"Heck of a Job!"

Understanding & Assessing Emotional Damage Claims in Employment Litigation

Presented By the Office of the Attorney General
State of California (Oakland)
January 9, 2008
12 noon – 5p.m.

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INTRODUCTIONS

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TOPICS TO BE DISCUSSED:

1. Who is **fpa**med and what is a Forensic Psychiatrist and Psychologist?
2. What is a Mental Disorder?
3. Why do employees litigate?
4. What are "forensic" psychiatrists and psychologists?
   - Distinguishing the training and role of a forensic psychiatrist from a forensic psychologist

TOPICS TO BE DISCUSSED:

5. Contrasting the independent “forensic” expert with the “treating” clinician
   - Differences in mission, perspective and approach
   - Differences in ethical obligations
   - The "Wearing Two Hat's" Problem: dual agency
   - The problem of "advocacy" in expert testimony.

TOPICS TO BE DISCUSSED:

6. The crucial functions performed by the forensic psychologist and neuropsychologist:
   - Why is psychological testing so important in forensic evaluations?
   - Why should only an experienced psychologist administer and interpret forensic testing?
   - What is the difference between a psychologist and a neuropsychologist?
   - What is a “battery” of tests?

TOPICS TO BE DISCUSSED:

7. The crucial functions performed by the forensic psychologist and neuropsychologist:
   - What are “validity” and “reliability” in psychological testing?
   - What is “effort” or “malingering” testing?
   - Is psychological testing a “lie detector?”
   - What are the most commonly used personality and intelligence test instruments and how do they work?
   - What are neurocognitive tests?

TOPICS TO BE DISCUSSED:

8. What are the most common employment complaints alleged to have caused the emotional injuries evaluated by forensic psychiatrists and psychologists?
9. Typical Issues addressed in a forensic psychiatric IME
10. The role of substance abuse in the workplace and in employment litigation

TOPICS TO BE DISCUSSED:

11. Common procedural problems associated with obtaining a forensic psychiatric IME:
    - Motions to Compel a mental examination
    - So-called "garden variety" emotional distress:
      Doyle v. Superior Court (Caldwell)
12. Tips on deposing mental health experts
13. Strategic reason for assessing psychological damages *while* (rather than *after)* liability is being established

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FORENSIC PSYCHIATRIC ASSOCIATES MEDICAL CORPORATION

The Depth and Breadth of our Forensic Psychiatric & Neuro- Psychological Practice

- •Medical, psychiatric, psychological and legal training at Columbia, Yale, UC Berkeley, UCSF, Johns Hopkins, Duke, Northwestern and New York Universities.
- •Board Certifications in Psychiatry & Psychology, Forensic Psychiatry & Psychology & Neuropsychology
- •Additional Training & Subspecializations in Forensic Psychiatry and Psychology, Addiction Medicine, Child and Adolescent Psychiatry, Acute Care Psychiatry, Psychopharmacology, Psychoanalysis, Neuropsychology and Pediatric Neuropsychology

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WHO IS (AND WHO IS NOT) A FORENSIC PSYCHIATRIC & PSYCHOLOGICAL EXPERT?

- CREDENTIALS:
  - BASIC PROFESSIONAL TRAINING AND CERTIFICATION
  - SPECIALTY BOARD TRAINING & CERTIFICATION
  - MEDICAL-LEGAL KNOWLEDGE
  - MEDICAL-LEGAL EXPERIENCE
  - PROFESSIONAL HONORS
  - PROFESSIONAL SOCIETY MEMBERSHIP
  - THE PROBLEM OF *"VANITY"* (i.e., "PSEUDO") BOARDS

“VANITY BOARDS”

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QUALIFICATIONS OF A FORENSIC PSYCHIATRIC EXPERT

- American Board of Psychiatry and Neurology (ABPN) Certification in Forensic Psychiatry Requirements:
  - MD + Internship + 3 year full time residency in Psychiatry
  - Diplomate ABPN (General Psychiatry)
  - Completion of 1 year Fellowship in Forensic Psychiatry at Approved Medical Institution
  - Passing ABPN's Comprehensive, ½ day, Examination in Forensic Psychiatry

ADVANCED CREDENTIALS IN PSYCHIATRY

- ABPN Diplomates (Board Certification) in General Psychiatry and/or Child Psychiatry *With Added Qualifications in Forensic Psychiatry*
- Fellows (FAPA) and Distinguished Fellows (DFAPA) of The American Psychiatric Association – recognized for special contributions to the field
- Membership in Professional Organizations:
  - American Psychiatric Association
  - American Academy of Psychiatry and the Law
- Faculty Appointments

QUALIFICATIONS OF A FORENSIC PSYCHOLOGICAL EXPERT?

- Education, Training & Experience
- Board Certification by the American Board of Professional Psychology (ABPP) and the American College of Law and Psychology
- To be eligible to apply for board certification in Forensic Psychology:
  - 100 hours in formal education, direct supervision or continuing education
  - 1000 hours of experience
    - Post-Doctoral Training Program
    - Post-Doctoral Experience
    - Work Sample Submission (written test)
    - Oral Examination

ADVANCED CREDENTIALS: PSYCHOLOGY

- Diplomates (ABPP & Other Psych Board Certification)
- Fellows (special contribution to the field)
- Membership in Professional Organizations
  - Society for Personality Assessment (SPA)
  - National Academy of Neuropsychology (NAN)
  - American Academy of Law and Psychology
  - American Board of Professional Psychology (ABPP)
  - National Register of Health Providers in Psychology

PROFESSIONAL ETHICS

- Forensic Psychiatry
  - Ethical Guidelines of the American Psychiatric Association and
  - Ethical Guidelines of the American Academy of Psychiatry & the Law
- Forensic Psychology
  - Ethical Guidelines of the American Psychological Association
  - APA Committee on Ethical Guidelines for Forensic Psychologists

FORENSIC PSYCHIATRISTS & PSYCHOLOGISTS DIFFER FROM TREATING CLINICIANS

- Different Ethical Obligations
- Different Missions
- Different Methods
- Different Perspectives

FORENSIC PSYCHIATRISTS & PSYCHOLOGISTS DIFFER FROM TREATING CLINICIANS

- Different Ethical Obligations:
  - Expert's ethical obligation is to provide to the fact finder objective opinion based upon evidence
  - The Treating Clinician's ethical obligation is to his patient: *Primum Non Nocere* ("First do no harm")

FORENSIC PSYCHIATRISTS & PSYCHOLOGISTS DIFFER FROM TREATING CLINICIANS

- Different Missions:
  - The mission of the Independent Expert is *to seek objective evidence*.
  - The mission of the Treating Clinician is *to relieve suffering*.

FORENSIC PSYCHIATRISTS & PSYCHOLOGISTS DIFFER FROM TREATING CLINICIANS

- Different Methods:
  - Forensic Expert strive to review all available data (All Medical Records, Legal Documents, Test Data and to conduct a Diagnostic Interview Examination of the Plaintiff)
  - Treaters rely almost exclusively upon their patient's subjective self report of "fact."

FORENSIC PSYCHIATRISTS & PSYCHOLOGISTS DIFFER FROM TREATERS

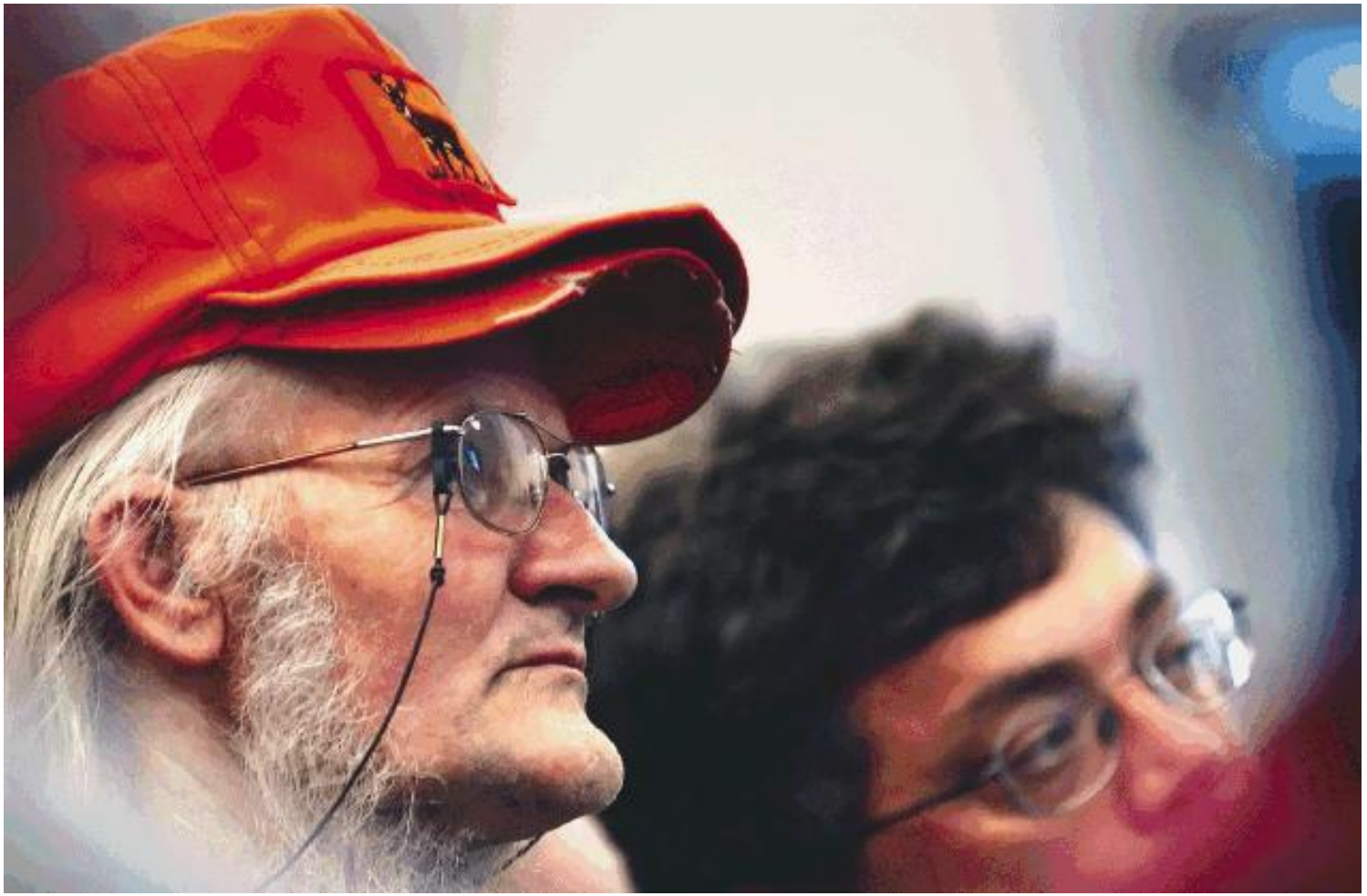
- Different Perspectives:
  - Forensic Experts seeks an *objective* perspective based upon a careful and detailed assessment of all the clinical evidence, *including psych testing whenever possible*.
  - In litigation, Treating Clinicians inevitably and appropriately *advocate* for their patient's own *subjectively defined self interest*

ADVOCACY

Often Physicians Confuse Their Roles as *Treating Clinicians* with Their Roles As *Independent Experts*, Creating…

THE PROBLEM OF *WEARING TWO HATS*

THE PROBLEM OF WEARING 2 HATS IS *DUAL AGENCY*…



… and *Role Confusion*

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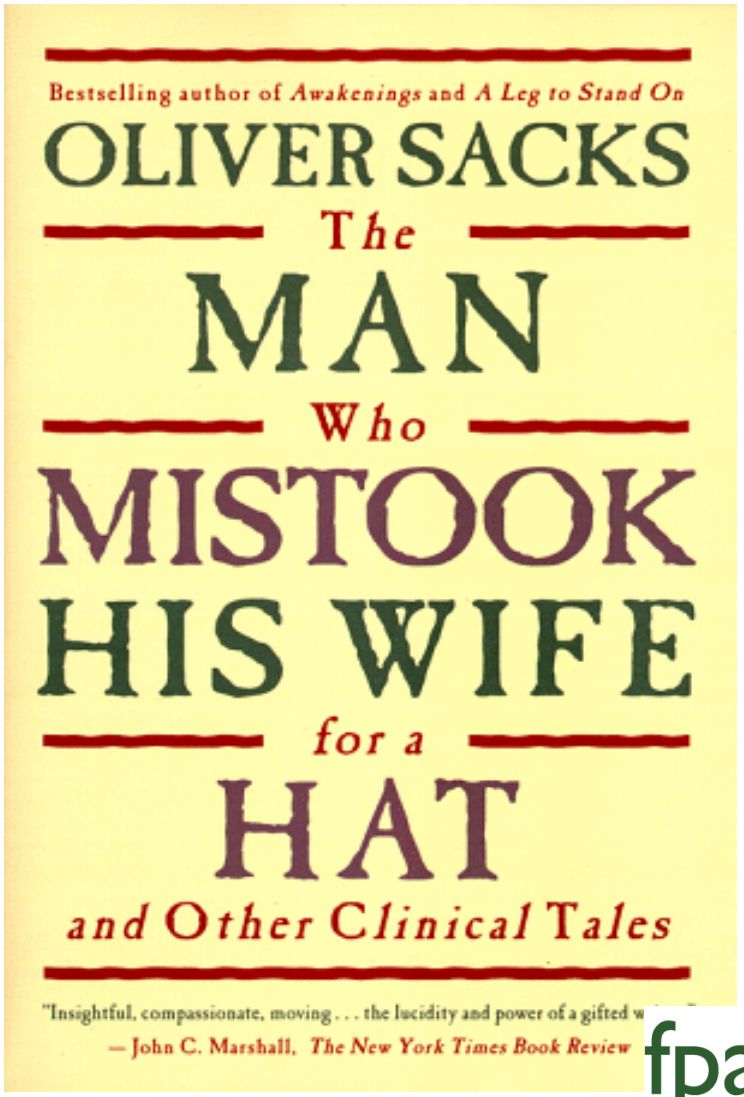
WHICH ALSO OCCURS WHEN…

- THE LAWYER MISTAKES HIS CLIENT'S *TREATING DOCTOR…*
- FOR AN *INDEPENDENT EXPERT*
- AS IN…



AND THE PROBLEM WITH ROLE CONFUSION IS…

THE ATTORNEY
HAS A “DOG”
AS HIS EXPERT

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EXPERT vs. ADVOCATE

1. Although It Is Appropriate for Treating Clinicians to *Advocate for Their Patients…*

2. Independent Experts Should NEVER "Play Lawyer" and *Advocate for Plaintiff or Defendant*.

3. *Independent Experts Should Only Advocate for their own Evidence-Based Opinions* – Nothing More, Nothing Less.

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FORENSIC PSYCHIATRISTS & PSYCHOLOGISTS COLLABORATE - WE DON'T DUPLICATE

- We complement each other's expertise
- We differ in our…
  - Professional Education
  - Post-Graduate Training
  - Areas of Special Expertise

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What is a Mental Disorder?

- A *clinically significant* behavioral or psychological syndrome or behavior pattern
  - associated with *present distress* (e.g., a painful symptom) or *disability* (i.e., *functional impairment* in one or more important areas of functioning)
  - or with a *significantly increased risk* of suffering death, pain, disability,
  - or an *important loss of freedom*.
    - (DSM-IV)

Standard Nomenclature: *DSM-IV(TR)*

- Multi-Axial System
  - Axis I Major Acute Psychiatric Conditions
  - Axis II Personality Disorders
    - Maladaptive chronic patterns of behavior
  - Axis III Medical Issues
  - Axis IV Psychosocial Stressors
  - Axis V Global Assessment of Functioning
    - GAF 1- 100 scale

Limitations of *DSM-IV (TR)* Approach

- Diagnostic categories are not discrete entities with absolute boundaries
- Heavy reliance on *clinical interview* data and examinee's *self report*
- Pseudo *evidence-based*
- *Static, not dynamic, diagnoses*

Limitations of *DSM-IV(TR)* Approach

- In Forensic contexts, DSM classification is *insufficient to meet many legal standards* of interest to attorneys and adjudicators. It is not sufficient to establish the existence of " mental disability" or "mental disease". Additional information is required to meet these legal standards. This usually includes information about the individuals *functional* (i.e. real-world) impairments and how these impairments affect specific abilities within an individual.

DSM-IV (TR)
Cautionary Statement

- "The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement *among clinicians and investigators. The proper use of these criteria requires specialized clinical training* that provides both a body of knowledge and clinical skills."

DSM-IV (TR)
Cautionary Statement

- "The clinical and scientific considerations involved in categorization of these conditions as mental disorders *may not be wholly relevant to legal judgments*, for example, that take into account such issues as individual responsibility, disability determination, and competency."

Other Limitations of *DSM-IV (TR)* Approach

- It should also be noted that inclusion in the DSM-IV classification system does not necessarily convey any information about the *cause* (etiology) of the disorder.
- Nor does it convey information as to whether the individual can *"control"* his or her behavior.

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WHY DO EMPLOYEES LITIGATE?

- The legitimately injured: employees who have *actually* been wronged, injured or both.
- The emotionally troubled: employees who *believe* that they have been wronged, injured or both, *regardless of the validity of that belief.*
- Somaticizers: individuals who experience their emotional pain as physical dysphoria.
- The extortionists: malingerers who *fake* injury to *shake-down* compensation out of *a sense of entitlement* (sociopaths).
- Any combination of the above.

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THE EXTORTIONIST

…Someday, and that day may never come,
I'll call upon you to perform a service for me….
- Don Corleone

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THE SHAKEDOWN ARTIST

…after you've "hit on" me while I've been working for you, do you really think you can fire me, just like that? I've been damaged!!

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WHY EMPLOYEES LITIGATE

And then there are those employees who rarely litigate, but are just *unfit for duty….*

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MOST COMMON PSYCHIATRIC FOCUS IN EMPLOYMENT LITIGATION

NIED & IIED Arising from…

- Allegations of ethnic, gender, age or disability discrimination and/or harassment
- Allegations of disability (ADA and FEHA accommodation demands)
- Questions about employee's fitness for duty
- Wrongful termination
- Traumatic stress: *does the employee have PTSD or not?*
- Traumatic brain injury: mild or moderate?

TYPICAL QUESTIONS ASKED IN A FORENSIC PSYCHIATRIC IME

- Does the plaintiff have a *"mental disorder"* (per *DSM-IV –TR*)?
- If so, what specific *functional impairments* does the plaintiff exhibit?
- Was the mental disorder *caused* by the alleged conduct of the defendant?
- What is the disorder's *normal course and prognosis*?

TYPICAL ISSUES ADDRESSED IN A FORENSIC PSYCHIATRIC IME

- What is the *recommended treatment* for the disorder? (Is the treatment that Plaintiff is *currently* receiving *appropriate*?)
- What is the *typical cost* for the recommended treatment?

THE CRUCIAL ROLE OF THE FORENSIC PSYCHOLOGIST & NEURO-PSYCHOLOGIST IN EMPLOYMENT LITIGATION

- The unique functions performed by the forensic psychologist and neuropsychologist:
  - Why is psychological testing so important in forensic evaluations?
  - Why only experienced psychologists should administer and interpret forensic testing?
  - What is the difference between a psychologist and a neuropsychologist?
  - What is a “battery” of tests?

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THE CRUCIAL ROLE OF THE FORENSIC PSYCHOLOGIST/NEURO-PSYCHOLOGIST IN EMPLOYMENT LITIGATION

- The unique functions performed by the forensic psychologist and neuropsychologist:
  - Are psychological tests "lie detectors?"
  - The reliability and utility of the Rorschach Inkblot Personality Test.
  - When is neuro-cognitive testing indicated?
  - Malingering: when can it and when can it not be determined with "reasonable psychological certainty"

WHAT IS A FORENSIC PSYCHOLOGIST?

- Someone who has special training, education and supervised experience in applying Psychological Principles and Tests in legal settings.
- Someone who has training in Legal Standards and Cases and considers the legal context in which Psychological Methods are employed.
- Someone who is required to demonstrate evidence to support their opinion.

Committee on Ethical Guidelines for Forensic Psychologists

- Obligation to provide services in a manner consistent with the highest standards of their profession.
- Do not provide services on the basis of “contingency fees”.
- Have an obligation to document and be prepared to make available all data which form the basis for their opinions.

Committee on Ethical Guidelines for Forensic Psychologists

- Must provide documentation in a manner which is subject to reasonable judicial scrutiny.
- Must recognize that the standard for documentation is higher that for general clinical practice.
- Must provide the best documentation available under the circumstances.

Dismissal of Evidence – Daubert Finding

- "Test Administrators should follow carefully the standardized procedures for administration and scoring specified by the test publisher"
  - Standards for Educational and Psychological Testing of the American Psychological Association.
  - Failure to follow standardized procedures may constitute an ethical violation (unless there is a compelling reason to do so).

Standards for Testimony

- Forensic Psychologists have an obligation to present their findings in a fair manner.
- They do not misrepresent evidence by omission or commission of data.
- They must not participate in partisan attempts to avoid, deny or subvert evidence contrary to their own position.
- They may make a forceful presentation of their data and their reasoning upon which their opinions are based.

What is Clinical “Evidence?”

Clinical “evidence” should be obtained from a variety of sources. These should information obtained from the following areas:

- Historical data
- Behavior observed during the assessment
- Psychometric testing data

Historical Data

Sources for historical data that can be useful often include these areas:

- Medical history, including the history of past problems as well as those related to the current litigation
- Psychiatric history, including the history of past problems as well as those related to the current litigation
- Academic history
- Work history
- Legal history

Behavior During the Assessment

Behavior occurring during the clinical evaluation can provide valuable information. This may include

- Unusual emotional states that seem strange or inappropriate to the situation
- Unusual or atypical motor behavior
  - restlessness
  - tremor
  - startle reactions
  - unusual use or poor use of arms/hands/legs
  - unusual gait or posture
  - unusual or inappropriate facial expressions
- Poor attention and concentration
- Apparent lack of effort or fluctuating effort levels

What is Psychometric Testing Data?

Psychometric testing data includes the scores and pattern of scores and individual responses provide by the following types of tests:

- Intelligence tests (e.g. WAIS-III and WISC-IV)
- Personality tests
  - Self-Report endorsement tests (e.g. MMPI-2)
  - Projective tests (Rorschach Inkblot Test)
- Neurocognitive Tests (e.g. WMS-III, D-KEFS, etc.)
- Tests of "effort" and malingering (e.g. the Test of Memory Malingering/TOMM)

How Can Testing Help?

- Psychological testing is a powerful tool that can provide important information about a plaintiff's state of mind.
- It is a primary means of obtaining objective information about the examinee's emotional and cognitive functioning.
- It is one of the best means available to assess response orientation, level of effort and the likelihood of malingering.

What is a Battery Of Tests?

- A *test battery* is comprised of a group of tests selected to help answer specific questions relevant to the case. Tests are selected to *provide information regarding the individual's level of functioning* and the *presence or absence of particular emotional or cognitive disorders.*

- Test selection also should be guided by the *reliability and validity* of each of the tests.

What Does a Test Battery Include?

The domains assessed may include

- Intellectual Ability (IQ level)
- Attention, Self-Monitoring and Higher Order Problem Solving (Executive Functions)
- Memory
- Personality
- Sensory-Motor Skills
- Motivation and Effort

What Is Reliability?

In psychological assessment, reliability measures whether you would get the same or very similar results if the individual is assessed

- later with the same instrument.
- by another examiner with the same instrument.

What Is Validity?

Validity assesses whether the test measures what it is supposed to measure.

For example, does a PTSD test accurately identify only people with PTSD, or does it also identify people who are “faking” PTSD, or those who have other anxiety disorders or depression?

Commonly Used Tests of Personality

- SELF REPORT PERSONALITY TESTS
  - Minnesota Multiphasic Personality Inventory, 2nd Ed. (MMPI-2)
  - Personality Assessment Inventory (PAI)
  - Millon Clinical Multiaxial Inventory, 3rd Ed. (MCMI-III)
    - Problems with bias
- PROJECTIVE TESTS
  - Rorschach Inkblot Test
    - Helps assess bias (psychological x-ray)
    - Is as reliable as any other personality test

Validity & Reliability of the Rorschach

The Society of Personality Assessment's Endorsement of the Rorschach, Published in the Journal of Personality Assessment, 85(2), 219-237, 1985.

This article was intended for psychologists, other mental health professionals, educators, attorneys, judges, and administrators. Its purpose was to present a summary of the issues and evidence concerning the Rorschach.

The article concludes and affirms that **the Rorschach possesses reliability and validity similar to that of other generally accepted personality assessment instruments and its responsible use in personality assessment is appropriate and justified.**

Neuropsychological Tests

- Wechsler Adult Intelligence Scale-III (WAIS-III), Wechsler Intelligence Scale for Children-IV (WISC-IV)
- Wechsler Memory Scale–III (WMS-III)
- Numerous specialized tests:
  - Executive functioning (logical & goal oriented behavior)
  - Aphasia (language)
  - Academic functioning
  - Motor functioning
  - Visual-Spatial functioning
  - Halstead-Reitan Neuropsychological Battery
  - Luria-Nebraska Neuropsychological Battery

Symptom Validity/Effort Tests

- Malingering tests
  - Personality tests
    - MMPI-2
    - PAI
    - MCMI-III
  - Memory/Neuropsychological
    - Test of Memory Malingering (TOMM)
    - Word Memory Test (WMT)
    - Victoria Symptom Validity Test (VSVT)
    - Validity Indicator Profile (VIP)
    - Structured Interview of Reported Symptoms (SIRS)

Standardized Scores

- Good tests have “standardized scores” which allow comparisons to be made with specific groups (e.g. patients with PTSD) or with the general population.
- If the same test is scored by a different person, the results should be the same.
- Objective scores are used to achieve a higher level of confidence about the findings.
- Tests without standardized scores are largely subjective in nature:
  - They are not reliable.
  - Their validity may be in question.
  - Their usefulness in court is questionable.
  - Their results may easily be biased.

Use of Non-Standardized Tests

When deposing a mental health expert who has used non- standardized tests, consider asking the following questions:

- Are any standardized tests available that could have been used to measure the areas of concern (emotional, cognitive, etc.)?
- Were the findings of non-standardized test relied upon in forming an opinion?
- If not used in forming any opinions, why were the non-standardized test(s) administered?
- Did the non-standardized test(s) provide a reliable pattern of findings?
- Does the expert know whether or not the non-standardized test(s) are routinely used and relied upon by psychologists in court?

STANDARD PROCEDURES & DISMISSAL OF EVIDENCE

American Psychological Association

- "Test Administrators should follow carefully the standardized procedures for administration and scoring specified by the test publisher".
  - Standards for Educational and Psychological Testing of the American Psychological Association
- Failure to follow standardized procedures may constitute an ethical violation (unless there is a compelling reason to do so).
- Daubert Finding

What Evidence Should be Considered?

- Behavior that is observed.
- Employment records
- Medical records
- Legal records
- Educational records
- Psychological Test Results

How is Evidence Measured?

- Bias must always be considered when a patient is in litigation.
- Has the patient's account of their illness or injury changed over time?
- Are they a reliable historian?
- Do they have an ax to grind?
- How much do they stand to gain?

More Reliability = More Validity

- Are the patient's account of their history consistent with the work records?
- Are there witnesses that can back their story up?
- Are their complaints consistent with the medical history?
- Have they had similar problems before?

HELP US HELP YOU

- Get us the facts!
- The one record subpoena we really need is the one that was not sent!
- Whenever there is an injury, get all the patient's medical records, not just the past few years.
- Whenever there is a brain injury being litigated, get all the school records, too. Especially High School!

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PSYCHIATRIC/PSYCHOLOGICAL RECORDS

- Psychiatric and Psychological records are almost always kept in separate files and require additional specific signed releases.
- Most psychologists will only release test data to another psychologist and always require separate signed releases in addition to subpoenas.
  - It is usually easiest to agree to a mutual exchange of test data directly between the psychologists.

ALWAYS DEMAND "RAW TEST DATA" FROM OPPOSING PSYCHOLOGIST & PSYCHIATRIST

- Do not accept opposing experts reports without "raw data" when psychological tests were administered and summarized.
- Have "raw data" analyzed by your own psychological expert and re-scored if needed.
- Opposing experts may underplay or completely omit highly significant psychological test data from their reports.

STIPULATED PROTECTIVE ORDER

- Stipulates test data may be turned over to the other side and will not be kept as part of the public record (or will be sealed); they may not be used for any other purpose apart from the present litigation; and they will not be copied or distributed in any form outside the present litigation.
- Best way to get access to test data
- Protects psychologists from ethical concerns
- Avoids conflicts between attorneys and psychologists

STIPULATED PROTECTIVE ORDER

- Stipulates test data may be turned over to the lawyers and will not be kept part of the public record (or will be sealed); the data may not be used for any other purpose apart from the present litigation; and the data may not be copied or shared in any form outside the present litigation; the data and all copies will be returned to the psychologist or destroyed at the end of the litigation.

WHAT DO WE EXPECT TO LEARN?

- Presence or absence of an acute or reactive emotional problem. The type of problem that could hypothetically arise, e.g. anxiety, depression, PTSD, brain injury, etc.

- Presence or absence of a long standing or pre-existing medical and/or emotional condition that if affecting the present situation.

FINDINGS

- The extent to which the pre-existing problems are causing the present complaints.
- The extent to which the plaintiff may be consciously malingering.
- Signs of exaggeration without conscious motivation.
- Legitimate Injury with or without exaggeration.

Q & A

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Substance Abuse In Employment Litigation

David Kan, M.D.

Forensic Psychiatric Associates

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Definitions – Substance "Abuse"

A. Maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

   - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)

   - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

   - Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct

   - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Definitions – Substance "Dependence"

- Requires 3 Criteria over 12 month period
  - **Tolerance,** as defined either by the need for increasing amounts of the substance to obtain the desired effect or by experiencing less effect with extended use of the same amount of the substance.
  - **Withdrawal**, as exhibited either by experiencing unpleasant mental, physiological, and emotional changes when drug-taking ceases or by using the substance as a way to relieve or prevent withdrawal symptoms.
  - **Longer duration** of taking substance or use in greater quantities than was originally intended.
  - Persistent desire or repeated **unsuccessful efforts to stop or lessen** substance use.
  - A relatively large amount of **time spent in securing and using the substance, or in recovering from the effects of the substance.**
  - **Important** work and social **activities reduced because of** substance **use**.
  - **Continued substance use despite negative physical and psychological effects of use.**

Prevalence

- Among full-time workers 18 to 64 y.o (NSDUH 2004-5)
  - 8.8 percent reported current heavy alcohol use
  - 8.2 percent reported current illicit drug use
  - ~30% overlap
- In the past year
  - 7.4 percent of these workers were dependent or abusing alcohol
  - 1.9 percent were dependent or abusing illicit drugs

Affected Industries

- Highest rates of current illicit drug use:
  - Accommodations and food services industry (16.9%)
  - Construction industry (13.7%).
- Highest rates of current heavy alcohol use
  - Construction industry (15.9%)
  - Arts, Entertainment, and Recreation industry (13.6%)
  - Minig industry (13.7%).

Impact of Addiction

- Illicit Drug Users
  - 1.5x likely to miss 2 or more days of work in last month due to illness/ injury
  - 2.6x more likely to skip 1+ days of work in last month
  - 1.6x more likely to have left employer in last year
  - 1.9x as likely to have been terminated
- Heavy Alcohol users
  - 1.5x likely to miss 2 or more days of work in last month due to illness/ injury
  - 2.2x more likely to skip 1+ days of work in last month
  - 1.3x more likely to have left employer in last year
  - 1.6x as likely to have been terminated

SAMHSA 1999 Data

Impact of Addiction

- Lost Productivity (deBenardo 2001)
  - 25-33% lower
- Sick Leave
  - 300% higher health insurance rates
- Worker's Compensation Claims
  - Addiction linked to 40% of industrial fatalities and 47% of industrial injuries

Drug Free Workplace Act 1988

- TITLE 41 > CHAPTER 10 > § 701
  - Prohibit use on job
  - Prohibit working under the influence
  - Provides employee notification requirements
- Prohibits unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance

ADA Title I and V
Section 12114c

- **Drug addiction may be a "disability" if it "substantially limits one or more ... major life activities." 42 U.S.C. Section 12102(2)**
- **Current use of illegal drugs does not make "qualified individual with disability"**
- **Can be qualified individual with disability**
  - Completed program and is now drug-free
  - Participating in supervised rehabilitation program and is now drug free

Workplace Drug Testing

- **Workplace Drug Testing**
  - Is not considered a medical examination
- **Alcohol Testing**
  - Is considered a medical examination and thus must meet need and necessity
  - Individuals with current alcohol-related disorders are protected under the ADA
- **ADA does not conflict with DOT or other Federal Regulation**
  - ADA trumps state/local law when conflict arises

Workplace Drug Testing

- Pre-employment examination
- Periodic random testing
- Post-incident/accident
- For Reasonable Cause
- Random Testing (safety/security sensitive positions)
- Work Fitness Examinations
- Job Transfer examinations
- Continuing-care testing (workers in treatment where testing is a condition of continuing employment)

Addiction and Americans with Disabilities Act

- **Brown v. Lucky Stores**, 246 F.3d 1182
  - Employer permitted to terminate an alcoholic employee for violating a rational rule of conduct even if the misconduct was related to the employee's alcoholism

- **Hernandez v. Hughes Missile Systems Co.,** DJDAR 6518 (9th Cir. June 11, 2002)
  - Hernandez fired after Cocaine+ on Utox
  - Hernandez went to rehabilitation
  - 9th Circuit ruled that Hernandez was qualified individual with disability and history of addiction alone even related to reason for termination was not grounds not to rehire

Evaluating Addiction in Litigation

- Drug / Alcohol Testing
  - Different Detection Windows
  - Multiple drug testing technologies
    - Blood – Current intoxicants
    - Urine – Recent Use
    - Saliva – Recent Use – not good for Cannabis
    - Hair – up to 3 months
  - Invasiveness
- How Much and Diagnoses are far less important that impact of use

Evaluating Addiction in Litigation

- Indirect Laboratory testing
  - Blood Count, Liver Function Tests
- Physical Examination / Observation
  - Sweating, pupillary dilation, agitation
  - Sequelae of Alcoholism
    - Alcohol on Breath
    - Rosacea, Angiomata
- Co-Occurring Physical Conditions

Evaluating Addiction in Litigation

- Psychological Symptoms
  - Intoxication vs. Withdrawal
  - Toxidromes effective mimics of psychiatric disorders
    - Depression
    - Mania
    - Anxiety States
  - High rates of co-occurring disorders with addiction
- Cognitive Abnormalities
  - Intoxication vs. Kindled damage

Addiction Myths

- Myth of Self Medication
- Myth of Detoxification
- Myth of Character Weakness
- Myth of Treatment Ineffectiveness

Alcohol

- Most Prevalent
- Intoxication Effects Well known
- Problem Drinking
- Deleterious Effects Women > Men
- Patterns of Absenteeism

Cannabis

- Prop 215 contradicts Federal Law
- “Medicinal Marijuana”
- Paranoia, Psychosis, Anxiety

Cocaine + Amphetamine

- Central Nervous System Stimulants
- High doses and/or use for long enough duration can produce psychosis, agitation, anxiety, anger
- Cessation of use associated with dysphoria
- Amphetamine epidemic problematic, but somewhat overstated

Opiates

- Non Prescribed use growing
- Chronic opiates rx'd for pain conditions generally NOT impairing when taken as prescribed
- Look for early refills, lost rx, multiple prescribers
- DOJ CURES form
- Methadone / Buprenorphine treatment of choice
- Detoxification of limited long-term efficacy

Treatment Works!

- Psychosocial
  - AA/NA
  - EAP
  - Outpatient vs. Residential
  - Detoxification & Relapse Prevention
- Medications
  - Detoxification
  - Relapse Prevention
  - Deterrant
  - Agonists

Q & A

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COMMON PROCEDURAL PROBLEMS ASSOCIATED WITH FORENSIC PSYCHIATRIC ASSESSMENT

- Motions to Compel a mental examination
- So-called “garden variety” emotional distress: *Doyle v. Superior Court (Caldwell)*

Doyle v. Superior Court (Caldwell) (1996) 50 Cal.App.4th 1878 , 58 Cal.Rptr.2d 476

- OPINION MIHARA, J.

  This petition seeks to overturn an order compelling petitioner Cindy Doyle to undergo a mental examination and to pay monetary sanctions to real party Daniel Caldwell for opposing his motion to compel this mental examination. Doyle claims that this mental examination was not justified under Code of Civil Procedure section 2032 because her allegation that she had suffered emotional distress arising from Caldwell's alleged sexual harassment of her ***which was not ongoing*** and had ended in October 1994 ***did not place her "mental condition" in controversy*** in her sexual harassment action against Caldwell. **We agree** with Doyle that her allegation did not place her mental condition in controversy, and we issue a peremptory writ of mandate.

Doyle v. Superior Court (Caldwell) (1996) 50 Cal.App.4th 1878 , 58 Cal.Rptr.2d 476

- The problem of so-called "garden variety" emotional damages.
  - Lack of parity: imagine "garden variety" cardiac disease or a "garden variety" orthopedic injury.
  - Based upon a "junk science" notion of what constitutes a mental disorder.

TIPS ON DEPOSING MENTAL HEALTH EXPERTS

GENERAL TOPICS TO COVER WHEN DEPOSING MENTAL HEALTH EXPERT

- Qualifications?
- Compensation?
- Expert's Experience including % plaintiff vs. % defense?
- What was assignment?
- What work done to fulfill assignment?
- Reviewing Expert's File Material
- Opinions formed?
- Basis for each opinion?
- Additional work requested, if any?
- Whether changing particular facts would change Expert's opinions?

HOW TO PUT AN EXPERT OUT ON A LIMB

HOW TO PUT AN EXPERT OUT ON A LIMB

Ask about his specific training to do particular tasks and/or procedures:

e.g., some psychiatrists administer psychological tests (MMPI-2, MCMI-III)

Almost all psychiatrists who do this have no specific training in either the administration of tests and, more importantly, the interpretation of psychological test data, as is required by the test publishers and as clearly stated in their manuals for specific tests.

HOW TO PUT AN EXPERT OUT ON A LIMB

Ask the typical deposition question, "How many of your prior cases, Doctor, are plaintiff vs. defense?"

If the plaintiff says 50:50 or 1/3:2/3, you can ask to see a total case list for all cases during the past 4 years (as required for Federal cases under FRCP Rule 26a).

HOWEVER, A MUCH BETTER QUESTION BY WHICH TO ASSESS AN EXPERT'S INTEGRITY IS…

"Doctor, in what % of the cases that come to you do you either not accept or after an initial review offer a preliminary opinion *that you know is not supportive of the inquiring attorney's litigation theory?"*

(Based upon my experience, 5% – 10% is a reasonable number .)

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HOW TO PUT AN EXPERT OUT ON A LIMB

Finally, flattery will get you everywhere because (as with certain attorneys)

SIZE (of medical egos) *does matter*.

…AND HOW TO CUT IT OFF!

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AND HOW TO CUT IT OFF!

Try this…

- Compliment the Expert on his extensive CV and considerable experience, then…
- Invite the Expert to opine *generally* about medical aspects of your case: e.g., "Doctor, someone with your extensive training and experience must have seen and perhaps treated many patients with mental symptoms similar to those Mr. Jones."
- Next narrow down the open ended question with specific medical questions that are at best *tangential to his expertise*; or ask the expert to *"explain"* general medical of surgical aspects of the case.
- Then ask the doctor a specific medical question that is clearly outside of his specialty training and expertise.
- Surprisingly, sometimes even experienced Experts will fall prey to their own hubris and opine broadly, drifting into….

PUFFERY

AND HOW TO CUT IT OFF!

- If the expert foolishly follows your lead and SURGES into opinions well outside of his expertise, realizing his error, he may become embarrassed and defensively speak in medical jargon to obscure his wide excursion beyond his field expertise.

- Then ask him exactly what in his formal training gives him the authority to opine on an issue that is clearly outside of his scope of practice and experience…?

FROM AN ACTUAL DEPO…

Q. Doctor, what in your background and training qualify you to administer the MCMI-III (psychological test)?

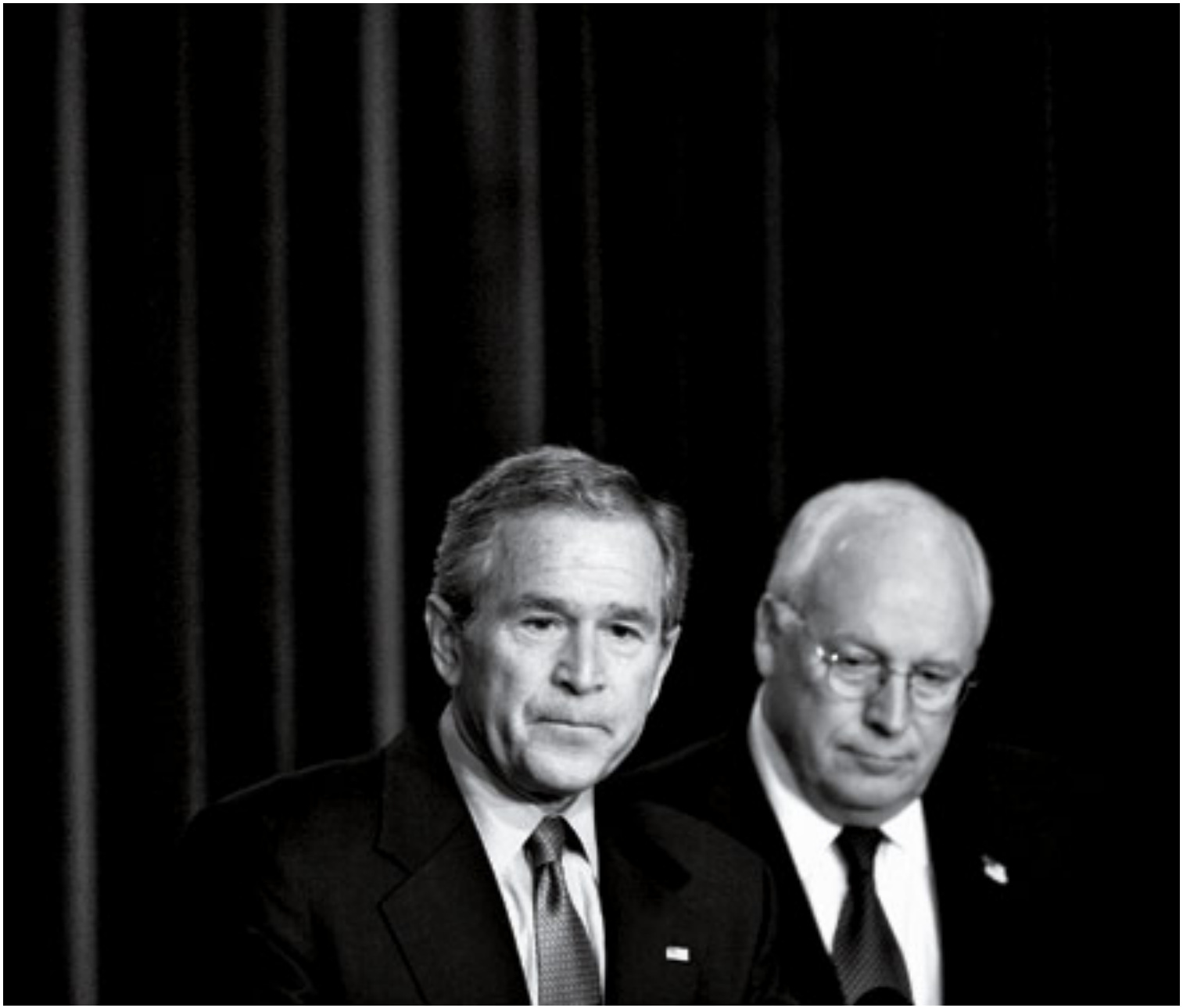
A. I think that psychiatrists and neurologists can put lead boots on and (only) give the certain examination that they were taught by certain teachers, or they may attempt to explore a variety of things ***that are at the limits, at the periphery, of what they have been trained.***

AND HOW TO CUT IT OFF!

[The expert witness deponent has just acknowledged that he is working *"at the periphery"* or *beyond the limits* of his training, experience and expertise!]

AND HOW TO CUT IT OFF!

Then restate for the record what he has just told you…*and observe his expression change…*

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TIPS ON DEPOSING MENTAL HEALTH EXPERTS

- The difference between experts who base their opinions and conclusions on clinical evidence and….

- Experts who base their opinions essentially upon their own authority…

Is Narcissism!

("It is true because I say it's true!")

Signs and Symptoms of the Narcissistic Expert

- Name dropping from the literature…
  - During deposition, the Expert will try to "blow smoke" by repeatedly quoting "authorities" and "the literature" in his field with which he assumes you are unfamiliar.
- Remedy:
  - Stay with him and…

Remedy for the Expert Name Dropper

- Relentlessly pursue detailed SPECIFIC questions *and* request copies of the SPECIFIC documents (books and journal articles) to which he loosely and repeatedly alludes.
- Ask him what are the SPECIFIC points from these articles by nationally recognized authorities that the Expert believes support his own opinions in the case and ask him why?
- Have your own expert carefully review the name-dropped literature.
- Often the actual journal name and article titles are "temporarily forgotten" by the expert, or the authorities' opinions turn out to have been tortuously misapplied to the current case.

Signs and Symptoms of the Narcissistic Expert

Ad hominem disparagement of opposing experts:

A. "And *if one is naive and stupid enough* to administer a test such as the Rorschach to a person in the context of a defense IME, *one needs one's head examined*, because the Rorschach is akin to asking a patient to disrobe……that is a source of concern that I have had, not only in this matter but with Dr. Ronald Roberts who seems to now be in affiliation with Dr. Levy in the group of forensic psychiatrists based in Mill Valley. I think it's a use and a misuse and abuse of psychological testing…."

Signs and Symptoms of the Narcissistic Expert

- Practicing beyond the scope of their competence and expertise:

e.g., Forensic Psychiatrists who operate beyond the scope of their training and competence often administer and interpret (or simply quote in an IME report) the computer-generated analysis of psychological tests, rather than relying on a skilled Forensic Psychologist to administer, interpret and analyze the psychological test data produced .

Signs and Symptoms of the Narcissistic Expert

The CV's omnipresent *"Vanity Boards"*

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Vanity Boards

- Offer a diplomate in forensic sciences or neuropsychology for the payment of a hefty fee
- Do not require applicants to
  - meet any rigorous educational and background requirements
  - submit any work samples nor
  - pass any formal examination process of their knowledge, ethics and competence.

WHAT CONSTITUTES SPECULATION?

Speculation occurs…

- Whenever an expert can not give an opinion consistent with the standard of proof
- Whenever an expert gives an opinion beyond the standard of proof in their field
- Whenever an expert tries to give a legal opinion
- Whenever there is not objective evidence to support one's opinion
- When scientific data is inconsistent with one's opinion

SPECULATION vs. EVIDENCE-BASED OPINION

SHOW ME THE MONEY!

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SUMMARY OF KEY POINTS

1. **What Constitutes Professional Expert Opinion vs. Speculation?** Ans. Evidence-Based Opinion
2. **Establishing Professional Qualifications and Areas of Expertise** – credentials, training & experience
3. **How to Lead an Expert Out On a Limb**
   - Determine if opinions exceed the scope of expert's training and practice
   - Request evidence for claimed % ratio of plaintiff:defense civil cases
   - Flattery
4. **How and When to Cut It Off**:
   - Elicit puffery
   - Elicit exaggerated, overly broad, speculative opinions
   - Clarify expert's scope of practice and competence to opine, based upon specific formal scientific training
5. **The Difference Between Experts Who Base Their Opinions on Objective Clinical Evidence vs. Experts Who Base Their Opinions Substantially On Their Own "Authority":** Ego and Narcissism (i.e., grandiosity)
6. **What is speculation?**

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3 STRATEGIC REASONS FOR ASSESSING PSYCHOLOGICAL DAMAGES *WHILE* (RATHER THAN *AFTER)* LIABILITY IS ESTABLISHED

1. Settlement
2. Settlement
3. Settlement

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"Heck of a Job!"

Understanding & Assessing Emotional Damage Claims in Employment Litigation

Presented By the Office of the Attorney General
State of California (Oakland)
January 9, 2008
12 noon – 5p.m.

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