluations wish to remain at work but their employers question their ability to do so or to do so safely. This difference of opinions generally results in some type of conflict or crisis. Requests for evaluation may arise at any point in the crisis, up to and including litigation that may arise from the dispute between employer and employee.

Unique Perspectives on Workplace Mental Health Evaluations

This book offers a number of unique perspectives in the quickly evolving arena of mental health assessments arising at the interface of psychiatry, psychology, and employment. The first of these is a focus on the critical dynamic in any disability or disability-related evaluation: the relationship between the individual's internal world and external circumstances. The evaluee's internal world comprises the individual's psychiatric status, psychological issues, and the meaning and value of work to that individual. The meaning and value of

work is influenced by many of the social aspects of employment. External circumstances, also a component of the model, consist of the job requirements, the social, hierarchical, and cultural aspects of any job situation, and other non-job-related factors, such as family or health circumstances.

The relationship between work and psychiatric disorders requires a model that accounts for a complex, dynamic, and changing relationship between relevant factors. Contrary to what many believe, the relationship between work and psychiatric illness cannot always be predicted on the basis of severity of illness or the stress of the work. Many individuals with severe psychiatric disorders are able to function in work settings, and even to utilize work settings to maintain or improve their functioning by increasing structure, social contact, and maintaining an income and employment benefits. Work is also an important outcome variable in its own right, correlated with although not identical to other outcome variables such as symptom severity, need for hospitalization, and social relations functioning. Work is therefore an area of functioning over time that is both semi-independent of and related to other areas of functioning in psychiatric disorders (Straus & Davidson, 1997).

Our model assumes that the dynamic relationship between the individual's internal world and external circumstances is the key issue in understanding disability problems and conflicts. Disability and disability-related evaluations differ in regard to which aspects of the dynamic relationship are of interest, such as level of impairment, causation of injury, accommodations to continue working, or fitness for duty. This model of assessment will be supported by a review of empirical evidence and scientific data regarding the relationships between specific psychiatric disorders and associated functional impairments. This data is then reviewed in the context of the process of the development of work disability, and visual models are offered to assist mental health professionals develop case formulations to help analyze the data and the process, unique to each individual, of the development of disability.

The subject matter and approach are also unique in that when such topics are reviewed, they are not typically placed simultaneously in a mental health and legal context. This text represents a collaboration between two experienced and award-winning professionals, a clinical professor of psychiatry and legal scholar. This collaboration has resulted in a text that provides a review of relevant case, statutory, and administrative law regarding each type of specific evaluation as well as the legal issues such as liability and confidentiality relating to the performance of such evaluations generally.

Finally, this text is the first to suggest both general and specific guidelines for these work-related evaluations. Such guidelines have only recently become available from the American Academy of Psychiatry and the Law (Gold et al., 2008), an effort in which one of the authors was instrumental. This text expands on these guidelines, updating evolving law and placing the discussions of general and specific types of disability and disability-related evaluations in their legal contexts.

The book provides extensive discussion of different and relevant factors in disability and disability-related evaluations before suggesting guidelines. Chapter 1 reviews relevant ethical obligations; Chapter 2 reviews relevant legal duties that arise in these employment evaluations, including those related to confidentiality and the Health Insurance Portability and Accountability Act; Chapter 3 explores the positive and negative psychological aspects of work; and Chapter 4 gives an overview of the relationship between specific psychiatric disorders and potential work-related impairments. These chapters are also unique in their reliance on evidence-based studies to support opinions and provide guidance in employment evaluations. Chapter 5 describes the process of psychiatric disability development, a process that has not been widely discussed in any context. These discussions inform the suggested guidelines for evaluation provided in Chapter 6.

The last three chapters of the book provide specific and focused discussion of disability evaluations relative to Social Security, workers' compensation programs, and private disability insurance benefits (Chapter 7); evaluations related to the ADA (Chapter 8); and fitness-for-duty issues (Chapter 9). These chapters will provide a review of the legal or administrative standards that govern how the mental health evaluation is conducted or used, the types of information to which the evaluator is entitled or must use to form an opinion, mental health issues specific to type of employment conflict, specific issues for evaluation, and guidelines specific to type of evaluation where they differ from the general guidelines reviewed in Chapter 5.

In conclusion, this text addresses the issues regarding mental health disability and disability-related evaluations requested due to the common challenges, crises, and conflicts arising in the workplace. It is inevitable that general clinicians' patients will encounter such problems, bringing them into the realm of clinical practice. It is also inevitable that these problems will result at times in the need for forensic evaluations and expert testimony. Learning to provide competent and thorough disability and disability-related evaluations will help mental health professionals at all levels of practice and experience meet their responsibilities to patients and to the administrative and legal systems that govern the world of competitive, paid labor.

Chapter 1
Taking the High Road: Ethics and Practice in Disability and Disability-Related Evaluations

Introduction

When Studs Terkel penned that people must work "or else," it is unlikely he was thinking about mental health disability and disability-related evaluations. Nevertheless, such evaluations commonly occur, often in a highly charged context of claims, conflict, and dispute. The outcome of these mental health evaluations can be life altering. Careers, financial stability, benefits, or legal decisions and awards can hinge upon the opinion of a mental health professional.

These circumstances create multiple opportunities for ethical and practical conflicts that can potentially influence opinions in mental health evaluations. Many of the assumptions, practices, and habits arising from clinical training and practice can create biases that may affect the provision of disability and disability-related evaluations. Although the law sets standards for some types of these assessments, many occur outside the legal process. In any event, professional requirements for ethical conduct and competency may exceed those set by law. This chapter will review ethical obligations; related legal obligations will be reviewed in depth in the next chapter.

Professional ethics associated with disability and disability-related evaluations, often referred to as third-party evaluations, differ in some significant respects from those associated with clinical care. Understanding the ethical obligations attendant upon third-party employment evaluations and the practical implications of these ethical obligations can provide guidance to mental health professionals when addressing some of the challenges that arise in conducting them. No systematic ethical guidelines specific to mental health disability or disability-related evaluations have to date been accepted by any professional organization. However, both psychiatric and psychological organizations have adopted ethical guidelines that are relevant and provide guidance to those conducting disability and disability-related evaluations.

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The ethical guidelines and principles referenced here include

1. The American Academy of Psychiatry and the Law (AAPL): Ethics Guidelines for the Practice of Forensic Psychiatry, 2005 (http://www.aapl.org) (see Appendix A).
2. The American Medical Association (AMA): Code of Medical Ethics and Current Opinions, 2006–2007 (http://www.ama-assn.org).
3. The American Psychiatric Association (APA): Opinions of the Ethics Committee on the Principles of Medical Ethics, With Annotations Especially Applicable to Psychiatry, 2008.
4. The American Psychological Association: Ethical Principles of Psychologists and Code of Conduct, 2002.
5. Committee on Ethical Guidelines for Forensic Psychologists of Division 41 of the American Psychological Association and the American Board of Forensic Psychology: Specialty Guidelines for Forensic Psychologists (1991) (see Appendix B).
6. The American Psychology-Law Society (AP-LS), Division 41 of the American Psychological Association, and the American Board of Forensic Psychology: Specialty Guidelines for Forensic Psychologists, fourth revised draft, 2008 (not yet adopted).

The Ethical Obligation to Practice Within Areas of Expertise

One of the primary ethical obligations of any mental health professional is to practice within their area of expertise (American Medical Association, 2006; American Psychological Association, 2002; American Psychiatric Association, 2008). Specialty guidelines and ethics opinions address this obligation directly in regard to forensic evaluations (American Academy of Psychiatry and the Law, 2005; American Medical Association, 2006, Opinion E-9.07; Committee on Ethical Guidelines for Forensic Psychologists, 1991; American Psychological-Law Society, 2008). As previously discussed, mental health professionals providing disability and disability-related evaluations should consider the possibility that litigation or administrative processes may arise from claims requiring mental health assessments. Thus, the specialty guidelines for forensic clinicians may be interpreted to apply to third-party evaluations of all kinds whether litigation has occurred or not. Failure to support claims of expertise can have significant legal implications (see Chapter 2).

Evaluators should have experience with the various types of disability and disability-related evaluations and be familiar with the variety of subjects that form the basis of well-reasoned opinions in these assessments. In any given case, any or all these areas may be relevant in supporting or refuting employment claims. These include

- the relevant legal or administrative contexts of the evaluations;
- mental health issues that commonly arise in the workplace;

- the manifestations of mental disorders that can specifically affect functioning and how they relate to the specific context of each evaluation;
- the research that supports these assessments; and
- the requirements of competent disability and disability-related evaluations, including the questions that need to be addressed in each specific evaluation.

Ethics and Relationships in Third-Party Evaluations

Mental health professionals conducting disability and disability-related evaluations should understand their ethical obligations to all the involved parties. The ethical obligations of the mental health professional associated with treatment relationships typically are owed only to the patient, except in situations in which the patient presents a danger to self or others. However, disability evaluations generally involve three parties: the mental health professional, the evaluee, and the retaining or referring employer, agency, attorney, or institution. The retaining or referring party, commonly referred to as the third party, is the recipient of the information obtained in the evaluation.

This three-way relationship creates new and different ethical obligations than those associated with patient treatment and is the source of many of the ethical challenges associated with disability and disability-related evaluations. Many mental health professionals assume that in a third-party evaluation, the lack of the traditional physician/patient relationship means that traditional ethical obligations to the evaluee are abrogated. As the fields of forensic psychiatry and psychology have evolved over recent years, this analysis has come to be considered overly simplistic. In fact, the involvement of the third party creates new ethical obligations to the third party and alters rather than eliminates some of the traditional clinical ethical obligations toward the evaluee.

The Relationship with the Third Party

The clinician's primary ethical duties in disability and disability-related evaluations are owed to the third party. The purpose of the evaluation, even if initiated by the evaluee, is to provide information to a third party for consideration of some administrative, legal, or financial action. Thus, the primary ethical obligation is to strive to provide the third party with opinions regarding the issue in question. The guidelines adopted by the Committee on Ethical Guidelines for Forensic Psychologists Guidelines (1991), their proposed revision (American Psychology-Law Society, 2008), the APA ethical guidelines (American Psychiatric Association, 2008), and the AAPL ethical guidelines (2005) all recognize that this obligation affects the traditional relationship between the mental health professional and the individual undergoing evaluation.

The Physician–Evaluee Relationship in Employment Evaluations

The existence of a relationship with the third party in a disability or disability-related evaluation does not automatically preclude the existence of ethical duties owed to the evaluee. For example, basic ethical principles such as proscriptions against inappropriate sexual or physical behavior are obviously not abrogated by the primary ethical obligation to the third party. Although the view that ethical principles attendant upon a treatment relationship do not apply in employment evaluations is inaccurate, the nature of the obligations attendant upon the relationship must be different in a relationship where the primary ethical obligation is owed to a third party. For example, the obligation to maintain confidentiality cannot apply without modification in an evaluation whose express purpose is to communicate to a third party information that would normally be considered confidential.

The question of whether mental health professionals have ethical obligations to evaluees in third-party evaluations such as in independent medical evaluations (IMEs), given the primary relationship with a third party, and if so, the nature of those obligations, has been extensively discussed (Appelbaum, 1990; Candilis et al., 2007; Stone, 1984; Weinstock & Garrick, 1995; Weinstock & Gold, 2004). As the ethical guidelines clarify, mental health professionals performing employment-related evaluations do have ethical obligations toward an evaluee.

The AMA explicitly states, "When a physician is responsible for performing an isolated assessment of an individual's health or disability for an employer, business or insurer, a limited patient–physician relationship should be considered to exist. . ." (American Medical Association, 2006, Opinion E-10.03). The AMA ethics guidelines also state that physicians performing IMEs have the same obligations as physicians in other contexts to provide objective evaluations, maintain patient confidentiality, and disclose conflicts of interest.

The APA has not directly addressed the nature of the physician–patient relationship in any guidelines adopted to date. However, the APA Principles of Medical Ethics (2008) and the AAPL ethical guidelines (2005) imply the existence of a limited relationship in third-party evaluations. AAPL's ethical guidelines state, "Psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society" (American Academy of Psychiatry and the Law, 2005), acknowledging ethical obligations both to the evaluee and to the third party who often represents a public interest such as justice, disability benefits, or civil rights. The underlying rationale for some of AAPL's guidelines implies an ethical obligation toward the evaluee's welfare that follows from a physician–patient relationship.

The AP-LS also addresses the issue of whether a relationship exists between a psychologist and an evaluee in a third-party evaluation. Their proposed revised ethical guidelines (2008) specifically state, "In their work, forensic practitioners establish relationships with those who retain their services (e.g., retaining

parties, employers, insurers, the court) and those with whom they interact (e.g., examinees, collateral contacts, research participants, students). Forensic practitioners recognize that associated obligations and duties vary as a function of the nature of the relationship" (p. 8). These guidelines advise psychologists that "Forensic practitioners are aware that there are some responsibilities, such as privacy, confidentiality, and privilege that may attach when the forensic practitioner agrees to consider whether a forensic practitioner–client relationship shall be established" (American Psychology-Law Society, 2008, p. 8).

Nevertheless, the AMA, the APA, the AAPL, and the AP-LS acknowledge that despite the existence of a relationship with the evaluee, an ordinary physician–patient or psychologist–client relationship does not exist in third-party evaluations, including disability and disability-related evaluations. As APPL (2005) states, the ethical duties owed to the evaluee have to be balanced against the primary ethical obligations to the third parties requesting or utilizing the evaluation. Mental health professionals providing disability and disability-related evaluations might therefore best be seen as having a primary duty to the third party and a "secondary" duty to an evaluee (Weinstock & Garrick, 1995).

Inevitably, conflicts between the secondary ethical obligation to the evaluee and the primary duty to the third party will arise. In most circumstances, the primary obligation to the third party will outweigh the duties to the evaluee. For example, the fundamental medical ethic of nonmaleficence, generally rendered as "Do no harm," is not straightforward in disability and disability-related evaluations. Information gathered in the course of a disability evaluation or IME may ultimately be used in ways that may cause the evaluee emotional distress or result in financial harm. However, mental health professionals are obligated to provide honest assessments, even if these turn out not to advance the evaluee's interests.

In other circumstances, the primary duty to the third party can and should be overridden. Situations may arise in which the welfare of the evaluee cannot be ignored, such as when an evaluee presents with high risk of suicide or harm to others. Some authors suggest that circumstances that create concern of harm to the evaluee, such as distortion of proceedings or process due to uncontrolled bias or racism, override all other ethical obligations (Candilis et al., 2007). However, other ethical issues, such as the extent of confidentiality and what constitutes informed consent, arise more commonly in disability and disability-related evaluations. The resolution of these conflicts is less straightforward and raises ethical and sometimes legal concerns that should be carefully evaluated.

Disclosure and Informed Consent

One of the clinician's primary responsibilities to evaluees in disability and disability-related assessments is to be honest regarding the nature and purpose of the examination (American Academy of Psychiatry and the Law, 2005;