Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Disability

Lisa Ramshaw, MD, DPhil, FRCPC[1]; Sumeeta Chatterjee, MD, FRCPC[1];
Treena Wilkie, BScH, MD, FRCPC[1]; Graham Glancy, MB, ChB, FRCPsych, FRCPC[1]

The authors would like to thank the National Working Group (Todd Tomita, Alberto Choy, Mansfield Mela, Jeff Waldman, Richard Schneider, Brad D. Booth, Jocelyne Brault, Mathieu Dufour, and Aileen Brunet) for their essential contributions. They would also like to thank their expert reviewer, Roy O'Shaughnessy.

Reviewed and approved by the Canadian Academy of Psychiatry and the Law (CAPL) Board of Directors on June 28, 2022.

STATEMENT OF INTENT: CAPL Resource Guide for Reference and Training

This document is intended as a review of legal and psychiatric principles to offer practical guidance in the performance of forensic evaluations. This resource document was developed through the participation of forensic psychiatrists across Canada, who routinely conduct a variety of forensic assessments and who have expertise in conducting these evaluations in various practice settings. The development of the document incorporated a thorough review that integrated feedback and revisions into the final draft. This resource document was reviewed and approved by the Board of CAPL on June 28, 2022. It reflects a consensus among members and experts, regarding the principles and practices applicable to the conduct of forensic assessments. This document does not, however, necessarily represent the views of all members of CAPL. Further, this resource document should not be construed as dictating the standard for forensic evaluations. Although it is intended to inform practice, it does not present all currently acceptable ways of performing forensic psychiatry evaluations and following these guidelines does not lead to a guaranteed outcome. Differing facts, clinical factors, relevant statutes, administrative and case law, and the psychiatrist's clinical judgement determine how to proceed in any individual forensic assessment.

This resource document is for psychiatrists and other clinicians working in a forensic assessor role who conduct evaluations and provide opinions on legal and regulatory matters for the courts, tribunals, and other third parties. Any clinician who agrees to perform forensic assessments in any domain is expected to have the necessary qualifications according to the professional standards in the relevant jurisdiction and for the evaluation at hand.

See the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*, which applies to all of the guidelines and will not be repeated below. See also the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Overarching Principles for Civil Psychiatry Assessments* and the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Fitness to Work/Practise*.

OVERVIEW OF DISABILITY

Disability assessments are a type of workplace assessment focused on the individual's health and functional impairments. They are conducted at the request of third parties including

insurance companies, provincial disability plans, or legal counsel to determine eligibility for compensation. Fitness to work assessments (*see the Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Fitness to Work/ Practise*), on the other hand, are evaluations of the individual's ability to work in a specific setting, and they are conducted at the request of the employer, union, professional body, or legal counsel.

Canadian Law and Definitions of Disability and Impairment

Psychiatrists including forensic psychiatrists are often asked to assess matters related to disability and impairment. *Disability* and related terms are legal terms of art, although clinicians and laypersons may use them in other contexts. The precise definition of disability, impairment, and other concepts varies depending on each individual case, provincial or federal statutes, administrative regulations, and specific wording in insurance policies. The American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment defines *disability* as "an umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease." (1) It defines *impairment* as "a significant deviation, loss, or loss of use of any body structure or function in an individual with a health condition, disorder, or disease." Although the guide is an American publication, there is no Canadian equivalent; thus, it has often been often relied upon in Canada. The Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text revised (DSM-5-TR) provides no definition of impairment, although it includes the criterion that symptoms must cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" in order to be considered a diagnosis. (2) It is important to note that one can have an impairment without necessarily having a disability - a person may, for example, have insomnia that does not prevent them from performing their essential duties of occupation, and therefore they would not be seen as disabled under the insurance policy. (3) Other important definitions related to disability are outlined in Table 1.

Insurance companies generally use their own definition of disability, which is included in individual insurance contracts. Most definitions focus on the idea that the insured person is unable to perform the essential duties of their employment due to some type of illness or disorder.

In Canada, courts have applied what they call a "social model" in defining disability. This definition focuses on the barriers that people face as a result of perceived disabilities. The focus is more on how society treats the disability than the disability itself. Because this definition relies on the perception of a person's limitations (see, for example, *Hinze v. Great Blue Heron Casino* [4]), someone can be said to have a disability when they lack functional impairment; similarly, someone who has a functional impairment may not have a disability if they face no barriers as a result of it. For example, in *J.L. v. York Region District School Board* (5), the complainant had flat feet, but this did not create a barrier for the complainant in the given situation. In *Anderson v. Envirotech Office Systems* (6), the complainant had bronchitis, but again, this was not considered a disability because it did not create a barrier for him to "participate fully in society." "Disability" is essentially a social construct under this model (see also, *Quebec v. Boisbriand* [7]; *Granovsky v. Canada* [8]).

Disability is a concept that is analyzed contextually. That is, what is considered a disability will vary from person to person and case to case. The courts have emphasised the subjective component of disability, which looks at how the person with the disability views themselves and the disability (see *Dawson v. Canada Post Corp.* [9]). What may seem like an impairment to one person may not to another. This subjective component also extends to societal perceptions. Because disability is socially constructed under the social model of disability, what is considered a disability varies among cultures, communities, and environments. This line of reasoning extends as far as classifying perceived disability as such when it can be shown that perception has created a barrier for a person with a perceived disability. Perceived disability can be present-oriented or future-oriented. In the case of the latter, if someone is facing barriers because others expect them to have a disability in the future (and are thus treating them in a discriminatory fashion), this would qualify as a disability.

The other contextual element of defining disability is the situation itself. That is, what is considered a disability varies according to what the person with the disability is required to do. What may qualify as a disability in one occupation may not in another occupation if the occupations have different demands. The analysis depends on the barriers the person with the disability faces in that particular circumstance.

Medical Diagnoses and Disability

As the social model focuses heavily on the social element of disability, the precise medical diagnosis is not as important. In Canadian law, it is rare for an employee to be required to disclose their diagnosis to an employer to qualify for accommodation. In most cases, asking for accommodation is sufficient. In rarer cases, when a medical assessment is required, a medical professional may be asked to convey to the employer what accommodations would be appropriate. In many cases, a treating medical professional is not required to disclose a diagnosis, and providing a diagnosis could cause difficulties for the person and the employer.

In general, the courts place more weight on the nature of the disability and how it impacts function at work rather than a specific medical diagnosis. Disability is viewed as an evolving concept. On the biomedical side, new conditions and treatments are constantly being discovered and created. On the social side, society's attitudes are also continually changing. Barriers faced by people with disabilities can be the product of discriminatory attitudes, and as these attitudes change, the barriers that people with disabilities face change along with our perception of disability.

Mental health issues are a leading cause of disability in Canada, with a mental disorder prevalence of approximately 20%. (10) Individuals with a mental disorder comprise approximately one-third of people on disability. (11) In 2017, 7% of the Canadian population had a mental health-related disability. (12) Depression, the most frequent cause of mental health disability, affects 7.9% to 8.6% of the population, while schizophrenia affects 1.4%. (13) Bipolar disorder affects 2.2% of the population. (14) Of those with serious mental illnesses, approximately 70% to 90% are unemployed. (10)

Based on the statistics above, it is not surprising that disability assessments are the most requested type of evaluation for nontherapeutic reasons. Consequently, mental health clinicians are frequently asked to comment on a person's ability to participate in the workplace. In most cases, treating physicians or psychiatrists deal with these issues, for instance via government disability payments and short-term disability assessments. These are often briefer evaluations, and documentation requirements might be limited to the completion of standardized forms provided to the physician. The potential difficulties of relying solely on treatment providers in conducting such evaluations, in which they would have a dual role, have been addressed in the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*. Forensic psychiatrists are more commonly involved in complicated situations in which private insurance companies or employers request a more detailed evaluation. There are various types of assessments depending in part on the referral source. (See Table 2 for examples.) As well, there are a variety of factors that can trigger a disability evaluation request (15), including:

- The condition being claimed as a disability is not usually disabling
- Lack of objective medical evidence to substantiate the claim
- Duration of the disability is longer than usual for the condition
- Vague diagnosis given by the treating physician
- Medical treatment given or proposed appears inadequate or inappropriate
- Suspicions about malingering or fraud
- Lack of cooperation by the evaluee
- Change in status of disability policy (e.g., own occupation rider changing to any occupation)
- Potential availability of alternate funding (e.g., poor prognosis so the Canada Pension Plan [CPP] would cover part of the benefits)
- Inconsistent or potentially contradictory file information

In Canada, *disability* is defined under the Human Rights Code of each province and territory, with each providing an alternative definition of disability for the purpose of compensation. Provinces and territories have other definitions of disability for compensation purposes (e.g., regional disability acts). Canadian case law complicates the meaning even more. In *Quebec v. Boisbriand* (7), the court said,

> [b]y placing the emphasis on human dignity, respect, and the right to equality rather than a simple biomedical condition, this approach recognizes that the attitudes of society and its members often contribute to the idea or perception of a "handicap." In fact, a person may have no limitations in everyday activities other than those created by prejudice and stereotypes.

In *Granovsky* (8), the Supreme Court of Canada said,

> The concept of disability must therefore accommodate a multiplicity of impairments, both physical and mental, overlaid on a range of functional limitations, real or perceived, interwoven with recognition that in many important aspects of life the so-called "disabled" individual may not be impaired or limited in any way at all.

In this case, the court emphasized that disability resulted from a failure to accommodate and, thus, is a social construct created by this failure.

Cases in which the courts have defined mental health conditions in disability-related matters include those enumerated in Table 3. Recognizing that people with mental illnesses often have comorbidities, examples of clinical conditions in which the court confirmed disability include addiction to drugs or alcohol (*Entrop v. Imperial Oil Limited,* 2000 [16]; Ontario (*Disability Support Program) v. Tranchemontagne,* 2010 [17]), obesity (*Ball v. Ontario (Community and Social Services),* 2010 [18]), and perception of obesity as a disability (*Turner v. Canada Border Services Agency,* 2014 [19]), chemical sensitivities (*Noe v. Ranee Management,* 2014 [20]; *Redmond v. Hunter Hill Housing Co-op*, 2013 [21]), perception of having a future disability (*Hinze v. Great Blue Heron Casino,* 2011 [4]), and chronic headaches *(Ottawa (City) v. Canada (Human Rights Comm.) (No. 2),* 2005 [22]). Clinical conditions where the court did not confirm a disability include colds and other common ailments (*Davidson v. Brampton (City),* 2014 [23]; *Quebec v. Boisbriand,* 2000 [7]), bronchitis (as it did not create a barrier

to full participation in society) (*Anderson v. Envirotech Office Systems,* 2009 [6]), and flat feet (*J.L. v. York Region District School Board,* 2013 [5]). Although temporary conditions can be considered disabilities, this may depend on the severity and commonality of the ailment (*Mou v. MHPM Project Leaders,* 2016 [24]).

In the final analysis, the definition of disability depends on the specific statute, insurance policy, regulation, or contractual definition operating in a particular case. The forensic psychiatrist's role is to perform a thorough evaluation and identify a clear relation among psychiatric symptoms and how these affect the evaluee's ability or capacity to perform the essential duties of their employment.

Table 1. Examples of Disability Report Definitions

Limitation/impairment	A task a person can no longer do because of a medical/psychiatric condition (e.g., unable to concentrate for 10 minutes due to depression, attention-deficit hyperactivity disorder [ADHD] or cancer treatment)
Restriction	A task a person can do but should avoid doing, due to a medical/psychiatric condition, to prevent worsening/relapse of the condition (e.g., working overnight shifts if recently recovering from a manic episode)
Essential tasks	Elements of a job someone is hired to do at minimally acceptable performance levels (e.g., type 80 words per minute, maintain professional demeanour)
Reasonable accommodation	Changes to the workplace that will allow an impaired employee to carry out the essential tasks of their job without causing undue hardship to the employer (e.g., wear noise-cancelling headphones, have tasks divided into smaller components)
Undue hardship	A complex legal concept where accommodation strategies would incur health and safety risks or be so onerous that they are not reasonable; large organizations would have less undue hardship than small organizations (e.g., not interacting with patients if you are hired as a front-line nurse)
Non-disability leaves	Permissible job leaves for non-disability reasons (e.g., bereavement, childcare issues, attendant care) can be paid or unpaid depending on the terms of the employment contract

Table 2. Types of Disability Assessments

- Workplace Safety and Insurance Board
- Private insurers
  - Short- and long-term disability (25)
- Employer-initiated assessment
  - Employers may require an independent or second opinion
  - Provincial disability plan—generally performed by treating physicians
- Canada Pension Plan (CPP) disability income
  - Generally performed by treating physicians
- Employment insurance
  - These may be performed by treating physicians, although independent medical examiners may be retained in certain cases.

Table 3. Court Cases for Mental Health Conditions and Disability

Case	Disability	Context
Eagleson Co-Operative Homes Inc., 2006 (26)	Plaintiff diagnosed with dysthymia due to borderline personality disorder is considered a person with a disability as defined under the Ontario Human Rights Code. Complainant filed for wrongful eviction and won.	Housing Discrimination Case
Hydro-Québec v. Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ), 2008 (27)	Plaintiff diagnosed with reactive depression and mixed personality disorder with borderline and dependent character traits. Complainant filed for wrongful dismissal and won.	Labour and Employment Law
Dodgson v. Great West Life Assurance Co., 2014 (28)	Plaintiff diagnosed with major depressive disorder, panic disorder with agoraphobia, marijuana dependence, and alcohol abuse (past). Possible borderline personality features noted. Plaintiff found to be a person with a disability. Complainant filed for long-term disability benefits and won.	Insurance Case

Case	Disability	Context
Francis v. Ontario, 2020 (29)	Class action civil suit broadly defined mental illness to include borderline personality disorder and posttraumatic stress disorder (PTSD). Diagnoses to be included pre-negotiated by counsel. This was a class-action re: segregation and is only relevant for the pre-agreed definition of "mental illness."	Civil Law

Workplace-specific disability assessments may be conducted in situations involving occupational health and safety acts, which are unique to each province (e.g., Ontario's Workplace Safety and Insurance Act [30]). Previously known as workers' compensation, these acts seek to compensate workers for injuries or disabilities attributable to the workplace. Some interprovincial and international industries, such as highway transport and banking, fall under federal rather than provincial jurisdiction under the Canada Labour Code. (31) Typically, the treating hospital or psychiatrist is asked to provide a report. Although this is a no-fault program, this does not mean that no disputes are litigated. (32) In particular, evaluations under this regime are made particularly difficult by the demand that an opinion include whether the disability or psychiatric symptomatology is caused by a workplace issue or accident.

Disability evaluations unrelated to occupational health and safety acts may not require proof that the disability arose from the workplace. Most disability plans have clauses compensating for periods of being disabled from the specific tasks of the employment (i.e., own occupation) that may continue for up to two years, at which time, a clause specifying disability is defined as being unable to work in any area in which the person may be qualified (i.e., any occupation).

In psychiatry, we know that biological, psychological, and social factors contribute to psychiatric presentations. In particular, a pre-existing mental disorder may predispose a person to being especially sensitive to stresses in the workplace. Examples of stresses include witnessing a workplace accident, being subject to violence in the workplace, or being harassed in the workplace. First responders are particularly at psychological risk given their exposure to traumas. Certain jurisdictions, like Ontario, assume that when a first responder, such as a firefighter, presents with posttraumatic stress disorder (PTSD), the disorder must have been caused by a stressor that happened in the workplace unless there is good reason to think otherwise.

In most provinces and territories, the Workplace Safety and Insurance Board can order a health examination to determine if they are liable for payment. The employer, on the other hand, may request a fitness to work assessment (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Fitness to Work/Practise*). In complicated cases, a forensic psychiatrist may be retained to perform an independent medical examination to assist the board or tribunal in reaching a decision. These decisions can then be appealed to the court system. The evaluation is like other types of disability evaluations. The board will want to hear whether the workplace issue or injury, which must have occurred during employment to qualify, caused the disability. The board will also likely ask to be informed of the percentage or level of impairment.

THE DISABILITY ASSESSMENT

Referral Question(s)

It is important to obtain written referral questions that include definitions prior to starting an evaluation, as definitions of impairment and disability vary. The referral question might include whether the person is claiming short-term disability or long-term disability. (25) Certain insurance policies also have clauses relating to whether a person can continue in the job they were doing before the onset of the disability (i.e., own occupation) or whether they can work in a different profession despite their impairment (i.e., any occupation). Employers will often want to know whether the evaluee could still work with reasonable accommodations despite an impairment (see below). In addition, the referring party can request information about any limitations, restrictions, or any treatments or accommodations that could assist the person to return to work.

The Assessment Setting

Disability evaluations are typically performed in private offices, outpatient clinics, the lawyer's office, and in some circumstances, the employee's workplace. It may be easier to ensure appropriate arrangements for a comfortable and safe interview environment in the psychiatrist's own office.

The assessor considers the same safety precautions as in any other forensic psychiatric evaluation. The general principles of limited confidentiality apply here (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*).

Sources of Collateral Information (Including Interviews)

As in other forensic evaluations, collateral information is essential. It is the forensic assessor's task to gather objective information regarding the evaluee's impairment and disability. Referral sources can provide independent material that informs the evaluation before the assessment. Sometimes, the assessor can obtain written consent to acquire the material.

The assessor can also obtain permission from the referral source prior to the interview if the assessor or multidisciplinary team member intends to contact collateral sources, such as family members, acquaintances, and other people in the workplace. It is generally accepted that consent is obtained from the evaluee prior to contacting family members and acquaintances.

Collateral information can be provided in different forms of written records or interviews, including the following:

- **Job descriptions**: A detailed job description could be provided by the referral agency to assess the relation between psychiatric symptoms and elements of the job. The work description may include a job-demands analysis that informs about the cognitive, emotional, and stress demands of the position, including what the workplace considers essential tasks.
- **Personnel files**: These can contain significant information about the evaluee's performance and attitudes. They may include disciplinary proceedings, anomalous behaviours, and evidence of difficulties that may be relevant to the evaluation. It can also be helpful to obtain personnel records from previous employers that may, for example, reveal patterns of behaviour.
- **Medical records**: Psychiatric, mental health, and general practitioner records, as well as any notes and summaries from treating doctors and counsellors may be helpful in the assessment. Any documented evidence of symptoms of mental disorder, as well as whether an evidence-based algorithm of treatment is delivered in adequate doses for an adequate period of time.
- **Informants**: Friends, acquaintances, work colleagues and supervisors, and family are all potential informants. The forensic assessor must consider potential bias and agenda, as informants may knowingly or unknowingly distort their self-report.
- **Information from a private investigator**: At times, the referral source provides information that has been acquired from the surveillance of an individual. For example, there may be video footage of the evaluee engaging in behaviour they have claimed they are unable to do. This goes to the credibility and reliability of the information, which can be useful in formulating conclusions.

The Interview Process

As described in the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*, informed consent is required at the start of any assessment. This includes an explanation of the limited confidentiality of the report and parameters of its release. Another significant preliminary issue is whether there are any conflicts of interest. In particular, the assessor ensures they have no personal or professional relationship with the evaluee. The interview process is a thorough psychiatric interview that includes a history of psychiatric symptoms; personal history, including previous medical and surgical history; enquiry into substance use; family history; and mental state examination (see *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*). Given the frequent adversarial stance of disability evaluees, the assessor may begin the interview focusing on information that is not emotionally charged, such as current living situation, including who is living at home with them. The assessor may move to an overview of the evaluee's leave, including when they went on disability (versus sick leave), whether they were without income for periods, and if they attempted to return to work.

Next, the assessor could review neutral details of the evaluee's job, including when they were hired, their starting position and any promotions, the size of their work team, their hours of work, and daily tasks of their position. Additional areas of interest are the evaluee's working relationship with colleagues and supervisors and any perceived bullying or harassment; any grievances, and whether they were found to have a basis; and aspects of work they enjoyed or disliked. It is also important to clarify if the evaluee's position is still available (many employers are only required to hold a position for two years) and whether they would like to return to that position and place of employment.

The assessor may find it helpful to elicit information about any history of childhood illness and how this was managed within the family, as well as illness in the family in general. They may focus on occupational history, including jobs the evaluee has done and why they left and moved to the next position. This could reveal a pattern of problems in the workplace that may or may not be related to psychiatric symptomatology; alternatively, it could reveal a pattern of workplace success

and stability. This will help in understanding characteristics of the evaluee's personality and coping styles in the face of adversity and can help the assessor understand the evaluee's motivation and attitudes about returning to work.

Part of the interview that is less common in other psychiatric interviews but integral to a disability assessment is a detailed history of the evaluee's typical day. This will include questions about what time they get up in the morning, who cooks their meals, whether they have a caretaker role within the household, and how they spend various portions of the day. It also includes whether they dress themselves, toilet themselves, or do household chores. It can be helpful in determining the evaluee's abilities, to ask about a good day and a bad day. This information may already be included in the referral file with an in-home occupational therapy assessment diminishing the need to review in the psychiatric evaluation.

This detailed history of a typical day would be followed by eliciting a similar history of the evaluee's typical workday, including details of any relevant tasks, which will point the assessor to specific questions concerning the capacity required to perform that work. This allows the assessor to consider how psychiatric and functional symptomatology affect the individual's ability to perform this particular job. For example, if someone with paranoid delusions works with the public, it would be important to determine if and how their delusions impact their interactions.

Other important areas of inquiry include the evaluee's hobbies, recreation, interests, social activities, and interactions, and whether they can still participate in these. This could include inquiries about travel and vacations. If there is surveillance information that supports or contradicts the evaluee's response regarding these activities, this is taken into consideration. The assessor looks for capacity to function in nonwork-related activities that have common elements with work demands to gauge how the person performs. This is especially relevant when asking about activities that require sustained attention, motivation, persistence, pace, and cognitive activity, as noted in the AMA Guides. (1) That said, stress tolerance might be specific to factors in the work environment and not leisure activities.

As with all legally defensible psychiatric evaluations, the assessor reviews current and past symptoms of illness to support a DSM diagnosis, even though the diagnosis may not be emphasized or even mentioned in the assessor's final opinion. The AMA Guides emphasize using the DSM for a diagnosis, although it was written when the DSM-IV TR was the most recent classification in psychiatry. (1) An evaluee might, at times, disproportionately emphasize life stressors, suggesting life was "perfect" except for their "toxic work environment." Alternatively, they may see other areas of life, such as a failed relationship, as the only stressor, minimizing other potential contributions to their stress.

A history of substance use and its effects on the individual are important in a disability evaluation. Substances can mimic various psychiatric disorders or may worsen symptoms, interfere with treatment efficacy, or signal poor coping skills. Whether the diagnosis of a substance use disorder fulfills the criteria for disability is up to the final decision-maker.

The assessor gains an understanding of the evaluee's previous treatments based on their health care records and self-report. They establish whether the evaluee has had a thorough diagnostic examination previously, been adequately treated for an adequate amount of time, complied with treatment, and attempted and completed a reasonable treatment algorithm. Further, the assessor notes the evaluee's response to each treatment.

Although there are no clear lines to distinguish a person who is considered "disabled" from one who is not, the following categories (derived from the AMA Guides) can help organize the assessment:

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

Adjunctive Testing, Including Standardized Psychometric Testing

The AMA Guides use three scales to rate an individual's level of impairment: the Brief Psychiatric Rating Scale (BPRS; developed for psychotic symptoms), the Global Assessment of Functioning (GAF) scale, and the Psychiatric Impairment Rating Scale (PIRS). (1) While these scales may be used to guide conclusions, they have limitations, and their use varies in Canada. Further, while the GAF was part of the marked multiaxial classification in the DSM-IV-TR, the DSM-5 abandoned this scale due to its conceptual lack of clarity and questionable psychometrics in routine practice, and instead suggested the use of the World Health Organization Disability Assessment Schedule (WHODAS-2.0) for those with a medical disorder. (2) This measure is based on self-report with no validity scales, and as such it has limitations. Some assessors in the United States and Canada have continued to use the GAF.

Medical investigations are conducted where relevant. Standardized psychometric testing may assist the assessor in understanding cognition, personality organization, and response style. Neuropsychological testing can be especially informative if a cognitive disorder is the focus of attention.

Formal personality testing can be helpful in supporting clinical diagnoses, especially regarding personality traits and disorders. Many of the standard personality tests have embedded validity scales, which can be most helpful in coming to conclusions about impression management, exaggeration or minimization of symptoms, or malingering. It is important to note that whether raw data from the psychometric testing will be released to other parties will depend on the guidelines set out by the individual tests and by the individual governing bodies.

Video and Audio Recording

For a discussion and guidance about video or audio and recording assessments, please see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*. The principles discussed therein equally apply to all third-party psychiatric evaluations.

Assessment of Self-Report Validity

As with every forensic psychiatric assessment, the assessor must consider the validity of the evaluee's self-report, including conscious or unconscious attempts to minimize or exaggerate psychiatric symptoms. The AMA Guides note that in a disability assessment, there is clear motivation to at least exaggerate symptoms or dysfunction, as the confirmation of disability may mean avoiding responsibility and the possibility of monetary gain. (1) However, the presence of such motivation is not synonymous with the presence of malingering. Malingering occurs across a spectrum and includes features such as fabricating, exaggerating, minimizing, and being vague or inconsistent about symptoms or claiming to experience unusual symptoms.

Drukteinas estimates that between 30% and 70% of people attending for disability evaluation display some type of symptom exaggeration or fabrication. (33) According to the DSM-5-TR, malingering should be suspected with any of the following: medicolegal context, marked discrepancy between the individual's claimed distress or disability and the objective findings, lack of cooperation during the diagnostic evaluation, diagnosis of antisocial personality disorder. (2) It is considered best practice in some circumstances to avoid the term "malingering" and instead use terms such as "over-endorsement," "symptom fabrication," "impression management," "symptoms without any objective basis," or "inconsistent responses," all of which have a more neutral tone. The assessor attempts to differentiate between a factitious disorder and malingering. In a factitious disorder, the evaluee presents symptoms to assume the sick role, whereas in malingering, the goal is to obtain money or other benefits. Both symptom exaggeration or minimization occur along a spectrum. The assessor's role is to determine the degree to which symptoms are exaggerated or minimized and how much the bona fide symptoms interfere with the evaluee's functional ability to work. (33) Some evaluees may intentionally feign good health in order to return to work due to a change in their benefits or, possibly, to retain their position, or they may present with a façade of wellness due to a lack of insight into the severity of their impairments.

In addition to weighing the self-report of the individual, the assessor will employ specialized skills in the mental state examination to assess symptom exaggeration, minimization, and fabrication. In conjunction with clinical expertise, a screening tool, such as the Miller Forensic Assessment of Symptoms Test (M-FAST) (34), or a test, such as the Structured Interview of Reported Symptoms, 2nd Edition (SIRS-II) (35), can be helpful. The assessor can also use the Minnesota Multiphasic Personality Inventory-2-Restructured Form MMPI-2RF (36)/MMPI-3 (37) or Personality Assessment Inventory (PAI) (38) to assist in understanding positive or negative impression management and other aspects of validity. Consultation with a psychologist or forensic psychologist may be considered.

The possibility of symptom exaggeration, minimization, or fabrication reinforces the importance of obtaining collateral information, using objective measures of functioning, having a solid understanding of mental disorders, refining mental state examination skills, and not relying solely on self-report. It also underscores the importance of avoiding the dual role of being both the treating and assessing psychiatrist wherever possible.

THE DISABILITY REPORT

Referring parties typically request a written report at the conclusion of disability evaluations. In some situations, however, a preliminary verbal report or written report might be requested.

The general principles of a forensic psychiatric report apply to the disability assessment. The assessor makes every effort to make the tone and language of the report non-judgemental and free from medical jargon. (39) Medical terms, when used, are explained.

See Table 4 for an example of a template for a disability report. The report includes the referral source, purpose of the assessment, information sources, and an acknowledgement of the evaluee's informed consent to participate in the evaluation. There is a summary of the evaluee's relevant background information, a review of the disclosure, and the collateral sources of information. The report describes the core assumptions the assessor has made based on their review of the data acquired, which in turn supports their final opinion. Opinions about the reliability of the data and any concerns about impression management are also

addressed. The assessor may provide an analysis of the information emphasized in the assessment as well as a comment on information that was not thought to contribute to the opinion, with an explanation of their decision.

The assessor may begin the opinion section of the report with a clinical summary of the case; predisposing, precipitating, perpetuating, and protective factors at play may be described. This is followed by an opinion addressing the specific questions of the assessment, which includes the DSM diagnoses, as applicable (for some employer-requested evaluations, the assessor may be asked not to report diagnoses or other personal health information), and an explanation of the symptomatology relevant to aspects of the evaluee's employment. The assessor provides specific examples of how a psychiatric symptom affects the evaluee's ability to fulfill their essential functions at work or how it leads to a restriction or limitation that might affect their ability to perform these functions. (39) The assessor tries to link any psychiatric symptoms to specific functional tasks of the particular employment. In particular, the facets of pace, persistence, or concentration may be particularly relevant to the ability to complete tasks in the workplace. The report may address the ability to complete workplace tasks and whether these can be completed with extra supervision, or rest periods.

The evaluee's previous treatments and responses to treatments are documented. Further, it is important to consider if a generally accepted or evidence-based algorithm for the treatments was used and whether treatment was optimized with regard to type and length of treatment and sufficiency of doses. Insurance will usually request treatment recommendations, which would include pharmacological and psychotherapeutic treatments. If requested, the assessor may provide a prognosis of the evaluee's expected chances of recovery from the disorder with references to future impairment and recommendations for future investigations and treatments.

If asked, the assessor may suggest reasonable accommodations to enable the evaluee to fulfill the essential functions of the job. This is defined as modifications or adjustments to the work environment that will allow persons with disabilities to enjoy equal benefits and privileges of employment as other employees. The accommodations may not be reasonable if they impose undue hardship on employers. Undue hardship may entail extensive cost or disruption to the organization, or impact it in other ways. (32,40) The accommodations should be "reasonable" and not require significant reorganization, promotion, or expense. Inappropriate recommendations might include creating a new position, eliminating essential job functions, not interacting with a supervisor, reducing performance standards, eliminating performance evaluations, and providing a stress-free work environment. (39,41) Some additional "reasonable accommodation" suggestion and resources can be found at www.askjan.org. In the final analysis, the decision whether an accommodation is reasonable is judiciable.

Table 4. Example of a Template for a Disability Report

- Referral source
- Reason for assessment and specific question(s) to be addressed
- Summary of expertise and acknowledgement of duty to provide opinion evidence that is fair, objective, nonpartisan, and related only to matters within the assessor's area of expertise (wording will depend on the jurisdiction)
- Sources of information and date and length of interviews
- Preliminary caution including informed consent
- Introduction/identifying information
- Concerns identified
- Onset and course of symptoms and associated functioning
- Review of current symptoms
- Typical day (before and after onset of problems)
- Social/recreational routines
- Recent occupational status in relation to symptomatology
- Occupational history
- Personal history
  - Early history
  - Education history
  - Relationship history
  - Legal history
  - Family history
- Psychiatric history and mental health treatments
- Substance use history
- Medical and surgical history
- Mental state examination
- Collateral information
- Results of adjunctive tests or investigations, including rating scales
- Opinions and recommendations:
  - Summary (essential features of background)
  - Limitations and reliability of the information
  - Addressing specific questions related to disability, which may include:
    - Diagnoses (and rationale for each) and symptomology (and impact on function)
    - Prior treatments and impact
    - Recommendations for treatment, management, and work accommodations
    - Other considerations
- Signature block

Author Affiliations

[1]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada.

REFERENCES

1. Rondinelli RD. AMA guides to the evaluation of permanent impairment. Chicago (IL): American Medical Association; 2006.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders 5 Revised (DSM-5-TR). Arlington (VA): American Psychiatric Association Publishing; 2022.
3. Gagnon F, Kertay L. Avoiding psychiatric disability overdiagnosis, part 1: general disability and occupational disability—going beyond medical impairment assessments. AMA Guides Newsletter 2021;26(4):37.
4. Hinze v. Great Blue Heron Casino [2011] HRTO 93 (2011).
5. JL v. York Region District School Board [2013] HRTO 948 (2013).
6. Anderson v. Envirotech Office Systems [2009] HRTO 1199 (2009).
7. Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City), 1 SCR 665 (2000).
8. Granovsky v. Canada (Minister of Employment and Immigration), 1 SCR 703 (2000).
9. Dawson v. Canada Post Corp., 2008 CHRT 41 (2008).
10. Mental illness and addiction: facts and statistics. n.d. [cited 2023 June 26]. Available from: https://www.camh.ca/en/driving-change/the-crisis-is-real/mental-health-statistics.
11. Booth BD, Watts J, Dufour M. Lessons from Canadian courts for all expert witnesses. J Am Acad Psychiatry Law 2019;47(3):278–285.
12. Statistics Canada. Mental health-related disabilities in Canada, 2017. Her Majesty the Queen in Right of Canada as represented by the Minister of Industry. 2019.
13. Report on mental illness in Canada; 2002. [cited 2023 June 26]. Available from: https://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf.
14. "Psychology works" fact sheet: bipolar disorder; 2019. [cited 2023 June 26] Available from: https://cpa.ca/psychology-works-fact-sheet-bipolar-disorder/.
15. Yaren S. The psychiatrist's role in disability claims. In: Bloom H, Schneider R, editors. Mental disorder and the law: a primer for legal and mental health professionals. Toronto (ON): Irwin Law; 2013.
16. Entrop v. Imperial Oil Limited [2000] CanLII 16800 (2000).
17. Ontario (Disability Support Program) v. Tranchemontagne [2010] ONCA 593 (2010).
18. Ball v. Ontario (Community and Social Services) [2010] HRTO 360 (2010).
19. Turner v. Canada Border Services Agency [2014] CHRT 10 (2014).
20. Noe v. Ranee Management [2014] HRTO 746 (2014).
21. Redmond v. Hunter Hill Housing Co-op [2013] BCHRT 276 (2013).
22. Ottawa (City) v. Canada (Human Rights Comm.) (No. 2) [2005] FCA 311 (2005).
23. Davidson v. Brampton (City) [2014] HRTO 680 (2014).
24. Mou v. MHPM Project Leaders [2016] HRTO 327 (2016).
25. Anfang SA, Wall B. Long-term disability evaluations for private insurers. In: Gold LH, Vanderpool DL, editors. Clinical guide to mental disability evaluations. New York (NY): Springer; 2013. p 241–257.
26. Eagleson Co-Operative Homes Inc., Re, (2006) 218 O.A.C. 321 (DC)
27. Hydro-Québec v. Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ), 2008 2 SCR 561, 2008 SCC 43.
28. Dodgson v. Great West Life Assurance Co. et al., 2014 ONSC 389.
29. Francis v. Ontario, 2020 ONSC 1644.
30. Workplace Safety and Insurance Act, 1997, SO 1997, c. 16, Sched. A.
31. Canada Labour Code, RSC 1985, c. L-2.
32. Anfang SA, Gold LH, Meyer DJ. AAPL practice resource for the forensic evaluation of psychiatric disability. J Am Acad Psychiatry Law 2018;46(1):103.
33. Drukteinas AM. Psychiatric disability. In: Gold L, Frierson RL, editors. Textbook of forensic psychiatry. 3rd ed. Arlington (VA): American Psychiatric Association Publishing; 2018.
34. Miller HA. Miller forensic assessment of symptoms test: M-FAST; professional manual. Psychological Assessment Resources; 2001. [cited 2023 June 26]. Available from: https://www.parinc.com/Products/Pkey/230.
35. Rogers R. Structured interview of reported symptoms. In: Corsini RJ, editor. The Corsini encyclopedia of psychology. Hoboken (NJ): John Wiley & Sons; 2010. p. 1–2.
36. Ben-Porath Y, Tellegen A. Minnesota Multiphasic Personality Inventory-2 Restructured Form. Minneapolis (MN): University of Minnesota Press; 2008.
37. Ben-Porath Y, Tellegen A. Minnesota Multiphasic Personality Inventory-3. Minneapolis (MN): University of Minnesota Press; 2020.
38. Morey LC. The Personality Assessment Inventory professional manual. Lutz (FL): Psychological Assessment Resources; 2007.
39. Gold LH, Shuman DW. Evaluating mental health disability in the workplace. New York (NY): Springer; 2009.
40. Barras A, Selby JA, Beaman LG. Rethinking Canadian discourses of "reasonable accommodation." Social Inclusion 2018;6(2):162-172.
41. Piechowski LD, Rehman U. Americans with Disabilities Act evaluations. In: Drogin EY, Datillo FM, Sadoff RL, et al, editors. Handbook of forensic assessment: psychological and psychiatric perspective Hoboken (NJ): Wiley; 2011.