Commentary: Disability Evaluations—Are the Evaluators Able?

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Disability assessments of patients are among the most common nontherapeutic evaluations requested of treating psychiatrists. Yet, there has been relatively little empirical analysis of how psychiatrists approach these evaluations in real clinical practice. Treating psychiatrists, those both with and without forensic expertise, struggle with the challenge of dual agency and overlapping therapeutic and forensic roles. Making the different roles clear to the patient can allow for more therapeutic exploration and alliance around further treatment goals, expectations, and interventions. Given the high prevalence of psychiatric disability and requested evaluations, psychiatric trainees would benefit from formal teaching, and it should be considered an important area for psychiatric continuing education.

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In setting the context for their interesting study, Christopher and colleagues[1] remind us of some striking statistics about psychiatric disability: the federal Social Security Administration (SSA) provides benefits for more than 3.3 million adult Americans disabled by mental disorders, the largest group of any diagnostic category. The lost work productivity from psychiatric disability has been estimated at $150 billion annually. Disability assessments of patients are among the most common nontherapeutic evaluations requested of treating psychiatrists. One can only conclude that this is an enormously important subject, at least in terms of the sheer number of patients, physicians, and dollars involved. Yet, there has been relatively little empirical analysis of how psychiatrists approach these evaluations in real clinical practice. I commend the authors for beginning to illuminate this question by evaluating the differences between how forensic and nonforensic psychiatrists approach and view evaluations for Social Security disability benefits.

This work naturally built on that in an earlier study by Christopher *et al.*,[2] in which they examined the experience of senior psychiatric residents in performing disability evaluations. Residents reported having limited experience and training, a limited understanding of what constitutes psychiatric disability, and a lack of confidence in their ability to perform evaluations accurately. Most of the residents reported no didactic training on psychiatric disability. The authors concluded that residents may be underprepared to perform disability evaluations, a gap that training programs should address. It raises the logical question of how prepared the more senior psychiatrists are: those who are in practice and those who teach our trainees.

In the current study, Christopher *et al.* surveyed general and forensic psychiatrists' experiences and beliefs about performing Social Security disability (SSDI) evaluations. As hypothesized, they found that psychiatrists with forensic experience were more likely than those without to identify the inherent dual-agency conflict, potentially adversely affecting both the disability determination process and the treatment relationship, by having treating clinicians evaluate their own patients.[3] Yet, even while the AAPL members better recognized dual-agency concerns and made efforts to avoid such a conflict (i.e., by declining to complete disability evaluations for their own patients), the data do not clearly indicate that AAPL members are always more capable of managing this conflict. Most of the AAPL psychiatrists responding to the survey still felt pressure to complete disability forms, did not consistently obtain informed consent from their patients for the evaluation

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process, and primarily identified themselves as advocates when performing disability assessments. The authors concluded that:

> . . . many psychiatrists, regardless of their forensic expertise and recognition of the dual-agency conflict, struggle with the management of overlapping therapeutic and forensic roles when performing disability assessments. . . . A substantial minority of the respondents in both groups reported having identified a patient as disabled despite believing that he could work [Ref. 1, p 187].

Why? The authors suggest that perhaps treating clinicians

> . . . rationalize that the SSA will right their wrong after considering the input from an independent examiner or, seeing themselves as an advocate for their patients, will feel that they are ethically justified, given the inherent conflict in dual-agency assessments. Whatever the reason, this practice, which is of particular concern, likely reflects the difficulty psychiatrists have in performing a forensic task faithfully when it poses a risk to the therapeutic alliance [Ref. 1, p 187].

The authors note that many general psychiatrists are confused by the SSDI application process and often fail to recognize that the Social Security Administration (SSA) gives greater weight to the opinion of a treating clinician (who presumably has a more detailed and longitudinal perspective on a claimant's symptoms and impairment). Treating psychiatrists may regard the process as arbitrary, inconsistent, or unfair and believe that many initially denied claims are subsequently successfully appealed. Providing a thorough and comprehensive evaluation (and detailed written report) takes time and effort, and there is typically no additional compensation to the treating clinician other than reimbursement for copying records. Finally, there is the oft-discussed question of clinical ethics versus forensic ethics.[4]

Unfortunately, the SSDI eligibility determination process may be getting only more confusing and complicated.[5] In August 2010, the SSA proposed changes that would allow SSDI adjudicators to use standardized tests to determine whether an applicant's mental health condition interferes with his ability to function in a work setting. Currently, no such tests are used to evaluate quantitatively the workplace functioning of adult SSDI applicants. Advocacy and professional organizations note that currently there are no accepted standardized tests that specifically measure occupational impairment. They fear that the proposed new rules will lead to misuse of existing instruments or that adjudicators will dismiss other more subjective evidence of an applicant's work impairment due to mental illness. In a November 2010 letter to the SSA, the American Psychiatric Association cautioned ". . . without additional development and assessment, the clinical, scientific and psychometric foundations of employing such [standardized] tests for disability determination are unreliable, and their interpretation by adjudicators may be inadequate and unfair to applicants with mental illnesses."[6] Furthermore, the APA raised concerns about the current SSA psychiatric review technique and internal five-point impairment rating scale, finding:

> . . . this scale to be unanchored, allowing wide latitude for subjective interpretation of what qualifies as a "marked" or "extreme" level of functional impairment. Without more specific guidance for assigning functional limitations on this scale, which is not currently contained in the proposed rule, we believe use of the five-point scale could bring a false level of precision to determining functional impairment.[6]

So, what should a treating clinician do?[7] Perhaps the cleanest approach is to educate one's patient about dual agency and the difference between the evaluative/forensic role and the treatment relationship/alliance. As a treating clinician, I have long taken the position with my patients that my role is to treat symptoms and impairment, not to assess their eligibility for public or private disability benefits, which fundamentally is a legal or regulatory decision, not a clinical one. With the patient's consent, I will release medical records, typically in place of completing the insurer's (or government agency's) specific form. The medical records ideally provide enough clear contemporaneous clinical data about symptoms, functioning, restrictions (what the patient should not do), and limitations (what the patient cannot do). Sometimes, I provide more substantial data in the treatment note in anticipation that it will be used for disability determination purposes. I try to be very careful not to use the word disability or certify to it. I see my role as providing clinical data regarding functional impairment, and my treatment notes should be the best source; let the adjudicators interpret how the record meets their specific criteria. I admit that this approach is not always as easy or straightforward as it seems. Occasionally, I receive phone calls from an adjudicating clinician seeking additional clarification or information, which I am happy to provide with appropriate patient consent. It is rare that I am asked to complete much additional paperwork, beyond releasing the actual treatment records and perhaps the collateral phone call. If my pa-

tient is denied benefits, I remind him of my role as treater, not as disability adjudicator, and how I merely provided the available clinical data with his consent. Making the different roles clear to the patient can allow for more therapeutic exploration and alliance around further treatment goals, expectations, and interventions.

What should a forensic evaluator do? That is obviously a very different role and a different task. There is a growing body of literature to educate and inform forensic psychiatrists who perform psychiatric disability evaluations, including AAPL's own 2008 Practice Guideline for the Forensic Evaluation of Psychiatric Disability[8] and a recent Guttmacher Award-winning text by Gold and Shuman.[9] Approaches to disability assessment have common conceptual themes, but may differ, depending on the specific context (e.g., SSDI, private disability insurance benefits, fitness for duty evaluations, and assessment of impaired professionals).[10–13] The forensic (or general) psychiatrist performing these evaluations should be familiar with the literature. Over the past 15 years, I have consulted for several private disability insurers, helping them to understand and evaluate claims of psychiatric disability. Reviewing thousands of cases, and reading hundreds of independent medical evaluations (IMEs), I have been impressed with, and sometimes, depressed by, the wide qualitative variability of forensic disability assessment, often provided by individuals with seemingly little training, experience, credentials, or certification.[14] Even among individuals with great forensic expertise in legal issues of competency, dangerousness, and responsibility assessment, there is often a surprising lack of parallel sophistication regarding disability evaluation. I fully agree with the recommendations of Christopher *et al.* that "given the high prevalence of psychiatric disability and its associated costs, general psychiatry residents and forensic psychiatry fellows may further benefit from the development of a formal curriculum on this topic, and it should be regarded as an important area to cover in psychiatric continuing education" (Ref. 1, p 188).

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