Forensic Psychiatry in the Workplace

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Disclaimer

No commercial or other conflicts of interest.

Opinions expressed are my personal ones, and not those of McLean or Harvard Medical School.

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Scope

- Most of you are on the front line in making clinical decisions
- My perspectives: parachuting (or phoning) in to mitigate, alarm, or assure
- Case examples—lots of feedback wanting these last year

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My Role

- Usually as a fitness for duty, sometimes threat assessment

  for violence or suicide
- Sometimes urgent
- Sometimes asked to medicalize a difficult worker who has been poorly managed—not appropriate
- Pre-employment, post-employment, return to work, specialized (e.g. biolab, police)

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Pre-evaluation

- Is it a psychiatric emergency? Psychotic? Manic?
- Is there an acute threat of violence? Have police been involved?
- What are the workplace behaviors of concern?
- What have been the observations of supervisors, coworkers?
- Why have they not been handled by routine administrative procedures?
- What is the employee’s baseline functioning at work?

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Permitted Clinician Reporting

- HIPAA and state privacy laws.
- **Good faith belief** that patient poses **a serious and imminent threat** to another person
- May divulge protected health information of a **minor** to a parent or guardian in most cases
- If patient has signed a written **authorization**
- ****Absent consent, concerned other/friend/family may contact police or courts******
- Involving certain criminal activity
- May also report information to law enforcement about a crime that has occurred on the premises of the health care facility.

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Usual Evaluation Procedures

- Discuss and review presenting problem
- Broad record review when feasible
- Employee cannot be required to provide personal medical/psychiatric records
- Social media!!
- On-site school records available if violence risk
- Interview collaterals in advance when feasible
- Informed consent verbal and written (“Lamb”)
- No gratuitous info in report
- Mass law requires report release to patient if requested
- Duty to protect may trump confidentiality

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Safety Considerations First

- If psychotic/manic/agitated: ER, not workplace
- Consider on-site security/police
- Low bar for requiring frisk/car inspection
- Evaluee may be irate, offended
- Potential anger, substance use, paranoia
- Consider safety plans
- Always ask about gun access, try to confirm
- Always ask about thoughts of harm to self/others
- Do not rely on words only: **total clinical picture**
- Never ignore “hairs on back of neck”
- Fine to ask if patient verging on violence to you
- “You are frightening me.”

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High Stakes for Doctor and Patient

- Loss of job, student status, relationships
- Loss of privacy, confidential psychiatric information
- Assessment inherently stigmatizing, humiliating
- Potential for litigation
- Risk to the general public with certain professions (physicians, airline pilots, police)

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David Rosmarin, MD

CONSENT TO FITNESS FOR DUTY EXAMINATION

1. I, ____,
agree to be psychiatrically examined by David Rosmarin, M.D.

2. Dr. Rosmarin has advised me that the purpose of this examination is to come to an opinion, at the request of: ___________________

3. I understand that anything I say cannot be considered confidential, as it may become part of Dr. Rosmarin's's report and/or communicated to the party who has requested the evaluation. I understand that Dr. Rosmarin's report may be communicated in part or entirely to my insurer, my benefits management company, and/or my employer and legal counsel. **4.** Dr. Rosmarin has advised me that this examination does not establish a doctor-patient relationship, and that Dr. Rosmarin will not provide treatment to me, at this time or in the future. **5**. I agree to Dr. Rosmarin discussing his findings with and releasing a report of his findings to:

6.I understand that Dr. Rosmarin will release his findings only to the above party/parties, except if required by court order or law. I also understand that Dr. Rosmarin does not control the distribution of the findings or report, if any, after they have been forwarded to the above party/parties. **7**.In the event that Dr. Rosmarin determines I am a danger to myself or others, Dr. Rosmarin may breach the confidentiality restrictions above.

Signed: __________________Date: ___________

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ADA & FFD

Even if disabled per ADA:

•"Direct threat" may result in termination

•"a **significant risk of substantial harm** to the health or safety of the individual or others that cannot be limited or reduced by reasonable accommodations."

•"Accommodations" not required for severe conduct problems

"Nothing in the ADA prevents an employer from maintaining a workplace free of violence or threats of violence..." (EEOC)

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ADA & FFD

•May not discriminate due to a disability

• Employee must be able to perform "**essential job functions**"—with or without "**reasonable accommodations**"

•Different expectations and job functions on a loading dock not interacting with customers versus meet and greet at Tiffany's

•Employer may require a fitness for duty eval when safety question arises

•Employer liable if **knows or should know** risks to others

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Risk Assessment History

- Careful assessment of past violence, perhaps the best predictor: most violent act, trajectory up or down?, associated ideation at the time of violence
- Assess phenomenology of each prior act
- Get collateral info (victim, family, police)
- Ask collaterals about level of concern
- Discern pattern of violence: psychotic? SA? Narcissistic rage? Revenge for disrespect/shame?
- Is violence ego-dystonic or ego-syntonic?

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Tolerate Ambiguity

Need to triangulate:

1. Anxiety/ambiguity/uncertainty
2. Duty to mitigate violence risk
3. Tendency to over-assess risk

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Risk Assessment, not Prediction

- **Magnitude**: verbal, shove, strike, shoot
- **Likelihood**: low, medium, high
- **Imminence**: immediate, short-term, chronic
- **Frequency**: one-time, repeated
- For each and overall: low, medium or high
- Be humble, tolerate uncertainty, and try to articulate the valence given each factor.

- Someone may be low imminence, moderate likelihood, chronic risk, and high potential magnitude—high magnitude always the case with guns.

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Structured Professional Judgment

- What are **dynamic** factors?
- Stressors, family/school/work conflicts, active symptoms, medication refusal/adherence, treatment availability, SA, living arrangements, limited choices, humiliation, entitlement, grudge, fatalism, grandiose fantasies, concurrent suicidality, **gun access**
- What are **static** factors?
- History of violence, mental illness, antisocial/narcissistic/paranoid/obsessive traits, violent subculture, brain insults, past injustices
- What valence is accorded each factor—a matter of judgment
- Is physician risk aversion static or dynamic?

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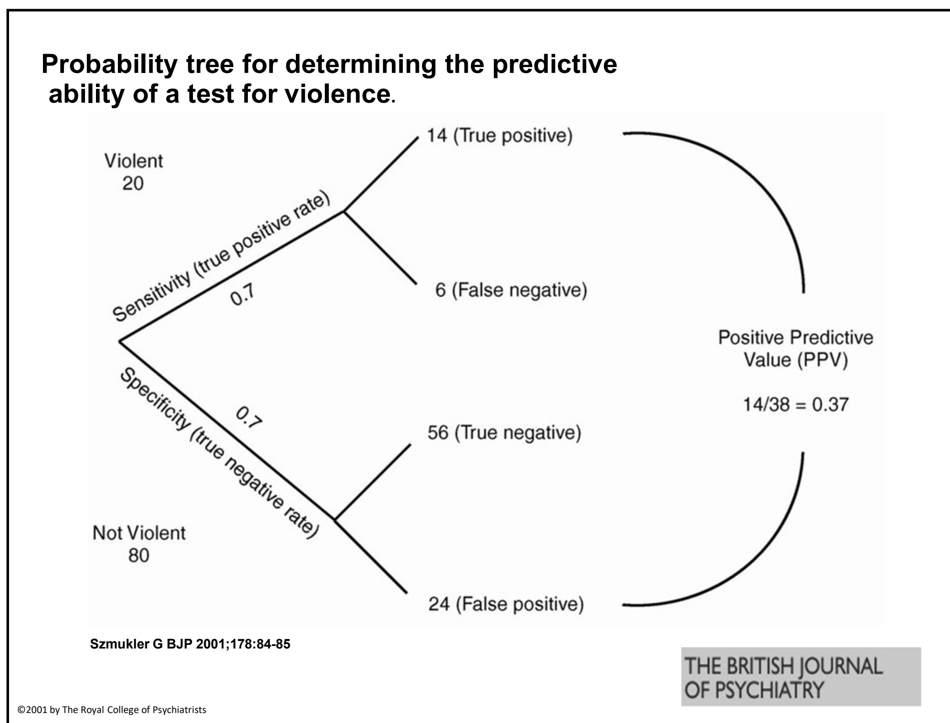

Childhood Brutalization

"Hurt people hurt people."

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Rosmarin's Ocean of Anxiety: 9 of 18

- Anti-social attitudes or culture
- SA
- Past history violence
- Active major mental illness, high+ / low - sx
- Psychosis crescendo, especially first event: paranoia, commands, (MacArthur: threat/control override sx not substantiated)
- Anger
- Depression, brooding, irritability
- Stalking, boundary breaches

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Rosmarin's Ocean of Anxiety: 9 More

- Ongoing stressor/loss
- Externalizes blame
- Desperation/narrow thinking/status loss
- Preoccupation with violence
- Grievance/revenge
- Justification/entitlement
- Specific > implied threat
- Steps taken/planning
- Fatalism/suicidality
- **Gun access, fixation, recent acquisition**

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Range of Outcomes

- Low risk/FFD, return to duty, home, school
- Return under certain conditions; Rx
- Return when outside treater says ok (with or without forensic return exam)
- Outside treatment serves as warning "radar"
- Significant risk: no return to duty, home, school
- **Access/cost may argue for employer/school payment for appointments or medications**
- Emergency: police, commitment, duty to protect

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