

Forensic Psychiatric Evaluation of Workers' Compensation Claims in a Managed-Care Context

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Among the staples of forensic psychiatric evaluation are independent medical evaluations (IMEs) for work-related psychiatric and neuropsychiatric claims, ranging from post-traumatic stress disorder to chronic pain syndromes accompanying and compounding impairment due to other medical conditions. To provide a comprehensive evaluation and an objective opinion, forensic psychiatrists must know how the social organization of medical care can limit the claimant's prior access to psychiatric evaluation and care. Today, psychiatric referral and treatment are increasingly restricted by managed health care. In this context, the scope of forensic psychiatric analysis and opinion formulation can include an evaluation of whether and how such restrictions have played a role in or substantially influenced the prior treatment history and current presentation and impairment of the claimant.

The case vignettes below are composites based on the forensic psychiatric practice experience of the authors and members of the Harvard Medical School Program in Psychiatry and the Law at the Massachusetts Mental Health Center. They are composed to illustrate how a psychiatric workers' compensation evaluation can be helpful when the forensic evaluator has an awareness of the social context of primary

medical and mental health care in today's managed-care-dominated health care environment.

Case Vignettes

Case 1

A middle-aged woman had recurrent periods of disability due to chronic fatigue. Although treated with multiple antidepressants for chronic fatigue syndrome by her primary care physician, she had never been referred for a psychiatric evaluation. A forensic psychiatric examination as part of an independent medical examination revealed a long history of symptoms consistent with affective disorder, a developmental history of abuse as a child, subsequent dysfunctional/abusive relationships, and episodes of affective dysfunction with paranoia and symptoms of hypomania. Treatment over the years consisted only of prescriptions of antidepressants and no documentation of symptoms of hypomania and paranoia. Recently, because she had lodged overtly paranoid complaints of mistreatment at work by most supervisors and coworkers, she was referred to a work-stress clinic group and placed on disability. The patient's initial refusal of a psychiatric referral was taken at face value, and no further attempts were made to explore its meaning. On inquiry to the nurse case manager, the fear of stigmatization was presented as the reason that a psychiatric referral was never made. However, during the forensic psychiatric examination, the patient revealed an openness to a recommendation of psychiatric referral when it was tactfully presented to her. In fact, she said that she was getting tired of "just

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being given pills" and "continuing to drive people away."

Case 2

A middle-aged man was placed on disability for one month after multiple arguments with his supervisor and complaints of wrist pain that he attributed to carpal tunnel syndrome caused by computer usage. His symptoms were unsubstantiated by physical examination. Medical records from his primary care physician noted his being upset and angry but described no mental status examination and no history of psychiatric symptoms other than mild insomnia. His physician recommended that he be placed on disability and prescribed paroxetine and ibuprofen (for pain management). No counseling, psychotherapeutic intervention, or psychiatric referral was provided. Lack of adequate mental health insurance coverage, based on a behavioral carve-out system, was noted by his primary care physician in the accompanying notes, along with a reference that the patient was still in the denial phase of his illness and did not want to be viewed by his wife as having a psychiatric problem. Presenting himself as demoralized, the patient seemed surprised when asked to consider whether the risk of stigma of seeing a psychiatrist was set in stone or was to some extent under his control. Moreover, it became clear that his current job impairment and being on disability were more of a stigma than the idea of seeing a psychiatrist to get help. He acted relieved to learn after the independent medical examination that he was depressed, his condition was not chronic or hopeless, and he could benefit from psychiatric treatment.

Perspective

These vignettes are composite stories of people who made inappropriate workers' compensation claims and lost not only their claims but also the opportunity for adequate treatment for their psychopathic disorders. In the relationships with the forensic psychiatrists conducting the IMEs, the patients' resistance to psychiatric labeling was identified and, with encouragement that treatment was not hopeless, resolved, and the patients subsequently accepted recommendations for psychiatric treatment. These outcomes could have been attained earlier.

Independent medical examiners conducting work disability or workers' compensation evaluations often become aware that patients' alleged work impair-

ments may be more a consequence of inadequate prior psychiatric evaluation and treatment than a symptom of underlying medical disorders.¹ Adequate evaluation and treatment of such patients by their primary care physicians should include not only consideration of psychiatric conditions within the differential diagnosis, but recognition that the patient's resistance to psychiatric referral and treatment perhaps should be a primary focus of a discussion of the problem with the patient.²

Several factors in the primary medical care setting can limit the ability of primary care physician to provide needed initial evaluation and treatment. Primary care physicians often can be reimbursed for only a short amount of patient care time. In some capitated systems, such as "behavioral carve-out systems," a primary care physician's referral of a patient to a mental health clinician for treatment effectively costs the primary care physician reimbursement for primary care availability. Feeling helpless to care for patients while also conducting economically viable medical practices, physicians compromise by prescribing rather than treating and simply taking patients' refusal of psychiatric referral and treatment at face value. Further impediments to appropriate psychiatric referral and treatment of patients labeled as work impaired include behavioral carve-outs, capitation systems, and other arrangements that place the primary care physician in a gatekeeping role. Such arrangements also confront primary care physicians with potential conflicts of interest that may further inhibit the recognition of the need for psychiatric treatment and referral and the effective exploration of the meaning of a patient's refusal of such referral. Primary care physicians in managed care contexts may therefore inadvertently rationalize "gagging" themselves to avoid exploring psychiatric referral and treatment.

Patients' fears of stigmatization when not discussed in the primary care context may also be magnified by several factors. These include realistic concerns about being stigmatized by unsophisticated family members and by the community³ and narcissistic or depression-driven hypersensitivity.⁴ Such hypersensitivity to stigmatization can be further compounded by third-party attitudes, such as nurse-clinician case managers validating fears of stigmatization by blindly accepting the patient's refusal of psychiatric treatment and referral. Patients who are depressed in relationship to a work impairment often

feel discouraged, hopeless, and helpless—feelings that can become pervasive. Thus, when the question of a psychiatric referral is first broached, it may not be understood by the patient as a hopeful indicator that the patient could benefit from treatment. Instead, it is likely to be initially experienced in light of preexisting social prejudices regarding the alleged lack of efficacy of psychiatric treatment and, for a patient with already lowered self-esteem due to depression, as an overconcern about the risk of stigmatization.

Today, there is a need for a deeper and more comprehensive IME analysis that includes recognition of the potential inadequacy of prior patient evaluation and treatment and the impact of limited evaluations and treatments on the patient. Proceeding in this manner may be more time consuming and therefore increase the cost of forensic psychiatric IMEs, but it ultimately yields a more objective, comprehensive, and helpful IME evaluation. The penumbra of the unsubstantiated managed health care arguments includes the fallacy that limiting psychiatric care of insured employees provides actual savings to employers and society at large. From a social cost perspective, being mindful of the potential dynamics of the interactions among the different parties allows for recognition of the all too often hidden costs to the patient and society of managed-care-influenced failures to provide adequate psychiatric referral, evaluation, and treatment.

Managed health care influences may not be immediately obvious to the forensic psychiatrist when encountering inadequate or limited initial psychiatric evaluations and treatment plans in the course of an IME. For example, even when initial patient dismissal of psychiatric referral is recognized by the primary care physician as being driven by fear of stigmatization, in a managed-care-dominated primary care context, such fears are often seen as insurmountable barriers to adequate psychiatric referral and treatment rather than as initial primary clinical care treatment foci. Thus, the rationalization of economic disincentives for psychiatric referral found in the primary medical care record may masquerade as an ethics dilemma pitting respect for alleged patient preferences or patient autonomy against the patient's need for psychiatric evaluation and treatment.

Conclusion

Premature disability determinations in general medical settings for patients with mental health problems, when recognized, can be appropriately addressed, processed, and resolved. By the same token, the fear of stigmatization can best be considered a treatable symptom rather than an insurmountable barrier to treatment condemning the examinee to permanent impairment. Our observations are that it is often only subsequent to the independent medical examination that patients are sufficiently informed to be able to make informed choices regarding clinically indicated psychiatric treatment.

We need public policy solutions that shift the paradigm from limiting care toward limiting disability. Otherwise, we will continue to be faced with individuals and families suffering needlessly as a consequence of untreated or partially treated mental illness. At the same time, the social costs of the consequences of a fragmented robbing-Peter-to-pay-Paul insurance system will continue at the current level where untreated mental illness in the workplace costs U.S. corporations billions of dollars each year.⁵

We have described forensic psychiatric evaluations that consider the health care context for work-related injury and disability claims. These can be helpful in individual cases and useful for educating both primary care clinicians and employers.^{6,7} However, they are no substitute for system-wide solutions that free primary clinical care and mental health referral and treatment from managed-care domination.

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