

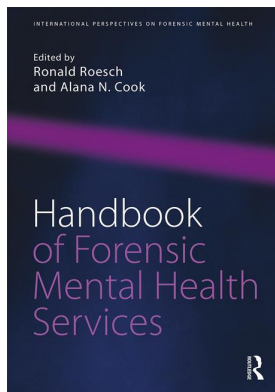
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Publisher: *Routledge*

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



Handbook of Forensic Mental Health Services

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Civil Forensic Assessment

Publication details

<https://www.routledgehandbooks.com/doi/10.4324/9781315627823.ch3>

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Published online on: 26 May 2017

How to cite :- Laura S. Guy, Amanda D. Zelechowski. 26 May 2017, *Civil Forensic Assessment from: Handbook of Forensic Mental Health Services* Routledge

Accessed on: 15 Nov 2019

<https://www.routledgehandbooks.com/doi/10.4324/9781315627823.ch3>

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Civil Forensic Assessment

Laura S. Guy and Amanda D. Zelechowski

Mental health professionals (MHPs) are frequently asked to provide observations or opinions regarding the emotional, behavioral, and/or cognitive functioning of an individual involved in the legal system whose mental state is at issue. The main types of legal proceedings in which MHPs typically participate in such roles are criminal and civil (and, perhaps less frequently, administrative hearings). As is the case for evaluations conducted in criminal proceedings (see Chapter 2 of this book), the referral question for each type of civil forensic assessment is grounded in a specific legal principle (Heilbrun & LaDuke, 2015). Broadly defined, civil law focuses on disputes between private parties and negligent acts that have resulted in harm to others. The key feature that distinguishes civil from criminal proceedings is that, in the former, disputes are between citizens rather than between a citizen and the state or government. Disputes between citizens can arise in diverse areas such as property, contracts, and family law. As such, MHPs engaged in civil forensic practice could address a broad range of issues related to, for example, guardianship, parenting capacity, child custody, fitness for duty, disability, malpractice, testamentary capacity, and civil commitment.

In part because in civil proceedings there is typically no threat to loss of liberty, as is the case for criminal proceedings (a key exception being civil commitment, which consequently sometimes is referred to as a “quasi-criminal” proceeding), the burden of proof tends to be lower in civil than criminal proceedings. Detailed overviews of civil forensic assessment, including explanations regarding civil legal procedure, can be found in seminal references such as Heilbrun (2001), Heilbrun, Grisso, and Goldstein (2009), Melton et al. (2007), Otto and Weiner (2013), Roesch and Zapf (2013), and Weiner and Otto (2014).

Mental health professionals who accept referrals for forensic evaluations must be aware of key principles or issues pertaining to competent and ethical practice. These principles apply regardless of whether one is practicing in civil or criminal arenas, and include considerations such as the distinction between therapeutic and forensic assessment; the use of general psychological tests and specialized forensically relevant instruments and forensic assessment instruments; reliance on archival and third-party information; routine consideration or focused evaluation of response

style, including malingering; and special considerations for report writing and the provision of expert witness testimony. These broad practice issues relevant to MHPs participating in the legal system have been discussed in detail elsewhere (e.g., Melton et al., 2007), and are also highlighted in the introduction to Chapter 2 of this book and will not be repeated here.

In the remainder of the chapter, we discuss four of the more common types of forensic evaluations performed in civil proceedings: child custody, fitness for duty, civil commitment, and damages within the context of emotional injury (sometimes referred to as psychological injury) cases. Readers interested in a more detailed discussion of these areas are referred to three books in *Best Practices in Forensic Mental Health Assessment*, a book series published recently by Oxford University Press: child custody (Fuhrmann & Zibbell, 2012), civil commitment (Pinals & Mossman, 2012), and personal injury claims (Kane & Dvoskin, 2011). Readers interested in a more in-depth discussion of fitness for duty evaluations are referred to Piechowski and Drukteinis (2011).

Child Custody

Historical Overview

Only fairly recently have psychology and social science begun to play a prominent role in child custody determinations. Determination of what is in the best interests of the child has trended increasingly toward examining the relationship with both parents (as opposed to either an inherent maternal or paternal preference); accordingly, clinical expertise is increasingly sought in research, evaluation, mediation, parent coordination, and post-separation intervention.

Mental health professionals were initially retained to assess “psychological parenthood” during the child custody determination process. This typically included evaluating a child’s emotional attachment that results from “day-to-day attention to his needs for physical care, nourishment, comfort, affection, and stimulation” (Goldstein, Freud, & Solnit, 1973, p. 17), which prompted criticism for the inherent degree of subjectivity (Marafiate, 1985). Despite attempts to more specifically define psychological parenthood, judicial decision-making about custody remained rather idiosyncratic. As a result, MHPs were increasingly asked to aid the judicial officer in evaluating psychological parenthood and, later, the best interests of a child (Melton et al., 2007).

Over the last several decades, judges have been called upon to consider substantially more factors than were historically required. For example, in the United States, the Uniform Marriage and Divorce Act (1987) requires the court to consider, among other things, such factors as: the interaction and interrelationship of the child with his or her parent or parents, his or her siblings, and any other person who may significantly affect the child’s best interest; the child’s adjustment to his or her home, school, and community; and the mental and physical health of all individuals involved. Similarly, in Canada, the court’s primary consideration when

making custody decisions is the best interests of the child. Factors to be considered by the judge in each province or territory are outlined in each jurisdiction's Family Law Act but typically include factors such as the child's physical, social, emotional, and education needs; the child's cultural, linguistic, religious and spiritual upbringing and heritage; parent-child relationship and bonding; parenting abilities of each individual; each parent's mental, physical, and emotional health; each parent's willingness to support the development and maintenance of the child's relationship with the other parent; the typical schedule of both parents and children; available support systems of each parent; sibling issues; care arrangements before the separation; plans proposed for the child's care and upbringing; family violence, abuse, or intimidation; and the child's wishes.

Although there remains debate in the literature regarding the extent to which a psychological evaluator can or should contribute to this decision-making process, as well as the utility of those contributions, MHPs are being relied upon more frequently as family law courts become increasingly crowded (Melton et al., 2007). However, Melton and colleagues (2007) pointed out that, in the overall area of child custody determinations, "relevant empirical knowledge is especially limited and that prevailing legal standards are especially problematic" (p. 561). It is clear that society has come a long way from previous generations, which deemed children property and without any rights, to the now-current practice of considering the child's welfare as the paramount concern in any custody determination proceeding. However, substantial progress still needs to be made, as this area of forensic mental health assessment is often considered the most underdeveloped and least empirically supported (Emery, Otto, & O'Donohue, 2005).

Guiding Principles

As previously noted, the lack of empirical research on long-term outcomes of evaluation methods and recommendations, as well as substantial disagreement in the field regarding evaluation process and content, make child custody evaluations one of the most difficult types of forensic psychological assessments to conduct (Bow & Quinnell, 2001). The ideal methods of conducting such evaluations are widely debated (e.g., Melton, Petrila, Poythress, & Slobogin, 2007; Heilbrun, Marczyk, & DeMatteo, 2002) and, over the last several decades, numerous guidelines and resources on conducting ethical and competent child custody evaluations have been produced. Examples include specific sets of professional guidelines and codes of ethics developed for psychologists (American Psychological Association, 2010a, b), forensic psychologists (American Psychological Association, 2013), psychiatrists (American Psychiatric Association, 2006), forensic psychiatrists (American Academy of Child and Adolescent Psychiatry, 1997; American Psychiatric Association, 1988; American Academy of Psychiatry and the Law, 2005), clinical social workers (Luftman, Veltkamp, Clark, Lannacone, & Snooks, 2005), and qualified mental health professionals (Association of Family and Conciliation Courts, 2006), as well as a plethora of published resources and evaluation frameworks (e.g., Heilbrun, 2001; Grisso, 2003).

One likely catalyst for this surge of published guidance was a period of criticism of the nature and quality of child custody evaluations (Emery et al., 2005), particularly given the simultaneously increasing evidence base and standardization of procedures used in other areas of civil and criminal forensic assessment (Heilbrun, 1995). As a result, family law and psycholegal scholars increasingly called for minimum standards of practice within the field of child custody evaluations (e.g., Bow & Quinnell, 2002; Gould, Kirkpatrick, Austin, & Martindale, 2004; Grisso, 2005; Kirkpatrick, 2004; Melton et al., 2007). Although there is no single model or framework for conducting child custody evaluations that has gained universal acceptance, there are some basic components and assessment considerations that most evaluations tend to incorporate in some capacity (Zelechowski, Fuhrmann, Zibbell, & Cavallero, 2012).

The Child Custody Evaluation Process

Overview

Along with the general principles of civil forensic assessment discussed earlier in this chapter (e.g., defining the client, clarifying the nature of the evaluator's relationship with the involved parties, obtaining collateral data), there are typically additional considerations and components involved with child custody evaluations, depending on the specific referral question. One of the primary logistical considerations is related to the referral source. Depending on the jurisdiction, child custody evaluations are typically ordered by the legal decision-maker (i.e., the judge) or requested by one or both of the parties involved. In most situations, it is preferable for the evaluation to be court-ordered and the evaluator appointed by the court and/or stipulated to by both parties, in order to preserve and protect the evaluator's neutrality. When an evaluator is retained by only one side in these high-conflict family law matters, a "battle of the experts" often ensues, subjecting the family to multiple evaluations and the evaluator to increased perceptions of serving as a "hired gun" or being compensated for an opinion that favors the side that hired the evaluator.

Referral questions tend to vary widely and can be very broad and vague (e.g., "evaluate issues relevant to custody") or very specific (e.g., "evaluate whether the mother should be allowed to relocate the child to another state"). Common referral questions include: issues related to the legal and physical custody arrangement, visitation schedule, issues related to relocation, allegations of abuse or domestic violence, functional capacity of one or both of the parents due to mental illness and/or substance use, and the nature of the relationship or bond between the child and each parent. The challenge with many referral questions, as specified by the court or requesting party, is that they reference legal standards (e.g., "provide recommendations regarding the custodial arrangement that is in the best interest of the child"), and it often falls to the evaluator to translate these legal questions into psycholegal constructs that can be appropriately assessed by a mental health professional.

Fortunately, advances in empirical research and the publication of numerous professional guidelines previously discussed have highlighted several psycholegal constructs most relevant to child custody determinations. These include: (1) information about parents and parenting capacity; (2) information about children and their developmental needs; (3) information about the relationship between parents and their children; and (4) information about the relationship between the parents or co-parenting (Fuhrmann & Zibbell, 2012). General procedural elements for evaluating these psycholegal constructs are reviewed below.

Data Collection

Most court-ordered child custody evaluations include the following basic components: informed consent/assent process, interview(s) with each parent, interview(s) with each child (as developmentally appropriate), parent-child observations (as appropriate), interviews with collateral sources (e.g., significant others, teachers, medical and mental health providers, etc.), and record review (e.g., school records, police reports, correspondence, etc.). Some evaluations also include the use of assessment instruments or psychological testing and/or home visits.

Using the psycholegal constructs outlined above, we start with the evaluation of parents and parenting capacity. Assessing each parent's capacity in a child custody matter typically involves evaluating the parent's strengths and weaknesses, as they specifically relate to his/her ability to meet the needs of his or her child(ren). This may include assessing many parent variables, including physical and mental health, parenting style, discipline, adaptability, and stability. The evaluation of these parent-related attributes is typically done by synthesizing the data gleaned from interviewing the parent, talking with collateral sources (e.g., the child(ren), the parent's current significant other, close relatives, treatment providers), reviewing relevant records, and directly observing the parent interact with the child(ren). The types of information sought through these data collection methods may include background information about the parent (e.g., family background, education and employment history, physical and mental health history, legal involvement, relationship history, current living situation), history of the relationship between the parents and the current custody dispute, parental involvement with the child(ren), the child(ren)'s developmental status and needs, current concerns and desired outcome, and any additional relevant issues (Fuhrmann & Zibbell, 2012).

Next, evaluating the specific needs of the child(ren) is typically done through interviewing the child directly (if developmentally appropriate), interviewing the parents about the child, interviewing collateral sources (e.g., teachers, medical and mental health providers, close extended family members), and observing the child interact with both parents. The informed consent process is particularly critical with children and adolescents, including helping the child(ren) understand the role of the practitioner and who will have access to the information he/she shares with them. The types of information sought through the interviews and observations typically include the child's current functioning (e.g., how he/she presents in the interview

Table 3.1 Assessment Instruments Frequently Administered to Parents in Child Custody Evaluations

Category	Title of Instrument
Personality Assessments	Minnesota Multiphasic Personality Inventory-2 (Hathaway & McKinley, 1989) Millon Clinical Multiaxial Inventory-IV (Millon, Grossman, & Millon, 2015)
Projective Assessments	Rorschach Test (Rorschach, 1998) Thematic Apperception Test (Murray, 1973)
Parent Inventories	Parenting Stress Inventory (Abidin, 1995) Parent–Child Relationship Inventory (Gerard, 1994)
Child Custody Instruments (<i>not empirically validated</i>)	Ackerman–Schoendorf Scales for Parent Evaluation of Custody (Ackerman & Schoendorf, 1992) Bricklin Perceptual Scales (Bricklin, 1990a) Parent Awareness Skills Survey (Bricklin, 1990b) Perception of Relationships Test (Bricklin, 1989)

alone and with each parent, temperament, physical and mental health, developmental status, communication, emotion regulation), interactions with and responsiveness to each parent, perception of and relationship with each family member, perception of life in each parent's home, and understanding of and preferences regarding the separation and custody determination (Fuhrmann & Zibbell, 2012).

With respect to psychological assessment instruments used with children during child custody evaluations, there is a similar dearth of empirical data demonstrating validity and utility of using specific assessment instruments in this context (Fuhrmann & Zibbell, 2012). The assessment instruments most frequently administered to children in custody matters are projective drawing tasks, projective assessments, personality assessments, behavior rating scales completed by the child and/or the parent(s), and symptom inventories (Fuhrmann & Zibbell, 2012).

Following a thorough assessment of each parent and child, the third primary psycholegal construct is the fit between the parent's attributes and the child(ren)'s needs. In other words, to what degree do the strengths and weaknesses of each parent correspond to the specific needs and abilities of the child(ren)? Assessment of this construct typically involves synthesizing the data gathered in evaluating the parents and essentially mapping it onto the data gathered for each child to determine the match (or mismatch) between the parent's functional capacities and the child's needs. Observing the child(ren) interact with each parent in structured and unstructured ways can also be useful in assessing the dynamic between the child and parent. Similarly, home visits can provide additional insight into the family interaction and environment in each home.

A final element for consideration is the nature of the relationship between the parents following separation, given the substantial body of research demonstrating

Table 3.2 Assessment Instruments Frequently Administered to Children in Child Custody Evaluations

<i>Category</i>	<i>Title of Instrument</i>
Projective Drawing Tasks	House–Tree–Person Kinetic Family Drawing
Projective Assessments	Rotter Incomplete Sentences Blank (Rotter & Rafferty, 1950) Thematic Apperception Test (Murray, 1973) Children’s Apperception Test (Bellak & Bellak, 1974) Rorschach Test (Rorschach, 1998)
Personality Assessments	Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A; Butcher et al., 1992)
Behavior Rating Scales	Youth Self-Report (YSR; Achenbach & Rescorla, 2001) Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 2006) Conners Behavior Rating Scales (Conners, 2008)
Symptom Inventories	Children’s Depression Inventory-2 (CDI-2; Kovacs, 2014)

the detrimental effects of parental conflict on children (Cummings & Davies, 2010). Specific variables to consider include the nature and severity of conflict between the parents, how conflict is expressed, the degree to which the child(ren) exposed to or involved with the conflict, and the presence of co-parenting skills (e.g., cooperation, facilitation of the child’s relationship with the other parent, productive communication and coordination). This information can be obtained through interviews with each parent, the child(ren), collateral sources, record review, and behavioral observations.

Interpretation and Reporting

Just as there are numerous methods to gather information relevant to determining what is in a child’s best interests in custody determinations, there are also many ways to organize and interpret that information. Some evaluators organize the information chronologically, providing the court with a timeline of historical information leading up to the current situation and corresponding recommendations. Other evaluators organize information topically, providing a brief synthesis and conceptualization focused specifically on the referral question(s). Another way to interpret and report the plethora of information gathered is Fuhrmann and Zibbell’s (2012) interpretation framework:

1. Generate and analyze hypotheses.
2. Consider alternative hypotheses.
3. Consider the impact of parental deficits on parenting.

4. Consider a child's special needs/developmental stage in terms of the demand on parenting skills.
5. Consider the fit between parents and children.
6. Consider the current co-parenting relationship.
7. Consider special issues, including cultural and ethnic context.
8. Interpret conservatively (“[D]o not go beyond the data and state opinions that lack sufficient empirical support”).

(p. 172)

Irrespective of the model or framework used to interpret the data gathered, it is important to ensure that all factors required by the particular jurisdiction's regulations or legal standards have been considered and evaluated, as necessary.

Additional Considerations

Beyond the particular components of the child custody evaluation process, there are some broader considerations to bear in mind when involved with this area of forensic mental health assessment. Child custody evaluation tends to be one of the riskiest areas in which forensic evaluators are involved, given the extremely high levels of conflict between the parties. The process involves many ethical considerations, including clarifying the specific role played by the evaluator, maintaining boundaries related to that role, narrowing the scope of the evaluation and subsequent recommendations, balancing the nature and equity of communication with the parties and with the court, among numerous other considerations (Pepiton, Zelgowski, Geffner, & Pegolo de Albuquerque, 2014).

In the United States, psychologists involved with child custody evaluations continue to be one of the highest groups against whom ethical and licensing board complaints are filed (Benjamin & Gollan, 2003; Pope & Vetter, 1992). Part of the reason for this is that child custody evaluators are given legal immunity in many states, which prohibits parents from filing malpractice lawsuits if they are unhappy with the outcome of the evaluation; however, they are not prohibited from filing ethical complaints with a state licensing board or national psychological organization. Given the nature of this high-risk practice area, it is extremely important for MHPs to ensure that they have the adequate training and expertise to conduct these types of forensic assessments, are thorough and transparent in the informed consent process regarding how information will be collected and reported, and are unbiased and comprehensive in their connection between the data gathered and the recommendations and conclusions provided.

More detailed discussion of specific considerations and practice recommendations can be found in the following references: Ackerman, 2006; Acklin & Cho-Stutler, 2006; Connell, 2006; Fuhrmann & Zibbell, 2012; Gould & Martindale, 2007; Grisso, 2005; Otto, Buffington-Vollum, & Edens, 2003; Roll, 1998; Tillbrook, Mumley, & Grisso, 2003; Vasquez, 1999; Weinstock & Markan, 2006.

Fitness for Duty

Employees with mental health problems, especially when unmanaged, potentially present a range of difficulties for employers, including reduced productivity, decreased organizational effectiveness, and diminished staff morale. In some cases, mental health problems can pose a direct threat to the safety of the employee, others in the workplace, or the public. For individuals in public safety or other 'high-risk' occupations, such as police officers, military personnel, firefighters, physicians, security personnel, airline pilots or operators of other mass transit vehicles, or those working at dangerous sites such as nuclear power facilities, their job by definition places them in a position in which their actions potentially affect the welfare of others. Employers may request a Psychological Fitness for Duty Evaluation (FFDE) to help them understand whether an incumbent employee is able to safely and effectively perform his or her essential job functions. Employers may consider requesting an FFDE under a variety of circumstances. Most commonly, the employer, a coworker, or others observe the employee to be exhibiting signs of emotional disturbance or psychological stress, behaving in a hostile or threatening manner, or engaging in other behaviors that reasonably lead them to be concerned for their safety or that of others.

Since the first professional standards on conducting FFDEs were published roughly 25 years ago (e.g., Inwald, 1990), several standards have been published, mainly linked to specific occupations. A key resource for professionals completing FFDEs with police is the guidelines adopted in 1998 and ratified in 2004 by the International Association of Chiefs of Police (International Association of Chiefs of Police, Police Psychological Services Section 2009). Comprehensive reviews of FFDE practice generally (Borum, Super, & Rand, 2003; Gold & Shuman, 2009; Rostow & Davis, 2004; Wettstein, 2013), as well as for specific populations such as physicians (Price & Meyer, 2013) and police officers (Corey, 2011; Pinals & Price, 2013), also are available. Evaluators performing FFDE of physicians in the United States should consult the American Psychiatric Association Guidelines (Anfang, Faulkner, Fromson, & Gendel, 2005) as well as the American Academy of Psychiatry and the Law's (2005) guidelines on disability, which contains a section on point.

In addition to professional practice resources, FFDE evaluators should be knowledgeable about the relevant sources of law, both local and federal, in their jurisdiction of practice as well as relevant policies of the organization for which they are working. As just one example of relevant case law in the United States, it has been established that an agency has the right to mandate psychological testing (e.g., *Conte v. Horcher*, 1977) and has a responsibility to psychologically evaluate personnel (e.g., *Bonsignore v. City of New York*, 1982). In cases where the FFDE request was triggered by concerns about risk for violence, employers may be taking steps to discharge their duty under the Occupational Safety and Health Act of 1970 (OSHA, 1970), which requires employers to provide workplaces free from known hazards that can cause death or serious harm (including violence).

Both evaluators considering accepting FFDE referrals and workplaces requesting such evaluations face a substantial burden of ensuring the requisite qualifications of the mental health practitioner are met (see Guller, 2010). Unless unavoidable, clinicians should not conduct FFDEs of individuals with whom they have a current or previous treatment relationship. Rather, the role of treating clinicians should be limited to that of a third-party informant or fact witness (e.g., providing factual data pertaining to clinical history, treatment history, and progress). In the next section, we discuss the basic steps in conducting FFDEs by independent professionals who have the requisite knowledge, skills, and training to do so.

Practice of FFDE

Prior to accepting the referral, the evaluator should discuss several key issues with the employer and obtain concrete answers to several questions. What are the specific concerns related to the employee's ability to perform his or her job? What is the reason the employee is believed to have a psychological or cognitive condition that impairs his or her performance of the essential functions of the position? The employer should be encouraged to provide specific examples of behavior, statements, work productivity (or lack thereof), and/or observations of coworkers or managers. The evaluator also should inquire as to whether the employee was advised of the referral for a FFDE, and whether the employee is mandated to complete the evaluation as a condition of continued employment.

Other key elements for discussion prior to accepting the referral include ensuring the referral is appropriate clinically and legally, the latter by conducting a threshold analysis (see below); clarifying the specific referral questions; discussing the particular legal standards and policies governing the evaluation; clarifying specifics pertaining to the employee's rights and limitations to access to the report and other personal health information; clarifying what information will be included in the evaluator's oral and/or written report (e.g., the Americans with Disabilities Act, or ADA, imposes limits on how much information can be shared with the employer); clarifying when and how the employee will be given feedback (e.g., in person or not, and developing a response plan should the employee react with clinically significant distress); and discussing fees, the role of the evaluator, and procedures to be used in conducting the FFDE, including the specific types of collateral data the evaluator will expect from the employer. The evaluator may wish to obtain written informed consent from both the employer and the employee (see IACP FFDE Guidelines, 2009).

Regarding the first point above—conducting a threshold analysis—a key legal issue in FFDE practice involves determining whether the employer has assessed the need for an evaluation in a reasonable and appropriate manner, as specific requirements often must be met for employers to lawfully request an FFDE. Evaluators should be aware of the relevant sources of law in their jurisdiction (both local and federal) and ensure the referral is legally appropriate before agreeing to complete the FFDE not only to promote fair treatment of the employee but also to protect

themselves from liability. For example, in the United States, for an FFDE to be permissible under the ADA the evaluation must be (1) job-related and (2) consistent with business necessity (42 U.S.C. §12112(d)(4)(A); 29 C.F.R. §1630.14(c)). According to the Equal Employment Opportunity Commission (EEOC) Enforcement Guidance, this requires that employers have (1) objective evidence that the employee's ability to perform a defined job safely or effectively is compromised, together with (2) a reasonable basis for suspecting that the employee has a mental health condition or impairment that is directly causing the problems with job performance or safety (known from credible third-party information, direct observation, or other reliable evidence). The EEOC defined concerns about job safety in terms of whether a medical condition causes an employee to pose a direct threat, where a direct threat is conceptualized as a significant risk of substantial harm to the health or safety of the individual or others that reasonable accommodation cannot eliminate or reduce.

Regarding clarification of the referral question, irrespective of the type of forensic evaluation, evaluators always should seek detailed information to clarify what the employer wants the evaluator to address in the course of the FFDE. Examples of issues that may arise include questions about disability and/or accommodation, the nature of any impairment (e.g., cognitive, memory, neuropsychological functioning generally, substance use, personality disturbance, severe mental illness, etc.), effects of medications, risk of violence to self or others, recommendations for future treatment or opinions on adequacy of current treatment, and recommendations pertaining to restricted or limited duty. Evaluators should consider the legal and ethical issues related to all aspects of the referral questions. For example, whereas most FFDE experts recommend offering opinions about treatment, others do not (e.g., Corey, 2011). Issues regarding communication of such opinions also should be decided on in advance. For example, Wettstein (2013) advised that recommendations regarding treatment and interventions be made but not communicated directly to the employee so as to avoid creating the appearance or expectation of a treatment relationship.

Evaluation Procedures

As with all forensic evaluations, data from multiple sources and methods are critical. The key data sources in an FFDE include collateral documents, collateral interviews, and an interview with the employee. Certain types of psychological testing additionally may be helpful for some cases. Each of these data sources is discussed briefly.

Collateral Documents

The evaluator should obtain and review collateral documents prior to the interview to facilitate preparation for conducting an effective and efficient interview. Some types of records (e.g., medical records) may require the employee's permission to obtain, and so practically may not be reviewed until following the interview. The

evaluator should consider obtaining the following types of information, as is appropriate for the particular case:

- Company organizational hierarchical schema (including the employee's position).
- Relevant company policies or procedures.
- Terms of any relevant labor agreement or contract.
- Job description or job analysis.
- Resume, curriculum vitae, or work record.
- Performance evaluations, including any commendations.
- Disciplinary or other internal investigations, letters, or actions (full range of seriousness, from warnings to termination).
- Incident reports of any triggering events, including witness statements or memos from supervisors or coworkers regarding their observations or problems they have experienced with the employee.
- Preemployment or any other psychological evaluations.
- Remediation or accommodation interventions.
- Short- and long-term disability claims, decisions, and supporting documents.
- Workplace Compensation Board claims, decisions, and supporting documents.
- Medical leaves (reasons, lengths).
- Summary of any health care information that may be relevant to the FFDE (e.g., notes from physicians provided by the employee to support request for accommodation or leaves of absence).
- For police FFDEs in particular: internal affairs investigations, formal citizen/public complaints, use-of-force incidents, reports related to officer-involved shootings, and civil claims.
- Any other supporting or relevant documentation related to the employee's psychological fitness for duty.

Collateral Interviews

Individuals who may have any information relevant to the referral questions should be invited to participate in an interview. Work personnel, such as coworkers, supervisees, or supervisors who witnessed or were directly impacted in any way by the employee's behavior, especially with respect to a triggering event, should be considered. Family members can provide history relevant to the job performance concerns, and also may be able to provide data of value for assessing the employee's ability to function in non-work-related contexts. Current treating professionals may yield rich clinical data regarding historical, recent, and current functioning.

Psychological Testing

Any psychological tests used should be selected based on their expected utility for providing information relevant to the particular psychological problems raised for a

given case. Evaluators may choose to use semistructured diagnostic interview schedules given the explicit predicate question of psychological concerns that precipitated the referral. Depending on the parameters of the specific psychological concerns, evaluators may choose to administer tests to screen for cognitive, memory, or other neuropsychological issues, or assessment of these domains using more comprehensive test batteries or specialized tools, together with tests of effort. Self-report and objective tests of personality and psychopathology could prove useful not only in terms of providing data about clinical conditions, but also because of embedded validity scales that can provide data about the employee's response style. As is the case for any psychological evaluation, evaluators should select tests that are relevant to the referral question, have been normed on the population of interest, and have established empirical support for their psychometric properties. Evaluators also may choose to administer tests developed specifically to assess response style and symptom validity.

Interview With the Employee

The in-person interview allows the employee to give a description of the events from their perspective as well as their perceptions regarding their ability to stay at (or return to) work. An employee's ideas regarding possible modifications to ameliorate any work deficits also could be queried. The interview additionally provides the evaluator the opportunity to reconcile differences between the employee's self-report and data from collateral sources. A mental status exam and psychosocial history should also be taken. Particular attention should be devoted to work history preceding the triggering event or current problems, with both the current and previous employers. The evaluator also should inquire regarding conflict between the employee and others in the workplace and actual, attempted, or threatened violence toward oneself or others. Should risk of violence be an issue, a targeted clinical assessment of this domain should be undertaken (see the section on civil commitment below and Chapters 2 and 4 of this book for more information on violence risk assessment).

Causal Nexus

Having gathered pertinent data from multiple sources, the evaluator's task is to come to an opinion as to whether (1) the employee has symptoms of a psychological disorder; (2) the employee may be unable to safely or effectively perform the defined job; and (3) there is a reasonable basis for believing the cause of any impairment in an essential job function may be attributable to a psychological condition or impairment (see Figure 3.1). Essentially, an FFDE requires the evaluator to make a judgment as to whether there are deficiencies in a particular area of competence and, if so, whether the deficits are attributable to a psychological condition. As such, Grisso's (2003) functional model of evaluating competencies is a logical approach to follow when formulating an opinion about fitness for duty.

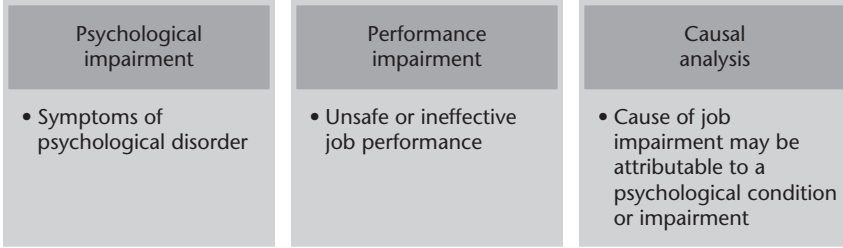


Figure 3.1 Opinions Required in Fitness for Duty Evaluations

Applying the key components of Grisso's model, the evaluator first conducts a *functional assessment*, considering the employee's strengths and weaknesses with respect to the functional abilities relevant to the particular job requirements. Next, the evaluator conducts a *causal analysis*, determining whether a valid psychological condition exists, and whether deficits in functioning are causally related to the symptoms of the psychological condition. The evaluator should rule out competing explanations for the observed impairments (e.g., situational factors, such as contextual workplace environment factors, or factors about the employee other than psychological issues that may affect work functioning, such as achievement drive) and then formulate and test hypotheses about the cause of the functional impairment. Next, the evaluator conducts an *interactive analysis* of deficits in light of case-specific demands, considering whether the employee's functional capacity is adequate to meet the relevant occupational demands. Comparisons are then made between the functional capacity and the relevant legal standard. The evaluator may be required or choose to provide a clear opinion regarding the ultimate issue. Other models with features similar to Grisso's functional capacity approach also have been proposed for conducting FFDEs (see Battista, 1988; Corey, 2011; Heilbrun, 2001; Morse, 1978).

Civil Commitment

Many countries in the world engender legal avenues to involuntarily commit individuals, most often to an inpatient facility, for care and treatment for a major mental illness. Typically, the basis for inpatient civil commitment in contemporary legislation or case law requires the individual—as a result of a major mental illness—to be likely to face serious harm and for there to be no less restrictive alternative than an inpatient setting to prevent this harm. Risk for two types of serious harm typically are considered: physical harm to the person herself resulting from suicide or serious self-harm; and physical harm to others. Thresholds regarding the severity of potential injury associated with the risk, as well as the specificity and recentness of behavioral evidence required to support said risk varies between jurisdictions. Some civil commitment laws also allow for consideration of risk of physical impairment or injury because of an inability to care for or protect oneself (for an overview of criteria by state, see <http://mentalillnesspolicy.org/studies/state-standards-involuntary-treatment.html>).

As such, contemporary civil commitment procedures blend the government's *parens patriae* authority with considerations of the patient's welfare. Historically, the pendulum has swung between these two extremes. For example, in the United States, the basis for involuntary hospitalization was initially the patient's "need for treatment" or consideration of the patient's "welfare" (*In re Oakes*, 1845). Around the 1960s, however, the patient's "dangerousness to others" became a key criterion (see *Lessard v. Schmidt*, 1972; *O'Connor v. Donaldson*, 1975). Evidence of a recent overt act, attempt or threat to do substantial harm to another person is typically required. A focus on dangerousness necessitated civil commitment evaluation procedures to include consideration of the patient's risk of violence to others.

Almost invariably, the foundational prong of the presence of a major mental illness focuses only on disorders with severe psychotic or mood symptoms. However, substance abuse (on its own) also can be a substantive ground for civil commitment. For example, in roughly two-thirds of U.S. states, statutes allow for the civil commitment of people at risk of harming themselves or others on account of substance use that has resulted in chronic or habitual lack of self-control. Other civil commitment statutes have expanded the range of allowable mental illnesses even further. In the U.S., Sexual Psychopath or Sexually Violent Predator (SVP; see Witt & Conroy, 2009) laws loosened the range of mental health conditions allowable as the basis for commitment, including personality disorders and chronic, untreatable conditions (e.g., *Kansas v. Crane*, 2002). SVP laws are distinct from more traditional types of civil commitment laws in other ways as well. For example, historically, civil commitment has involved short-term commitment based on imminent risk for physical harm typically due to serious mental illness. In contrast to traditional determinate civil commitment laws, indeterminate SVP commitment laws consider long-term risk (i.e., over the remainder of one's life, not in the upcoming days and weeks) and consider acts not involving serious physical injury (e.g., sexual communication or interference).

Mental health professionals may be mandated by case law, statute, internal policy, and/or professional codes of ethics to assess and take action to protect potential victims from violence or to prevent harm to a person who poses a risk of serious self-harm, suicide, or other hazard arising from the presence of a mental disorder. With respect to risk of violence to others, a landmark case known internationally is that of *Tarasoff v. Regents of the University of California* (1976). In that case, the California Supreme Court held that psychotherapists who know or should know of their patient's probability of causing injury to identifiable third parties are obligated to take reasonable steps to protect the foreseeable victim from danger. Most states endorsed similar "duty to protect" laws, with many states expanding language to include nonidentifiable victims.

Assessment Issues

An overview of assessment practices, including assessment instruments, for each of the foundational prongs for civil commitment is reviewed next.

Risk of Suicide

An empirically informed framework for assessing suicide risk was provided by Joiner and colleagues almost two decades ago (Joiner, Walker, Rudd, & Jobs, 1999). Recently, this framework was updated (Chu et al., 2015) based on recent empirical findings regarding factors that increase risk for suicide; it also extended Joiner and colleagues' work by integrating flexible risk classification levels (low, moderate, severe, extreme) with risk factors grounded in the interpersonal theory of suicide (Joiner, 2005). Research clearly demonstrates that a history of suicide attempts is a robust risk factor for suicide (Nock et al., 2008). Nevertheless, roughly half the individuals who commit lethal self-harm do so on their first attempt (Suokas, Suominen, Isometsä, Ostamo, & Lönqvist, 2001). As such, in addition to previous suicidal behavior, Chu and colleagues' (2015) framework considers several current or acute risk factors.

They noted that two especially robust markers for high suicide risk are suicidal thoughts and desire; and resolute plans and preparation for suicide. In the absence of plans or preparations for suicide and other notable risk factors, severe suicidal ideation does not carry a particularly high risk for suicide (Joiner et al., 1999). In terms of suicidal thoughts, risk is heightened when thoughts are frequent, are of high intensity, and include active thoughts of suicide in general and committing suicide. Intensity of suicidal desire should take into account multiple facets (i.e., intensity, frequency, duration or preoccupation, and content of suicidal thoughts). Related clinical states that operate as acute warning signs also will be relevant to this domain, including agitation, social withdrawal, insomnia/nightmares, irritability, and talking about suicide. Finally, relatively more specific, resolved, and lethal plans and methods for suicide raise risk, having taken preparations to carry through with one's plan, and having access to the means needed to carry out the plan (e.g., firearm) also raise risk considerably.

In addition to the core risk factors related to attempt history, ideation, plans, intent, and access to means, Chu et al. identified other significant risk factors that should be considered when assessing risk of suicide: thwarted belongingness, or social isolation and an unmet need for social connectedness; perceived burdensomeness, which refers to the belief that one is a burden or liability to family, friends, and/or society; nonsuicidal self-injury, or directly and purposefully inflicting physical harm to oneself in the absence of intent to die; stressful life events, such as death of a loved one, employment loss, and marital separation or divorce; hopelessness; impulsivity; and psychopathology. With respect to the latter factor, clinical conditions that are of particular concern include substance use; mood and anxiety disorders, especially depressive and bipolar disorders; eating disorders; impulse control disorders; psychotic symptoms; and personality disorders. Other clinical conditions such as agitation, marked irritability, social withdrawal, severe weight loss, severe affective states, and sleep disturbances are considered to be acute indicators of suicide risk.

The Linehan Risk Assessment and Management Protocol (LRAMP, formerly called the University of Washington Risk Assessment and Management Protocol;

Linehan, Comtois, & Ward-Ciesielski, 2012) was developed with twin goals of enhancing clinicians' ability to assess and manage suicidal behaviors, and decreasing their fears of treating individuals at risk of suicide. It provides an empirically derived structured checklist for assessing, managing, and documenting suicide risk. The LRAMP is organized into four sections: impetus for LRAMP assessment; ratings on particular risk and protective factors selected based on the evaluatee's characteristics, such as age, sexual orientation, and treatment setting; consideration of specific evidence-based suicide risk management strategies (individualized application of the most relevant strategies is left to the clinician's discretion); and communication regarding overall evaluation of risk and plans regarding reassessment.

Recently, the LRAMP was adapted for online use (see <http://behavioraltech.org/products/lssn.cfm>). In the Linehan Suicide Safety Net (LSSN), clinicians can access the LRAMP and receive practice support via this web-based multimedia tool. Preliminary research on the LSSN revealed good user satisfaction, as measured via ratings of its acceptability and usability, and enhanced confidence when assessing and managing suicide risk (Harned, Lungu, Wilks, & Linehan, 2016).

Risk of Violence to Others

Violence risk assessment can be bisected into discretionary and nondiscretionary approaches. Discretionary but unstructured approaches, referred to as unstructured clinical judgment, are not supported by research and should not be used. Discretionary approaches that are structured, referred to as structured professional judgment (SPJ), and nondiscretionary approaches, referred to as the actuarial approach, both enjoy substantial empirical support.

As described in the often-quoted definition by Grove and Meehl (1996, p. 294), the actuarial approach is "a formal method (that uses) an equation, a formula, a graph, or an actuarial table to arrive at a probability, or expected value, of some outcome." Risk factors are typically identified using statistical procedures and selected according to the strength of their association with the outcome of interest (violence of some sort) in a particular construction sample (i.e., empirical item selection). Many actuarial risk assessment tools assign weights to risk factors of varying magnitude based on the assumption that weights optimized for a specific risk factor will be equally applicable to all individuals. The defining feature of the actuarial approach is the creation and application of consistent, inflexible rules for integrating predictive factors. Both strengths and weaknesses associated with the actuarial approach to violence risk assessment have been well documented (e.g., Guy, Douglas, & Hart, 2015).

Irrespective of the potential utility of actuarial schemes, a key feature eschews their use in civil commitment proceedings. As described earlier, civil commitment laws require the basis for involuntary commitment to stem from the nexus between risk for harm and mental illness. In other words, not only must the individual have a mental illness but the risk of harm must be posed as a result of the mental illness. Of course, individuals who are at risk of harm to themselves or others may or may not

have a mental illness. Moreover, individuals who have a mental illness and who pose a risk for violence to self or others may be at risk primarily because of risk factors other than the mental illness (e.g., organic impairment, problematic personality traits, current substance use, etc.). The only approach to understanding the degree to which a causal nexus between the mental disorder and risk for harm exists is *vis-à-vis* clinical formulation. Clinical judgment of any sort, including clinical formulation, however, is prohibited under actuarial schemes. As such, they are irrelevant to the assessment task required in civil commitment proceedings. Moreover, courts appear to value this kind of approach. For example, in Canada, over several decades the Supreme Court consistently has held that the use of discretion by mental health and criminal justice professionals (e.g., psychiatrists and psychologists, police and corrections officers, prosecutors and judges, and parole and review boards) is not only appropriate but necessary (see Kropp & Hart, 2004). We therefore turn our attention to the SPJ approach to violence risk assessment.

Development of the SPJ approach to violence risk assessment and management began in the mid-1990s (for early examples of SPJ instruments, see Kropp, Hart, Webster, & Eaves, 1994, 1995; Webster, Eaves, Douglas, & Wintrup, 1995; Webster, Douglas, Eaves, & Hart, 1997; and, for more general discussions, see Douglas & Kropp, 2002; Douglas, Cox, & Webster, 1999; Hanson, 1998; Hart, 2001). To date, at least 23 SPJ instruments have been developed for use with children, adolescents, and adults for assessing risk of general and specific forms of violence, and several are in development (see Guy et al., 2015). The two SPJ tools of most relevance to civil commitment with adults are those that focus on risk for general violence: the Historical Clinical Risk Management – 20, Version 3 (HCR-20^{V3}; Douglas, Hart, Webster, & Belfrage, 2013) and the Short-Term Assessment of Risk and Treatability (START; Webster, Martin, Brink, Nicholls, & Desmarais, 2009). Both the START (O’Shea & Dickens, 2014) and the HCR-20 have a solid empirical basis of psychometric evaluation. With respect to the HCR-20, at least 350 disseminations are now available on versions 2 and 3 of this tool (Douglas et al., 2016).

Comprehensive evaluation using the SPJ model comprises several steps (see Douglas, Hart, Webster, & Belfrage, 2013; Hart et al., 2003). First, evaluators gather the necessary information, ideally from multiple sources. Next, they consider the presence of the standard set of factors included on the tool, selected based on the degree to which they demonstrate empirical support at the nomothetic level; typically, evaluators rate each factor according to whether it is definitely present, partially/possibly present, or absent. Third, evaluators consider the individual relevance for risk of violence of each item at the idiographic level; typically, ratings are made as to whether the factor is of low, moderate, or high importance for the evaluatee’s risk for violence or the degree to which the factor may complicate risk management efforts.

Next, evaluators engage in individual case formulation, considering, among other things the ways in which factors may operate to influence risk (e.g., as a motivator, disinhibitor, or destabilizer). Evaluators then turn their attention to the future

and develop scenarios of violence and nonviolence. Using these scenarios, evaluators develop risk management recommendations, which may incorporate key types of risk management strategies, including monitoring, treatment, supervision, and victim safety planning. Finally, evaluators communicate their overall or summary judgments about different facets of risk, and may use categorical labels as a shorthand way to summarize the perceived level of risk and corresponding degree of intervention judged to be required to diminish this risk.

We conclude by noting that, because the only risk factor typically required for consideration in traditional civil commitment proceedings (i.e., not SVP proceedings, or commitment hearings precipitated by risk due to substance use) is major mental disorder, in practice, clinical opinions about an individual's suitability for civil commitment are typically based on what technically is referred to as (very focused) unstructured clinical judgment. Although major mental disorders such as psychotic-spectrum disorders are associated with violence, albeit with a relatively small overall effect size (Douglas, Guy, & Hart, 2009), mental illness can affect the way in which other risk factors influence an individual's decision-making regarding violence perpetration. For this and other reasons, clinicians would have good reason to use an empirically validated SPJ tool for civil commitment evaluations when time permits.

Risk of Harm Resulting From Inability to Care for or Protect Oneself

Empirically validated guidelines for assessing this prong have not been developed, to our knowledge. As is the case for the civil commitment requirements related to risk for violence to self or others, specific behavioral criteria are provided in the relevant statute. Considerations here will include, for example, whether the individual, because of mental illness, is unable to satisfy basic needs for nourishment, medical care, shelter, or safety, thereby creating a likelihood of physical harm to the individual.

Civil Damages

As noted at the outset of this chapter, avenues are available for resolving civil disputes in Western legal systems. The three most typical categories of relief include monetary compensation (i.e., damages) for harm suffered; an injunction, used to prevent the defendant from doing something she or he plans to do; and specific performance, used to impel the defendant to do something she or he was supposed to. In this section, we focus on emotional damage claims, which are typically resolved by the awarding of monetary compensation. Several excellent and more comprehensive reviews are available on psychological evaluation of emotional damages (Foote & Lareau, 2013; Goodman-Delahunty & Foote, 2011; Kane & Dvoskin, 2011; Koch, Douglas, Nicholls, & O'Neill, 2006), as well as on the psychology pertaining to determination of damages by juries (e.g., Greene & Bornstein, 2003).

Although emotional damage claims are commonplace in contemporary Western society, historically individuals could not recover for such damages in the absence of physical contact or injuries. In the United States, much of the law regarding emotional distress claims originated in common law. Beginning in the early 1900s, the law began to allow for recovery for emotional damages in the absence of a physical injury. In a case involving a horse that defecated on the lap of a woman seated in the front row at a circus, which was upsetting but did not result in physical harm, the court held she was allowed to recover for damages because there was unwanted touching of her body (*Christie Brothers Circus v. Turnage*, 1928).

A key legal concept underlying claims for emotional damages is the tort, which is a civil wrong that unfairly causes an individual to suffer harm or loss, as a result of which legal liability is attached to the person, also known as the tortfeasor, who committed the wrong. In tort law, a plaintiff must prove that the defendant breached a duty when she or he committed a tort, and that harm (to the person or property) resulted as a consequence. The plaintiff bears the burden of persuasion, which must be proven to a preponderance of the evidence. Several categories of tort exist, including intentional torts, defamation, privacy torts, strict liability, vicarious liability, emotional distress torts (which can involve intentional or negligent infliction of emotional distress), and negligence. Claims of negligence are the primary vehicle through which claims for emotional damages are advanced.

In claims of negligence, a plaintiff alleges that the defendant failed to act in way that a reasonable person would have acted under the circumstances and, as a result, she or he incurred an injury that otherwise would not have occurred. Whether the defendant intended to harm the plaintiff is not in question. Four elements are required to make a prima facie case for negligence: it must be established that there was a dereliction of duty directly causing damages. There must be a *duty* by the defendant to conform to a specific standard of conduct for the protection of the plaintiff (and others) against an unreasonable risk of injury. A duty can be created by relationship or status (either to a specific person or to others in society who can foreseeably be harmed by one's conduct) or, less commonly, by legislature, by courts, or by a jury. Foreseeability is a key concept that involves whether a reasonable person could anticipate the results of the action. In the absence of foreseeability, no duty is owed to that plaintiff. In other words, typically a plaintiff may be eligible to recover damages only if she can establish that a reasonable person would have foreseen a risk of injury to her under the circumstances (i.e., she was located in the foreseeable "zone of danger").

One of two standards of care govern the duty. The reasonable person standard of care is an objective standard that refers to what an ordinary, reasonable, prudent person would do in the same circumstance. Special standards of care apply in extreme circumstances or when the plaintiff and defendant are in a special relationship (e.g., for psychologists, there is a professional standard of care). Second, having established that a duty existed, it must be shown that the defendant breached the duty (i.e., her conduct fell short of what was required). Third, the defendant's breach must have been the actual cause of the plaintiff's injury (i.e., "but for" the

defendant's actions or lack thereof, injury to the plaintiff would not have occurred) or the proximate cause of the injury (i.e., whether one can have "reasonably foreseen" that the defendant's actions or lack thereof would lead to the injury). Finally, it must be shown that the plaintiff suffered injury or damage to person or property. For the forensic mental health professional, the key issue is assessing the type and extent of the plaintiff's injuries. In emotional distress or personal injury cases, the most common type of damages awarded are compensatory damages, which are intended to repay or indemnify the plaintiff for actual losses suffered and/or compensate for loss more generally arising from, for example, lost wages or medical expenses, as well as physical and mental/emotional pain and suffering.

Psychological Evaluation

Most commonly, the role of a forensic psychologist focuses on consultation regarding causation and damages and the assessment will center on the plaintiff's cognitive, affective, physiological, and interpersonal functioning and potential impairment across various domains, including activities of daily life, work or school, relationships, and overall quality of life. Readers seeking to complete these types of evaluations will find the overview by Foote and Lareau (2013) quite helpful, in which key elements of the evaluation process are detailed.

The core of the evaluation initially consists of examining the plaintiff's functioning before, during, and after the tortious act (see Goodman-Delahunty and Foote's temporal interval model, 2009, 2011). As would be the case for any forensic evaluation, the evaluator will gather information from various sources, including interviews with the plaintiff and collateral sources, review of secondary collateral documents, and possibly psychological testing. The focus of data collection for the time prior to the tort is on the plaintiff's experiences and functioning up to the day of the event in question, and should include a comprehensive bio-psycho-social assessment. Compiling a complete picture of the plaintiff's baseline functioning is an essential foundation to determining the extent of the injury the plaintiff experienced as a result of the defendant's conduct. The focus of data collection for the time during the tort is the plaintiff's emotional reactions and expected dynamic nature of symptoms and problems, and functioning and changes across various life domains. The evaluator will be attentive to influences of life events that occur during this time to emotional functioning. For data collection focusing on events and functioning in life domains following the tort, the evaluator will be attentive to whether the plaintiff's emotional reactions may have worsened, improved, or remained unchanged, and possible contributory events, such as participating in treatment, financial or legal stressors, and so on. Important legal documents to be obtained could include the plaintiff's complaint, which may have triggered development of interrogatories (i.e., specific questions from the defense) and subsequently the plaintiff's answers to the interrogatories.

The subsequent steps of the evaluation process focus on the forensic analysis, or case conceptualization. Here, the evaluator compares the plaintiff's functioning at

the time of the evaluation with her functioning prior to the occurrence of the tortious act; endeavors to identify the causal influences that may have created new or exacerbated preexisting emotional symptoms and problems; considers and explicitly addresses possible alternative sources of causation, remaining cognizant that a symptom or problem may be multiply determined rather than caused solely by the tortious act; and, finally, makes a future-oriented judgment pertaining to the expected nature, intensity, and duration of any impairment and associated treatment (taking into consideration the impact of any comorbid disorders) or other supportive interventions, together with their anticipated costs. In essence, the final step of the evaluation requires a prospective assessment of the plaintiff's future ability to function as she or he did prior to the tortious act in light of any intervention that may be expected to mitigate impairment. The evaluator's opinion will focus on whether the tortious act appears to have played a role in the plaintiff's current mental injury, together with any other identifiable contributing factors.

Concluding Comments

Forensic mental health professionals are uniquely positioned to contribute to decisions by triers of fact regarding resolutions of disputes in which negligent acts are alleged to have resulted in psychological or emotional harm to others. Although the stakes in civil forensic assessment domains do not include potential loss of liberty or life, as in criminal forensic assessment practice, the stakes in civil practice indeed are high: long-term implications for quality of life with respect to receipt of health care and financial support can be profound. As with any other type of forensic practice, it is incumbent on the evaluator to ensure that she or he understands the unique legal and psychological issues at play for the particular type of assessment and to maintain continuing competence over time.

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