



# The ADA, the Workplace, and the Myth of the "Dangerous Mentally Ill"

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## INTRODUCTION

For some persons with disabilities, paternalism, or overprotectiveness, may indeed be "the most pervasive form of discrimination."<sup>1</sup> For persons with mental disabilities, however, discrimination generally "is manifested by bias, distrust, stereotyping, fear, embarrassment, anger and/or avoidance."<sup>2</sup> Surveys consistently show that the public harbors

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<sup>1</sup> H. R. REP. NO. 101-485, pt. 2, at 74 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 356. When referring to persons with mental disabilities – or indeed any disabilities – the preferred terminology is "people first" language, which focuses on the person, not the disability. Thus, terms like "Americans with disabilities" or "person with epilepsy" are preferable to "handicapped persons" or "an epileptic." Congress used this language in the Americans with Disabilities Act ("ADA" or "the Act") to reflect the preferences of persons protected by the Act. *Id.* at 51, *reprinted in* 1990 U.S.C.C.A.N. 303, 333 (noting that "[m]any individuals with disabilities object to the use of such terms as 'handicapped person' or 'the handicapped'"); S. REP. NO. 101-116, at 21 (1989) (stating preference for term "individual with handicaps"). In 1992, Congress amended the Rehabilitation Act of 1973 to conform to this terminology. *See* Rehabilitation Act Amendments of 1992, Pub. L. No. 102-569, 106 Stat. 4344, 4348 (1992) (codified at 29 U.S.C. § 706(8) (1994)). I use that terminology in this article, except where referring to earlier Rehabilitation Act cases using the then-current statutory term "handicap," or where referring to a stereotype such as "the dangerous mentally ill," which does not reflect these sensibilities.

<sup>2</sup> NATIONAL INSTITUTE ON MENTAL HEALTH, SURGEON GENERAL'S REPORT ON MENTAL HEALTH 6 (1999) [hereinafter SURGEON GENERAL'S REPORT].

widespread fear of "the mentally ill." In the 1950s, the first national survey designed to assess public attitudes about mental illness revealed the pervasive belief that mental illness "is a very threatening, fearful thing" that "people want to keep as far from themselves as possible."<sup>3</sup> Recent research suggests that "the dangerousness stereotype has endured and probably increased over the past 50 years, even though there have been large-scale public education efforts focused on the nature, causes, and treatment of mental illnesses."<sup>4</sup> There is no evidence

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<sup>3</sup> Shirley Star, *The Public's Ideas About Mental Illness*, Paper Presented at the Annual Meeting of the National Association for Mental Health 6 (Nov. 5, 1955), *quoted in* Bruce G. Link et al., *Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance*, 89 AM. J. PUB. HEALTH 1328, 1331 (1999); *see* SURGEON GENERAL'S REPORT, *supra* note 2, at 7 ("Mental illness [in the 1950s] carried great social stigma, especially linked with fear of unpredictable and violent behavior.") (citations omitted).

<sup>4</sup> Link et al., *supra* note 3, at 1332; *see also id.* at 1328 (observing that "[r]ather than waning, . . . stereotypes of dangerousness are actually on the increase" and "the stigma of mental illness remains a powerfully detrimental feature of the lives of people with such conditions") (citations omitted); SURGEON GENERAL'S REPORT, *supra* note 2, at 7 (stating that by the 1990s, public perception "more frequently incorporated violent behavior"). *See generally* Leonard Kriegel, *Uncle Tom and Tiny Tim: Some Reflections on the Cripple as Negro*, 38 AM. SCHOLAR 412, 423 (1969) ("Stereotypes persist long after reality fades away."); Gary B. Melton & Ellen Greenberg Garrison, *Fear, Prejudice, and Neglect*, 42 AM. PSYCHOLOGIST 1007 (1987) (discussing historic and continuing discrimination against persons with mental disabilities).

"Dangerousness" is not the only stereotype attached to persons with mental disabilities. They frequently are viewed as lazy, malingering, weak or just plain "bad." In a semantic differential study, respondents described a typical man with mental illness as "dangerous, dirty, unpredictable, and worthless." Bruce Link, *supra* note 3, at 1328 (quoting J. NUNNALLY, *POPULAR CONCEPTIONS OF MENTAL ILLNESS* 51 (1981)). In a 1996 survey, nearly four in ten persons viewed major depression as the result or manifestation of a character flaw. *Id.* at 1330 (reporting that 38.2% said person's "own bad character" was likely cause of their symptoms of depression). Roughly two out of three persons thought that alcoholism likely resulted from the "way the person was raised," and a similar number attributed cocaine addiction to the person's "own bad character." *Id.* For a comprehensive, thoughtful account of society's pervasive "sanist" attitudes and their pernicious effects on persons with mental disabilities, *see* Michael L. Perlin, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* (2000).

Unfortunately, but undeniably, there is a hierarchy of disabilities, and mental disabilities are at or near the bottom. *See, e.g.,* John L. Tringo, *The Hierarchy of Preference Toward Disability Groups*, 4 J. SPECIAL EDUC. 295, 300 (1970) (citing mental illness as most stigmatizing of all disabilities). Public discourse divides persons with disabilities into two rough groups: the "deserving disabled," generally those with visible mobility impairments, preferably resulting from service to their country; and the "disfavored disabled," those whose disabilities manifest themselves through behavior, as with mental illness, or who are suspected of acquiring their disability through disfavored conduct, as with HIV or AIDS. *See* Cary LaCheen, *Achy Breaky Pelvis, Lumber Lung and Juggler's Despair: The Portrayal of the Americans with Disabilities Act on Television and Radio*, 21 BERKELEY J. EMP. & LAB. L. 223, 226-27 (2000). Nor are judges immune from the prejudices and misperceptions that pervade society. *See* Linda Hamilton Krieger, *Afterword: Socio-Legal Backlash*, 21 BERKELEY J.

of societal fears of the "dangerous mentally ill" abating in the decade since the enactment of the Americans with Disabilities Act ("ADA").

These fears pose a considerable obstacle to the employment of persons with mental disabilities. As the notion of "going postal" entered our lexicon, heightened fears of workplace violence spawned an industry devoted to workplace violence prevention.<sup>5</sup> An employer who falls prey to the powerful and widespread belief that persons with mental illnesses are inherently dangerous might cursorily conclude that it can – and indeed should – exclude an applicant or employee with a mental disability from the workplace under the ADA's direct threat provision. This provision states that an employer need not hire or retain an individual with a disability who presents a "direct threat to the health and safety of other individuals in the workplace."<sup>6</sup>

A hasty or reflexive resort to the direct threat provision to exclude persons with mental disorders, however, is neither warranted by the facts nor permitted by the ADA. Contrary to popular belief, current research demonstrates no more than a "weak" or "modest" association between mental disorders and the risk of violence.<sup>7</sup> Accordingly, "public fears are way out of proportion to the empirical reality" concerning the

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EMP. & LAB. L. 476, 518 (2000) (noting that "federal judges interpreting the ADA seem strangely oblivious to the problem of stigma or to the role the ADA's drafters expected it to play in the Act's implementation"); Barry Sullivan, *When the Environment is Other People: An Essay on Science, Culture, and the Authoritative Allocation of Values*, 69 NOTRE DAME L. REV. 597, 600 n.12 (1994) (reporting that West Virginia Supreme Court's Chief Justice stated during oral argument, "I wouldn't work within 500 yards of anyone who tested positive for HIV. I have a wife and children."); see also *Buck v. Bell*, 274 U.S. 200, 207 (1927) (opining that "three generations of imbeciles are enough"). Indeed, the Supreme Court has suggested that mental illness plus conviction of a crime – apparently any crime – is sufficient to prove a defendant "dangerous" to society and to commit that defendant involuntarily and indefinitely to a mental institution. See *Jones v. United States*, 463 U.S. 354, 364 (1983). Jones had pleaded guilty by reason of insanity to the crime of shoplifting. *Id.* at 365.

<sup>5</sup> See ELIZABETH CARLL, *VIOLENCE IN OUR LIVES: IMPACT ON WORKPLACE, HOME AND COMMUNITY* 169-70 (1999) (describing "Postal" video game); Vicki A. Laden & Gregory Schwartz, *Psychiatric Disabilities, the Americans with Disabilities Act, and the New Workplace Violence Account*, 21 BERKELEY J. EMP. & LAB. L. 246, 248 (2000) (discussing public perception that workplace violence is "epidemic").

<sup>6</sup> 42 U.S.C. § 12113(b) (1994).

<sup>7</sup> See Randy Borum et al., *Assessing and Managing Violence Risk in Clinical Practice*, J. PRAC. PSYCHIATRY & BEHAV. HEALTH, July 1996, at 205, 208 (stating that association between mental disorder and violence is "modest"); Jiri Modestin, *Criminal and Violent Behavior in Schizophrenic Patients*, 52 PSYCHIATRY & CLINICAL NEUROSCI. 547, 553 (1998) (suggesting that "the magnitude of the association between crime and/or violence and mental illness will probably be modest compared to demographic and socio-economic variables"); John Monahan & Jean Arnold, *Violence by People with Mental Illness: A Consensus Statement by Advocates and Researchers*, 19 PSYCHIATRIC REHABILITATION J. 67, 69 (1996).

link between mental disorders and violence.<sup>8</sup> Moreover, the likelihood that a person with a mental disorder will engage in violence depends not only on the presence of the disorder, but on many other factors. Such factors include age, gender, socioeconomic status, personal traits, the presence and possibly the content of any current psychotic symptoms, alcohol or substance abuse, and the presence of hostile or threatening relationships.<sup>9</sup>

Under the ADA, an employer may not act based on generalized fears about the risk of violence by persons with mental disorders. The ADA's direct threat provision prohibits reliance on such "common sense" fears, which are often erroneous assessments of risk. Instead, Congress imposed a standard requiring a direct threat determination based on an individualized inquiry into the actual, current risks posed by the individual applicant or employee. The employer must assess any risks according to current objective medical or scientific information about whether and how a disability may endanger workplace health or safety.<sup>10</sup> Following this assessment, the employer may exclude or restrict the individual only if the risk is "significant," rather than remote or speculative. Moreover, if that risk can be sufficiently reduced or eliminated by reasonable accommodations, including modifications to workplace practices, then the employer may not exclude the employee.<sup>11</sup> In short, the direct threat inquiry is carefully structured "to ensure that employers are acting on fact rather than fear, information rather than ignorance, and medical evidence rather than mythology."<sup>12</sup>

This article examines current scientific literature about the link between mental disorders and violence and assesses that evidence under the rigorous standards of the direct threat defense. It then explores two important implications for employers. First, employers may not determine *categorically* that persons diagnosed with mental disorders present a significant risk of workplace violence and therefore must be excluded from the workplace or restricted in their job duties. As stated, the direct threat defense is specifically designed to replace such

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<sup>8</sup> Bruce Link & Ann Stueve, *New Evidence on the Violence Risk Posed by People with Mental Illness*, 55 ARCHIVES GEN. PSYCHIATRY 403, 403 (1998).

<sup>9</sup> See *infra* Part II.B.

<sup>10</sup> See *infra* text accompanying notes 58-60.

<sup>11</sup> 42 U.S.C. § 12111(3) (1994) (defining direct threat as "significant risk of harm to the health and safety of others that cannot be eliminated by reasonable accommodation"); *id.* § 12111(10) (defining "undue hardship").

<sup>12</sup> *EEOC v. Prevo's Family Mkt., Inc.*, 135 F.3d 1089, 1101 n.3.(6th Cir. 1998) (Moore, J., dissenting).

generalized fears with individualized inquiries. And, in any event, mental disabilities are particularly unsuited for such generalizations for two reasons: mental disabilities vary widely in their severity and their symptomatology, and individuals who have mental disabilities differ greatly in their ability to control their conduct despite the presence of the disability. Accordingly, an employer's direct threat analysis must include a careful assessment of the individual's recent conduct, current symptoms, prognosis, compliance with treatment, co-occurring alcohol or substance abuse disorders, personal traits including self-restraint or discipline, and other factors that could increase or decrease the individual's risk of violent behavior.

Second, under the ADA employers must assess the risk of violence in the *workplace*, not in a vacuum, and in light of *reasonable accommodations* to reduce that risk.<sup>13</sup> Here the implications of the social science research are intriguing and potentially transformative. There is an emerging consensus that violence arises out of situations and relationships rather than solely from an individual's disposition. Thus, the employer's duty to reduce or eliminate risks through reasonable workplace accommodations may open the door to demands that an employer undertake measures to change workplace dynamics to reduce the risks of violent confrontations. In addition, because persons with mental disorders are often victims of abuse and harassment, which may escalate into violence, an employer might have to implement workplace policies to prevent or punish such abuse and harassment. The employer might also need to modify non-essential workplace rules, perhaps permitting an employee with a mental disorder to walk away from angry or aggressive confrontations.

Such accommodations are not necessarily novel. Employers should be familiar with similar workplace policies prohibiting gender- or race-based harassment. Permitting an employee with a mental disorder to remove himself from a situation when he feels he may become violent is similar to permitting an employee with epilepsy to leave his work station when he fears he will have a seizure. Nonetheless, employers are particularly resistant to providing behavioral accommodations for employees with mental disabilities, even where expense is not an issue and the employer would approve similar requests for other reasons.<sup>14</sup>

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<sup>13</sup> See 42 U.S.C. § 12113(b) (1994) (stating employer may require that individual not pose "direct threat to the health or safety of other individuals in the workplace"); *id.* § 12111(3) (defining "direct threat").

<sup>14</sup> See Susan Stefan, "You'd Have to Be Crazy to Work Here": Worker Stress, the Abusive Workplace, and Title I of the ADA, 31 LOY. L.A. L. REV. 795, 800-01 (1998) (reporting research

Professor Susan Stefan, who has documented this phenomenon, explains:

ADA cases involving psychiatric disabilities raise issues at the heart of the employment relationship: the scope of permissible behavior of supervisors toward employees; the extent to which tolerance of stress is an 'essential function' of either a given job or employment in general; and the extent to which a worker is expected to tolerate insensitivity or abuse by supervisors or co-workers. ADA psychiatric disability claims focus increasingly on the balance between what employees must endure in a 'normal' work environment – or risk being held unqualified for employment – and what employers must change about work environments – or risk being held not to have reasonably accommodated an employee with a psychiatric disability.<sup>15</sup>

Employers reluctant to provide accommodations designed to help an employee perform the essential functions of the job are unlikely to embrace accommodations designed to help the employee refrain from violence. Even if we accept that the employee ultimately must bear responsibility for conforming to workplace rules, we should not overlook the contribution of the workplace in triggering or discouraging violent or disruptive misconduct. Research suggests that when a person with a mental disorder engages in any violent or threatening act, people too quickly attribute the conduct to the disorder and label the person "violent." Closer examination, however, may reveal that this person was simply responding to bullying, coercion, or even outright violence by

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that reveals that employers are "generally unwilling" to give persons with mental disabilities workplace accommodations that are "common personnel practices routinely adopted in other circumstances," even if it will cost more to pay disability benefits than to make a simple behavioral accommodation or routine personnel move). Objections to the ADA's reasonable accommodation requirement are by no means limited to issues affecting employees with mental disabilities. See, e.g., Samuel Issacharoff & Justin Nelson, *Discrimination with a Difference: Can Employment Discrimination Law Accommodate the Americans with Disabilities Act?*, 79 N.C. L. REV. 307, 340-41 (2001) (criticizing reasonable accommodation standard for its failure to spread risk among employers); Lisa A. Lavelle, Note, *The Duty to Accommodate: Will Title I of the Americans with Disabilities Act Emancipate Individuals with Disabilities Only to Disable Small Businesses?*, 66 NOTRE DAME L. REV. 1135, 1171 (1991) (noting that reasonable accommodation requirement's broad, generic definition creates potential for increase in litigation). A broad defense of the distributive or corrective norms underlying the accommodation provision is beyond the scope of this article; my concern is simply that the provision not be given short shrift when applied to an employee with a mental disability or an accommodation designed to reduce or eliminate the risk of violence.

<sup>15</sup> Stefan, *supra* note 14, at 802.

another. What if this is the workplace dynamic? Does the danger come from a "violent employee"? If so, is it the employee with the mental disorder? Or does the danger result in part from a volatile situation that prompted a violent response from a vulnerable employee? A clearer picture of the complex relationship between mental disorders and violence, as well as the requirements of the ADA's direct threat defense, is necessary to assess employers' responsibilities in maintaining workplace safety without discriminating against persons with psychiatric disabilities.

### I. BACKGROUND ON THE AMERICANS WITH DISABILITIES ACT

Before delving into the extensive social science literature on violence and mental disorders, it is important to address two background issues. The first issue is terminology. The ADA protects persons with *disabilities*, including mental or psychiatric disabilities. On the other hand, social science research focuses on persons with mental or psychiatric *disorders*. These categories are not identical, but significant overlap makes the social science research instructive when applying the ADA. The second issue concerns the proper interpretation of the direct threat provision.<sup>16</sup> Mindful that people often maintain exaggerated or irrational fears about persons with disabilities,<sup>17</sup> Congress purposefully adopted a rigorous direct threat standard that harnesses science, medicine and a fact-specific inquiry to assess actual, rather than perceived, threats to health and safety.

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<sup>16</sup> The origins, development, and proper legal interpretation of the ADA's direct threat standard form an important story in American disability law that requires its own treatment. See Ann Hubbard, *Interpreting and Implementing the ADA's Direct Threat Defense*, 95 NW. U. L. REV. (forthcoming 2001). For present purposes, we need only sketch the highlights in order to draw concluding lessons for the employer who seeks to exclude an individual with a mental disability as potentially violent.

<sup>17</sup> During deliberations on the Act, Congress heard testimony from individuals with disabilities who had been excluded from schools, jobs, and public accommodations on the unsubstantiated grounds that they posed a danger to others. E.g., *Americans with Disabilities Act of 1989: Hearing on H.R. 2273 Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary*, 101st Cong. 48 (1989) (testimony of Peter Addesso, Paralyzed Veterans of America) (testifying that he was thrown out of restaurant because his wheelchair was considered fire hazard); *id.* at 153 (testimony of Laura Cooper, Chair, Disabled Lawyers Committee, American Bar Association) ("In 1986, I was thrown out of a shopping mall because a security officer believed that my electric wheelchair was a safety hazard to other patrons.").

A. Correspondence Between Congressional Definition of "Mental Disabilities" and Medical Definition of "Mental Disorder"

1. Mental Disabilities

This article refers both to "mental disabilities," as defined by the ADA, and "mental disorders," as defined by mental health professionals, including the American Psychiatric Association (APA). The terms differ in some respects because the first term is used to define legal protections, while the second guides diagnosis and treatment decisions. The mental disorders discussed in this paper can also be called "mental illnesses."<sup>18</sup>

The ADA defines disability to include a "mental impairment that substantially limits a major life activity," a record of such an impairment, or being regarded as having such an impairment.<sup>19</sup> The regulatory definition of "impairment" includes "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, or specific learning disabilities."<sup>20</sup> Therefore, "mental disability" refers to a mental impairment that manifests itself in an individual with sufficient duration and severity that it substantially limits one or more of that individual's major life activities. In other words, to refer to an "individual with a mental disability" is to express a legal conclusion about the effect that a mental disorder has on that individual's functioning.

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<sup>18</sup> The understanding of terms like mental disorder and mental illness may vary depending on the context. Compare Laura Milazzo-Sayre et al., *Serious and Severe Mental Illness and Work: What Do We Know?*, in MENTAL DISORDER, WORK DISABILITY, AND THE LAW 13, 15-16 (Richard J. Bonnie & John Monahan eds., 1997) (relying on definition of "serious mental illness" from Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAHMSA)), with DEBORAH ZUCKERMAN ET AL., THE ADA AND PEOPLE WITH MENTAL ILLNESS: A RESOURCE MANUAL FOR EMPLOYERS 7 (1993) (defining "mental disability" as neurological impairment due to developmental and organic disorders, and "mental illness" to include thought, mood, and anxiety disorders), and John Monahan, *Mental Disorder and Violent Behavior: Perceptions and Evidence*, 47 AM. PSYCHOLOGIST 511, 514 (1992) (referring to "mental disorders" as "those major disorders of thought or affect that form a subset of the Axis I of the [DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS]"), and Robert F. Schopp & Michael R. Quattrocchi, *Predicting the Present: Expert Testimony and Civil Commitment*, 13 BEHAV. SCI. & L. 159, 176-77 (1995) (stating that "mental illness" is not technical clinical term).

<sup>19</sup> 42 U.S.C. § 12102(2) (1994).

<sup>20</sup> 29 C.F.R. § 1630.2(g) (2000). This definition was taken from the original Rehabilitation Act regulations written by the Department of Health, Education and Welfare. See S. REP. NO. 101-116, at 8 (1989); 45 C.F.R. § 84.3(j)(2)(i) (1999).

## 2. Mental Disorders

Mental disorders are defined more broadly. The most authoritative source for defining mental disorders is the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, or DSM.<sup>21</sup> Courts frequently use the DSM as a guide for determining mental disability under the ADA,<sup>22</sup> but the DSM defines disorders and conditions that are not protected by the statute.<sup>23</sup> While the ADA covers only those disorders that substantially limit a "major life activity," the DSM is not so limited.<sup>24</sup> Even where the DSM defines the disorder in part by functional limitations, those limitations may be too transitory or insignificant to satisfy the ADA.<sup>25</sup> This is especially true if

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<sup>21</sup> AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994) [hereinafter DSM-IV]. This manual was first published in 1952 (DSM-I), and the latest edition, DSM-IV, was published in 1994. DSM-IV defines a mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress . . . or disability . . . or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." *Id.* at xxi.

<sup>22</sup> See e.g., *Boldini v. Postmaster Gen.*, 928 F. Supp. 125, 130 (D.N.H. 1995) (holding that "in circumstances of mental impairments, a court may give weight to a diagnosis . . . described in the [DSM-IV]"); *Pandazides v. Va. Bd. of Educ.*, 804 F. Supp. 794, 803 (E.D. Va. 1992) (describing DSM-IV as "nationally recognized directory of mental illness"), *rev'd on other grounds*, 13 F.3d 823 (4th Cir. 1994); EEOC, NOTICE NO. 915.002, EEOC ENFORCEMENT GUIDANCE: THE AMERICANS WITH DISABILITIES ACT AND PSYCHIATRIC DISABILITIES 3 (1997), available at <http://www.eeoc.gov/docs/psych.html> [hereinafter EEOC ENFORCEMENT GUIDANCE] ("The DSM-IV has been recognized as an important reference by courts and is widely used by American mental health professionals for diagnostic and insurance reimbursement purposes.").

<sup>23</sup> "The DSM-IV also includes conditions that are not mental disorders but for which people may seek treatment (for example, problems with a spouse or child). Because these conditions are not disorders, they are not impairments under the ADA." EEOC ENFORCEMENT GUIDANCE, *supra* note 22, at 3-4. In addition, the ADA expressly excludes from the definition of "disability" the following DSM conditions: transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders; compulsive gambling, kleptomania, or pyromania; or psychoactive substance use disorders resulting from current illegal use of drugs. 42 U.S.C. § 12211(b) (1994).

<sup>24</sup> Some DSM diagnoses are based on "behavioral or psychological distress," or pain, rather than on "disability," which the DSM defines as an "impairment in one or more important areas of functioning." DSM-IV, *supra* note 21, at xxi.

<sup>25</sup> For example, the DSM criteria for a major depressive episode include certain symptoms of impaired mood and functioning during a two-week period. DSM-IV, *supra* note 21, at 327. The ADA's definition of an "actual" disability does not encompass impairments of such short duration. See 29 C.F.R. § 1630.2(j) (2000) (stating that "temporary, non-chronic impairments of short duration, with little or no long term or permanent impact, are usually not disabilities" and providing example of "broken leg that takes eight weeks to heal . . . [as an] impairment of fairly brief duration"). The EEOC's Enforcement Guidance recognizes that an impairment may be a disability when it has

the person with the disorder is taking medication; the DSM directs a diagnosis based on the underlying disorder, while the ADA focuses on the treated condition.<sup>26</sup> In addition, "important areas of functioning"

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lasted or may last several months or, for an episodic, recurring condition, when it is in an active, substantially limiting phase. See EEOC ENFORCEMENT GUIDANCE, *supra* note 22, at 8 (stating that mental impairment "is substantially limiting if it lasts for more than several months and significantly restricts the performance of one or more major life activities during that time"); *id.* (stating that severe impairment may constitute disability if its duration is "indefinite and unknowable or is expected to be at least several months"); *id.* at 9 (stating that chronic, episodic conditions may be disabilities "if they are substantially limiting when active or have a high recurrence in substantially limiting forms"); see also *Leisen v. City of Shelbyville*, 153 F.3d 805, 808 (7th Cir. 1998) (holding firefighter with depression not substantially limited in learning simply because she could not obtain paramedic certification during probationary period); *Sanders v. Arneson Prods.*, 91 F.3d 1351, 1354 (9th Cir. 1996) (finding that psychological impairment lasting 3.5 months with no residual effects was not disability), *cert. denied*, 520 U.S. 1116 (1997).

One commentator has suggested that, if an episodic disorder that substantially impairs functioning is likely to be chronic or recurrent, the court should presume a disability under the ADA. Stephanie Proctor Miller, *Keeping the Promise: The ADA and Employment Discrimination on the Basis of Psychiatric Disability*, 85 CAL. L. REV. 701, 718-19 (1997) (identifying major depression, bipolar disorder, schizophrenia, and severe anxiety disorders as most likely to become chronic) (citations omitted). In addition, a plaintiff with major depressive episodes of relatively short duration might be able to claim ADA protection based on a "perceived" disability or a "record of" a disability. See 42 U.S.C. § 12111(2)(B) (1994) ("record of" disability); *id.* § 12111(2)(C) ("perceived" disability); 29 C.F.R. § 1630.2(k) (2000) ("record of" disability); *id.* § 1630.2(l) ("perceived" disability); *Sch. Bd. of Nassau County v. Arline*, 480 U.S. 273, 281 (1987) (holding that prior hospitalization for tuberculosis was sufficient to establish "record" of handicap under Rehabilitation Act); *Olson v. Gen. Elec. Astrospace*, 101 F.3d 947, 955 (3d Cir. 1996) (finding that employee presented jury question on perceived disability where former supervisor, who recommended against hiring employee, knew of his hospitalization for mental illness, made multiple references to his illness in evaluation, and questioned his job commitment in light of absences resulting from his illness); *Holihan v. Lucky Stores, Inc.*, 87 F.3d 362, 363 (9th Cir. 1996) (finding issue of fact existed as to perceived disability where employer terminated employee after receiving medical reports diagnosing depression, anxiety, and stress), *cert. denied*, 520 U.S. 1162 (1997); *Mendez v. Gearan*, 956 F. Supp. 1520, 1524-26 (N.D. Cal. 1997) (remanding for determination of whether Peace Corps regarded plaintiff as having disability when it refused to let her serve as volunteer until she could prove that her depression would not recur).

<sup>26</sup> See *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 482, 488-89 (1999) (finding that, because ADA requires that people be evaluated in their corrected state and plaintiffs could wear glasses or contacts to correct their vision, they did not meet ADA's definition of disabled); *Kotlowski v. Eastman Kodak Co.*, 922 F. Supp. 790, 798 (W.D.N.Y. 1996) (finding that, with antidepressants, plaintiff was not substantially limited in major life activity). The plaintiff who is held not to have an actual disability because she functions well with medication or corrective devices might still demonstrate that the employer discriminated because of her "record" of a disability, 42 U.S.C. § 12102(2)(B) (1994), or because the employer "regarded" her as having a disability, *id.* § 12102(2)(C). She might also qualify as disabled if her medication has side effects that substantially limit a major life activity. See *Sutton*, 527 U.S. at 484 (rejecting implication that "in determining whether an individual is disabled, courts and employers could not consider any negative side effects suffered by an

under the DSM, such as sustaining interpersonal relationships, may or may not be held to be "major life activities."<sup>27</sup>

One of the most important distinctions between the APA's diagnoses and the ADA's protection is the treatment of drug and alcohol abuse and dependence. Under the APA, the current abuse of or dependence on alcohol or drugs constitutes a disorder. Under the ADA, however, the current use of illegal drugs is not protected, even if that use would constitute a substance abuse disorder warranting clinical treatment.<sup>28</sup> Furthermore, while the ADA's definition of disability encompasses alcoholism, the statute permits an employer to discipline an employee for deficiencies or misconduct related to the use of drugs or alcohol.<sup>29</sup> The ADA expressly authorizes employers to require an alcohol- and drug-free workplace.<sup>30</sup>

### 3. The Focus of This Article

While the DSM broadly defines mental disorders, research on the relationship between mental disorders and the risk of violence often has focused more narrowly on "severe" or "major" mental disorders listed under Axis I of the DSM.<sup>31</sup> These include "disorders commonly accompanied by psychotic symptoms such as schizophrenia, schizoaffective disorder, manic-depressive disorder . . . as well as severe forms of other disorders, such as major depression, panic disorder, and obsessive-compulsive disorder."<sup>32</sup> To conform to the scope of relevant

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individual resulting from the use of mitigating measures, even when those side effects are very severe") (citations omitted); *Guice-Mills v. Derwinski*, 967 F.2d 794, 797 (2d Cir. 1992) (considering side effects of antidepressant in finding plaintiff to be person with disability).

<sup>27</sup> See, e.g., *McAlindin v. County of San Diego*, 192 F.3d 1226, 1240 (9th Cir. 1999) (holding, by divided panel, that "interacting with others" is major life activity); *Soileau v. Guilford of ME, Inc.*, 105 F.3d 12, 15 (1st Cir. 1997) (assuming, arguendo, that ability to get along with others was major life activity).

<sup>28</sup> 42 U.S.C. § 12211(b) (1994) (excluding from definition of "disability" any psychoactive substance use disorders resulting from current illegal drug use).

<sup>29</sup> *Id.* § 12114(c)(4) (1994); see, e.g., *Collings v. Longview Fibre Co.*, 63 F.3d 828, 836 (9th Cir. 1995) (finding no ADA violation for discharging factory workers who bought and sold drugs at work); *Little v. FBI*, 1 F.3d 255, 259 (4th Cir. 1993) (upholding discharge of FBI agent based on, among other things, intoxication on duty).

<sup>30</sup> 42 U.S.C. § 12114(c)(1)-(2).

<sup>31</sup> The DSM lists diagnoses under five categories or axes. Axis I includes clinical disorders – including depressive disorders, schizophrenia and schizophreniform disorders, bipolar disorder, and anxiety disorders – and other conditions that may be a focus of clinical attention. Axis II includes personality disorders and mental retardation. See DSM-IV, *supra* note 21, at 25-27.

<sup>32</sup> *Laura Milazzo-Sayre et al.*, *supra* note 18, at 16. The definition of persons with "serious mental illness" is less restrictive, encompassing persons over eighteen years of age

studies,<sup>33</sup> as well as to the ADA's definition of "disability," this article focuses on Axis I mental disorders and excludes personality disorders and alcohol and drug abuse or dependence disorders.<sup>34</sup> Thus, our question is when an employer may conclude that a qualified individual with an Axis I mental disability – such as schizophrenia, major depression or bipolar disorder – poses a direct threat of workplace violence.

### B. Congressional Imposition of a Rigorous, Objective Direct Threat Standard

The direct threat provision codifies standards set forth in *School Board of Nassau County v. Arline*,<sup>35</sup> a case decided under Section 504 of the Rehabilitation Act of 1973, a predecessor to the ADA.<sup>36</sup> In *Arline*, a schoolteacher experiencing a relapse of tuberculosis challenged the school system's decision to fire her for fear that she might infect others. The Supreme Court first rejected the school system's argument that a contagious disease is not a "handicap," reasoning that Congress expressly extended the Rehabilitation Act's protection to "those who are

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who "currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities." *Id.* at 14 (citing 1993 definition from Center for Mental Health Services of SAHMSA).

<sup>33</sup> The principal risk assessment studies have used different criteria to classify or select participants and to define violence. See John Monahan, *Risk Assessment of Violence Among the Mentally Disordered: Generating Useful Knowledge*, 11 INT'L J.L. & PSYCHIATRY 249, 255 (1988) (commenting on variety of inconsistent research variables in risk assessment studies). Compare Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761, 763 (1990) (evaluating persons with "schizophrenia, major depression, mania or bipolar disorder, . . . obsessive-compulsive disorder, panic disorder, and phobia," as well as persons suffering from alcohol and drug abuse or dependence), with Modestin, *supra* note 7, at 547 (evaluating persons with schizophrenia and related disorders).

<sup>34</sup> Most people alleging employment discrimination based on psychiatric disabilities report one of three diagnoses: depression, bipolar disorder, or post-traumatic stress disorder. Susan Stefan, *Delusions of Rights: Americans with Psychiatric Disabilities, Employment Discrimination and the Americans with Disabilities Act*, 52 ALA. L. REV. 271, 277-78 (2000) (citing Cumulative ADA Charge Data – Merit Factor Resolutions, available at <http://www.eeoc.gov/stats/ada-merit.html>). Although claims by persons with personality disorders are relatively rare and are not the focus of this article, those disorders may present particular challenges for employers and courts. See *id.* at 278-80.

<sup>35</sup> 480 U.S. 273 (1987).

<sup>36</sup> Section 504 provides: "No otherwise qualified handicapped individual in the United States, . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 29 U.S.C. § 794(a) (1976).

regarded as impaired and who, as a result, are substantially limited in a major life activity."<sup>37</sup> In doing so, "Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment."<sup>38</sup> The Court recognized, however, that "[a] person who poses a *significant risk* of communicating an infectious disease to others in the workplace will not be otherwise qualified for his or her job if reasonable accommodation will not eliminate that risk."<sup>39</sup>

The Court offered specific guidance on how to determine whether a person presents such a significant risk. First, "in most cases, the district court will need to conduct an *individualized inquiry* and make appropriate findings of fact."<sup>40</sup> Second, the determination should be based on "reasonable medical judgments given the state of medical knowledge,"<sup>41</sup> with deference to the judgments of public health officials.<sup>42</sup> Finally, the Court identified four factors to determine whether a risk is significant: "(a) the nature of the risk (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm."<sup>43</sup> Congress embraced *Arline's* analysis when it adopted the direct threat provision of the ADA.<sup>44</sup>

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<sup>37</sup> *Arline*, 480 U.S. at 284.

<sup>38</sup> *Id.* (citations omitted).

<sup>39</sup> *Id.* at 287 n.16 (emphasis added).

<sup>40</sup> *Id.* at 287 (emphasis added).

<sup>41</sup> *Id.* at 288; *see id.* at 285 (requiring "reasoned and medically sound judgments").

<sup>42</sup> *Id.* at 288.

<sup>43</sup> *Id.* (quoting Brief of Amicus Curiae American Medical Association at 19, *Sch. Bd. v. Arline*, 480 U.S. 273 (1987) (No. 85-1277)). Today these four factors are called the "*Arline* factors."

<sup>44</sup> *See, e.g.*, H.R. REP. NO. 101-485, pt. 2, at 76 (1990), *reprinted in* 1990 U.S.C.C.A.N. 202, 359 (stating that "the term 'direct threat' is meant to connote the full standard set forth in the *Arline* decision"); *id.*, pt. 3, at 34 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 457 ("The [House Judiciary] Committee intends to codify the direct threat standard used by the Supreme Court in *School Board of Nassau County v. Arline*."); *id.* at 45, *reprinted in* 1990 U.S.C.C.A.N. at 468 (defining direct threat as "[a] significant risk to the health or safety of others that cannot be eliminated with reasonable accommodation" and noting that "[t]his definition was added to clarify that the direct threat standard is a codification of the analysis in *Arline*"); S. REP. NO. 101-116, at 27 (1989) ("The standard to be used in determining whether there is a direct threat is whether the person poses a significant risk to the safety of others . . . , not a speculative or remote risk, and that no reasonable accommodation is available that can remove the risk.") (citing *Sch. Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987)).

Under the direct threat standard, the employer must satisfy five requirements to demonstrate that an employee or applicant with a mental disability poses a "direct threat" of violence in the workplace. First, the employer must base any risk assessment on an *individualized assessment* of the unique strengths, limitations and risks that the individual would present in the job in question. Accordingly, assumptions or generalizations about the risks posed by a group of persons sharing a disability are incompatible with the ADA's focus on individual abilities and limitations.<sup>45</sup> Indeed, Congress specifically denounced reliance on generalized assumptions that persons with mental disabilities pose a risk of violence. Instead, where the anticipated threat is violent conduct, the employer must conduct an individualized inquiry that focuses on the employee's or applicant's actual behavior. The House Judiciary Committee was explicit:

[A]n employer may not assume that a person with a mental disability, or a person who has been treated for a mental disability, poses a direct threat to others. This would be an assumption based on fear and stereotype. The purpose of creating the "direct threat" standard is to eliminate exclusions which are not based on objective evidence about the individual involved. Thus, *in the case of a person with mental illness there must be objective evidence from the person's behavior that the person has a recent history of committing overt acts or making threats which caused harm or which directly threatened harm.*<sup>46</sup>

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<sup>45</sup> See H.R. REP. NO. 101-485, pt. 2, at 58-59 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 340-41; S. REP. NO. 101-116, at 28 (1989) (noting that focus on group abilities goes against aims of ADA); *see also* *Sutton v. United Air Lines*, 527 U.S. 471, 483 (1999) (emphasizing that "[t]he definition of disability . . . requires that disabilities be evaluated 'with respect to an individual' and be determined based on whether an impairment substantially limits the 'major life activities' of such individual") (emphases added); *id.* (finding it impermissible to "speculate about a person's condition" or to "make a disability determination based on general information about how an uncorrected impairment usually affects individuals, rather than on the individual's actual condition").

<sup>46</sup> H.R. REP. NO. 101-485, pt. 3, at 45-46 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 468-69 (emphasis added). Only two years earlier, when amending the Fair Housing Act, Congress adopted a similar standard for when a landlord could justifiably exclude a person with a mental disorder under a direct threat standard:

Any claim that an individual's tenancy poses a direct threat and a substantial risk of harm must be established on the basis of a history of overt acts or current conduct. Generalized assumptions, subjective fears, and speculation are insufficient to prove the requisite direct threat to others. In the case of a person with a mental illness, for example, there must be objective evidence from the person's prior behavior that the person has committed overt acts which caused harm or which directly threatened harm.

The House Committee on Education and Labor agreed:

For people with mental disabilities, the employer must identify the specific behavior on the part of the individual that would pose the anticipated direct threat. *This determination must be based on the behavior of the particular disabled person, not merely on generalizations about the disability.*<sup>47</sup>

Second, consistent with *Arline*, the ADA defines "direct threat" as a "significant risk to the health and safety of others that *cannot be eliminated by reasonable accommodation.*"<sup>48</sup> In *Bragdon v. Abbott*,<sup>49</sup> the Supreme Court reaffirmed that a remote or speculative harm is insufficient.<sup>50</sup> The Court stated, "[b]ecause few, if any, activities in life are risk free, *Arline* and the ADA do not ask whether a risk *exists*, but whether it is *significant.*"<sup>51</sup> The requirement to reduce or eliminate risk through reasonable accommodations obligates the employer to consider, and possibly employ, requested measures that could reduce the risk of violent

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H.R. REP. NO. 100-711, at 29 & n.79 (1988), reprinted in 1988 U.S.C.C.A.N. 2173, 2190 & n.79.

<sup>47</sup> H.R. REP. NO. 101-485, pt. 2, at 57 (1990), reprinted in 1990 U.S.C.C.A.N. 303, 339 (emphasis added); see also S. REP. NO. 101-116, at 27 (1989) ("For people with mental disabilities, the employer must identify the specific behavior on the part of the individual that would pose the anticipated direct threat.").

This sensitivity to exaggerated or unsubstantiated fears about persons with mental disabilities was not universal. Both Houses turned back efforts to deny the ADA's protection to persons with mental disabilities. Senator Armstrong proposed a floor amendment to exclude from the definition of "disability" all disorders included in the DSM. 135 CONG. REC. S10,773, S10,785 (1989) (statement of Sen. Armstrong); see Robert L. Burgdorf Jr., *The Americans with Disabilities Act: Analysis and Implications of a Second-Generation Civil Rights Statute*, 26 HARV. C.R.-C.L. L. REV. 413, 451 (1991) (recounting Senator Armstrong's "rais[ing] the specter of a potential roll call on individual amendments" to remove individual DSM conditions). Senator Helms supported this amendment out of respect for an employer's "moral" objections to hiring persons with mental disabilities. 135 CONG. REC. S10,773, S10,786 (1989) (statement of Sen. Helms) (inquiring whether "an employer's own moral standards [would] enable him to make a judgment about" manic depressives, schizophrenics, transvestites, or kleptomaniacs). Even more striking, Representative Douglas of New Hampshire distributed a memo to his fellow House members arguing that protecting mental disabilities under the ADA "would open the door for 'Berserkers: Time Bombs in the Work Place.'" Jean Campbell & Caroline L. Kaufmann, *Equality and Difference in the ADA: Unintended Consequences for Employment of People with Mental Health Disabilities*, in MENTAL DISORDER, WORK DISABILITY, AND THE LAW, *supra* note 18, at 225-26.

<sup>48</sup> 42 U.S.C. § 12111(3) (1994) (emphases added).

<sup>49</sup> 524 U.S. 624 (1998).

<sup>50</sup> *Id.* at 649-50; see S. REP. NO. 101-116, at 27 (1989) (citing section 102(b) and *Sch. Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), which state that remote or speculative harm will not do).

<sup>51</sup> *Bragdon*, 524 U.S. at 649 (citing *Arline*, 480 U.S. at 287 & n.16; 42 U.S.C. § 12182(b)(3) (1994)).

workplace incidents involving an employee with a mental disability.

Third, the employer has the *burden of proving* that the individual poses a significant risk to the health and safety of others. This requirement is contested,<sup>52</sup> and its justification requires extensive examination of the language, structure, and legislative history of the statute, the direct threat provision's relationship to an affirmative defense under Title VII, and the outcome of a struggle between Congress and the Supreme Court involving the allocation of burdens under that Title VII provision.<sup>53</sup> Such an examination demonstrates that allocating the burden of proof to the employer is consistent with congressional intent to make the direct threat standard a stringent test, one that ferrets out untested, unfounded assumptions. This point is significant, because clinical predictions of violence are an uncertain enterprise, and uncertainty works against the party who bears the burden of proof.<sup>54</sup>

Fourth, the employer may consider only whether the individual poses a potential harm *to others*, not harm *to self*. Consistent with Congress's express finding that "individuals with disabilities continually encounter various forms of discrimination, including . . . overprotective rules and policies,"<sup>55</sup> Congress applied the direct threat provision to "the health or safety of *other individuals* in the workplace."<sup>56</sup> Thus, Congress defined

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<sup>52</sup> Compare *Nunes v. Wal-Mart Stores, Inc.*, 164 F.3d 1243, 1247 (9th Cir. 1999) ("Because this is an affirmative defense, Wal-Mart bears the burden of proving that Nunes is a direct threat."), and *Sullivan, supra* note 4, at 687-88 (stating that "one of the burdens that rests with the party seeking to exclude a disabled person . . . is the burden of establishing that the disabled person would present a 'significant risk' or a 'direct threat' to the health or safety of others"), with *Moses v. Am. Nonwovens, Inc.*, 97 F.3d 446, 447 (11th Cir. 1996) ("The employee retains at all times the burden of persuading the jury either that he was not a direct threat or that reasonable accommodations were available."), and Jeffrey A. Van Detta, *'Typhoid Mary' Meets the ADA: A Case Study of the 'Direct Threat' Standard Under the Americans with Disabilities Act*, 22 HARV. J.L. & PUB. POL'Y 849, 865 n.64 (1999) ("Logically, . . . the burden should be on the plaintiff to prove that a disability does not pose a 'direct threat.'") (citing *EEOC v. Amego, Inc.*, 110 F.3d 135, 144 (1st Cir. 1997)).

<sup>53</sup> See *Hubbard supra* note 16. For present purposes, I will simply point out that the direct threat provision, 42 U.S.C. § 12113(b) (1994), is listed under the heading "Defenses" and that the EEOC interprets the ADA as assigning to the employer the burden of proving that the individual with a disability presents a direct threat. 29 C.F.R. § 1630.15(b), (c) (1999) ("Disparate Impact Defenses"); *id.* app. § 1630.15 (Interpretive Guidance) ("With regard to safety requirements that screen out an individual with a disability or a class of individuals with disabilities, an employer must demonstrate that the requirement, as applied to the individual, satisfies the 'direct threat' standard in § 1630.2(r) in order to show that the requirement is job-related and consistent with business necessity.") (emphasis added).

<sup>54</sup> See *Sullivan, supra* note 4, at 640 (suggesting that scientific uncertainty in assessing risk works against party with burden of proof).

<sup>55</sup> 42 U.S.C. § 12101(a)(5) (1994) ("Findings").

<sup>56</sup> *Id.* § 12113(b) (emphasis added).

direct threat to refer to "a significant risk to the health and safety of *others* that cannot be eliminated by reasonable accommodation."<sup>57</sup>

Finally, and of particular importance, an employer must not base a direct threat determination on anecdotal or outdated information, but on the *current state of medical knowledge or other objective evidence*.<sup>58</sup> The *Arline* court considered this focus on objective information necessary to "replace . . . reflexive reactions to actual or perceived handicaps"<sup>59</sup> with "reasoned and medically sound judgments."<sup>60</sup> The pervasiveness and tenacity of negative "reflexive reactions" to individuals with mental disabilities heightens the need for an objective antidote to pernicious mythologies and unfounded fears. To comply with the requirements of an individualized, objective assessment of the actual risk of violence posed by a particular applicant or employee, the employer (or its medical and legal advisers) must have some specialized knowledge. The employer must know not only the extent to which mental disorders generally contribute to an increased risk of violence, but also what symptoms, diagnoses, situations or personal characteristics might indicate an increased or decreased risk.

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<sup>57</sup> *Id.* § 12111(3) (1994) (emphasis added). Despite this textual clarity, the EEOC has issued regulations defining direct threat as "a significant risk of substantial harm to the health or safety of *the individual* or others that cannot be eliminated or reduced by reasonable accommodation." 29 C.F.R. § 1620.2(r) (2000) (emphasis added). Department of Justice regulations interpreting the parallel direct threat standard under Title III conform to the language of the statute, looking exclusively to the risk to others. 28 C.F.R. § 36.208(a) (2000) ("Direct threat means a significant risk to the health or safety of *others* that cannot be eliminated by a modification of policies, practices, or procedures, or by the provision of auxiliary aids or services.") (emphasis added). At least one federal court of appeals has squarely held that the defense encompasses a risk of harm to self. *Moses v. Am. Nonwovens, Inc.*, 97 F.3d 446, 447 (11th Cir. 1996).

<sup>58</sup> See *Sch. Bd. of Nassau County v. Arline*, 480 U.S. 273, 288 (1988) (finding that determination of significant risk is to be based on "reasonable medical judgments given the state of medical knowledge," with deference to reasonable medical judgments of public health officials); see also *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998) (holding that "the risk assessment must be based on medical or other objective evidence"); 29 C.F.R. § 1630.2(r) (requiring determination that individual poses direct threat to be based on "an individualized assessment of the individual's present ability to safely perform the essential functions of the job" and on "a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence").

<sup>59</sup> *Arline*, 480 U.S. at 285.

<sup>60</sup> *Id.* at 286 n.15.

## II. THE CURRENT OBJECTIVE EVIDENCE ON THE ASSOCIATION BETWEEN MENTAL DISORDER AND RISK OF VIOLENCE

Public fears of violence by persons with mental disorders are grossly exaggerated, but not entirely baseless. As the Surgeon General stated in his 1999 *Report on Mental Health*, "[t]here is a small elevation in risk of violence from individuals with severe mental disorders (e.g., psychosis), especially if they are noncompliant with their medication," but "the overall likelihood of violence is low."<sup>61</sup> Somewhere between two extremes – "any person with a mental illness is to be feared" or "there is no reason to fear any person with a mental illness" – emerges a complex truth, nuanced and not yet fully understood. As Professor John Monahan has observed, "few questions in mental health law [are] as empirically complex or as politically controversial" as the relationship between mental disorder and violent behavior.<sup>62</sup> In recent years, advances in research have caused experts to reexamine and revise their assessments of that relationship.

Throughout the 1980s, research on violence and mental disorder focused principally on violence by hospitalized mental patients and assessed the prevalence of violent acts before, during and after hospitalization.<sup>63</sup> Because these studies rarely provided comparative data on the prevalence of violence in the community at large, they offered little insight into whether there was a fundamental relationship between mental disorder and violent behavior.<sup>64</sup> Accordingly, after reviewing more than two hundred studies on the association between violent crime and mental disorder, two of the nation's leading researchers concluded that any apparent relation between crime and mental disorder "can be accounted for largely by demographic and

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<sup>61</sup> SURGEON GENERAL'S REPORT, *supra* note 2, at 7, 8 (citations omitted).

<sup>62</sup> Monahan, *supra* note 18, at 511.

<sup>63</sup> *Id.* at 514.

<sup>64</sup> *Id.* Moreover, these studies have an inherent bias, in that they looked exclusively at public hospital mental patients, many of whom were involuntarily committed under a "danger to self or others" standard. Because "[v]iolent behavior [wa]s one of the reasons that these disordered people were selected out of the total disordered population for hospitalization," they can be expected to overrepresent the prevalence of violence among all persons with mental disorders, including those who never have been hospitalized. *Id.* at 515. In addition, the prevalence of violence during hospitalization could reflect the skill of the staff in diffusing violent situations and in mitigating the symptoms of the disorder. *Id.* And the rates of violence following hospitalization again could be a function of the type of patient selected for hospitalization, as well as the nature and duration of the treatment during hospitalization and the criteria for determining eligibility for discharge. *Id.*

historical characteristics that the two groups share."<sup>65</sup> The researchers found that, "when appropriate statistical controls are applied for factors such as age, gender, race, social class, and previous institutionalization, whatever relations between crime and mental disorder are reported tend to disappear."<sup>66</sup>

In the last decade, however, the availability of more sophisticated epidemiological data has led toward a recognition that there is at least a modest association between mental disorder and violence.<sup>67</sup> In a 1997 "Consensus Statement," more than forty of the nation's leading experts stated: "The results of several recent large-scale research projects conclude that only a weak association between mental disorders and violence exists in the community."<sup>68</sup> Significantly, these results "do not provide support for fears that persons with a mental disorder are frequently responsible for serious violence."<sup>69</sup> To the contrary, these studies confirm that the "vast majority" of people who have mental

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<sup>65</sup> John Monahan & Henry Steadman, *Crime and Mental Disorder: An Epidemiological Approach*, in CRIME AND JUSTICE: AN ANNUAL REVIEW OF RESEARCH 152 (M. Tonry & N. Morris eds., 1983).

<sup>66</sup> *Id.*; see also Paul E. Mullen, *A Reassessment of the Link Between Mental Disorder and Violent Behaviour, and Its Implications for Clinical Practice*, 31 AUSTL. & N.Z. J. PSYCHIATRY 3, 3 (1997) ("In the early 1980s there was a clear consensus among mental health professionals and researchers regarding the relationship between mental disorder and violent and criminal behavior."); Edward P. Mulvey, *Assessing the Evidence of a Link Between Mental Illness and Violence*, 45 HOSP. & COMMUNITY PSYCHIATRY 663, 663 (1994) ("For the last 15 years or so, it was generally accepted that mentally ill individuals are no more likely than other people to commit violent acts in the community.").

<sup>67</sup> See Borum et al., *supra* note 7, at 208 (noting that the association between mental disorder and violence is "modest"); Peter M. Marzuk, *Violence, Crime and Mental Illness: How Strong a Link?*, 53 ARCHIVES GEN. PSYCHIATRY 481, 485 (1996) (emphasizing that "the magnitude of the association between violence and mental illness, however statistically significant, is still modest"); Modestin, *supra* note 7, at 553 (suggesting that "the magnitude of the association between crime and/or violence and mental illness will probably be modest compared to demographic and socio-economic variables"); Mulvey, *supra* note 66, at 664 (stating that "the size of the association [between mental illness and violence], while statistically significant, does not appear to be very large, . . . [and] the absolute risk for violence posed by mental illness is small").

<sup>68</sup> Monahan & Arnold, *supra* note 7, at 70.

<sup>69</sup> James C. Beck, *Epidemiology of Mental Disorder and Violence: Beliefs and Research Findings*, 2 HARV. REV. PSYCHIATRY 1, 5 (1994); see HAROLD I. KAPLAN & BENJAMIN J. SADOCK, SYNOPSIS OF PSYCHIATRY: BEHAVIORAL SCIENCES, CLINICAL PSYCHIATRY 873 (8th ed. 1998) (asserting that "the fear with which some people regard all psychiatric patients is completely out of proportion to the few who are an authentic danger to others"); Pamela J. Taylor & John Monahan, *Commentary: Dangerous Patients or Dangerous Diseases?*, 312 BRIT. MED. J. 967, 967 (1996) (finding "no data to support the media caricature of people with a mental disorder, the shunning of former patients by employers or neighbours, or the laws increasing constraints proposed by politicians pandering to public fears").

disorders are not violent.<sup>70</sup> In fact, experts overwhelmingly agree that the mere diagnosis of an individual with a serious mental illness does not lead to the conclusion that she is likely to engage in violence.<sup>71</sup>

At the same time, experts have identified and begun to answer various questions about which people with psychiatric disorders are likely to behave violently. Those questions include: how significant are prior acts of violence; which, if any, diagnoses indicate a tendency toward violence; which, if any, symptoms correspond to an increased risk of violence; what situations may trigger a violent or aggressive response; who are the most likely targets; what social, economic and demographic characteristics or personality traits may make a person more likely to act violently; and what is the effect of alcohol or other substance abuse? Findings from recent epidemiological and prospective studies help answer these questions.

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<sup>70</sup> Patricia A. Brennan, Sarnoff A. Mednick & Sheilagh Hodgins, *Major Mental Disorders and Criminal Violence in a Danish Birth Cohort*, 57 ARCHIVES GEN. PSYCHIATRY 494, 499 (2000) (confirming that "most individuals with major mental disorders are not violent, and most violent individuals do not have a major mental disorder"); Lynne Lamberg, *Mental Illness and Violent Acts: Protecting the Patient and the Public*, 280 JAMA 407, 408 (1998) (quoting James C. Beck, Associate Professor of Psychiatry at Harvard Medical School, who summarized nearly fifty recent studies linking mental illness and violence: "The vast majority of persons with major mental disorders do not commit violent crimes."); Monahan, *supra* note 18, at 519 ("By all indications, the great majority of people who are currently disordered – approximately 90% from [one leading] study – are not violent."); Monahan & Arnold, *supra* note 7, at 70 ("Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number, and especially in those who use alcohol and other drugs."); Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, in VIOLENCE AND MENTAL DISORDER: DEVELOPMENTS IN RISK ASSESSMENT 101, 119 (John Monahan & Henry Steadman eds., 1994) [hereinafter VIOLENCE AND MENTAL DISORDER] (stating that "most mentally ill people do not commit assaultive acts").

<sup>71</sup> See, e.g., Renée L. Binder, *Are the Mentally Ill Dangerous?*, 27 J. AM. ACAD. PSYCHIATRY & L. 189, 195 (1999) (concluding that diagnosis is not "irrelevant to violence risk," but "it seems that symptoms are a better marker for violence potential than diagnoses *per se*."); Brennan, Mednick & Hodgins, *supra* note 70, at 499 ("The knowledge that a person has a major mental disorder, by itself, is of limited use to policy makers and clinicians concerned with preventing violent behavior."); Deidre Klassen & William A. O'Connor, *Demographic and Case History Variables in Risk Assessment*, in VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 229 ("The evidence can be viewed as suggesting that at least some aspects of mental illness may be direct contributors to the occurrence of violent incidents. But at the present time, it appears that *diagnosis alone is not a reliable risk marker.*") (emphasis added); Modestin, *supra* note 7, at 553 (suggesting that "the acuity of the illness and particularly of positive symptoms is of more importance [in predicting violence] than the diagnosis itself"). For a helpful analysis of the evolution, validity and admissibility of violence risk assessments, see John Monahan, *Assessment, Scientific Validity and Evidentiary Admissibility*, 57 WASH. & LEE L. REV. 901 (2000).

A. *Epidemiological Evidence and Prospective Studies*

Two epidemiological studies form the foundation for the recent progress toward answering these questions. The first is Professor Jeffrey Swanson's seminal research based on data from the Epidemiological Catchment Area (ECA) survey of the National Institute of Mental Health. The "largest community study of psychiatric disorders ever conducted in the United States," the ECA collected data from more than 30,000 households in five cities.<sup>72</sup> Although the ECA was designed to assess the existence of psychiatric disorders, not the prevalence of violence, its survey included five violence-related questions. Those questions allowed Swanson and his colleagues to compare rates of violence by persons with diagnosed mental disorders with rates of violence by persons with no such diagnosis.<sup>73</sup>

The results showed that there was indeed an association between psychiatric disorder and a tendency to engage in violence. The data "demonstrate[d] that individuals in the community with psychiatric disorders are more likely to engage in assaultive behavior, by their own report, than those who are free of mental illness and substance abuse."<sup>74</sup> Specifically, of those persons who were free of any disorder, 2% committed a violent act in the preceding year. Persons with only anxiety disorders committed violent acts at a similar rate of 2.37%. Persons with only affective disorders like depression had a 3.45% rate of violence. Finally, for persons diagnosed with schizophrenia or related disorders

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<sup>72</sup> Swanson et al., *supra* note 33, at 761, 762.

<sup>73</sup> *Id.* at 762-63. The five questions, designed to diagnose antisocial personality disorder or alcohol abuse or dependence disorder, were:

1. Did you ever hit or thrown things at your wife/husband/partner? Were you ever the one who threw things first, regardless of who started the argument? Did you hit or throw things first on more than one occasion?
2. Have you ever spanked or hit a child (yours or someone else's) hard enough that he or she had bruises or had to stay in bed or see a doctor?
3. Since age 18, have you been in more than one fight that came to swapping blows, other than fights with your wife/husband/partner?
4. Have you ever used a weapon like a stick, knife or gun in a fight since you were 18?
5. Have you ever gotten into physical fights while drinking?

<sup>74</sup> *Id.* at 768-69.

only, that number rose to 8%.<sup>75</sup>

Moreover, violence was considerably more prevalent among persons who had more than one disorder, frequently a pairing of an Axis I psychiatric disorder and an alcohol or substance abuse disorder. Indeed, Swanson found "a nearly linear relationship between the number of diagnoses and the rate of violence."<sup>76</sup> Taking multiple diagnoses into account, the prevalence of violence among all persons with schizophrenia-related disorders, obsessive-compulsive disorder, panic disorder, major depression or bipolar disorder ranged from 10.66% to 12.69%.<sup>77</sup> Although these rates are five to six times the rates of violence by persons with no disorder, they also indicate that seven out of eight persons with schizophrenia and nine of ten persons with major depression did not report a single incident of violence.

A second epidemiological study, using data from the Washington Heights area of New York, confirmed Swanson's finding of a greater prevalence of violence among persons with psychiatric disorders.<sup>78</sup> This study, conducted by Professor Bruce Link and colleagues, compared the violent behaviors of psychiatric outpatients and discharged psychiatric inpatients with never-treated members of the same community.<sup>79</sup> Patients were divided into three groups: first-treatment patients, repeat-treatment patients, and former patients.<sup>80</sup> Resulting data revealed that "[a]ll three patient groups had consistently higher percentages [of violent conduct] – sometimes two to three times higher – than never-treated community residents."<sup>81</sup> Link cautioned, however, that the risk of violence associated with mental patient status was modest when "[c]ompared to the risk associated with variables like age, gender and education."<sup>82</sup> Moreover, violence associated with a mental disorder

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<sup>75</sup> *Id.* at 766.

<sup>76</sup> *Id.* Of all respondents with a single diagnosis, 6.81% reported violence. For two diagnoses, the rate rose to 17.51%, and for three diagnoses, the rate was 22.36%. *Id.* at 767.

<sup>77</sup> *Id.* at 766-67.

<sup>78</sup> Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 277 (1992).

<sup>79</sup> *Id.* at 280. Participants were questioned about violent conduct in the preceding year, and their answers were augmented by official arrest reports. The questions addressed behaviors including hitting others, fighting, using a weapon in a fight, and hurting someone badly. *Id.* at 281. Respondents were asked whether they engaged in each behavior "very often, fairly often, sometimes, almost never, [or] never." *Id.* Arrests for assault, rape, sodomy, robbery, arson, and burglary causing injury or involving the use of a weapon were considered violent offenses. *Id.*

<sup>80</sup> *Id.* at 280.

<sup>81</sup> *Id.* at 283.

<sup>82</sup> *Id.* at 290.

constituted only "a trivial contribution to the overall level of violent/illegal behavior in American society."<sup>83</sup> For example, mental patient status was "far less important than gender" for several measures of violent conduct, and was "roughly comparable to a four-to-five-year difference in education" for two other measures.<sup>84</sup>

Subsequent researchers have attempted to confirm or refine these significant findings to help clinicians and policymakers identify the subset of persons with psychiatric disorders who present a risk of violent conduct. Most recently, the MacArthur Research Network on Mental Health and the Law conducted its ambitious Violence Risk Assessment Study ("MacArthur Study"), which led to the creation of an evidence-based actuarial tool to help inform clinical risk assessments.<sup>85</sup> To test that instrument, and to provide valuable data on the interaction of scores of factors thought to be associated with violence, researchers followed 1000 persons, aged 18 to 40, for a year following their hospitalization under civil commitment.<sup>86</sup> They concluded that while "violence is not a rare event" in the lives of persons discharged from psychiatric hospitals, the data "d[id] not necessarily indicate that discharged patients are, simply by virtue of who they are, more dangerous than their community neighbors."<sup>87</sup> Other MacArthur Study findings are discussed below.

These studies over the last decade have identified a number of factors that are potentially relevant to the risk of violence by a person who has a mental disorder. These factors include: (1) recent incidents of past violence; (2) personal characteristics that make a person (with or without a disorder) likely to become violent; (3) abuse of or dependence on alcohol or illicit drugs; (4) the context in which the violence is most likely to occur, including the triggers, the location and the targets; and (5) the

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<sup>83</sup> *Id.*

<sup>84</sup> *Id.* at 285. Men were "much more likely" to have been arrested for violent offenses, to have been involved in a physical fight, or to have hurt someone badly in a fight. *Id.* "[P]eople with less education [we]re significantly more likely than the better-educated" to have been arrested for a violent offense, to have hit others, to have used a weapon in a fight, or to have ever hurt someone badly. *Id.*

<sup>85</sup> JOHN MONAHAN ET AL., *RETHINKING RISK ASSESSMENT: THE MACARTHUR STUDY OF MENTAL DISORDER AND VIOLENCE* 7 (2001). Principal designers and researchers included John Monahan and Henry Steadman. Information and data from the study are available at <http://macarthur.virginia.edu/home.html>.

<sup>86</sup> *Id.* at 150-51.

<sup>87</sup> *Id.* at 33. Indeed, one report using data from the MacArthur Risk Assessment Study demonstrated that persons in this sample who did not have a co-occurring substance abuse disorder were no more likely than their neighbors to engage in violence. *Id.* (citing Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 400 (1998)).

presence or absence of psychotic symptoms and the specific nature of those symptoms. This article examines each factor in turn.

### B. Factors Related to a Risk of Violence

#### 1. Recent Past Violence

There is one point on which clinicians and researchers agree. Stated succinctly, an individual's recent commission of an act of violence, particularly as part of a pattern of violence, is "a strong if not the strongest predictor of future violence."<sup>88</sup> As one researcher has concluded, "[o]ne of the best predictors of future violence is a history of violence, with an increase in potential with each prior act of aggression."<sup>89</sup> Further, a person who has been a victim of violence, either as a child or as an adult, may be more prone to violence.<sup>90</sup> Persons from

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<sup>88</sup> Beck, *supra* note 69, at 5; see KAPLAN & SADOCK, *supra* note 69, at 567 (identifying "a history of violent acts with arrests or criminal activity" as one of best predictors of potential violent behavior); MONAHAN ET AL., *supra* note 85, at 47 (noting that "prior violence and criminality are strongly associated with the postdischarge violent behavior of psychiatric patients"); H. L. Kozol, *Dangerousness in Society and Law*, 13 U. TOL. L. REV. 241, 254 (1982)); Lynne Lamberg, *Prediction of Violence Both Art and Science*, 275 JAMA, 1712, 1712 (1996) ("The single best predictor of future violence is past violence."); Marzuk, *supra* note 67, at 485 ("One of the strongest predictors of future violence, after all, is past violence."); Dale E. McNeil, *Hallucinations and Violence*, in VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 183, 189 (explaining that personal risk factors for violence include previous violence and being raised in violent family); Modestin, *supra* note 7, at 552 ("Past behavior is the best predictor of the future behavior and the history of violence, arrests and convictions has repeatedly been shown to predict future violence and criminality."); Nathan Pollock, *Accounting for Predictions of Dangerousness*, 13 INT'L J.L. & PSYCHIATRY 207, 211 (1990) (citing H.V. HALL, VIOLENCE PREDICTION: GUIDELINES FOR THE FORENSIC PRACTITIONER (1987)) ("One fundamental tenet of predicting dangerousness is that violent behaviour cannot be predicted in the absence of an established pattern of violence.").

<sup>89</sup> Tony A. Fletcher, Samuel Jan Brakel & James L. Cavanaugh, *Violence in the Workplace: New Perspectives in Forensic Mental Health Services in the USA*, 176 BRIT. J. PSYCHOL. 339, 342 (2000); see Borum et al., *supra* note 7, at 210 (noting that past violent behavior "is probably the best single predictor of future violence," and that risk "increases with each prior episode"); see also Julian Barling, *The Prediction, Experience, and Consequences of Workplace Violence*, in VIOLENCE ON THE JOB: IDENTIFYING RISKS AND DEVELOPING SOLUTIONS 29, 33 (Gary R. VandenBos & Elizabeth Q. Bulatao eds., 1996) [hereinafter VIOLENCE ON THE JOB] (identifying past history of aggression as one of four factors predictive of workplace violence). *But see* Sue E. Estroff & Catherine Zimmer, *Social Networks, Social Support, and Violence Among Persons with Severe, Persistent Mental Illness*, in VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 259, 276-77 (noting that pattern from one study "diverge[d] from the findings of some previous studies" in that prior violence was not predictive of future violence).

<sup>90</sup> See MONAHAN ET AL., *supra* note 85, at 51 (observing that "the seriousness and frequency of prior physical abuse as a child was found to be associated with an increased

more violent neighborhoods are also more likely to engage in violence.<sup>91</sup> Of course, as discussed more fully below, the predictive force of past acts of violence will vary according to numerous other factors, including the setting in which the person acted violently, the target of that violence, and the person or event that triggered the violence.<sup>92</sup>

## 2. Predisposing Personal Traits

Personal traits – in particular, anger, impulsivity and aggressivity – have been another principal focus of research on indicators of an increased risk of violence.<sup>93</sup> Raymond Novaco has developed instruments to assess anger levels in persons with or without disorders.<sup>94</sup> These instruments detect and measure anger through factors such as

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rate of postdischarge violence"); Klassen & O'Connor, *supra* note 71, at 232, 235 (explaining that risk factors for violence include having experienced abuse or severe discipline as child or having been victim of violent crime). *But see* Estroff & Zimmer, *supra* note 89, at 276-77 (noting that having experienced physical or sexual abuse as child was not predictive of violence in one study of persons with severe, persistent mental illnesses).

<sup>91</sup> See MONAHAN ET AL., *supra* note 85, at 59, 60 (concluding that "violence by persons with mental disorders may be, in part, a function of the high-crime neighborhoods in which they typically reside" and that studies of violence that "do not control for such contextual measures as neighborhood disadvantage run the risk of overstating the effect of individual-level variables"); Link et al., *supra* note 78, at 285 (finding that "individuals from more violent neighborhoods are more likely . . . to report having been arrested . . . , having been involved in physical fights . . . and having used weapons in a fight"). See generally Eric Silver et al., *Assessing Violence Risk Among Discharged Psychiatric Patients: Toward an Ecological Approach*, 23 LAW & HUM. BEHAV. 237, 251 (1999) (finding that former mental patients are more likely to be violent when discharged into neighborhood where physical aggression is common).

<sup>92</sup> See *infra* text accompanying notes 119-54.

<sup>93</sup> E.g., Thomas J. Craig, *An Epidemiological Study of Problems Associated with Violence Among Psychiatric Inpatients*, 139 AM. J. PSYCHIATRY 1262, 1263 (1982) (observing that, for patients who had engaged in assaultive behavior before admission, anger was factor most strongly associated with assaultiveness); Stanley R. Kay et al., *Profiles of Aggression Among Psychiatric Patients: Covariates and Predictors*, 176 J. NERVOUS & MENTAL DISEASE 547, 551 (1988) (finding anger to be strongest predictor of physical aggression in psychiatric inpatients); see also Steven P. Segal et al., *Civil Commitment in the Psychiatric Emergency Room: Mental Disorder Indicators and Three Dangerousness Criteria*, 45 ARCHIVES GEN. PSYCHIATRY 753, 757 (1988) (finding that irritability and impulsivity were symptoms most strongly associated with dangerousness in study of psychiatric emergency commitments).

<sup>94</sup> See Raymond W. Novaco, *Anger as a Risk Factor for Violence Among the Mentally Disordered*, in VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 21, 30, 34 (discussing Novaco Provocation Inventory and Novaco Anger Scale) [hereinafter Novaco, *Anger as a Risk Factor*]. See generally Raymond W. Novaco, *Anger as a Clinical and Social Problem*, in 2 ADVANCES IN THE STUDY OF AGGRESSION 1 (Academic Press 1986) (setting forth view of anger as clinical-social problem); Raymond W. Novaco, *The Functions and Regulation of the Arousal of Anger*, 133 AM. J. PSYCHIATRY 1124 (1976) (presenting model of anger arousal, and discussing cognitive self-control processes affecting regulation of anger).

impatience, irritability, verbal abusiveness and easy frustration.<sup>95</sup> When Novaco measured a tendency for assaultiveness by evaluating the records of hospitalized psychiatric patients in California, he found that the rate of assaults by patients whom doctors rated "high anger" was seven times greater than for "low anger" patients.<sup>96</sup> These anger scores also had predictive value. Patients who were rated "high anger" in 1987 were three times more likely to assault in 1988 than were the low anger patients.<sup>97</sup> Novaco cautions that anger may be "neither necessary nor sufficient for aggression to occur,"<sup>98</sup> in part because of the importance of inhibitory mechanisms,<sup>99</sup> but he concludes that anger is a "potent activator of aggressive behavior."<sup>100</sup> The recent MacArthur Study confirmed the significance of anger in predicting violence, finding that "patients with high anger scores at hospitalization were twice as likely as those with low anger scores to engage in violent acts after discharge."<sup>101</sup>

Impulsiveness also may contribute to violence by hindering a person's ability to inhibit aggressive behavior.<sup>102</sup> Aggression, in turn, may be learned or developed in a social context or may result from a "hair-trigger" temper or from medical conditions, including certain thought disorders and neurological disorders.<sup>103</sup> Current research makes it difficult to determine whether and to what extent aggression in an individual is a symptom of a mental disorder.<sup>104</sup>

<sup>95</sup> Novaco, *Anger as a Risk Factor*, *supra* note 94, at 25.

<sup>96</sup> *Id.* at 26 (finding 3.8% of "low anger" patients and 28.5% of "high anger" patients were assaultive). "Assaultive" patients were those who had committed a physical assault in the thirty days preceding the survey. *Id.*

<sup>97</sup> *See id.* at 26-27 (finding "low anger" assault rate was 6.1% and "high anger" rate was 20.8%).

<sup>98</sup> *Id.* at 33.

<sup>99</sup> *Id.* at 53; *see* Borum et al., *supra* note 7, at 209 (finding that "[the e]xtent to which anger contributes to violence risk [is] contingent upon mechanisms mediating between aversive events and harmful behavior").

<sup>100</sup> Novaco, *Anger as a Risk Factor*, *supra* note 94, at 53. With respect to psychiatric inpatients, Novaco acknowledged that "the physical and social environment of the hospital itself is relevant to patient violence" and that the behavior and attitudes of hospital staff could provoke assaults. *Id.* at 24.

<sup>101</sup> MONAHAN ET AL., *supra* note 85, at 89.

<sup>102</sup> Ernest S. Barratt, *Impulsiveness and Aggression*, in *VIOLENCE AND MENTAL DISORDER*, *supra* note 70, at 71-72. Impulsiveness, which relates to the control of thoughts and behavior, is a character trait found in both mentally disordered and nondisordered persons. *Id.* at 61. One leading measure of impulsiveness considers speed of cognitive response, lack of impulsive control, adventure-seeking or extroversion, and risk taking. *Id.* at 63 (discussing factors in Barratt Impulsiveness Scale).

<sup>103</sup> *Id.* at 71.

<sup>104</sup> *Id.*; *see* Lamberg, *supra* note 88, at 1712 (suggesting that practitioners screen patients for personality traits associated with violence, including impulsivity, low frustration

The flip side of impulsivity is self-restraint or discipline, which may reduce a person's risk of violent conduct. Researchers note that some people with mental disorders display admirable self-restraint by disregarding, resisting or skillfully managing psychotic symptoms.<sup>105</sup> How individuals function with a mental disorder may depend not simply on the nature or severity of their disorder, but also on "who those people are, where their values lie, their ability to manage themselves in certain situations, and the specific ways in which their disorders, their coping mechanisms, and their vulnerabilities interact."<sup>106</sup> In addition, to the extent that self-discipline permits a person to comply with treatment, it also may reduce the risk of violent conduct.<sup>107</sup>

### 3. Alcohol and Drug Abuse or Dependence

Studies have produced striking statistics on violence rates among persons with a substance abuse diagnosis. In Swanson's ECA study, roughly one in four persons with alcohol abuse or dependence reported violence.<sup>108</sup> Swanson highlighted the powerful role alcohol abuse played in the overall level of violence in the community. The prevalence of violence among persons who abused alcohol was nearly twice that of people with schizophrenia,<sup>109</sup> and the alcohol abusers were far more

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tolerance, and inability to tolerate criticism); Kathleen Brady, *The Treatment and Prevention of Violence*, Address Before the American Psychiatric Association 153rd Annual Meeting (May 15, 2000), available at [http://www.medscape.com/Medscape/CNO/2000/APA/Story.cfm?story\\_id=1172](http://www.medscape.com/Medscape/CNO/2000/APA/Story.cfm?story_id=1172) (concluding that "impulsive aggression and violence go hand-in-hand").

<sup>105</sup> Take, for example, a woman with schizophrenia experiencing active psychotic symptoms that sometimes prompt her to look under the bed to see where the voices are coming from. She manages nonetheless to run her household, care for her child, and work an evening shift as a waitress. John S. Strauss & Larry Davidson, *Mental Disorders, Work, and Choice*, in *MENTAL DISORDER, WORK DISABILITY AND THE LAW*, *supra* note 18, at 109. Similarly, a teacher experiencing psychotic episodes manages to maintain control during the school day, only to "go wild" at home alone at night. *Id.*

<sup>106</sup> *Id.* (citing SAMUEL H. OSIPOW, *THEORIES OF CAREER DEVELOPMENT* (Prentice-Hall 1983)); see also Margaret Hart Edwards, *The ADA and the Employment of Individuals with Mental Disabilities*, 18 *EMPLOYEE REL. L.J.* 347, 365 (1992-1993) ("Employers must determine whether or not an individual applicant or employee possesses the attributes essential to satisfactory performance of the job. Individuals with mental disabilities often develop coping mechanisms, some of which may actually enhance their success in particular working environments.")

<sup>107</sup> See Lamberg, *supra* note 70, at 407 (noting that "persons with schizophrenia who are compliant with a treatment regimen probably are at no greater risk of committing violence than other people").

<sup>108</sup> Swanson et al., *supra* note 33, at 765 (finding 24.57% rate of violence for persons with alcohol abuse or dependence).

<sup>109</sup> *Id.* at 769 (finding that 25% of alcoholics reported violent behavior, while 12.7% of

numerous and "considerably less likely" to receive treatment.<sup>110</sup> These findings indicate that, "citizens stand a much greater chance of being assaulted by an alcoholic."<sup>111</sup> Subsequent research has confirmed the significant contribution of alcohol abuse to overall levels of violence in the community. One review of the epidemiological and case register studies revealed that, "persons with alcohol diagnoses represented less than 8% of the sample but accounted for 40.8% of all the reported violence."<sup>112</sup>

Swanson found an even stronger correlation between drug abuse and violence, reporting that more than one in three persons who used illicit drugs demonstrated violent behavior.<sup>113</sup> In fact, the rate of recent violence among substance abusers was generally more than twice as high as the rate among persons with a major mental disorder who were not substance abusers.<sup>114</sup> Moreover, "substance abuse itself was associated with a very high relative risk for assaultive behavior, whether or not it occurred in the presence of other major psychopathology."<sup>115</sup> On the other hand, about a third of persons with schizophrenia also abused alcohol or other drugs, so the proportion of harmful acts committed by persons with schizophrenia or schizophreniform disorders may be influenced by drugs and alcohol as well.<sup>116</sup>

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schizophrenics reported violent behavior).

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> Beck, *supra* note 69, at 3.

<sup>113</sup> Swanson et al., *supra* note 33, at 765 (finding 34.75% violence rate for drug abusers). Researchers separated marijuana from other drugs, and of persons diagnosed with cannabis abuse or dependence, 19.25% had been violent. *Id.*

<sup>114</sup> Swanson, *supra* note 70, at 112-13; *see also* Borum et al., *supra* note 7, at 211 (finding prevalence of violence twelve times greater for alcohol abuse or dependence and sixteen times greater for other drug dependence than for no diagnosis); Michael Soyka, *Substance Misuse, Psychiatric Disorder and Violent and Disturbed Behaviour*, 176 BRIT. J. PSYCHIATRY 345, 348 (2000) (citing "substantial evidence for substance misuse being a major risk factor for violence and aggression in patients with major mental disorder"); Taylor & Monahan, *supra* note 69, at 968 ("Substance misuse seems now to be at least as important a risk factor for violence as schizophrenia but still receives less clinical attention.").

<sup>115</sup> Swanson, *supra* note 70, at 113; Marzuk, *supra* note 67, at 484 (observing that use of alcohol and other psychoactive substances increases risk of violence for those with or without mental disorders).

<sup>116</sup> Swanson et al., *supra* note 33, at 769. Another study suggested that substance abuse may explain some of the increased rate of violence among persons hospitalized with affective disorders. Brennan, Mednick & Hodgins, *supra* note 70, at 497 ("When controlling for comorbid substance abuse and personality disorders, persons hospitalized with affective disorders were not at higher risk for violent crime than those who were never hospitalized.").

Henry Steadman's comparison of violence by persons discharged from a psychiatric hospital with that of persons from the same communities revealed that in the absence of substance abuse disorders there were no significant differences in the rates of violence for the two groups.<sup>117</sup> In other words, in the year following their discharge from acute inpatient hospitalization, persons who were diagnosed with schizophrenia, bipolar disorder or other major mental disorders, but who had no symptoms of substance abuse, were no more likely to engage in violence than their peers in the community who had never received psychiatric treatment. Among the discharged patients who also had a substance disorder, however, there was a significant increase in the rate of violence.<sup>118</sup>

#### 4. Social and Personal Context of Violence

A principal development in research on mental disorders and violence has been the recognition of the extent to which violence results from situational contexts, including hostile relationships and personal conflicts, rather than inhering in an individual. Professors Sue Estroff

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<sup>117</sup> Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 400 (1998).

<sup>118</sup> *Id.* The difference was pronounced during the first ten weeks following discharge, but narrower during the rest of the year, when the patient group became less violent. *Id.*; see also Lamberg, *supra* note 88, at 1712 (recognizing alcohol and other drug abuse as risk factors for violent behavior).

Apart from this Steadman study, which used MacArthur data, the recent MacArthur Study did not use community controls, so it does not offer an overall comparison between the patient groups and non-treated persons from the same communities. Patient data do reveal that the co-occurrence of alcohol or substance abuse significantly increases the risk of violent conduct. The prevalence of violence among persons with Axis I major mental disorders was 17.9%; for persons with a major mental disorder and substance abuse, 31.1%; and for persons with another mental disorder (generally personality disorders) and substance abuse, 43.0%. MONAHAN ET AL., *supra* note 85, at 63. Perhaps even more significantly, 54% of violent incidents occurred shortly after the patient had been drinking, and 23% occurred shortly after the patient had used illegal drugs. *Id.* at 22.

Other recent studies indicate that drug or alcohol abuse and treatment noncompliance may combine to increase the risk of violence. Randy Borum et al., *Substance Abuse, Violent Behavior, and Police Encounters Among Persons with Severe Mental Disorders*, 13 J. CONTEMP. CRIM. JUST. 236, 244 (1997) (finding that, among persons with severe mental disorders, interaction between medication noncompliance and substance use was related to increased likelihood of arrest); Marvin S. Swartz et al., *Violence and Severe Mental Illness: The Effects of Substance Abuse and Nonadherence to Medication*, 155 AM. J. PSYCHIATRY 226, 227 (1998) (discussing patient study that suggested that "medication noncompliance may exert an effect on violence by means of preexisting or concomitant relationship with alcohol or other drug abuse").

and Catherine Zimmer, in particular, have examined the social context in which persons with mental disorders threaten or commit violent acts. Estroff and Zimmer challenge the "largely unexamined assumption . . . that diagnosed persons engage in and incite violence primarily because they are mentally ill, independent of the actions of others who are not diagnosed or confined, and of social context and interpersonal situation."<sup>119</sup> Their view is that "the risk for violence is best assessed by investigating what kinds of persons, in what kinds of situations, and during what phase of their lives and illnesses are likely to engage in dangerous behaviors."<sup>120</sup> To that end, they followed 157 persons with major, enduring psychiatric disorders for eighteen months, interviewing the participants and, where possible, their significant others or family members.<sup>121</sup>

The interviews allowed Estroff and Zimmer to develop a picture of the situations in which threats or violence occurred and a profile of the typical targets. They concluded that "violence seldom happens unilaterally, and that hostility and violence *from others* is not uncommon in the personal histories and current social networks" of persons who have mental disorders.<sup>122</sup> Moreover, persons with mental disorders who perceived threats and hostility from their significant others were more likely to act violently.<sup>123</sup> Accordingly, the majority of the victims, including all of the repeat victims, were relatives.<sup>124</sup> Seven of ten repeat victims were mothers living with their child who was mentally disordered.<sup>125</sup> Strangers were seldom targets; more than three-fourths of

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<sup>119</sup> Estroff & Zimmer, *supra* note 89, at 259.

<sup>120</sup> *Id.* at 261 (emphasis omitted).

<sup>121</sup> *Id.* at 263-65. Participants were then grouped as those who neither threatened nor engaged in violence, those who only threatened violence, and those who actually engaged in violence. A violent act was defined as "an arrest or criminal charge and adjudication for assault and battery, manslaughter or murder;" a "danger-to-others" involuntary commitment specifying that the participant had hit, sexually assaulted, or threatened another person with an object or weapon; or a confirmed report of a violent act. *Id.* at 264.

<sup>122</sup> *Id.* at 271 (emphasis added); see M.C. Angermeyer et al., *Mental Disorder and Violence: Results of Epidemiological Studies in the Era of De-Institutionalization*, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY S1, S5 (1998) (recognizing that violence involving persons with mental disorders "is a reciprocal phenomenon and does not rest with the individual alone, but arises in the context of social relationships") (emphasis omitted).

<sup>123</sup> Estroff & Zimmer, *supra* note 89, at 279. Those who perceived hostility from unidentified others were far more likely to threaten violence, but no more likely to commit violence. *Id.* at 281.

<sup>124</sup> *Id.* at 285-86.

<sup>125</sup> *Id.* at 286. This may reflect conflicts that arise from the mother's caretaking role. See Binder, *supra* note 71, at 196 (observing that "the caretaking role rather than the type of kinship relationship with the patient seemed to be the most important factor in

the victims were known to the person with the mental disorder.<sup>126</sup> A later study by Estroff and several colleagues accentuates the extent to which persons with mental disorders direct their violence toward family members, particularly mothers.<sup>127</sup> Other studies confirm Estroff's and Zimmer's findings about the frequency with which homes are the locations and relatives are the targets of violence by persons with mental disorders.<sup>128</sup>

After examining the individual relationships and circumstances of the participants, Estroff and Zimmer cautioned that it is "a mistake to categorize people as violent or not, to conceptualize violence as a characteristic of a person without giving equal attention to the underlying or concurrent interpersonal and clinical processes and

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determining which family member became the victim" and may explain why nurses in acute inpatient facilities are frequent targets).

<sup>126</sup> Estroff & Zimmer, *supra* note 89, at 285.

<sup>127</sup> Sue E. Estroff et al., *Risk Reconsidered: Targets of Violence in the Social Networks of People with Serious Psychiatric Disorders*, 33 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY S95, S95 (1998). This study reviewed data from the Triangle Mental Health Survey, which conducted face-to-face interviews over a thirty-month period of 169 persons with severe mental disorders. *Id.* at S97. Results revealed that "mothers who live with adult children who have schizophrenia and co-occurring substance abuse bear a substantially elevated risk of becoming a target of violence, compared to other social network members." *Id.* at S95. The mother and child often were involved in "relationships . . . that [we]re reciprocally threatening and hostile." *Id.* at S100.

<sup>128</sup> From a year-long prospective study of psychiatric patients and community members in three cities, Henry Steadman found that "[t]he targets of both violence and other aggressive acts committed by the patient sample and by the community sample were most often family members, followed by friends and acquaintances." Steadman et al., *supra* note 117, at 399. Most violence or other aggressive acts occurred in the subject's home, in the home of another, outdoors or on the street, or in a bar, with patients relatively more likely to commit aggressive acts in their own homes, and community members relatively more likely to commit aggressive acts in a bar. *Id.* Patients were less likely than non-patients to target strangers. *Id.* at 400 (finding strangers were target of patients 10.7% of time and targets of non-patients 22.2% of time). Steadman thus concluded that "public fears of violence on the street by discharged patients who are strangers to them is misdirected. The people at highest risk are family members and friends in their own homes or in the patient's home." *Id.*

Similarly, Swanson's analysis of ECA data revealed that "a significant proportion of assaultive acts identified in these data were directed against spouses, cohabitants, or children." Swanson, *supra* note 70, at 121. The MacArthur Study revealed that 69% of incidents of violence occurred in a patient's home or another residence, with family members making up 51% of the targets. MONAHAN ET AL., *supra* note 85, at 20; *see also* J. Arboleda-Flórez, *Mental Illness and Violence: An Epidemiological Appraisal of the Evidence*, 43 CAN. J. PSYCHIATRY 989, 995 (1998) (finding that "family members (not the general public) are the most likely targets of violence by formerly hospitalized patients in the community"); Marzuk, *supra* note 67, at 485 (observing that, when persons with mental disorders are violent, "their families are more likely to be victims than are the unsuspecting persons on the street, in the workplace, in the school, or at the shopping mall").

contexts."<sup>129</sup> Rather, persons with psychiatric disorders who threaten or engage in violence may be responding to the violence and abuse that is "not uncommon[ly]" directed at psychiatric patients.<sup>130</sup> They concluded:

Abuse experienced by individuals with psychiatric disorders . . . is grossly underinvestigated, mirroring and contributing to a disproportionate and misleading focus on violent persons solely as perpetrators. Equally little is known about and equally little attention is paid to their versions of how and why violence occurs. Their fears and perceptions are too often considered to be symptoms rather than legitimate concerns.<sup>131</sup>

Other experts also acknowledge the limitations of a one-sided portrayal of persons with psychiatric disorders as inherently dangerous – a depiction that fails to include the violence or mistreatment they suffer or the circumstances that may trigger their violent responses. Recognizing that "for severe mental illness to lead to violence, social factors must intervene,"<sup>132</sup> Virginia Hiday suggests that, in some circumstances, the bullying or teasing inflicted on persons with mental disorders may spark anger and confrontation, which in turn escalates into violence.<sup>133</sup> Link recognizes that persons with mental disorders frequently are assaulted and suggests a similar dynamic whereby "psychotic symptoms [that] are incomprehensible to others . . . produce

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<sup>129</sup> Estroff & Zimmer, *supra* note 89, at 289.

<sup>130</sup> *Id.* at 289 (citations omitted). Their study revealed that "family and social network members clearly engage in behaviors as menacing as those of diagnosed patients, but responses other than diagnosis and civil commitment are made." *Id.*

<sup>131</sup> *Id.* at 291-92 (citations omitted). In a subsequent study, evaluating data from the ECA and the Triangle Mental Health Survey, Swanson reached a similar conclusion: "[V]iolence by people with mental illness often occurs within a context of highly constricted social networks, financial dependence, and an interpersonal environment that may actually be threatening – whether or not one suffers from delusions." Jeffrey Swanson et al., *Violence and Severe Mental Disorder in Clinical and Community Populations: The Effects of Psychotic Symptoms, Comorbidity, and Lack of Treatment*, 60 *PSYCHIATRY* 1, 20 (1997). Or to use an old cliché — just because you are paranoid, it doesn't mean that others are not out to get you. See also Virginia Aldigé Hiday, *Understanding the Connection Between Mental Illness and Violence*, 20 *INT'L J.L. & PSYCHIATRY* 399, 411 (1997) (finding that "the medical model's individual focus has resulted too often in physically aggressive behavior being incorrectly attributed to the mentally ill person, and resulted in the mentally ill person's legitimate fears being incorrectly attributed to psychotic symptoms") (citing Estroff & Zimmer, *supra* note 89, at 276-77; Sue Estroff et al., *The Influence of Social Networks and Social Support on Violence by Persons with Serious Mental Illness*, 45 *HOSP. & COMMUNITY PSYCHIATRY* 669, 677 (1994)).

<sup>132</sup> Virginia Aldigé Hiday, *The Social Context of Mental Illness and Violence*, 36 *J. HEALTH & SOC. BEHAV.* 122, 130 (1995).

<sup>133</sup> Hiday, *supra* note 131, at 401.

annoyance or fear that leads to attempts to coerce or control the psychotic person," arousing anger and "leading to a spiral that turns into violence."<sup>134</sup> Simply put, some violence by persons with mental disorders may be less a product of their illness than a "normal" (albeit undesirable) response to the unacceptable behavior of others. When persons with mental disorders react violently to a perceived threat, the threat may not be just "in their heads," but instead in their homes, communities – or workplaces.

### 5. Active Psychotic Symptoms

The concluding factor is the subject of an evolving understanding by experts: the role that active psychotic symptoms, including hallucinations and delusions, might play in producing violence. Early epidemiological studies suggested that the presence of such symptoms was one predictor of violent behavior. In Link's 1992 ECA study, for example, the existence of psychotic symptoms was associated with violent behavior not only for the patient groups, but also for the never-treated community residents.<sup>135</sup> Following further research, Link and Professor Anne Stueve suggested that only certain types of psychotic episodes – so-called "threat/control override symptoms," or those that make the person feel threatened or controlled by others – accounted for elevated rates of violence among mental patients.<sup>136</sup> Indeed, the presence of other psychotic symptoms, such as merely hearing voices, "was not significantly associated with rates of violence when the threat/control

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<sup>134</sup> Link et al., *supra* note 78, at 290 (citing Andrea Jacobson, *Physical and Sexual Assault Histories Among Psychiatric Outpatients*, 146 AM. J. PSYCHIATRY 755, 757-58 (1989)).

<sup>135</sup> *Id.* Link explained:

Not all current or former mental patients are more likely than the never-treated to engage in violent/illegal behavior, but primarily those who currently have psychotic symptoms. If a patient is not having a psychotic episode, or if psychiatric problems do not involve psychotic symptoms, then he or she is *no more likely than the average person* to be involved in violent/illegal behavior.

*Id.* (emphasis added).

<sup>136</sup> Bruce G. Link & Anne Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls*, in VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 144. These "threat/control override symptoms" included the participant's feelings that his mind was dominated by forces beyond his control, that thoughts were being put in into his head, and that there were people who wished to do him harm. *Id.* Their data demonstrated that "[t]he threat/control override psychotic symptoms are strongly associated with violent behaviors and largely explain the association between mental patient status and violence." *Id.* at 151.

override symptom scale was held constant."<sup>137</sup> Because this study relied on epidemiological data, rather than interviews with patients or observers, Link and Stueve could only infer that the violent conduct was prompted by or occurred simultaneously with psychotic symptoms. They cautiously concluded, however, that "[t]he robust pattern of findings . . . tips us in favor of the conclusion that there is a causal connection between some types of mental illness and violence."<sup>138</sup>

More recent studies have cast doubt on the predictive value of even active threat/control override symptoms. Two studies suggest that the traits of anger and impulsivity, rather than the presence of active psychotic symptoms, may explain increased violent behavior among some persons with mental disorders. The first, a prospective multistate study, measured violence in more than eleven hundred persons for a year following their discharge from acute psychiatric hospitalization.<sup>139</sup> Researchers found that, "[c]ontrary to popular wisdom and to the results of several other studies, the data from this study suggest that the

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<sup>137</sup> *Id.* at 155. Other symptoms included the feeling of having special powers; visions of things other people say they cannot see; the belief that something odd was going on; the sense that the participant's unspoken thoughts were being broadcast; the feeling of being possessed by a spirit or devil; and the feeling of being dead or dissolved. *Id.* at 144. Others have confirmed that it is the character of delusions, and not merely their presence, that is significant. See Taylor & Monahan, *supra* note 69, at 967 (asserting that, while delusions about "being under the control of something or someone else" are associated with violent offending, "the relation between violence and other psychotic symptoms, including hallucinations, is not impressive"); Pamela Taylor et al., *Delusions and Violence*, in VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 165 (noting that, even among psychotic patients, propensity to violence varies according to specific symptoms, including presence of paranoid delusions). Most recently, the MacArthur Study demonstrated that neither the presence of hallucinations in general nor of command hallucinations in particular was significantly related to acts of violence. MONAHAN ET AL., *supra* note 85, at 79. Only when the voices actually commanded violence was there any significant increase in violence. *Id.* at 79-80.

<sup>138</sup> Link & Stueve, *supra* note 136, at 142. Other experts have endorsed the conclusion that active psychotic symptoms contribute to the risk of violence. See, e.g., Hiday, *supra* note 132, at 124 (emphasizing that "only those [persons] who have major mental illness and recent psychotic symptomatology" have higher rates of violence); Jiri Modestin & Roland Ammann, *Mental Disorder and Criminality: Male Schizophrenia*, 22 SCHIZOPHRENIA BULL. 69, 74, 78 (1996) (finding that patients with acute schizophrenia were four times more likely than members of control group to have been convicted of violent crime, while patients with chronic schizophrenia were no more violent than control group (and were less likely to have committed traffic offenses)); Mulvey, *supra* note 66, at 665 (concluding that "[a]ctive symptoms are probably more important as a risk factor than is simply the presence of an identifiable disorder").

<sup>139</sup> Paul S. Appelbaum et al., *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study*, 157 AM. J. PSYCHIATRY 566, 566 (2000). The study identified the existence and content of participants' delusions and assessed patients according to the Novaco Anger Scale and the Barratt Impulsiveness Scale. *Id.* at 567, 570-71.

presence of delusions does not predict higher rates of violence among recently discharged psychiatric patients," regardless of the content of the delusions.<sup>140</sup> Instead, these researchers concluded that any increased risk of violence among patients with threat/control override symptoms was explained by their higher degree of anger and impulsivity.<sup>141</sup> The second study was the MacArthur Study, which concluded that the combination of anger, impulsiveness and suspiciousness, rather than thought/control override symptoms, likely explained higher violence rates in previous studies.<sup>142</sup> These two studies may prove more accurate than earlier studies because they were prospective, rather than retrospective, and because they used careful screening techniques to determine the presence of threat/control override symptoms.<sup>143</sup>

Although the MacArthur Study found that fewer than 10% of all incidents of violence occurred when the patient was having active psychotic symptoms,<sup>144</sup> the researchers acknowledged that delusions "can and do" cause violence.<sup>145</sup> Nonetheless, their data suggest that "delusional motivation of violence is rare."<sup>146</sup> Indeed, it bears emphasizing that no study has suggested that even threat/control override symptoms lead inexorably to violent conduct.<sup>147</sup> Link and Stueve deemed these symptoms merely an "'internal opportunity structure' that ma[de] violence more or less likely," and not an "accurate

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<sup>140</sup> *Id.* at 571.

<sup>141</sup> *Id.*

<sup>142</sup> MONAHAN ET AL., *supra* note 85, at 77 (asserting that prior studies pointing to threat/control override symptoms were better explained by the combination of "[a] generally suspicious attitude toward others" with "associated anger and impulsiveness"); *id.* (concluding that "nondelusional suspiciousness – perhaps involving a tendency toward misperception of others' behavior as indicating a hostile intent – does appear to be linked with subsequent violence and may account for the findings of previous studies") (emphasis added) (citation omitted).

<sup>143</sup> *See id.* at 76-77.

<sup>144</sup> *Id.* at 22.

<sup>145</sup> *Id.* at 77.

<sup>146</sup> *Id.* at 78 (quoting J. Junginger et al., *Delusions and Symptom-Consistent Violence*, 49 PSYCHIATRIC SERVS. 218, 218-20 (1998)).

<sup>147</sup> Link emphasized that "[t]he fact that psychotic symptoms explained differences . . . in recent violence does not mean that psychotic symptoms are a potent source of violent behavior in our society." Link et al., *supra* note 78, at 290. Rather, "[s]uch symptoms are relatively rare and are in no way as important as the influx of drugs, the breakdown of communities, and similar factors as causes of violent/illegal behavior." *Id.*; *see* Hiday, *supra* note 132, at 124 (noting that "the contribution to violence of major mental illness, current psychotic symptoms, or threat/control override symptoms is only modest"). Similarly, Link and Stueve found that the majority of study participants who had experienced the threat/control override psychotic symptoms had not engaged in any violence. Link & Stueve, *supra* note 136, at 156.

predictor of individual behavior."<sup>148</sup> Whether the person responded violently to these stimuli depended on "potent environmental and individual sources of violent behavior that have nothing to do with mental illness."<sup>149</sup> Other experts have cautioned that whether a person experiencing psychotic symptoms actually engages in violence depends on a complex array of personal, social and clinical factors.<sup>150</sup> Moreover, *past* psychotic symptoms bear no direct relationship to *present* risk of violence.<sup>151</sup>

### III. THE IMPLICATIONS FOR EMPLOYERS AND THE LAW

The recent literature and studies present a complex and evolving understanding of how the clinical aspects of mental disability interact with the dispositional, historical, and contextual or situational aspects of an individual's life to produce a risk of violence. What guidance does this research offer for the application of the direct threat defense to employment practices? Two principles emerge. *First*, employers may not act based on a generalized fear of all persons with mental disabilities. The vast majority of persons with mental disabilities never engage in violence, either in the workplace or elsewhere.<sup>152</sup> Moreover, the research "underscore[s] the inappropriateness of referring to [persons with mental disorders] as a homogeneous class."<sup>153</sup> Mental disorders present a staggering diversity of symptoms and functional impairments, as well as vastly different courses of illness, including severity, chronicity, recurrence, comorbidity, and response to treatment.<sup>154</sup> Furthermore, the

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<sup>148</sup> Link & Stueve, *supra* note 136, at 156.

<sup>149</sup> *Id.*

<sup>150</sup> *E.g.*, McNeil, *supra* note 88, at 188-96 (finding that whether hallucinations lead to violence depends on variables, including nature of underlying disorder, whether illness is stable or acute, whether patient is in hospital or community setting, and whether patient complies with pharmacological treatment). The MacArthur Study demonstrated that, while neither the presence nor the content of delusions was related to violent conduct, the "propensity to act on delusions in general (excluding violent actions) was the only significant association with a tendency to commit violent acts." MONAHAN ET AL., *supra* note 85, at 75.

<sup>151</sup> As Professor Monahan explained: "Being a former patient in a mental hospital – that is, having experienced psychotic symptoms *in the past* – bears no direct relationship to violence, and bears an indirect relationship to violence only in the attenuated sense that previous disorder may raise the risk of current disorder." Monahan, *supra* note 18, at 519.

<sup>152</sup> *See* sources cited *supra* note 70.

<sup>153</sup> Steadman et al., *supra* note 117, at 400.

<sup>154</sup> For example, while we speak generally of clinical depression, that disorder can manifest itself as a single major depressive episode, or it may be recurrent, with or without dysthymic disorder, with or without interepisode recovery, and with or without a seasonal

individuals who have these disorders present even greater diversity in innumerable other factors, including education, upbringing, social support, age, gender, coping mechanisms, and treatment compliance. These and other factors may intervene to determine whether the person acts on his violent impulses. Accordingly, recent medical and other objective evidence does not permit the conclusion that persons with a mental disability, *as a group*, present a significant risk of violence in the workplace.

Second, violence "is a reciprocal phenomenon and does not rest with the individual alone, but arises in the context of social relationships."<sup>155</sup> Harassment or abuse by coworkers, for instance, might incite a person with a mental disorder to respond with aggression or even violence. Accordingly, the employer who seeks to avoid workplace violence faces the task not simply of avoiding "violent employees," but of avoiding situations in which employees may become violent. Because an employer may base a direct threat determination only on significant risks that cannot be eliminated or reduced through reasonable accommodations, the employer might be required to implement measures designed to reduce the risk of violence involving persons with mental disabilities.

*A. The Impermissibility of the Categorical Equation of Mental Disability with Dangerousness*

Given the pervasive fears about mental disorders and the difficulty or cost of assessing the individual factors that make a person more or less prone to violence, some employers will be drawn to the easy solution of categorically excluding persons diagnosed with major mental disorders.<sup>156</sup> This approach, however, is incompatible with the ADA's

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pattern. *See* DSM-IV, *supra* note 21, at 388.

<sup>155</sup> Angermeyer et al., *supra* note 122, at S5; Estroff & Zimmer, *supra* note 89, at 271 (noting that "violence seldom happens unilaterally, and . . . hostility and violence from others is not uncommon" in lives of persons with mental disorders).

<sup>156</sup> Experts have recognized that the "state of the art in medical evaluations, as well as entrenched social stereotypes, combine to make it extremely difficult to apply [a dangerousness] standard objectively," and have stressed the importance of examining "how assessment of the risk of violence interacts with the stereotype of presumed violence." Jean Campbell, *Unintended Consequences in Public Policy: Persons with Psychiatric Disabilities and the Americans with Disabilities Act*, 22 POL'Y STUD. J. 133, 138 (1994).

Accuracy has been problematic, but is improving. Twenty years ago, "psychiatrists and psychologists [we]re accurate in no more than one out of three predictions of violent behavior over a several-year period among institutionalized populations that had both committed violence in the past (and thus had high base rates for it) and who were

overarching requirement of an individualized assessment of a person's strengths and limitations. Moreover, such generalizations are particularly inappropriate when applied to a supposed link between mental disorders and the risk of violence. These generalizations can be grossly inaccurate given the wide variability in individual risk, the modest levels of overall risk, and the realistic danger that the employer's group-based judgment is skewed by widespread, irrational fears of persons diagnosed with mental disorders. Mindful of the risk that such stereotypes and fears lead to unwarranted exclusions of persons with mental disabilities, Congress specifically denounced the assumption that a person with a mental disability is likely violent. Instead, as this part will demonstrate in detail, Congress directed individual evaluations that focus on a person's recent acts or threats of violence.

By adopting the *Arline* standard, Congress renounced the notion that employers might exclude *any* person with a particular disability merely because *some* (or even *many*) persons with the same disability pose a health or safety risk in the workplace. Congress instead mandated that the decision to exclude a person because of health or safety risks related to the disability must rest on an individualized, objective, fact-specific inquiry into whether the particular person actually poses a significant risk. With respect to decisions based on the risk of violence associated with mental disabilities, the legislative history was explicit that an employer may exclude an individual on this basis only if the employer can produce "*objective evidence from the person's behavior that the person has a recent history of committing overt acts or making threats which caused harm or which directly threatened harm.*"<sup>157</sup>

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diagnosed as mentally ill." John Monahan & Henry Steadman, *Toward a Rejuvenation of Risk Assessment Research*, in VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 5 (citing JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 47-49 (1981)). More recent studies have demonstrated that clinical accuracy is "better than chance," but with room for improvement. See, e.g., Charles W. Lidz et al., *The Accuracy of Predictions of Violence to Others*, 269 JAMA 1007, 1010 (1993); Douglas Mossman, *Assessing Predictions of Violence: Being Accurate About Accuracy*, 62 J. COUNSELING & CLINICAL PSYCHOL. 783, 790 (1994).

Moreover, research is producing new tools to increase the accuracy of predictions of violence. The most promising recent advances may come from the MacArthur Study. That study has designed an instrument (an iterative tree classification) to help clinicians assess a range of clinical, dispositional, historical, and contextual factors and to determine how they interact to produce violent conduct. See MONAHAN ET AL., *supra* note 85, at 148. Using this methodology, researchers were able to predict violence with an accuracy that "far exceeds the most optimistic accounts of the predictive validity of clinical judgments." *Id.* at 129.

<sup>157</sup> H.R. REP. NO. 101-485, pt. 3, at 45-46 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 468-69 (emphasis added); see also *id.*, pt. 2, at 57, *reprinted in* 1990 U.S.C.C.A.N. 303, 339 (stating that determination of direct threat of violence "must be based on the behavior of the particular disabled person, not merely on generalizations about the disability"); S. REP. NO.

Thus, Congress has directed that, where the purported threat stems from a mental disorder, the required objective evidence of an identified harm must be found in *the individual's behavior*. This stands to reason. Behavior is an obvious indicator of the existence and degree of risk because mental disorders are defined in part by and manifest themselves through behavior. In fact, a person's recent conduct and present functioning are perhaps the only useful measures of a mental disorder's actual effects on an individual's ability to perform a job without posing significant health or safety risks. For physical impairments, by contrast, the degree or severity often is quantifiable (by measuring vision, blood pressure, blood sugar, and the like), producing a measurement that provides a defensible, although imperfect, proxy for the severity of the disability or the degree of risk. To say that a commercial truck driver's corrected vision is 20/100 tells us more about his safety risks than does the revelation that the truck driver has bipolar disorder. We simply cannot make accurate generalizations about the latter condition with sufficient reliability to justify employment decisions.<sup>158</sup> An individualized inquiry into recent conduct is therefore the only way to make a well-informed decision about the abilities and risk factors of a person with a mental disorder.

But what of the fact that persons with major mental disorders are, *as a group*, more likely than the general population to engage in violent

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101-116, at 27 (1989) ("For people with mental disabilities, the employer must identify the specific behavior on the part of the individual that would pose the anticipated direct threat."); 29 C.F.R. app. § 1630.2(r) (2000) ("Determining whether an individual poses a significant risk of substantial harm to others must be made on a case by case basis."); *id.* (requiring employer to identify "the specific behavior on the part of the individual that would pose the direct threat").

<sup>158</sup> This comparison is offered not to express support for generalized exclusions based on physical disabilities, but to suggest that such exclusions based on mental disabilities are, if anything, less justifiable. So, for example, one court invalidated a police department's policy that automatically placed any police officer taking antidepressants into a disciplinary program for officers who had exhibited unacceptable behavior. *Krocka v. Bransfield*, 969 F. Supp. 1073, 1079 (N.D. Ill. 1997). Although this program involved increased supervision, it did not involve any safety control or monitoring. *Id.* at 1087. The officer had to remain in this program as long as he took medication, even if his doctors and the department's doctors found no impairment that affected his performance or created a risk to himself or others. *Id.* at 1079, 1086-87. The police department justified its blanket policy as being based on its "concern that the taking of psychotropic medication indicates an underlying psychological problem that could affect the safety of others, including the public and the officer's family." *Id.* at 1079. The court invalidated the policy because it was based "only on broad-based assumptions that people on Prozac exhibit symptoms that are 'significant deviations from normal behavior' often enough to require constant supervision." *Id.* at 1087. This could not substitute for an individual assessment of each officer's performance.

conduct? At the risk of belaboring this point, it bears repeating that Congress denounced employment decisions based on "averages and group-based predictions,"<sup>159</sup> even if those averages or predictions are accurate with respect to the group. Thus, generalizations about the mentally disordered as a group – even if true – are not a permissible basis for discriminating against an individual.<sup>160</sup> Instead, to demonstrate that an individual with a mental disability poses a significant risk of substantial harm by becoming violent in the workplace, the employer must have specific, objective evidence about that individual, based on the individual's actual or threatened conduct.<sup>161</sup>

The case against the categorical equation of mental disability and violence under the ADA runs even a level deeper. Imagine, for the sake of argument, that the ADA permitted employers to exclude a group of persons with a particular disability on the ground that, *as a group*, they present a significant risk of substantial harm to others in the workplace. Even under this rule, an employer could not justify an exclusion of all persons with a diagnosis of a major mental disorder. The group-based risk of violence simply is not *significant* enough to warrant the extraordinary step of a blanket exclusion. Professor Swanson's analysis of ECA data revealed that, for persons with a diagnosis of a single mental disorder, the rate of violence was roughly 7%.<sup>162</sup> This equals the

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<sup>159</sup> H.R. REP. NO. 101-485, pt. 2, at 58-59 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 340-41; S. REP. NO. 101-116, at 28 (1989); *see* H.R. REP. NO. 101-485, pt. 3, at 45 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 468 ("Decisions [under *Arline*] are not permitted to be based on generalizations about the disability but rather must be based on the facts of an individual case."). *See generally* Samuel R. Bagenstos, *Subordination, Stigma, and "Disability,"* 86 VA. L. REV. 397, 456-57 (2000) (noting that, although group-based classifications are not "inevitably irrational bases for drawing distinctions among individuals," civil rights statutes prohibit them anyway).

<sup>160</sup> Case law under Title VII reinforces the impermissibility of such group-based distinctions. The Supreme Court has held, for example, that even though, "[a]s a class, women live longer than men," this does not justify requiring female employees to make larger contributions to a pension fund. *City of L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 704, 710 (1978). This is true, the Court stated, even for employment decisions that are based on "events that are individually unpredictable." *Id.* at 710. Indeed, "[i]ndividual risks, like individual performance, may not be predicted by resorting to classifications proscribed by Title VII." *Id.* (emphasis added). This principle has no less force under the ADA, which is premised on the recognition of individual abilities and limitations.

<sup>161</sup> *See Edwards, supra* note 106, at 362 ("[A]ny determination that there is a direct threat must be based on the circumstances of the individual under consideration. The evidence must be compelling and supported by expert opinion.").

<sup>162</sup> Swanson et al., *supra* note 33, at 767. For persons diagnosed with schizophrenia or related disorders, the rate was 8%. *Id.* at 766. Including persons with multiple diagnoses, the prevalence of violence among all persons with schizophrenia-related disorders,

rate among young people (males and females) aged eighteen to twenty-four.<sup>163</sup> Accordingly, Professor Paul Mullen concludes that "[t]here is as much justification for being afraid of the mentally ill as there is to turn in fear from young men and women."<sup>164</sup> Link makes a similar point: "If higher rates of violent/illegal behavior are a 'rational' justification for the exclusion of mental patients and former patients, one might just as well advocate an exclusion of men or high school graduates in preference for women or college graduates!"<sup>165</sup> To make an even more striking comparison from Swanson's data, the rate of violence for men aged 18-24 who have lower socioeconomic status was 16% – more than twice the rate of persons with a mental disorder, and considerably higher than the rate (10.66% to 12.69%) for persons who have one *or more* mental disorders.<sup>166</sup> As Professor Monahan has observed, "[c]ompared with the magnitude of risk associated with the combinations of male gender, young age, and lower socioeconomic status, . . . the risk of violence presented by mental disorder is modest."<sup>167</sup>

These studies, which measured violence anywhere in the community, may actually overstate the risk for *workplace* violence.<sup>168</sup> Most incidents

obsessive-compulsive disorder, panic disorder, major depression, or bipolar disorder ranged from 10.66% to 12.69%. *Id.* at 765; *see also* Swanson, *supra* note 70, at 101, 112.

<sup>163</sup> *See* Mullen, *supra* note 66, at 7 (reporting violence rate for persons aged 18-24).

<sup>164</sup> *Id.*

<sup>165</sup> Link et al., *supra* note 78, at 290.

<sup>166</sup> Swanson et al., *supra* note 33, at 765, 767 (setting forth rate of all persons with schizophrenia-related disorders, obsessive-compulsive disorder, panic disorder, major depression, or bipolar disorder).

<sup>167</sup> Monahan, *supra* note 18, at 519. Many experts have reached similar conclusions. *See, e.g.,* Hiday, *supra* note 132, at 124 ("Other variables [other than mental disorder] are much more strongly predictive: being a young, adult, single male of lower socioeconomic status, and being a substance abuser hold far greater risks of violence."); Marzuk, *supra* note 67, at 482 (asserting that, because "men commit the vast majority of crimes in every culture," they pose greater risk of violence than the mentally ill) (citations omitted); *see also* Modestin, *supra* note 7, at 552 (stating that risk factors for violence include male gender, younger age, unmarried status, lower socioeconomic status, and residence in more urban community); Swanson, *supra* note 70, at 120 (noting that "several characteristics – being young, male, of low socioeconomic status, nonwhite (black or Hispanic), or single, separated or divorced – were significantly associated with committing assaultive acts").

<sup>168</sup> There is, unfortunately, little empirical information about the relationship between *workplace* violence and mental disorders, perhaps because concern about workplace violence is a relatively recent phenomenon or because of the difficulty of gathering data. One published study presented a "preliminary analysis" of 240 incidents of serious workplace violence. Theodore B. Feldmann & Phillip W. Johnson, *Violence in the Workplace: A Report on 240 Incidents*, 16 AM. J. FORENSIC PSYCHIATRY 5 (1995). After the authors learned of an incident, either through media reports or from consultations with businesses or agencies, they gathered more information by interviewing employers, victims, witnesses, and family members to attempt to determine whether mental disorders,

of violence by persons with mental disorders occur in homes, not workplaces, and most involve family members, not coworkers, customers, or strangers.<sup>169</sup> Moreover, these studies include the persons with the most severe symptoms, many of whom who are not employed, employable or seeking employment.<sup>170</sup> Nonetheless, even using these higher rates of violence, the comparisons are telling. When Congress

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substance abuse, or psychopathology was a factor in the incident. *Id.* at 8. "Whenever possible," they attempted to interview the perpetrators and perform psychological testing. *Id.* The authors assigned each perpetrator to a category, and concluded that 29% were criminals, 20% disgruntled employees, 19% mentally ill, 17% parties to domestic or personal disputes, 8% disgruntled customers or clients, 5% disgruntled students or trainees, and 2% abusive supervisors. *Id.* at 10. Because of methodological limitations, and because "disgruntled employees" and "mentally ill" were mutually exclusive categories, this study sheds little light on the extent to which employees with mental disorders are a factor in workplace violence. In the absence of reliable empirical evidence directly measuring an association between mental disorders and *workplace* violence, it is reasonable to look outside the workplace for guidance. See, e.g., Julian Barling, *supra* note 89, at 30-31 (finding "little scientific information about the causes and predictors of workplace violence" and looking to research on family violence as guide).

<sup>169</sup> See *supra* Part II A.4.

<sup>170</sup> The ECA study that produced these estimates of violence included some of the most severely disordered persons in the community, many of whom were "work disabled" — not employed, employable, or seeking employment. See Richard J. Bonnie & John Monahan, *Mental Disorder and Labor Force Participation: An Epidemiological Perspective*, in *MENTAL DISORDER, WORK DISABILITY, AND THE LAW*, *supra* note 18, at 11 ("Among people with the most serious disorders, the most incapacitating symptoms are virtually always associated with work-related impairment."); *id.* (finding that "among a subset of persons with the most severe mental disorders, job-related functional limitations are so pronounced as to preclude 'gainful employment' and thereby make the person eligible" for federal disability benefits).

In fact, the majority of persons with disabling mental disorders are not in the labor force. Edward H. Yelin & Miriam G. Cisternas, *Employment Patterns Among Persons with and Without Mental Conditions*, in *MENTAL DISORDER, WORK DISABILITY, AND THE LAW*, *supra* note 18, at 38. From 1982 through 1991, average workforce participation for all persons with psychotic disorders was only 21%; for persons with affective disorders, the rate was 33%. *Id.* at 38. These rates were based on data from the National Health Interview Survey ("NHIS"), which was conducted by the National Center for Health Statistics and the National Institute of Mental Health. The NHIS recorded not only the presence of a disorder, but whether it was disabling as well. For persons who had a non-disabling psychotic condition, the labor force participation was 59%; for those whose condition was disabling, 15%. *Id.* For persons with non-disabling affective disorders, labor force participation was 69%; if the condition was disabling, 20%. *Id.* Other research confirms that individuals with the most severe symptoms are the least likely to be in the labor market because there is a direct inverse relationship between severity of symptoms and level of employment. See Swanson et al., *supra* note 131, at 10. In the MacArthur Study, only 55% of patients reported working part-time or full-time during the year following their hospitalization. MONAHAN ET AL., *supra* note 85, at 21. Interestingly only 0.5% of violent incidents (and 1.7% of other aggressive acts) occurred in the workplace. *Id.* at 20. The authors suggest that the relative rarity of workplace incidents could be related to the low level of employment or to some "situational influence of this type of setting." *Id.* at 21.

specified that only a "significant" risk would satisfy the direct threat defense, it must have intended a risk quantifiably greater than what even the most prudent employers assume every day without hesitation from employees with no disabilities. To permit an employer to exclude a person with a mental disability as presenting a "significant" risk of violence, when it does not similarly guard against the greater risks presented by disadvantaged young men, would only resurrect the "misperceptions, ignorance, irrational fears, . . . [and] pernicious mythologies" that Congress banished from the direct threat determination.<sup>171</sup> Excluding persons based on mental disorders, but not on other, greater and more readily identifiable risk factors (such as age, gender and socioeconomic status) invites suspicion that the employer is falling prey to these discredited fears and mythologies. The use of the disfavored trait as a proxy, when other characteristics are more reliable, is a hallmark of impermissible stereotyping.

#### 1. Possible Exceptions to the Requirement of Individualized Inquiry

The preceding discussion demonstrates that group-based risk determinations about the risk of violence associated with mental disorders are generally incompatible with the ADA's core requirement of individualized assessments. There is, however, a potential narrow exception to this principle, one that would allow an employer to categorically exclude individuals with certain severe or advanced mental disabilities from specific jobs. Imagine, by way of analogy, a prospective beat police officer who is blind and therefore can neither observe criminals in the act nor chase them down, or a would-be firefighter who cannot walk and therefore cannot enter burning buildings or pull people to safety. It would seem pointless to require an employer to conduct a fact-specific, individualized inquiry to determine whether these applicants are qualified (meaning they can perform the essential functions of the jobs they seek) or whether their employment would impose significant risks to others in the workplace. Congress, in fact, anticipated a class of cases for which categorical exclusions would be appropriate, but the Senate Committee on Labor and Human Resources defined this class extremely narrowly:

[T]his legislation prohibits use of a blanket rule excluding people with certain disabilities except in the *very limited situation* where *in all cases* [the] physical condition *by its very nature* would prevent the

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<sup>171</sup> H.R. REP. NO. 101-485, pt. 2, at 56 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 338.

person with a disability from performing the essential functions of the job, even with reasonable accommodations.<sup>172</sup>

In all other cases, the committee insisted, categorical prohibitions are incompatible with the ADA's core requirement of individualized assessments.<sup>173</sup>

Applying this exception to mental impairments, it is hard to imagine a job for which a diagnosis of a mental disorder would "by its very nature" prevent a person from performing the job, even with reasonable accommodations.<sup>174</sup> Certainly a person who currently is experiencing – and responding to – paranoid delusions or violent command hallucinations should not be an armed law enforcement officer. This exclusion, however, is based on a factual inquiry into the individual's actual symptoms. It is not a categorical exclusion of all persons with any mental disorder (including depression and bipolar disorder) which, if severe enough, might conceivably produce delusions, which then might conceivably, in certain situations, lead to violent conduct. It may be that a majority – even a substantial majority – of persons with schizophrenia would pose a direct threat in a particular job, because either the symptoms of the illness or the side effects of the medication prevent them from maintaining a constant level of concentration and care.<sup>175</sup> That is a far cry from concluding that all persons with schizophrenia must be excluded from the workplace because they present a direct threat of violence.

A few courts have suggested an even broader exception to the requirement of individualized assessments. They would permit an employer to use categorical exclusions if it can demonstrate a factual

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<sup>172</sup> S. REP. NO. 101-116, at 27 (1989) (emphases added).

<sup>173</sup> *Id.* at 30-31.

<sup>174</sup> Granted, persons with a current diagnosis of pedophilia are unsuited to be day care workers, and persons currently diagnosed with pyromania should not be security guards or firefighters, but those conditions are excluded from the ADA. *See* 42 U.S.C. § 12211 (1995).

<sup>175</sup> *Cf.* *Pack v. KMart Corp.*, 166 F.3d 1300, 1302 (10th Cir. 1999) (upholding dismissal of pharmacy technician whose depression caused difficulty concentrating and led to errors, including mislabeling prescriptions and entering incorrect prescription data into pharmacy computer); *Robertson v. Neuromed. Ctr.*, 161 F.3d 292, 296 (5th Cir. 1998) (upholding dismissal of neurologist with attention deficit hyperactivity disorder who made mistakes in patients' charts and in dispensing medicine); *F.F. v. City of Laredo*, 912 F. Supp. 248, 251 (S.D. Tex. 1995) (holding that city did not violate Rehabilitation Act in refusing to let city bus driver with bipolar disorder return to job where his own doctor testified that, without medication, he could suffer "problems of judgment and changes of mood and reaction to stress," but that necessary dose of antipsychotic medication would "render him a safety operational risk" as bus driver).

basis for believing either (1) that all or substantially all persons in that class present an elevated risk as a class, or (2) that the employer is unable reliably to determine which members of that class present the harm. This is the basis of the "bona fide occupational qualification" or BFOQ exception to Title VII and the Age Discrimination in Employment Act (ADEA).<sup>176</sup> While Congress arguably did not include a BFOQ defense in the ADA,<sup>177</sup> at least two courts have used similar reasoning in ADA or Rehabilitation Act cases.<sup>178</sup> Assuming a BFOQ-type argument *ever* is compatible with the direct threat defense, careful analysis demonstrates that it cannot justify an employer's exclusion of all persons with a mental disability based on an alleged threat of violence.

First, an employer could not prove that all or substantially all persons with a particular DSM diagnosis pose a significant risk of harm to others

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<sup>176</sup> Although the ADEA generally prohibits discrimination against an individual aged forty or older on the basis of that person's age, 29 U.S.C. §§ 623(a), 631(a) (1994), the BFOQ exception permits classifications based on age "where age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business," 29 U.S.C. § 623(f)(1). Similarly, section 703(e) of Title VII permits classifications based on religion, sex, or national origin "in those certain instances where religion, sex or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise." 42 U.S.C. § 2000e-2 (1994). The standard for establishing a BFOQ comes from *Western Air Lines, Inc. v. Criswell*, 472 U.S. 400, 413-15 (1985).

<sup>177</sup> Although the language of 42 U.S.C. § 12113(a) appears at first to encompass only a disparate impact claim, inviting the employer's business necessity defense, it arguably could fit circumstances more analogous to the categorical exclusions under the BFOQ exception to Title VII. Analogies between the ADA and other statutes are difficult, however, in part because protected classes under other antidiscrimination laws are, for the most part, readily identifiable (men, women, persons over forty, and so forth). By contrast, with disabilities, the employer's blanket exclusions generally are based on a condition or impairment (for example, epilepsy or insulin-treated diabetes), but not, strictly speaking, on the protected characteristic of "disability." Some excluded persons would not qualify as a person with an actual disability (because they are not substantially limited in a major life activity), and the employer's exclusion would not necessarily indicate that the employer perceived them as disabled.

<sup>178</sup> See, e.g., *Davis v. Meese*, 692 F. Supp. 505, 520-21 (E.D. Pa. 1988) (upholding, under Rehabilitation Act, exclusion of all persons with insulin-treated diabetes from jobs as FBI agents or special investigators). In *EEOC v. Exxon Corp.*, 967 F. Supp. 208 (N.D. Tex. 1997), the court permitted the employer to demonstrate that employing rehabilitated substance abusers in sensitive positions posed a direct threat, and that it was impossible or highly impractical to reliably determine through an individualized assessment which rehabilitated substance abuser might relapse. In a subsequent proceeding, the court granted summary judgment to the plaintiffs on this issue. *EEOC v. Exxon Corp.*, 1 F. Supp.2d 635, 649-50 (N.D. Tex. 1998). Ultimately, the Fifth Circuit reversed, adopting a standard that appears even more tolerant of generalized exclusions, although the appellate court did not elaborate on its standard. *EEOC v. Exxon Corp.*, 203 F.3d 873, 875 (5th Cir. 2000) (suggesting that its standard presented hurdle for employers that was not "inevitably higher or lower" than individualized assessment under direct threat standard).

in the workplace. Quite the opposite is true. The vast majority of individuals with mental disabilities do not engage in violent conduct, in the workplace or elsewhere.<sup>179</sup> Moreover, courts generally permit employers to resort to protected classifications as proxies only where the alternative is to risk a potentially catastrophic harm. For example, the Supreme Court has found that the crash of a commercial passenger plane, or the loss of control – and possibly lives – in a maximum security prison constitute substantial risks.<sup>180</sup> Here, the anticipated harm—violent conduct—is only generally identified and may not be substantial. Research indicates that "[t]he majority of violent [workplace] incidents . . . involve less severe aggression in the form of fights and threats."<sup>181</sup> This may include a punch, a kick, a shove – not conduct that any employer should tolerate, but also not the kind of grave or catastrophic harm that warrants invoking an "extremely narrow exception"<sup>182</sup> to the ADA's preference for individualized inquiries.

Nor could the employer establish that it is impossible or highly impracticable to determine which employee with a mental disorder poses a significant risk of substantial harm.<sup>183</sup> Given the uncertainties of

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<sup>179</sup> See sources cited *supra* note 70.

<sup>180</sup> *W. Air Lines v. Criswell*, 472 U.S. 400, 418-20 (1985) (applying BFOQ based on airplane safety); *Dothard v. Rawlinson*, 433 U.S. 321, 336-37 (1977) (finding that gender is BFOQ for prison guards in inmate "contact" positions in poorly run male maximum security prisons, where risk is loss of "basic control of the penitentiary and protection of its inmates and other security personnel").

<sup>181</sup> Joel B. Bennett & Wayne E.K. Lehman, *Alcohol, Antagonism, and Witnessing Violence in the Workplace: Drinking Climates and Social Alienation-Integration*, in *VIOLENCE ON THE JOB*, *supra* note 89, at 108.

<sup>182</sup> *Criswell*, 472 U.S. at 412 (citing *Dothard v. Rawlinson*, 433 U.S. at 334).

<sup>183</sup> By contrast, in *Davis v. Meese*, 692 F. Supp. 505 (E.D. Pa. 1988), the court found this standard satisfied, upholding the FBI's exclusion of all persons with insulin-treated diabetes from positions as FBI special agents or investigative specialists. The court cited evidence that all persons with insulin-treated diabetes were at risk for a hypoglycemic episode, and that there was no "reliable method of determining in advance those insulin-dependent diabetics who do not present a substantial risk of having a sudden and unexpected severe hypoglycemic episode while on a duty assignment." *Id.* at 517. This decision is subject to criticism on numerous grounds, many of which are presented in Mark L. Baylor, Note, *Dulling a Needle: Analyzing Federal Employment Restrictions on People with Insulin-Dependent Diabetes*, 67 *IND. L.J.* 1067, 1081-89 (1992). See generally *Kapche v. City of San Antonio*, 176 F.3d 840, 847 (5th Cir. 1999) (finding that advances in monitoring and treating diabetes require reconsideration of blanket hiring bans).

Even assuming that *Davis* was correctly decided, it is distinguishable from cases involving mental disorders. In *Davis*, the court identified a specific risk – an unanticipated hypoglycemic episode – that is both common to (the court found that *all* persons with insulin-treated diabetes are at risk) and limited to persons with diabetes. By contrast, the risk of violent conduct is not and cannot be confined to persons with diagnosed mental disorders, who commit at most only about 5% of all violent acts. Moreover, the *Davis* court

clinical predictions of violence,<sup>184</sup> it might indeed be impossible or highly impractical to determine which *applicants* with mental disorders present a risk of violence. This is also true, however, for applicants without any diagnosed mental disorder. Nonetheless, if the applicant becomes an *employee*, he or she is likely to give early warning signs of an impending eruption. "Violence is the end result of a process, not an isolated event."<sup>185</sup> Indeed, researchers studying workplace violence have catalogued forms of indirect aggression that typically precede physical violence.<sup>186</sup> Case law confirms that assaultive conduct frequently is preceded by arguments, outbursts, or threats – conduct that would justify removal either because it indicates a significant risk of substantial harm or because it is disruptive and insubordinate.<sup>187</sup> Thus, for several

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found that the hypoglycemic episode could occur in any person with insulin-treated diabetes without warning, giving the person no opportunity to prevent or mitigate the episode (by eating or injecting insulin). Unless a court were to find that all persons with mental disorders are at risk of being seized or possessed by sudden fits of violence, then any propensity to violence is something the person could mitigate or control. The extent to which a person is capable of doing so can be determined only through an individualized assessment.

<sup>184</sup> See *supra* note 168.

<sup>185</sup> James C. Beck & Ronald Schouten, *Workplace Violence and Psychiatric Practice*, 64 BULL. MENNINGER CLINIC 36, 40 (2000). This means that "[t]here is generally plenty of opportunity to assess and map the risk of violence among people with psychosis. Few who are seriously violent present for the first time early in their illness . . ." Taylor & Monahan, *supra* note 69, at 968.

<sup>186</sup> Robert Folger & Robert A. Baron, *Violence and Hostility at Work: A Model of Reactions to Perceived Injustice*, in VIOLENCE ON THE JOB, *supra* note 89, at 68; *id.* at 66 (stating that employees may engage in "more subtle and covert forms of aggression" before resorting to violence); Joseph A. Kinney, *The Dynamics of Threat Management*, in VIOLENCE ON THE JOB, *supra* note 89, at 305 (finding "sequences" in behavior that culminate in violence).

<sup>187</sup> There are many examples of cases where the courts upheld the employer's dismissal of employees who were disruptive or threatening, but who had committed no actual violence against supervisors or coworkers. See *Jones v. Am. Postal Workers Union*, 192 F.3d 417, 429 (4th Cir. 1999) (finding employer not required to ignore employee's "egregious misconduct" of threatening supervisor); *Palmer v. Circuit Court*, 117 F.3d 351, 352 (7th Cir. 1997) (upholding dismissal based on abusive language and verbal threat), *cert. denied*, 522 U.S. 1096 (1998); *Hardy v. Sears, Roebuck & Co.*, No. CIV.A.4:95-CV-0215-HLM, 1996 WL 735565, at \*8 (N.D. Ga. Apr. 28, 1996) (upholding dismissal of employee with bipolar disorder who sometimes failed to take his lithium and who engaged in pattern of hostile, explosive behavior and once threatened his supervisor, causing substantial workplace disruption); *Boldini v. Postmaster Gen.*, 928 F. Supp. 125, 131 (D.N.H. 1995) (upholding termination of employee with severe stress-related disorder as not qualified based on her contentious verbal altercations with coworkers and customers, which created extremely hostile atmosphere, and for insubordination toward her supervisor); *Carrozza v. Howard County*, 847 F. Supp. 365, 367-68 (D. Md. 1994) (dismissing plaintiff's claim that her termination was because of her disability (bipolar disorder) where employer cited workplace misconduct, including loud, abusive, and insubordinate behavior); *Mazzarella v. United States Postal Serv.*, 849 F. Supp. 89, 97 (D. Mass. 1994) (upholding dismissal based

reasons - the modest group-based violence risk presented by persons with mental disabilities, the less serious harm that typically results from minor workplace aggression or violence, and the frequency of advance, on-the-job indications of impending violence - the BFOQ-style argument fails in the case of mental disabilities and the risk of violence.

## 2. More Effective Alternatives to Excluding Persons with Mental Disabilities

The foregoing discussion raises an interesting practical point. Trying to reduce workplace violence by categorically excluding individuals with diagnosed mental disabilities not only violates the ADA, it disregards the sources of the vast majority of workplace violence. To the extent that workplace violence poses a threat,<sup>188</sup> it comes overwhelmingly from customers or strangers, notably robbers, rather than from coworkers. Current or former employees are responsible for only about 7% of workplace assaults and homicides.<sup>189</sup> Of the relatively small share of

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on abusive language and property damage); *Butler v. Dep't of the Navy*, 595 F. Supp. 1063, 1066 (D. Md. 1984) (upholding dismissal of employee who had poor attendance record, failed to follow orders, and once threatened his supervisor); see also EEOC, TECHNICAL ASSISTANCE MANUAL ON THE EMPLOYMENT PROVISIONS (TITLE I) OF THE AMERICANS WITH DISABILITIES ACT OF 1990 § 4.5.4, at IV-12 (1992) (stating that person with psychological disorder whose behavior is "violent, aggressive, destructive or threatening" might pose direct threat to health or safety of others).

Of course, where threatening and disruptive behavior eventually leads to assaultive conduct, courts have little difficulty upholding the termination of the assailant. *E.g.*, *Fenton v. Pritchard Co.*, 926 F. Supp. 1437, 1441-42 (D. Kan. 1996) (upholding dismissal of male employee who harassed female coworker, followed her home, and slapped her); *Stola v. Joint Indus. Bd.*, 889 F. Supp. 133, 136 (S.D.N.Y. 1995) (upholding dismissal of apprentice electrician with anxiety disorder based on several events, including attacking union representative); *Marino v. United States Postal Serv.*, No. 92-11130-H, slip op. at 2 (D. Mass. June 29, 1993) (upholding dismissal of engineer who struck his supervisor); *Adams v. Alderson*, 723 F. Supp. 1531, 1532 (D.D.C. 1989) (upholding dismissal of computer programmer with adjustment and compulsive personality disorders who assaulted his supervisor), *aff'd sub nom. Adams v. G.S.A.*, No. 89-5265, 1990 WL 45737 (D.C. Cir. Apr. 10, 1990).

<sup>188</sup> In their recent article, Vicki A. Laden and Gregory Schwartz argue that fears of workplace violence are out of proportion to the actual danger. They cite data from the National Institute for Occupational Safety and Health ("NIOSH") to demonstrate that homicide accounts for 14% of employment-related deaths, well behind traffic accidents and unsafe working conditions. Laden & Schwartz, *supra* note 5, at 250 (citations omitted). Of all homicides committed in 1997, only 4.25% occurred in the workplace. *Id.* at 256 (citations omitted).

<sup>189</sup> Statistics show that 85% of workplace homicides occur in connection with robberies or other crimes perpetrated by outsiders, compared with 7% committed by current or former employees. Laden & Schwartz, *supra* note 5, at 256, 257 (citing BUREAU OF LABOR STATISTICS, NAT'L CENSUS OF FATAL OCCUPATIONAL INJURIES, 1997, at 2, available at

workplace violence committed by current or former employees, there are no readily available and reliable statistics indicating how many perpetrators had a mental disorder, much less how many incidents could be attributed to that disorder.<sup>190</sup> We do know that, in society as a whole, mental disorders "account for a minuscule portion of the violence that afflicts America."<sup>191</sup> Swanson calculates that the risk of violence associated with serious mental illness is "not very high – in the range of about 3.0% to 5.3%."<sup>192</sup> We also know that when persons with mental disorders engage in violence, they generally do so in their own homes or in the homes of relatives or friends rather than in the workplace. Their relatives or friends, not coworkers, are the most frequent targets.<sup>193</sup> Because their 3% to 5% share of overall violence occurs disproportionately in the home, we can anticipate that their contribution to workplace violence is therefore smaller.

There is further evidence that, if the concern is for "violent employees," the category of "mentally ill employees" is a poor proxy, because it is both under- and over-inclusive. In their article on personality disorders and violence, Thomas Widiger and Timothy Trull explained that the presence of four of ten criteria was sufficient to diagnose antisocial personality disorder (ASPD).<sup>194</sup> A diagnosis based on four of those

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<http://www.bls.gov/special.requests/ocwc/oshwc/foi/cfnr0004.txt>); BUREAU OF LABOR STATISTICS, 1997 OCCUPATIONAL INJURIES AND ILLNESSES (1998), *available at* <http://stats.bls.gov/oshhome.htm>; NIOSH, U.S. DEPT OF HEALTH & HUMAN SERVS., VIOLENCE IN THE WORKPLACE (1996), *available at* <http://www.cdc.gov/niosh/violcont.html>); *see* Samuel Jan Brakel, *Legal Liability and Workplace Violence*, 26 J. AM. ACAD. PSYCHIATRY L. 553, 554 (1998) (stating that "the classic worker-on-employer or worker-on-worker brand of violence comprises only a small minority of cases" of workplace violence); John D. Thompson, *Psychiatric Disorders, Workplace Violence and the Americans with Disabilities Act*, 19 HAMLINE L. REV. 25, 28 (1995) ("Although the media portrays workplace violence as a series of mass murders by disgruntled former employees, the problem is far more complex and multifaceted.").

<sup>190</sup> *See generally* Brakel, *supra* note 189, at 555 (stating that "by no means all of what is commonly classified as workplace violence is amenable to the insights or ministrations of psychiatrists").

<sup>191</sup> Monahan & Arnold, *supra* note 7, at 69; *see* Link et al., *supra* note 78, at 290 (stating that conduct by persons with major mental disorders constituted only "a trivial contribution to the overall level of violent/illegal behavior in American society"); Monahan, *supra* note 18, at 519 ("Clearly, mental health status makes at best a trivial contribution to the overall level of violence in society."); Mulvey, *supra* note 66, at 664 (asserting that "the absolute risk for violence posed by mental illness is small").

<sup>192</sup> Swanson, *supra* note 70, at 119. To use a comparison from a Swiss study, in a given year 161 persons with no disorder committed violence, compared to only two persons with schizophrenia. Modestin, *supra* note 7, at 553.

<sup>193</sup> *See supra* text accompanying notes 124-128.

<sup>194</sup> Thomas A. Widiger & Timothy J. Trull, *Personality Disorders and Violence*, in

criteria – inability or failure to sustain consistent work behavior, to honor financial obligations, to plan ahead, and to sustain a monogamous relationship – "may have little predictive validity for violent behavior."<sup>195</sup> By contrast, the presence of a single criterion – "a history of being 'irritable and aggressive, as indicated by repeated physical fights or assaults (not required by one's job or to defend someone or oneself), including spouse or child beating'" – would not result in a diagnosis, even though it "would suggest the presence of a maladaptive personality trait predisposing the person toward violent acts."<sup>196</sup>

The same is true for disorders like schizophrenia. A diagnosis of schizophrenia generally requires the presence of two of the following five criteria: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms such as affective flattening.<sup>197</sup> Bizarre delusions or certain kinds of hallucinations alone are sufficient for a diagnosis. But the person who is diagnosed on the basis of persecutory delusions may present a starkly different risk of violence than the person who is withdrawn, apathetic and catatonic. Similarly, the risk associated with bipolar disorder may hinge on whether a manic episode produces elation, euphoria and increased goal-directed activity or, instead, produces irritability, hostility and anger.<sup>198</sup>

Other violence researchers agree about the limited value of DSM diagnoses in predicting violence.<sup>199</sup> One researcher suggests that it would be more productive to assess the specific traits or symptoms

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VIOLENCE AND MENTAL DISORDER, *supra* note 70, at 203. A personality disorder reflects personality traits that are inflexible and maladaptive, that lead to behavior that deviates from cultural expectations, and that cause either significant functional impairment or subjective distress. DSM-IV, *supra* note 21, at 630. Widiger and Trull analyzed the diagnostic criteria presented in DSM-III-R, which was published in 1987 and which provided the diagnostic criteria for most of the studies discussed in this article. Although DSM-IV, published in 1994, modifies the diagnostic criteria for ASPD, this analysis serves as an informative illustration of how a diagnosis can fail to reflect a person's actual risk of violence.

<sup>195</sup> Widiger & Trull, *supra* note 194, at 217.

<sup>196</sup> *Id.* With 848 combinations of criteria that would produce a diagnosis of ASPD, persons who share this diagnosis "vary significantly" with respect to traits of impulsivity, hostility, and aggressivity. *Id.* at 218.

<sup>197</sup> DSM-IV, *supra* note 21, at 285. Negative symptoms include "restrictions on the range and intensity of emotional expression (affective flattening), in the fluency and productivity of thought and speech (alogia), and in the initiation of goal-directed behavior (avolition)." *Id.* at 275.

<sup>198</sup> *Id.* at 328-29 (describing manifestations of manic episode).

<sup>199</sup> *E.g.*, Klassen & O'Connor, *supra* note 71, at 239 (stating that while "at least some aspects of mental illness may be direct contributors to the occurrence of violent incidents, . . . diagnosis alone is not a reliable risk marker").

believed to be related to violence, rather than the diagnostic categories that are an indirect and not always accurate measure of those traits or symptoms.<sup>200</sup> Some employers have taken an approach along those lines, administering "personality tests" to prospective employees. Whether such a "personality" test complies with the ADA will depend on how it is designed, when and how it is administered, and the role it plays in the selection decision.<sup>201</sup> Other employers rely on "profiles" provided by risk

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<sup>200</sup> Marzuk, *supra* note 67, at 485 ("[I]t may prove fruitful to study temperaments, dimensional psychological traits such as impulsivity, and active symptoms such as hallucinations, delusions or uncontrollable anger than specific categorical disorders such as schizophrenia, major depression, or alcoholism.") (citation omitted).

<sup>201</sup> To the extent that these tests measure only undesirable traits or behaviors – dishonesty, anger, aggression, or poor judgment – they do not run afoul of the ADA. See 29 C.F.R. app. § 1630.2(h) (2000) (stating that definition of disability "does not include common personality traits such as poor judgment or a quick temper where these are not symptoms of a mental or psychological disorder"); Equal Employment Opportunity for Individuals with Disabilities, 56 Fed. Reg. 35,726, 35,741 (July 26, 1991) (to be codified at 29 C.F.R. pt. 1630) (recognizing distinction between impairments and "physical, psychological, environmental, cultural, and economic characteristics that are not impairments. Specifically, normal traits such as poor judgment or a quick temperament are not impairments."); EEOC ENFORCEMENT GUIDANCE, *supra* note 22, at 4 ("Traits or behaviors are not, in themselves, mental impairments. . . . [T]raits like irritability, chronic lateness, and poor judgment are not, in themselves, mental impairments, although they may be linked to mental impairments.") (citing EEOC COMPLIANCE MANUAL § 902.2(c)(4), Definition of the Term "Disability," 8 FEP Manual (BNA) 405:7258 (1995)); see also *Stewart v. County of Brown*, 86 F.3d 107, 111 (7th Cir.1996) (holding that sheriff's order of psychological evaluations and conclusion that plaintiff was temperamentally unfit to serve as sheriff's deputy "did not amount to a showing even of a perception of a mental impairment that substantially limits one or more of the major life activities"); *Daley v. Koch*, 892 F.2d 212, 214, 215 (2d Cir. 1995) (finding that "poor judgment, irresponsible behavior, and poor impulse control" do not constitute a disability absent "any particular psychological disease or disorder"); *Greenberg v. New York State*, 919 F. Supp. 637, 643 (E.D.N.Y. 1996) (holding that applicant for corrections officer position not protected by ADA because he did not have actual or perceived disability when was rejected because his pre-employment psychological test showed that he was unable to make sound safety and security decisions in emergencies); *Pouncy v. Vulcan Materials Co.*, 920 F. Supp. 1566, 1580 n.8 (N.D. Ala. 1996) (stating that "poor judgment, irresponsible behavior and poor impulse control do not amount to a mental condition that Congress intended to be" disability).

There is a risk, however, that such a test will violate the ADA's proscription on pre-employment medical examinations and inquiries to disclose the existence, nature, or severity of a disability. 42 U.S.C. § 12113(d)(2)(A) (1994). Congress cautioned that the direct threat provision was "not to be used to circumvent the prohibition against pre-employment inquiries into a person's disability" or "to justify generalized requests or inquiries related to medical records." H.R. REP. NO. 101-485, pt. 3, at 46 (1990), *reprinted in* 1990 U.S.C.A.N. 445, 469. Whether a "personality test" is a "medical" examination or inquiry will depend on a number of factors, including whether it is designed to reveal mental illness, whether it generally is interpreted by a psychologist, and whether it is used in a clinical setting. See EEOC, NOTICE NO. 915.002, ADA ENFORCEMENT GUIDANCE: PREEMPLOYMENT DISABILITY-RELATED QUESTIONS AND MEDICAL EXAMINATIONS (1997), available at <http://www.eeoc.gov/docs/preemp.html>; see also *Barnes v. Cochran*, 944 F.

managers, psychologists and human resources experts.<sup>202</sup> To the extent that these profiles accurately identify risk factors for workplace violence,<sup>203</sup> they respond to an employer's legitimate concerns better than epidemiological data about violence anywhere in the community.

A potentially more effective method for screening out employees prone to violence is a careful background check for recent workplace violence or convictions for violent crimes.<sup>204</sup> As noted earlier, researchers

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Supp. 897, 903-06 (S.D. Fla. 1996) (holding that pre-employment psychological examination conducted by licensed psychologist and covering matters tending to disclose certain psychological disorders was impermissible medical examination); Teresa L. Clark, *A Map for the Labyrinth: How to Conduct Job Interviews and Obtain Medical Information Without Violating the Americans with Disabilities Act*, 13 LAB. LAWYER 121, 125 (1997); William D. Hooker, *Psychological Testing in the Workplace*, 11 J. OCCUPATIONAL MED. 699, 705-06 (1996). Of course, there is also the risk that the test does not accurately measure risk factors. See Hooker, *supra*, at 700 (asserting that not all psychological tests marketed to employers meet scientific standards for reliability and validity).

<sup>202</sup> The composite portrait of the "typical workplace killer" is a middle-aged man who is withdrawn or a loner; prone to complain, blame others and hold grudges, and to abuse drugs or alcohol in times of stress; is distrustful and rigid, obsessed with guns or other weapons; and has few social supports or interests outside work. Laden & Schwartz, *supra* note 5, at 251 n.29 (citations omitted); see also Colleen Manigan, *The Graveyard Shift: Workplace Safety is a Full-Time Job*, 8 PUB. MGMT. 6, 9 (1994) (asserting that "berserkers" often are "loners who appear guarded, defensive and hostile[;] withdrawn from relationships with coworkers[;] fond of violent films, books and TV shows[;] suspicious and even clinically paranoid[;] without much social support[;] apt to externalize or blame others for their own problems[;] quick to perceive unfairness[;] fascinated by weapons[;] filled with job-related resentment[;] intimidating enough that bosses, coworkers and supervisors may let them get away with more than they should[; and] the victim of a layoff or personal loss such as divorce or separation"); Roland Maiuro, *We Must Reduce Violence in Workplace*, NEWSDAY, Sept. 29, 1998, at A37 ("The most common 'profile' of a violence-prone employee is a white male, 35 or older, who has few interests and social supports outside of work, an affinity for guns, a history of family problems, and a tendency to harbor resentments and grudges, verbalize extremist opinions and abuse drugs or alcohol during times of stress."). Cf. John Nicoletti & Kelly Spooner, *Violence in the Workplace: Response and Intervention Strategies*, in VIOLENCE ON THE JOB, *supra* note 89, at 280 (expressing belief that, while there is no "verifiable 'profile' of the workplace violence perpetrator, there are several validated risk factors for general violence: history of violence, poor impulse control, unsuccessful personal history, . . . substance abuse[,] . . . preoccupation with violence, current situational stressors, and mental illness").

<sup>203</sup> I am not suggesting that these profiles are acceptable substitutes for clinical assessments of a risk of violence, as I am not in a position to assess their effectiveness. Some commentators are skeptical of such short cuts. See Laden & Schwartz, *supra* note 5, at 247 ("[P]rediction of violence, even by skilled clinicians in highly controlled in-patient settings, is dubious at best. In the hands of employers, the 'tools' for predicting violence . . . have even less prognostic validity or reliability."). Nonetheless, whether excluding the hostile, blaming, gun-loving loner, see Manigan, *supra* note 202, at 9, effectively serves to eliminate or reduce workplace violence, at least it does not perpetuate disability-based stigma and disadvantage.

<sup>204</sup> When using criminal records, the employer should focus on convictions, rather than arrests, and, in making employment decisions, should consider the nature and seriousness

and clinicians have identified recent past violence as a reliable predictor for future community violence.<sup>205</sup> With respect to workplace violence, previous use of aggression has been documented as a personal characteristic of aggressive employees.<sup>206</sup> Perpetrators of violence "usually have a traceable history of disputes, interpersonal conflicts and failures," including a "history of threatening or assaulting others."<sup>207</sup> Therefore, a clinician assessing the risk that an employee will be violent should "begin by assessing the most recent act or verbalisation of violence, in as much detail as possible, as well as considering accounts of the nature and frequency of past violent acts committed by the employee."<sup>208</sup> This focus is consistent with the congressional directive that an employer seeking to exclude an individual with a mental disability based on a direct threat of violence must produce objective evidence of past threats or acts of violence.<sup>209</sup> Congress recognized, moreover, that it is "a *recent* history" of acts or threats that is most probative of future violence.<sup>210</sup> The predictive force of prior violence may be limited by intervening treatment.<sup>211</sup> In general, however, an employer likely has more to fear from the person who was fired from his

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of the offense, the time elapsing since the conviction or completion of the sentence, and the nature of the job for which the applicant has applied. *See, e.g.,* Green v. Mo. Pac. R.R. Co., 523 F.2d 1290, 1297 (8th Cir. 1975) (discussing Butts v. Nichols, 381 F. Supp. 573, 1974 U.S. Dist. Lexis 6900, 8 Empl. Proc. Dec. (CCH) P9740, 8 Fair Empl. Prac. Case (BNA) 676 (S.D. IA 1974), and relationship of conviction to employment hiring practices); *see also* Carter v. Gallagher, 452 F.2d 315, 326 (8th Cir. 1971) (en banc). The categorical exclusion of all persons who have been arrested has been held to have a disparate impact on minorities. *E.g.,* Reynolds v. Sheet Metal Workers Local 102, 498 F. Supp. 952, 963-64 (D.D.C. 1980), *aff'd*, 702 F.2d 221 (D.C. Cir. 1981).

<sup>205</sup> *See supra* note 88.

<sup>206</sup> Barling, *supra* note 89, at 34 (citing MICHAEL MANTELL & STEVE ALBRECHT, TICKING BOMBS: DEFUSING VIOLENCE IN THE WORKPLACE 30-31 (1994); James P. Graham, *Disgruntled Employees — Ticking Time Bombs?*, 36 SECURITY MGMT. 83, 83 (1991)).

<sup>207</sup> Fletcher, Brakel, & Cavanaugh, *supra* note 89, at 342.

<sup>208</sup> *Id.*; *see also* Kinney, *supra* note 187, at 306 ("Information about prior incidents of violence and disregard for established authority are very important to the assessment process.").

<sup>209</sup> H.R. REP. NO. 101-485, pt. 3, at 37 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 468-69 (stating that to satisfy direct threat defense "in the case of a person with mental illness there must be objective evidence from the person's behavior that the person has a recent history of committing overt acts or making threats which caused harm or which directly threatened harm") (footnotes omitted).

<sup>210</sup> *Id.* (emphasis added).

<sup>211</sup> *See* Schopp & Quattrocchi, *supra* note 18, at 172-73 ("[V]iolent conduct that occurred a year ago may be appropriately considered as evidence of current dangerousness for a subject who has spent the last year in closely supervised confinement and whose pathology now remains unabated, but not for another subject who responded to aggressive treatment with marked remission and who has been living unsupervised for the last 6 months.").

last job for assaulting his supervisor than from the person who is being treated for depression.<sup>212</sup>

In addition, research consistently has shown that use or abuse of illicit drugs or alcohol frequently contributes to violent altercations.<sup>213</sup> While the ADA does not permit an employer to exclude employees or applicants based on the status of being an alcoholic or a rehabilitated drug user, the Act defines "qualified individual with a disability" to exclude a person "who is currently engaging in the illegal use of drugs."<sup>214</sup> The Act also expressly permits employers to prohibit employees from using alcohol or illegal drugs or being under the influence of alcohol in the workplace.<sup>215</sup> Moreover, employers may punish misconduct (such as violence) related to drug or alcohol use the same as any other misconduct.<sup>216</sup> Finally, the Act does nothing to limit an employer's ability to conduct otherwise legal drug or alcohol testing of applicants and employees.<sup>217</sup> Accordingly, given the uncontroverted relationship between the use of alcohol and illegal drugs and violence, an employer might reduce the risk of violence more effectively by maintaining a drug- and alcohol-free workplace than by attempting to exclude persons with mental disorders.

In sum, the employer who focuses its attention on "avoid[ing] hiring lemons, nuts and flakes"<sup>218</sup> likely is misdirecting its attention. Much workplace violence is committed by persons without any diagnosed disorder and results from diverse causes, some related to working conditions.<sup>219</sup> Focusing on applicants or employees with mental disabilities overlooks many potential – and more likely – sources of workplace violence. Equating workplace violence with mental disorders thus may hurt not only the individuals with disabilities who are wrongly

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<sup>212</sup> See Kinney, *supra* note 187, at 305 (stating that "an undue focus on certain *types* rather than on *behaviors* can divert attention from individuals who are much more serious threats").

<sup>213</sup> See text accompanying notes 108-118.

<sup>214</sup> 42 U.S.C. § 12114(a) (1994).

<sup>215</sup> *Id.* § 12114(c)(1), (2).

<sup>216</sup> *Id.* § 12114(c)(4).

<sup>217</sup> *Id.* § 12114(c)(5), (d), (e).

<sup>218</sup> This quote is from an advertisement for a 1995 seminar at Baker University in Kansas designed to instruct employers in screening out "potentially dangerous 'nuts.'" See Mullen, *supra* note 66, at 7.

<sup>219</sup> See Campbell & Kaufmann, *supra* note 47, at 236 (expressing concern that "[e]mployers will be lured into a false sense of security if they focus their efforts on 'keeping the crazies out' and ignore the fundamental environmental factors that provoke workplace violence, such as low pay, long hours, high stress at work and home, little chance for advancement, and layoffs").

excluded, but also the employees or supervisors whose safety is not protected by a more reasoned and effective workplace violence prevention program.

*B. The Requirement of Reasonable Accommodations to Reduce the Risk of Violence*

While the employer's first responsibility in the objective, evenhanded application of the direct threat defense is to make hiring and other decisions based on the individual's actual limitations and abilities, rather than stereotypes or unfounded fears, the employer's obligations do not end there. Recall that the direct threat provision permits the employer to rely only on significant workplace risks that cannot be reduced or eliminated through reasonable accommodations.<sup>220</sup> Under this standard, an employer concerned with a risk of violence associated with a person's mental disability may be called upon to modify workplace practices to reduce that risk, by avoiding or altering conditions in the workplace that might lead that person to act violently. The social science research invites us to think about a wide range of accommodations, some of which might require the employer to expand its focus dramatically. Rather than thinking only about how to avoid "violent employees," the employer may need to focus on how to avoid situations that may lead employees to violent conduct.

Violence, the research shows, "is a reciprocal phenomenon and does not rest with the individual alone, but arises in the context of social relationships."<sup>221</sup> With respect to workplace violence, experts tell us that workplace stresses or conflicts can trigger confrontations that lead to

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<sup>220</sup> 42 U.S.C. § 12111(3) (1994) (defining "direct threat" as significant risk of harm to health or safety of others "that cannot be eliminated by reasonable accommodation"). When the statute speaks of "significant risk" that cannot be "eliminated," it is reasonable to interpret it to require the elimination of *significant* risks, but not the elimination of *all* risks. In other words, if an accommodation reduces a significant risk to the level of insignificance, the direct threat standard is not satisfied. EEOC regulations adopt this sensible interpretation, referring to "a significant risk of substantial harm . . . that cannot be eliminated *or reduced* by reasonable accommodations." 29 C.F.R. § 1630.2(r) (2000) (emphasis added). An employer need not provide an accommodation that would "impose an undue hardship on the operation of the [employer's] business." 42 U.S.C. § 12112(b)(5)(A) (1994). The employer has the burden of proving that the requested accommodation would impose an "undue hardship," *id.*, which the ADA defines as "an action requiring significant difficulty or expense, when considered in light of" numerous factors relating to the nature and cost of the accommodation, the employer's financial resources, and the nature of the employer's operations, *id.* § 12111(10).

<sup>221</sup> Angermeyer et al., *supra* note 122, at S5 (emphasis omitted).

violence.<sup>222</sup> Consistent with the conclusions of Estroff, Swanson and others,<sup>223</sup> two scholars who have examined workplace violence conclude that an employee's aggressive or threatening behavior may stem from "a complex interplay among many personal, social, cognitive, and situational factors."<sup>224</sup> Workplace policies to reduce or eliminate workplace conflicts by revising these "situational" factors may be advisable as sound management policy – and required as a reasonable

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<sup>222</sup> See, e.g., Beck & Schouten, *supra* note 185, at 40 ("Organizations that tolerate threats or verbal and physical assaults provide implicit permission for violent acts as a means of expressing and resolving conflict."); Folger & Baron, *supra* note 186, at 51, 61-62 (asserting that "[u]nderstanding why certain individuals emerge in workplace violence requires considering both their personal characteristics and many aspects of the environments in which they work"); Kinney, *supra* note 187, at 303 (explaining that behavior "typically occurs in a context, not in a vacuum"); Klassen & O'Connor, *supra* note 71, at 237 (stating that life events correlated with violence include work problems, low income, and crowded physical environments); Manigan, *supra* note 202, at 9 (advising that "keeping employees happy and stress-free can prevent an outburst" in workplace and encouraging employers to discourage violence by maintaining supportive work environment, developing effective grievance procedures, and formulating and enforcing strong anti-harassment policies).

Employers should not overlook *former* employees: a person who has been laid off is "six times more likely to commit violence than one who is still working." Lamberg, *supra* note 88, at 1712 (citing Ralph Catalano et al., *Using ECA Survey Data to Examine the Effect of Job Layoffs on Violent Behavior*, 44 HOSP. & COMMUNITY PSYCHIATRY 874, 876-77 (1993)); see Hiday, *supra* note 131, at 402 (noting that recent economic hardship in form of job loss is more predictive of violence than psychiatric disorder).

<sup>223</sup> See Borum et al., *supra* note 7, at 206 (arguing that risk of violence is "dynamic, contextual, and continuous," rather than "static, dispositional, and dichotomous"); *id.* (shifting focus from violence as label attached to persons with mental disorder to "person-situation interactions that produce conditions of risk which can change over time"); Hiday, *supra* note 131, at 400 (suggesting that "both violence and manifestations of mental illness largely grow from the structural arrangements in which individuals are embedded, and that the paths between mental illness and violence are mainly indirect and contingent"); Robert J. Menzies et al., *The Dimensions of Dangerousness Revisited: Assessing Forensic Predictions About Violence*, 18 LAW & HUM. BEHAV. 1, 24 (1994) (recognizing that "danger, violence, risk, psychopathy, conduct disorder, and related constructs are not discrete or insulated entities amenable to narrow scientific calibration – rather, they are complex, multidimensional, and discursively charged phenomena, with deeply engrained and contradictory connections to human thought and action and to wider social structures and cultural forces"); Pollock, *supra* note 88, at 211 (asserting that "[a] complex interaction of individual characteristics and environmental variables contribut[e] to violent behaviour").

<sup>224</sup> Folger & Baron, *supra* note 186, at 56. Colloquially, Folger and Baron speak of a "popcorn theory" of workplace dynamics: the employees are the kernels, and the workplace environment is the hot oil; personal traits, including personal vulnerabilities, determine which employee "explodes" first. *Id.* at 62; see also Barling, *supra* note 89, at 32 (asserting that accurate predictive model for workplace violence must take into account "both the person and the situation, and their interaction"); Beck & Schouten, *supra* note 185, at 40 (stating that workplace violence typically is product of three factors: personal variables, situational factors or triggers, and setting).

accommodation for a person with a mental disability.<sup>225</sup> Such policies include drafting and enforcing anti-harassment policies, educating supervisors and employees to increase their understanding and acceptance of persons with mental disabilities, and allowing a person with a mental disability to depart from workplace rules that are not essential to her job or the employer's operations.

Although such accommodations generally conform to sound management practices, in practice their implementation faces obstacles, from both employees and employers. Employees with a mental disability often will fail to seek an accommodation, either because they are reluctant to disclose their disability or because they lack the clarity to explain what they need and why. Accordingly employees often request an accommodation only after facing discipline for misconduct or performance deficiencies. This raises the difficult question whether the duty of accommodation ever requires employers to excuse past misconduct or performance deficiencies. Employers, for their part, have resisted implementing *behavioral*, as opposed to *physical*, modifications, perhaps because they do not understand the behavioral aspects of mental disorders or believe that issues concerning supervision and workplace culture are their prerogative.<sup>226</sup> One of the biggest obstacles may be the employers' sense that individuals must take exclusive responsibility for their misconduct.<sup>227</sup> But a richer appreciation of the situational and contextual nature of violence, and the role that workplace

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<sup>225</sup> Indeed, Professor Stefan would go a step further, suggesting that an employer's creation of a work environment pervaded by "free-ranging, universally applicable intimidation, insult and ridicule," in addition to violating the duty of reasonable accommodation, may provide the basis for a disparate impact claim of disability discrimination. Stefan, *supra* note 14, at 838.

<sup>226</sup> In one survey of employers asked to rate how easily they could accommodate certain disabilities, all physical problems except blindness were deemed easier to accommodate than emotional disturbances and alcohol and substance abuse. Ira H. Combs & Clayton P. Omvig, *Accommodation of Disabled People into Employment: Perceptions of Employers*, J. REHABILITATION, Apr./May/June 1986, at 42, 43. The research did not examine whether the employers' perceptions reflected fear of persons with mental or emotional disabilities, fear of coworkers' reactions, lack of awareness of how to accommodate non-physical disabilities, or some other concern.

<sup>227</sup> Research suggests that a lack of willingness to help persons with mental disabilities may stem in part from the belief that they should exercise control over their condition and their conduct. See Verena H. Menec & Raymond P. Perry, *Reactions to Stigmas Among Canadian Students: Testing Attribution-Affect-Help Judgment Model*, 138 J. SOC. PSYCHOL. 443, 451 (1998) (illustrating that perceived controllability is linked to greater anger, less pity); Bernard Weiner & Raymond P. Perry, *An Attributional Analysis of Reactions to Stigmas*, 55 J. PERSONALITY & SOC. PSYCHOL. 738, 745 (1988) (examining perceived controllability and stability of disabilities and how they affected others' pity, anger, and willingness to help).

norms may play in triggering or avoiding it, suggests that the responsibility of avoiding workplace violence involving employees with mental disabilities should not fall entirely on those employees. Once the employer has been alerted to the existence of a disability that is affecting the employee's ability to work, including the ability to refrain from disruptive or violent conduct, the employer has an obligation to help identify a workable accommodation. This may include permitting the employee to depart from non-essential workplace rules. Moreover, to the extent that the risk of violence stems from a volatile or abusive workplace or an insensitive supervisor, the employer may have an obligation to take reasonable steps to reduce the workplace factors that make violence more likely.

#### 1. Recognizing the Need For and Helping to Identify an Accommodation

Because the employer's accommodation duty extends only to *known* disabilities, and mental disabilities often are not obvious, the employee generally must both disclose the disability and explain the need for an accommodation.<sup>228</sup> For a person with a mental disability, this requirement, if applied with insensitivity to the circumstances, could prove onerous and unrealistic. Revealing the disability and articulating the needed accommodation requires courage. It also requires "the self-awareness, knowledge, and communication skills required to guide an unenlightened employer through the accommodation process"<sup>229</sup>—

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<sup>228</sup> EEOC, TITLE I INTERPRETIVE GUIDANCE, 29 C.F.R. app. § 1630.9 (1994) ("Employers are obligated to make reasonable accommodation only to the physical or mental limitations resulting from the disability of a qualified individual that is known to the employer. Thus, the employer would not be expected to accommodate disabilities of which it is unaware."). While an employer may ask an employee who is struggling whether the employee needs an accommodation, it generally is the responsibility of the employee with a disability to inform the employer of the need for a reasonable accommodation. *Id.*; cf. Hedberg v. Ind. Bell Tel. Co., 47 F.3d 928, 934 (7th Cir. 1995) ("[I]t may be that some symptoms are so obviously manifestations of an underlying disability that it would be reasonable to infer that an employer actually knew of the disability . . . . Nor should deliberate ignorance insulate an employer from liability.").

Once the employee requests an accommodation, the employer and employee are to engage in an "interactive process" designed to identify an accommodation that will permit the employee to perform the job's essential functions and will not impose an undue hardship on the employer. See 29 C.F.R. § 1630.2(o)(3) (2000) (stating that "informal, interactive process" should "identify the precise limitations resulting from the disability and potential reasonable accommodations that could overcome those limitations"). The Interpretive Guidance describes and illustrates the "problem solving" approach the statute requires. 29 C.F.R. app. § 1630.9.

<sup>229</sup> Christopher G. Bell, *The Americans with Disabilities Act, Mental Disability, and Work*, in

capacities that an employee with mental or emotional impairments may have difficulty summoning.

Recognizing this difficulty, one federal appeals court has concluded that, where an employee's *known* mental illness makes communication more difficult, "[t]he employer has to meet the employee half-way, and if it appears that the employee needs an accommodation but doesn't know how to ask for it, the employer should do what it can to help."<sup>230</sup> The case, *Bultemeyer v. Fort Wayne Community Schools*, involved Robert Bultemeyer, a custodial employee for the school system for fifteen years, who had bipolar disorder, anxiety disorder, and paranoid schizophrenia. Following a medical leave, Bultemeyer was to be reassigned to one of the employer's largest schools, where he would not receive the accommodations he had received at his last school.<sup>231</sup> During a tour of the new school, the custodial supervisor told Bultemeyer that if he moved as slowly on the job as he did on the tour, he would not get his work done on time.<sup>232</sup> Bultemeyer then told his employer that he needed a less stressful placement, but the employer denied that request.<sup>233</sup> When Bultemeyer failed to take his required physical and report to work, the employer fired him.

The Seventh Circuit reversed summary judgment for the employer, stating that "an understanding of mental illness is central to understanding Bultemeyer's request for accommodation and his complaint."<sup>234</sup> The school system had contended that the new assignment was no more stressful than any other custodial position, and that if Bultemeyer was not able to perform that position, he was not an "otherwise qualified individual" under the Rehabilitation Act.<sup>235</sup> The court rejected this argument. Even if the new job was objectively no more stressful than Bultemeyer's prior assignment, stress is subjective,

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MENTAL DISORDER, WORK DISABILITY, AND THE LAW, *supra* note 18, at 203, 205. Bell notes that the ADA reflects the characteristics of the disability rights advocates who urged its passage — "by and large, highly educated and disciplined professionals with good self-esteem and assertiveness skills" — and most of whom had physical rather than mental disabilities. *Id.* at 204. He concludes that "[p]ersons with severely impaired interpersonal, cognitive, or communication skills will find the ADA to be of significantly less benefit." *Id.* at 205.

<sup>230</sup> *Bultemeyer v. Fort Wayne Cmty. Sch.*, 100 F.3d 1281, 1285 (7th Cir. 1996).

<sup>231</sup> *Id.* at 1282.

<sup>232</sup> *Id.*

<sup>233</sup> *Id.* at 1281-82.

<sup>234</sup> *Id.* at 1284.

<sup>235</sup> *Id.*

especially when a person has a mental disability.<sup>236</sup> The employer had a duty to engage in an interactive process with Bultemeyer and his psychiatrist to determine what Bultemeyer perceived as too stressful. If the school system had accommodated Bultemeyer by finding him another position or "by simply sitting down with him and talking about the situation, he may have been willing and able to take the physical and report for work."<sup>237</sup>

Suppose, instead, that Bultemeyer had started the new job, struggled with it for a few weeks, then told his employer, "I can't handle this stress. I'm afraid I'll explode." Perhaps he added, "I feel like I want to throw things." The employer's responsibility would be the same. Rather than conclude either that Bultemeyer was not qualified because he could not handle the stress, or that he presented a risk of harm because he might "explode" or throw things, the employer would have a duty to determine, in consultation with Bultemeyer and his psychiatrist, whether there were reasonable measures that would reduce the actual or perceived stress of the job. This could permit Bultemeyer to continue working without posing a threat to anyone. It also would reinforce to Bultemeyer that he should come forward with these difficulties and seek help in resolving them, rather than letting the tension mount until he does succumb to disruptive behavior.

Once the employer becomes aware of the limitations resulting from the disability and the potential need for an accommodation, research into the underlying causes and immediate triggers of violence involving persons with mental disabilities provides the basis for tailoring accommodations that can reduce the risk of workplace violence. Potentially effective programs include disability education and anti-harassment policies, modifying supervisory methods, excusing past

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<sup>236</sup> *Id.*

<sup>237</sup> *Id.* at 1285; see *Miller v. Ill. Dep't of Corr.*, 107 F.3d 483, 486 (7th Cir. 1997) (finding that if "the nature of the disability is such as to impair the employee's ability to communicate his or her needs, as will sometimes be the case with mental disabilities, the employer, provided of course that he is on notice that the employee *has* a disability, has to make a reasonable effort to understand what those needs are even if they are not clearly communicated to him"); Leslie Goddard, *Searching for Balance in the ADA: Recent Developments in the Legal and Practical Issues of Reasonable Accommodation*, 35 IDAHO L. REV. 227, 247-58 (1999) (discussing employer's responsibility to help identify effective accommodation); cf. *Seaman v. CPSH, Inc.*, 179 F.3d 297, 300 (5th Cir. 1999) (noting that plaintiff must "produce evidence that the employer knew not only of the employee's disability, but also of the physical or mental limitations resulting therefrom"); *id.* at 301 (stating that "in cases involving mental difficulties . . . in which the resulting limitations are not obvious to the employer, an employee cannot remain silent and expect his employer to bear the burden of identifying the need for and suggesting appropriate accommodation").

misconduct or deficiencies, and permitting departures from workplace rules.

## 2. Education and Anti-Harassment Policies

Persons with mental disorders are often the targets of teasing, harassment and even assaults.<sup>238</sup> For a person with a mental disorder, conduct that the perpetrators might dismiss as "roughhousing" or "horseplay" may be perceived as especially threatening, enough to provoke a physical defense.<sup>239</sup> Because aggressive, badgering and assaultive conduct does not advance any legitimate interest of the employer, and risks running afoul of federal anti-discrimination statutes and state tort laws, employers should prohibit and discourage such conduct. For example, the employer might include disability awareness or education programs to reduce misunderstandings and anti-harassment policies to prohibit and punish disability-based harassment. This type of accommodation would advance the employer's interest in avoiding workplace violence without incurring an undue hardship. Accordingly, these actions should be recognized as a reasonable accommodation required by the ADA.<sup>240</sup>

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<sup>238</sup> Link et al., *supra* note 78, at 290 (stating that "psychiatric inpatients and outpatients have high rates of being assaulted") (citation omitted); *see also* Ralph v. Lucent Techs., 135 F.3d 166, 168-69 (1st Cir. 1998) (describing how employee with bipolar disorder and post-traumatic stress disorder suffered "breakdown" after years of sexual harassment by coworkers and was subject to further abuse upon his return to work); McClain v. Southwest Steel Co., 940 F. Supp. 295, 300 (N.D. Okla. 1996) (describing how plaintiff's coworkers called him "crazy" and "lunatic," questioned him about his Prozac use and hospitalization, and how his supervisor asked "what the f\*\*\* was wrong" with him).

<sup>239</sup> Cases under Title VII provide examples of egregious workplace conduct. In *McWilliams v. Fairfax County Bd. of Supervisors*, 72 F.3d 1191 (4th Cir. 1996), a group of mechanics known as the "lube boys" not only taunted, but repeatedly assaulted a coworker, by fondling him, by holding a broomstick to his anus while one coworker exposed himself, *id.* at 1193, and by blindfolding him, tying his hands together and pushing him to his knees, *id.* at 1198 (Michael, J., dissenting). The plaintiff, who had a learning disability that impaired his cognitive and emotional development, voluntarily dismissed a claim of disability harassment under the ADA, electing to pursue only a sexual harassment claim. *Id.* at 1193-94. The Fourth Circuit affirmed summary judgment for the employer, on the ground that the harassment might have been because of McWilliams' "shyness, or other form of vulnerability" or the perpetrators' "vulgarity and insensitivity and meanness of spirit," but that it was not because of McWilliams' sex. *Id.* In the absence of other obstacles, he might have fared better with his disability claim. For another case of egregious coworker misconduct, *see Quick v. Donaldson Co.*, 90 F.3d 1372 (8th Cir. 1996), a Title VII case where the plaintiff alleged that coworkers repeatedly "bagged" him (grabbed and squeezed his testicles).

<sup>240</sup> Although this article focuses on major mental disorders other than substance abuse disorders, alcohol and drug abuse and dependence are associated with violence in the

In fact, an employer's duty to avoid harassment may be directly analogous to its duty to avoid a hostile work environment based on race or gender.<sup>241</sup> In that case, the duty exists apart from whether an employee has requested less abusive treatment as a reasonable accommodation. This duty may also arise from Title V of the ADA, which provides, in part:

It shall be unlawful to coerce, intimidate, threaten, or interfere with any individual in the exercise or enjoyment of, or on account of his or her having exercised or enjoyed, or on account of his or her having aided or encouraged any other individual in the exercise or enjoyment of, any right granted or protected by this chapter.<sup>242</sup>

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community. See Swanson et al., *supra* note 33, at 769. In addition, alcohol may play a significant role in exacerbating the risk of violence on the job. See Barling, *supra* note 89, at 33-34 (hypothesizing that alcohol use was one of four factors that predict workplace violence, and noting that, in one study, binge drinking was associated with "psychological aggression against coworkers and subordinates") (citing L. Greenberg & Julian Barling, *Predicting Employee Aggression: Roles of Person Behaviors and Workplace Factors* (1995) (unpublished manuscript, on file with author)); Bennett & Lehman, *supra* note 181, at 106 (noting that when alcohol is added to employee frustrations, potential for aggression increases); Fletcher, Brakel & Cavanaugh, *supra* note 89, at 342 (stating that factors increasing potential for workplace violence include "alcohol or drug misuse and the availability of guns"); Nicoletti & Spooner, *supra* note 202, at 273, 280 (identifying substance abuse as one of several "validated risk factors for general violence"). Employers, therefore, may want to carry out policies to help employees recovering from substance abuse stay clean and sober and to prohibit all employees from using or being under the influence of illegal drugs or alcohol at work.

<sup>241</sup> Burlington Indus., Inc. v. Ellerth, 524 U.S. 742, 751-66 (1998) (discussing employer liability for harassment under Title VII); Faragher v. City of Boca Raton, 524 U.S. 775, 793-801 (1998) (same). See generally Glenn George, *Employer Liability for Sexual Harassment: The Buck Stops Where?*, 34 WAKE FOREST L. REV. 1 (1999) (discussing employer liability under Title VII). For a discussion of disability harassment, see Frank S. Ravitch, *Beyond Reasonable Accommodation: The Availability and Structure of a Cause of Action for Workplace Harassment Under the Americans with Disabilities Act*, 15 CARDOZO L. REV. 1475, 1485-88 (1994) and David C. Yamada, *The Phenomenon of "Workplace Bullying" and the Need for Status-Blind Hostile Work Environment Protection*, 88 GEO. L.J. 475, 515 (2000). See also Hendler v. Intelcom USA, 963 F. Supp. 200, 202-03 (E.D.N.Y. 1997) (finding that coworkers' comments, if severe and pervasive, about plaintiff's asthma and aversion to second-hand smoke could form basis of hostile work environment claim); Haysman v. Food Lion, Inc., 893 F. Supp. 1092, 1108 (S.D. Ga. 1995) (finding sufficient evidence to allow jury to find that plaintiff with disability "was subjected to negative stereotyping, threats, verbal abuse and other conduct which created an intimidating and hostile environment"); Davis v. York, Int'l, 2 A.D. Cases (BNA) 1816 (D. Md. 1993) (finding sufficient evidence to permit jury to find hostile work environment where manager mimicked speech and gait of employee with multiple sclerosis, perpetuated myths about her disease, and fostered atmosphere of resentment and pity among her coworkers).

<sup>242</sup> 42 U.S.C. § 12203(b) (1994).

Professor Bonnie Tucker has suggested that this provision "should be interpreted as requiring an employer to provide harassment free environments for employees with disabilities," which would include "responsibility for prohibiting employees without disabilities on its work force from harassing employees with disabilities."<sup>243</sup>

To the extent that coworkers' fears and misunderstanding contribute to violent incidents involving persons with mental disorders, workplace education and training may alleviate those triggers.<sup>244</sup> Link has hypothesized that "psychotic symptoms [that] are incomprehensible to others and produce annoyance or fear . . . lead to attempts to coerce or control the psychotic person," prompting anger and "leading to a spiral that turns into violence."<sup>245</sup> When supervisors and coworkers have more information about mental disorders, they are likely to become less fearful of employees with those disorders and less likely to misinterpret or overreact to their behavior.<sup>246</sup> Take the example of the computer programmer "who suffered hallucinations that could be distracting, [and who] found that audibly responding to the voices allowed him to continue successfully with his work."<sup>247</sup> "No doubt, the young man's talking to himself appeared unusual to his coworkers, but his work did

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<sup>243</sup> Bonnie P. Tucker, *The Americans with Disabilities Act of 1990: An Overview*, 22 N.M. L. REV. 13, 42 (1992); see *id.* at n.171 (noting that Christopher Bell, former EEOC Associate Legal Council for ADA Services, interpreted this provision in same manner).

<sup>244</sup> AIDS education programs might provide a model. See *Employee Education on AIDS Called Key to Preventing Workplace Conflicts*, 242 Daily Lab. Rep. (BNA) A-9 (Dec. 18, 1987).

<sup>245</sup> Link et al., *supra* note 78, at 290; Hiday, *supra* note 131, at 400-01 (noting that persons with mental disorders are often targets of bullying or teasing, which in turn might spark anger and confrontation, prompting them to respond defensively – and perhaps out of proportion – to that mistreatment).

<sup>246</sup> Bell, *supra* note 229, at 17 ("[T]o allay employee fears regarding persons with mental illness or other disabilities, an employer may wish to provide education to employees on the ADA and on the needs of persons with particular types of disabilities"); Laura Lee Hall, *Making the ADA Work for People with Psychiatric Disabilities*, in MENTAL DISORDER, WORK DISABILITY, AND THE LAW, *supra* note 18, at 267 ("The education of supervisors and coworkers [i]s a commonly cited accommodation. People often do not understand psychiatric disabilities, fear them, may feel uncomfortable around people with such a disability, or may simply not know how to act. At least two studies have shown that in-service education in higher educational settings decreases fear of disruption by people with mental disorders.") (citing Judith A. Cook et al., *Field-Testing a Postsecondary Faculty In-Service Training for Working with Students Who Have Psychiatric Disabilities*, 17 PSYCHOSOC. REHABILITATION J. 157, 166 (1993); Jessica Wolf & Stephen DiPietro, *From Patient to Student: Supported Education Programs in Southwest Connecticut*, 15 PSYCHOSOC. REHABILITATION J. 61, 64-67 (1992)).

<sup>247</sup> Hall, *supra* note 246, at 255-56 (citing Christopher Bell, Remarks at the Workshop on American with Disabilities Act, Mental Illness, and Employment, sponsored by the Office of Technology Assessment, U.S. Congress (Apr. 21, 1993)).

not suffer."<sup>248</sup> In such circumstances, the employer's example of acceptance and understanding may be necessary to the coworkers' acceptance of this behavior as unusual, but not menacing.

Contrast that uplifting anecdote with the discouraging experience of John Duda, a night custodian at a junior high school for eight years, who controlled his bipolar disorder with medication, and who was a recovering alcoholic.<sup>249</sup> One of his coping skills was to write in his diary during breaks when he was depressed or angry.<sup>250</sup> One night his coworkers seized the diary, saw that it contained threatening language, and copied pages of it for the principal, other administrators and coworkers.<sup>251</sup> In response, school officials told Duda he could not return to school premises without a "clean bill of health." Even after Duda provided the evaluations of three psychiatrists stating that he was stable, presented no danger to anyone, and could return to work, his employer permitted him to return only subject to certain restrictions. He was sent to another school, where he would work alone; he was required to notify the superintendent of any changes in his medication or counseling; and he was not allowed to discuss his diary or have any other conversations with school employees.<sup>252</sup> Furthermore, because of the incident involving his diary, he was not allowed to apply for a promotion to an open bus driver/custodian position.<sup>253</sup>

From the facts presented, it is hard to imagine a justification for segregating Duda.<sup>254</sup> There is no indication that he ever, in his eight years with the school system, threatened or committed violence in the

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<sup>248</sup> *Id.*

<sup>249</sup> *Duda v. Bd. of Educ.*, 133 F.3d 1054, 1055 (7th Cir. 1998).

<sup>250</sup> *Id.*

<sup>251</sup> *Id.* The district court granted the defendants' motion to dismiss for failure to state a claim, and the complaint did not disclose the content of the diary. However, the district court's memorandum opinion noted that the defense counsel had revealed that the diary contained some form of "death threat" against Duda's supervisor. *Id.* at 1055 n.1.

<sup>252</sup> *Id.* at 1055, 1056.

<sup>253</sup> *Id.*

<sup>254</sup> Indeed, the Seventh Circuit reversed the district court's motion dismissing Duda's claims, readily concluding that two of Duda's allegations — that he had been reassigned because of his bipolar disorder, *id.* at 1059-60 (citing 42 U.S.C. § 12112(b)(1) (1994); 29 C.F.R. app. § 1630.2(o) (2000)), and that he had been denied the opportunity for a promotion, *id.* at 1060 (citing 42 U.S.C. § 12112(a), (b)(5)(B)) — survived the motion to dismiss. As for the requirement that he notify the superintendent of schools of any changes in his course of treatment, the court concluded that such a requirement gave rise to a valid claim. *Id.* at 1060 (citing 42 U.S.C. § 12112(d)(4)(A)). However, the court recognized that there are circumstances in which prudent employers, concerned about workplace safety, would be justified in requiring information of this type. *Id.* (citing *Yin v. California*, 95 F.3d 864, 867-68 (9th Cir. 1996)).

workplace. He was in treatment and appeared to have his bipolar disorder under control. Although we do not know the exact nature of the allegedly threatening diary entry, we know he wrote to relieve anxiety and depression.<sup>255</sup> Thus, writing death fantasies about his boss may have been a desirable alternative to releasing his frustration or aggression in other ways.<sup>256</sup> In any event, even after all three psychiatrists who evaluated Duda cleared him to return to work, school officials continued to treat him as if he posed a threat. One of the most troubling aspects of this case is the school system's apparent failure to discipline Duda's coworkers for seizing his diary.<sup>257</sup> By endorsing the transgressors' efforts and transferring Duda elsewhere, the employer squandered the opportunity to articulate and enforce workplace norms that all persons, including those with mental disabilities, are to be treated with dignity and respect. Such workplace standards could prevent explosive and potentially violent confrontations between persons with mental disabilities and their coworkers.

### 3. Modifying Supervisory Methods

Potentially volatile conflicts involving persons with mental disabilities arise with supervisors as well as coworkers.<sup>258</sup> When experiencing difficulties with a supervisor, the person with a disability may ask, as a reasonable accommodation, for a new supervisor or a new style of supervision. Employers usually deny such requests,<sup>259</sup> sometimes

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<sup>255</sup> *Id.* at 1055.

<sup>256</sup> Two images come to mind here. One is Eliza Doolittle's hymn of revenge, "Just You Wait, Henry Higgins," in which she fantasizes about leaving her tutor to drown. *See MY FAIR LADY* (Warner Bros. Pictures 1964). The other is the African-American constable who hyperbolically wished for the death of a Republican president. *See Rankin v. McPherson*, 483 U.S. 378, 392 (1987) (holding that statement was protected by First Amendment). It may well be that Duda's comparable hyperbole sparked an overreaction by school officials.

<sup>257</sup> In his complaint, Duda attempted to bring a constitutional claim against supervisory school officials for "condon[ing], acquiesc[ing] and participat[ing] in" the violation of his Fourth Amendment rights by failing to investigate the circumstances surrounding the theft of his diary pages or to discipline the employees responsible for it. *Duda*, 133 F.3d at 1061.

<sup>258</sup> Indeed, Professor Stefan's analysis of hundreds of cases alleging discrimination based on mental disabilities has led her to conclude that "[m]ost often, . . . an excellent employee began to experience problems after the arrival of a new supervisor." Stefan, *supra* note 14, at 797.

<sup>259</sup> *E.g.*, Edwards, *supra* note 106, at 366 (noting that employers "may be less likely to enthusiastically embrace this [accommodation] duty for an individual with a mental disability than they would for an individual with a physical disability" because "[a]ttitudes toward individuals with mental disabilities are less sympathetic and more driven by fear of violence or disruption in the work environment"); Laden & Schwartz, *supra* note 5, at 268 ("[A]ccommodations likely to enable individuals with psychiatric disabilities to [perform

reflecting a "toughen up" mentality.<sup>260</sup> One industrial psychologist who performs psychiatric fitness for duty examinations has questioned why these examinations "seldom inquire[] if the worker is fit but the workplace is not."<sup>261</sup>

One may agree with courts that conclude that the ADA does not require the employer to shuffle employees around until each finds his perfect match in a supervisor.<sup>262</sup> That, however, is a far cry from

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essential functions of the job] are routinely deemed per se unreasonable by reviewing courts."); Laura F. Rothstein, *The Employer's Duty to Accommodate Performance and Conduct Deficiencies of Individuals with Mental Impairments Under Disability Discrimination Laws*, 47 SYRACUSE L. REV. 931, 957 (1997) ("Ordinarily, most courts have not required changing supervisors as an accommodation."); Stefan, *supra* note 14, at 800 (noting that "few ADA cases involve employers who were willing to admonish abusive supervisors or insist on a workplace environment of civility"); Karen Dill Danforth, Note, *Reading Reasonableness Out of the ADA: Responding to Threats by Employees with Mental Illness Following Palmer*, 85 VA. L. REV. 661, 677 (1999) (stating that accommodations "routinely allowed in cases of physical illness, may be deemed to be unreasonable when requested by an employee with a psychiatric disability").

<sup>260</sup> See Regina Austin, *Employer Abuse, Worker Resistance, and the Tort of Intentional Infliction of Emotional Distress*, 41 STAN. L. REV. 1, 2 (1988) (asserting that workers are "expected to respond to psychologically painful supervision with passivity, not insubordination and resistance" and to "develop stamina and resilience"); Miller, *supra* note 25, at 736 (noting how employers and courts are likely to view non-physical accommodations, such as flexible scheduling, time off for therapy, increased supervision, and positive feedback, as request to be coddled); Stefan, *supra* note 14, at 803 (stating that "unpleasant personality conflicts, and even worker abuse are . . . commonly seen as simply intrinsic features of the workplace").

<sup>261</sup> Carroll M. Brodsky, *Psychiatric Aspects of Fitness for Duty*, 11 J. OCCUPATIONAL MED. 719, 723 (1996); see S. Anthony Baron, *Organizational Factors in Workplace Violence: Developing Effective Programs to Reduce Workplace Violence*, 11 J. OCCUPATIONAL MED. 335, 341 (1996) (explaining how employer-employee considerations "are like a bow drawn across a tightly-strung violin. Excessive, constant, irritating contact leads to increased tension . . . and an ultimate snap."); *id.* at 341-42 (identifying characteristics of high-risk environment); Brodsky, *supra*, at 723 (describing "chaotic work environment - one of arbitrary supervision, irresponsible work demands, rapidly changing supervisors and assignments, good performance evaluations by one supervisor and 'improvement needed' ratings from the next").

<sup>262</sup> See *Wernick v. Fed. Reserve Bank*, 91 F.3d 379, 384 (2d Cir. 1996) (finding no indication in ADA or Rehabilitation Act that "Congress intended to interfere with personnel decisions within an organization's hierarchy"); *Lewis v. Zilog, Inc.*, 908 F. Supp. 931, 948 (N.D. Ga. 1995) ("Forcing transfers of employees under the guise of reasonably accommodating employees under the ADA inherently would undermine an employer's ability to control its own labor force."); *Mazzarella v. United States Postal Serv.*, 849 F. Supp. 89, 95 (D. Mass. 1994) (concluding that it was "not reasonable . . . to expect the USPS to juggle personnel so as to entirely remove the possibility that a supervisor may offend a particular employee"); *Laden & Schwartz, supra* note 5, at 268 (stating that courts often find accommodations, such as transferring employee away from stressful coworkers or abusive supervisor, unreasonable as matter of law); see also EEOC, ENFORCEMENT GUIDANCE: REASONABLE ACCOMMODATION AND UNDUE HARDSHIP UNDER THE AMERICANS WITH DISABILITIES ACT ¶ 32 (1999) (stating that reasonable accommodation may require new

concluding that the ADA permits an inflexible stance on accommodations involving supervision. Persons with mental disorders may experience problems communicating or getting along with others. In the workplace, their conditions may make it more difficult to understand and follow instructions or to handle harsh criticism. If an employee can perform all the essential functions of the job, provided she receives clear, detailed instructions and constructive feedback, requiring this improved communication often will impose little burden on the employer. Accommodations for sensory impairments offer an apt analogy. Just as employers may need to modify the way they communicate with employees with impaired sight or vision, so too may they need to adapt the way they communicate with employees with impaired cognition or an emotional disorder. In a broader sense, just as stairs make jobs inaccessible to many people with mobility impairments, supervisors' attitudes or conduct may make jobs inaccessible to many people with mental disabilities.<sup>263</sup>

*Kent v. Derwinski*<sup>264</sup> illustrates that interpersonal accommodations for persons with mental disabilities can be effective, easily achieved, and hence obligatory under the ADA. Dianne Kent, diagnosed as mentally retarded, clinically depressed and schizophrenic (non-delusional), worked in a Veterans Administration hospital laundry under a rehabilitation program employing persons with disabilities.<sup>265</sup> Her emotional impairments created difficulties with interpersonal

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supervisory methods, but does not require new supervisor).

A problem arises, however, when an employer, who routinely grants employees' requests for transfers, reassignments, or other modifications for reasons other than disabilities, denies the same requests when sought as an accommodation for a mental disability. See Stefan, *supra* note 14, at 800-01 (finding that review of ADA cases revealed employers' tendency to deny requested accommodations for persons with psychiatric disabilities, even though requested accommodations were common practice routinely adopted in other circumstances). This could occur, for example, if an employer attributes any conflict between an employee with a disability and their supervisor to the employee's disability, rather than asking, as the employer normally would, whether each might work more effectively with someone else.

<sup>263</sup> See Miller, *supra* note 25, at 737 (commenting on employers' unwillingness to alleviate avoidable interpersonal stressors as reasonable accommodation for persons with mental disabilities: "It would be surprising if the court took the same attitude toward . . . a physically disabled person's request that the employer alleviate the 'stress' of not being able to reach the shelves in her office, or a hearing-impaired employee's complaint about the 'stress' of not being able to use a phone that was not TDD-equipped.").

<sup>264</sup> 790 F. Supp. 1032 (E.D. Wash. 1991).

<sup>265</sup> *Id.* at 1035. While the federal employer in this case may have had a greater duty toward this plaintiff than a private employer would have toward its employees, the accommodations it provided here would be effective and not unduly burdensome in many private settings.

relationships, performance anxiety at work, and sensitivity to criticism. To succeed at work, she needed a structured work environment with specific directions.<sup>266</sup> Her first supervisor, Joe Smith, was a retired military sergeant who taught her the job by quietly explaining her mistakes to her. He also reprimanded coworkers who taunted her as "brain dead" or a "droolie."<sup>267</sup> At the time Smith left the hospital, he found Kent's work "fully satisfactory." He explained to his successor, Susan Randall, that Kent was disabled and that Randall should "talk to [her] to correct her, but not yell at her."<sup>268</sup> Randall soon complained about Kent's appearance and her lack of communication and tried to hold her to the productivity standards of a higher position.<sup>269</sup> For more than a year, Randall stood by when other workers taunted Kent.<sup>270</sup> When Kent's productivity suffered, Randall would ask her "Can't you work any faster than that?"<sup>271</sup> When Kent had disagreements with coworkers, Randall focused on Kent's role, taking her aside and lecturing her for up to two hours. Randall's other supervisory methods included "ordering [Kent] to stand against the wall and not work, grabbing [her] arm in the restroom and ordering her to keep silent about the conditions in the laundry; and criticizing [her] for her behavior, which was due to her [disability]."<sup>272</sup> Kent was hospitalized twice during Randall's tenure. She ultimately resigned, and filed a claim of discrimination under the Rehabilitation Act.<sup>273</sup>

The district court found that Kent was "otherwise qualified" for her job and that, under Smith's supervisory methods, she would have been able to continue as a productive employee.<sup>274</sup> The court found that the accommodations initiated by Smith, a "soft approach" to discipline and supervision and a suppression of Kent's coworkers' taunting, "are consistent with good management techniques and are not an undue hardship on the defendants, as evidenced by their use by Mr. Smith."<sup>275</sup>

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<sup>266</sup> *Id.* See generally Klassen & O'Connor, *supra* note 71, at 238 (stating that structure, which is "the degree to which a setting exerts control over its occupants, . . . appears to be a useful construct for addressing situational factors and risk of violence").

<sup>267</sup> *Kent*, 790 F. Supp. at 1036.

<sup>268</sup> *Id.*

<sup>269</sup> *Id.* Kent was performing at 132% of the work standard for her position. *Id.*

<sup>270</sup> *Id.* at 1037.

<sup>271</sup> *Id.*

<sup>272</sup> *Id.* Despite Randall's criticism of Kent, she rated Kent's performance "fully satisfactory." *Id.* at 1038.

<sup>273</sup> *Id.*

<sup>274</sup> *Id.* at 1040.

<sup>275</sup> *Id.* The court also concluded that Kent was constructively discharged. *Id.* at 1041

Here, a supportive supervisor reduced the employee's anxiety and enabled her to do her job. It takes little imagination to see that the same flexible approach to supervision might help other employees with mental disabilities stay focused and refrain from disruptive or violent conduct.<sup>276</sup>

#### 4. Excusing Past Misconduct or Deficiencies

Complicating the issue of reasonable accommodations for mental disabilities is the fact that those requests frequently come only *after* the occurrence of some workplace conflict or employee misconduct. Does the ADA's duty of reasonable accommodation require an employer to overlook or excuse an employee's *past* violation of workplace standards? The issue of excusing or accommodating past misconduct is particularly important for persons with mental disabilities, which often manifest themselves through behavior, sometimes even before the person realizes that he has a mental disorder. Consider a stock scenario. A person with an undiagnosed mental disorder threatens but does not physically harm his supervisor. Alarmed by his own behavior, the employee consults a psychiatrist, who diagnoses bipolar disorder and prescribes medication that stabilizes the disorder and helps prevent future outbursts. At this point, the employee no longer poses (if he ever did pose) any significant risk of violence. The employer concedes that the employee does not satisfy the direct threat standard, but fires him based on his past misconduct of threatening the supervisor. The employee in turn sues under the ADA, alleging that the duty of reasonable accommodation requires that the employer give him a second chance.

There is a consensus that in most, if not all, situations the employer may discipline an employee with a disability for past workplace misconduct, even if that misconduct was the product of the disability.<sup>277</sup>

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(finding that "a reasonable person, looking at the totality of the circumstances, would have found Ms. Kent's work situation intolerable and discriminatory because of her handicap and would have felt forced to quit").

<sup>276</sup> Hostile or abusive supervisors, or other stressful working conditions, may trigger not only violent incidents, but also the occurrence or aggravation of a mental disorder. Stefan, *supra* note 14, at 800 (finding that "in the vast majority of cases the disability appeared to be triggered or greatly exacerbated by aspects of the workplace environment that could have easily been remedied, but were not").

<sup>277</sup> This view is expressed by the EEOC, EEOC ENFORCEMENT GUIDANCE, *supra* note 22, at 29, and by a majority of federal courts that have addressed the question. *E.g.*, Jones v. Am. Postal Workers Union, 192 F.3d 417, 429 (4th Cir. 1999) (explaining "the law is well settled that the ADA is not violated when an employer discharges an individual based upon the employee's misconduct, even if the misconduct is related to a disability");

Most cases applying this rule have involved conduct outside commonly accepted norms of workplace behavior, because it was insubordinate, divisive, disruptive, or threatening. In such cases, courts generally permit an employer to deem the employee not "qualified," thus obviating the need for the employer to prove that the employee presents a direct

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Hamilton v. Southwestern Bell Tel. Co., 136 F.3d 1047, 1052 (5th Cir. 1998) (finding that "[the ADA] does not insulate emotional or violent outbursts blamed on an impairment"); Maddox v. Univ. of Tenn., 62 F.3d 843, 848 (6th Cir. 1995) (holding that "[the] employer must be permitted to take appropriate action with respect to an employee who has engaged in criminal or egregious conduct, regardless of whether the employee is disabled"); cf. Den Hartog v. Wasatch Acad., 129 F.3d 1076, 1088 (10th Cir. 1997) ("[T]he language of the ADA, its statutory structure, and the pertinent case law, suggest that an employer should normally consider whether a mentally disabled employee's purported misconduct could be remedied through a reasonable accommodation."). While most courts reason that the discipline was because of the misconduct, and not because of the disability, the Second Circuit concludes that, if the disability produced the misconduct, the discipline was because of the disability, but if the misconduct meant that the employee was not "qualified," the employer's action is not discriminatory. See Teahan v. Metro-N. Commuter R.R. Co., 951 F.2d 511, 516 (2d Cir. 1991).

The ADA specifically addresses misconduct or performance problems related to alcohol or illegal drugs. See 42 U.S.C. § 12114(c)(4) (1994) (providing that employer "may hold an employee who engages in the illegal use of drugs or who is an alcoholic to the same qualification standards for . . . job performance and behavior that such [employer] holds other employees, even if any unsatisfactory performance or behavior is related to the drug use or alcoholism of such employee"). There is no equivalent statement about misconduct related to other disabilities, which has led to the suggestion that "because Congress did not specify that individuals with mental illness be held to the same standards of conduct as their non-disabled counterparts, they did not intend this to be the case." Danforth, *supra* note 259, at 681-82; see Nielsen v. Moroni Feed Co., 162 F.3d 604, 609 (10th Cir. 1998) ("[T]he status-conduct dichotomy exists only in the context of alcoholism and illegal drug use. Outside of those contexts . . . the ADA protects both the disability and the conduct."); Edwards, *supra* note 106, at 371 (considering possibility that "an individual with a mental disability other than alcoholism is entitled to a modification of qualification standards for employment or of job performance or behaviors when the unsatisfactory performance or behavior is related to the mental disability").

There is an attractive argument that the employer's duty of reasonable accommodation may encompass the duty, in limited circumstances, to excuse minor misconduct that is tied to a mental disorder, especially where the employee has since obtained treatment that reduces the likelihood that the misconduct will occur. Laura Rothstein has thoughtfully identified the circumstances in which such a "second chance" might be appropriate. She suggests that deficiencies could be excused without creating a direct threat or imposing an undue burden where (1) the conduct was isolated, caused no actual harm, and is not likely to recur, and (2) the job does not involve "public safety, health care, role modeling, fiduciary or similar trust, [or] supervisor and consistency issues." Rothstein, *supra* note 259, at 967. As an example, Rothstein offers *Landefeld v. Marion Gen. Hosp., Inc.*, 994 F.2d 1178 (6th Cir. 1993), in which a physician with undiagnosed bipolar disorder took mail from his colleagues' mailboxes. There was no evidence of any actual harm (say, from taking patient records), and once he was diagnosed and under treatment, there was little risk that this misconduct would recur.

threat.<sup>278</sup> But the employer may discipline the employee with a disability *only* "if it would impose the same discipline on an employee without a disability."<sup>279</sup>

Thus, in our hypothetical, most courts would permit the employer to fire the employee, *provided* that threatening a supervisor is, in itself, a firing offense, without regard to whether it signals any future risk. This is because the discipline was based on *past misconduct*, not *future dangerousness*. This rule is fair in theory, but vulnerable in practice. One danger is that the employer may interpret the conduct in light of popular stereotypes of the dangerous mentally ill, freighting it with more "dangerousness" than even the most cautious objective observer would attribute to it. Unfounded fears of or aversion to persons with mental disorders could lead the employer to magnify the seriousness of the misconduct and conclude that seemingly minor misconduct warrants severe sanctions. Suppose, for instance, that the employer's policy is to fire only for a "serious" or "credible" threat and to impose a week's suspension for an empty threat. If an employee with no known mental disorder says, "leave me alone, or I'll throw you out the window," this is likely to be treated as insubordinate, but not directly threatening. What if an employee known to have bipolar disorder makes the same statement? When the employer knows that the employee has a disorder that may contribute to a risk of violence, the employer certainly should not shrug off signs of aggression or credible threats of violence. The

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<sup>278</sup> E.g., *Boldini v. Postmaster Gen.*, 928 F. Supp. 125, 131 (D.N.H. 1995) (upholding discipline of employee with severe anxiety who could not "accept and follow instructions and refrain from contentious arguments and insubordinate conduct with supervisors, co-employees or customers"); *Carrozza v. Howard County*, 847 F. Supp. 365, 367-68 (D. Md. 1994) (granting summary judgment for employer where employee with bipolar disorder was "loud, abusive and insubordinate").

<sup>279</sup> EEOC ENFORCEMENT GUIDANCE, *supra* note 22, at 29. More specifically, "nothing in the ADA prevents an employer from maintaining a workplace free of violence or threats of violence," but it can discipline an employee with a disability only "if it would impose the same discipline on an employee without a disability." *Id.*; see also Equal Employment Opportunity for Individuals with Disabilities, 56 Fed. Reg. 35,726, 35,733 (July 26, 1991) (to be codified at 29 C.F.R. pt. 1630) (referring to revisions in regulation to "clarify that employers may hold all employees, disabled (including those disabled by alcoholism or drug addiction) and nondisabled, to the same performance and conduct standards"); EEOC COMPLIANCE MANUAL § 902.2, n.11, Definition of the Term "Disability," 9 FEP MANUAL (BNA) 405:7529, n.11 (1995) (stating that employer "does not have to excuse . . . misconduct, even if the misconduct results from an impairment that rises to the level of a disability, if it does not excuse similar misconduct from its other employees"); *id.* at 24 n.72 ("If the employee requests reasonable accommodation in order to address the misconduct, the employer must grant the request, subject to undue hardship."); Miller, *supra* note 25, at 728 & n.169 (asserting that, if employers discipline employees with disabilities for off-duty conduct, they should do same for employees without disabilities).

problem, as we have seen, is that exaggerated fears or stereotypes about the "violent mentally ill" might preclude an objective assessment of the seriousness of the threat.

Professor Linda Hamilton Krieger offers a thoughtful explanation of how this distortion of perceptions frequently occurs.<sup>280</sup> Because we tend to interpret a person's words or conduct in light of our own stereotypic expectations,<sup>281</sup> the employer who believes the stereotype of the "violent mentally ill" may reflexively, but inaccurately, deem this statement a "serious" threat. Moreover, when behavior is undesirable or conforms to a stereotype, we are more likely to attribute it to a stable personality trait, rather than to the situation, and to predict that it will recur.<sup>282</sup> Thus, for the employee with bipolar disorder, the employer may think not that the employee *got* angry, but that he *is* angry, and that he will continue to be angry and insubordinate – or violent.<sup>283</sup>

The analysis may be further muddied when two considerations, "disruptive" and "potentially dangerous" are lumped together. The employer may fail to conduct a careful and independent analysis of either the disruption (is it a firing offense?) or the danger (is there a significant risk of substantial harm?). Or the employer may make the leap from the first point to the second, concluding that the employee with a mental disorder who engages in disruptive conduct is *therefore* potentially dangerous. Consider *Palmer v. Circuit Court of Cook County*.<sup>284</sup> Marquita Palmer did not get along with a coworker or with her supervisor, who twice had suspended her for rude, inappropriate and insubordinate comments in the workplace. While on medical leave for treatment for her paranoid delusions, Palmer telephoned her nemeses, calling them "bitches," and phoned a friend and former co-worker to say that she was "so sick" of her supervisor that she "could just kill her."<sup>285</sup>

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<sup>280</sup> See Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 STAN. L. REV. 1161, 1202-07 (1995).

<sup>281</sup> *Id.* at 1202-04 (citing H. Andrew Sagar & Janet Ward Schofield, *Racial and Behavioral Cues in Black and White Children's Perceptions of Ambiguously Aggressive Acts*, 39 J. PERSONALITY & SOC. PSYCHOL. 590, 596-97 (1980)). For example, behavior that is seen as "restrained" or "prudent" by a white male might be viewed as "passive" in a woman or an Asian American. *Id.* at 1203.

<sup>282</sup> *Id.* at 1204-05.

<sup>283</sup> Studies show that we tend to punish stereotype-consistent behavior more severely than the same behavior that does not activate a stereotype. *Id.* at 1205-06 (citations omitted).

<sup>284</sup> 905 F. Supp. 499 (N.D. Ill. 1995), *aff'd*, 117 F.3d 351 (7th Cir. 1998), *cert. denied*, 522 U.S. 1096 (1998). For a detailed analysis of this case, see Danforth, *supra* note 259.

<sup>285</sup> *Palmer*, 905 F. Supp. at 502.

Not surprisingly, Palmer's employer fired her following this incident. Again not surprisingly, the district court granted summary judgment for Palmer's employer on her Rehabilitation Act charge.

The court first found Palmer not qualified because her "disruptive and abusive behavior" showed her unable to deal civilly with coworkers.<sup>286</sup> That is unobjectionable, unless evidence showed that non-disabled employees were not disqualified and fired for similar conduct. The problem, however, is that the court went on to assume that Palmer's "inability to control her behavior, even if she 'had no intention to do harm to anyone,' made [her] a 'direct threat to the health and safety' of the other workers."<sup>287</sup> There was no evidence that, in all her altercations, Palmer had laid a hand on anyone (although she claimed to have been assaulted).<sup>288</sup> Nor did the employer inquire of Palmer's therapist or any other professional whether Palmer was likely to resort to violence. In fact, the phone calls that led to Palmer's firing were her angry response to the employer's refusal to meet with Palmer and her therapist to discuss ways to resolve workplace conflict and ease Palmer's discomfort about returning to work.<sup>289</sup>

There is a danger in inviting an employer to conclude, without examination, that because an employee is verbally threatening or abusive and mentally ill, she therefore must be dangerous. Yet when the Seventh Circuit affirmed the district court's grant of summary judgment for Palmer's employer, it used regrettably sweeping language. The court stated that the ADA protects only "qualified" individuals with disabilities and that "threatening other employees disqualifies one." The court added that it could not believe that the duty of reasonable accommodation "runs in favor of employees who commit or threaten violent acts."<sup>290</sup> This broad statement could be read to displace the direct threat analysis altogether by permitting an employer to fire *any* employee with a mental disability who makes *any* threat against a coworker or supervisor. This would allow the employer to bypass the crucial inquiries into whether the threatening statement was serious, whether the harm threatened was serious, whether the risk of acting on the threat was significant, whether all threats by all employees meet with the same punishment, or whether the employer either could have made

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<sup>286</sup> *Id.* at 509.

<sup>287</sup> *Id.* at 510 (citing Palmer's affidavit).

<sup>288</sup> *Id.* at 501 (noting that Palmer alleged that her threat to "throw [her coworker] out the window" was in response to coworker's striking and pushing her).

<sup>289</sup> *Id.* at 502.

<sup>290</sup> *Palmer*, 117 F.3d at 352 (citations omitted).

or could make reasonable accommodations to reduce or eliminate any risk of harm.<sup>291</sup>

Moreover, in evaluating the alleged past misconduct of an employee with a mental disability, there is the risk that coworkers' or supervisors' allegations that the person is uncooperative or "frightening" may reflect nothing more than the coworkers' or supervisors' discomfort about being around a person with a mental disability. By way of analogy, imagine a tight-knit group of white male employees complaining that a recently hired female or minority employee was "not a team player," or didn't get along with others. To assume automatically that the problem resides entirely in the new hire could disregard the existing employees' potentially discriminatory motives or actions and send them the message that they do not have to tolerate anyone who is different. There is no reason in logic or life to suppose the same difficulties do not arise when the employee's difference is based on a mental disability, a difference that frequently invokes scorn or fear.<sup>292</sup> Nonetheless, research has shown a tendency to blame a person with a mental disability for any altercation that he is involved in, without carefully considering the circumstances or the culpability of the other party.<sup>293</sup>

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<sup>291</sup> At least one commentator has given the *Palmer* decision this reasonable (and perhaps inescapable) reading and has condemned it as a broad violation of the ADA's requirement of reasonable accommodation. Danforth, *supra* note 259, at 686-95. The *Palmer* court's statement would be more defensible if references to employees' threats of violence were limited to "direct threats," that is, menacing comments that, in light of the individual circumstances and the employee's conduct, objectively presented a significant risk of substantial harm. See Nicoletti & Spooner, *supra* note 202, at 280, 283 (asserting that, in analyzing whether threat is credible, employer should consider any supporting or contradictory evidence, for example, whether employee who threatens to "blow up the place" has experience with or access to explosives).

<sup>292</sup> Indeed, Congress anticipated adverse customer or coworker reaction to persons with disabilities and stated that the possibility of such reaction did not justify discrimination. H.R. REP. NO. 101-485, pt. 3, at 30-31 (1990), reprinted in 1990 U.S.C.C.A.N. 445, 453 (stating that employer may not refuse to accommodate person because of adverse coworker reaction or exclude person based on lack of customer acceptance).

<sup>293</sup> See Estroff & Zimmer, *supra* note 89, at 259, 291-92 (observing that abuse experienced by persons with mental disorders is underinvestigated, that "little attention is paid to their versions of how and why violence occurs," and that their perceptions "are too often considered to be symptoms rather than legitimate concerns"); see also Laden & Schwartz, *supra* note 5, at 265 (discussing case of *Cody v. Cigna Healthcare*, 139 F.3d 595 (8th Cir. 1998), where individual with psychiatric disability was "demonized by her co-workers after she requested an accommodation" and fired after her coworkers "banded together in an effort to oust her by tormenting her and by portraying her to her supervisor as lethal"); Miller, *supra* note 25, at 743 (stating that conflicts with employee with mental disability often arise "from nondisabled employees' preconceptions, fears, and prejudices against people with mental illness"); Stefan, *supra* note 14, at 822 (noting that courts see getting along with supervisors and coworkers "as an essential function *and* as the responsibility of

In sum, in most circumstances, an employer is not required to overlook past misconduct by a person with a mental disability, even if the misconduct is related to the disability. But here we should be cautious. Given widespread stereotypes of persons with mental disabilities as blameworthy, undeserving, or malingering, we must be vigilant against employer decisions that are infected by these myths. We must ensure that the individual's actual misconduct is evaluated objectively against the employer's own workplace standards. Simply put, employers may not discipline persons with mental disabilities more harshly than they discipline others. Moreover, given the powerful cultural myth of the "dangerous mentally ill," we should take care that any workplace misconduct by a person with a mental disability is not reflexively taken as a warning of "potential dangerousness." Automatic leaps from "disruptive" or "insubordinate" to "potentially dangerous" and then to a "direct threat" are not permissible under the direct threat defense. That standard requires a more informed, considered and individualized assessment of actual risks.

#### 5. Permitting Departures from Workplace Rules

Regardless of an employer's responsibility concerning *past* conduct, once an employee requests a reasonable accommodation, the employer might be required to adjust its standards *prospectively* to allow minor conduct deviations that result from mental disabilities. That is, it might be required to excuse, and to require its employees and supervisors to accept or overlook, conduct that is unusual, but that does not interfere with any worker's essential job functions.<sup>294</sup> One commentator has suggested that whether an employer will need to accommodate some unpleasantness or "mildly aberrant behavior" will depend on the nature

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the disabled employee").

<sup>294</sup> See Caroline L. Kaufmann, *Reasonable Accommodations to Mental Health Disabilities at Work: Legal Constructs and Practical Applications*, J. PSYCHIATRY & L. 153, 160 (1993) (discussing survey which showed that most common accommodations for mental disabilities included extra tolerance for unusual behavior and written instructions); Miller, *supra* note 25, at 715 ("Where . . . the employee's 'misconduct' is a result of a disability, does not pose a harm to others, and does not substantially impact the quality of the work, the ADA requires that the employer accommodate the 'misconduct.'"); see also Den Hartog v. Wasatch Acad., 129 F.3d 1076, 1087 (10th Cir. 1997) (finding that, in some circumstances, "the employer must tolerate eccentric or unusual conduct caused by the employee's mental disability, so long as the employee can satisfactorily perform the essential functions of his job"); Overton v. Reilly, 977 F.2d 1190, 1195 (7th Cir. 1992) (requiring EPA to make allowance for chemist's occasional naps, caused by his antidepressant, where chemist performed at level that met employer's expectations).

of the job, the extent of customer contact, and the risk of any workplace harm.<sup>295</sup> The aforementioned computer programmer's audible dialogue with his internal voices is one example.<sup>296</sup> Although the boundaries of permissible behavior will vary by the nature of the workplace and the position held, it is important that an employer clearly articulate its expectations. Furthermore, an employer must carefully examine whether those expectations can be modified to accommodate a mental disability, without compromising the employee's performance, disrupting other employees' performance, or otherwise imposing an undue hardship on the employer.<sup>297</sup>

The employer may need to modify work rules to help an employee with a mental disability control aggressive and violent impulses that are related to the disability. Take an employee with a mental disability that makes him volatile and prone to eruptions when pressured or teased by coworkers. Permitting the employee to walk away from tense or angry confrontations, perhaps to walk around the parking lot until he cools down, might be a reasonable accommodation, even if workplace rules generally require the supervisor's prior approval to leave the work station. Other accommodations that may help an employee with a disability remain calm and in control of disability-related impulses include permitting phone calls to friends and other supportive individuals, teaching supervisors to give clear and detailed instructions regarding job duties and constructive feedback on performance, and modifying the job to eliminate unnecessary stress.<sup>298</sup>

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<sup>295</sup> Barbara Lee, *Reasonable Accommodation Under the Americans with Disabilities Act: The Limitations of Rehabilitation Act Precedent*, 14 BERKELEY J. EMP. & LAB. L. 201, 231-32 (1993).

<sup>296</sup> The EEOC offers the example of a warehouse worker who, as a result of his mental disability, came to work looking disheveled, in violation of the employer's policy requiring employees to be neat and courteous. Because his job did not require interacting with customers or coworkers, a neat appearance was not an essential function, so waiving this requirement was a reasonable accommodation. EEOC ENFORCEMENT GUIDANCE, *supra* note 22, at 29-30.

<sup>297</sup> One commentator has noted that, in cases involving employees with mental disabilities, disagreements about employers' expectations "underlie the vast number of . . . discrimination suits." Edwards, *supra* note 106, at 361. In the absence of any "behavioral profile" for a position, "finders of fact have simply applied their own standards of what should be and what should not be tolerated in the workplace," with "widely varying results." *Id.*

<sup>298</sup> For a more thorough discussion and examples of potential accommodations for a person with a mental disability, see GARY PHELAN & JANET BOND ARTERTON, *DISABILITY DISCRIMINATION IN THE WORKPLACE* § 8.19 (1995); Edwards, *supra* note 106, at 369-82; Hall, *supra* note 246, at 263-73; Rothstein, *supra* note 259, at 940; and Thompson, *supra* note 189, at 49-52. For illustrations of how employers should conduct an individualized inquiry to determine the degree to which the stress is inherent and whether it can be reduced as a

## CONCLUSION

*Arline's* command to evaluate workplace risks in light of current medical or other objective information leads us to a growing body of knowledge about how mental disorders interact with personal, social, and situational factors to produce an increased risk of violence. Study after study demonstrates that "[p]eople with the same diagnosis behave differently under different conditions depending on their age and gender, living environment, personal history, cultural orientation, and position in the social structure."<sup>299</sup> This realization, as we have seen, has two broad implications for employers concerned about the risk that a person with a mental disorder will engage in workplace violence. The first implication, that a diagnosis alone is insufficient under the ADA to establish a direct threat to workplace health or safety, may come as a surprise to those employers who have been inundated with the myth of the "dangerous mentally ill." The practical effect of this rule, prohibiting the employer from declaring an individual a "direct threat" without an objective, fact-based assessment of that individual's personal risk factors for violence, is neither onerous nor unfamiliar. It is precisely this kind of stereotypic assumption that the ADA and other antidiscrimination statutes forbid. Granted, conducting this individualized assessment requires something more than the "quick fix" of screening out anyone with a major mental disorder. This simply reflects the congressional determination that the interests of individuals with disabilities in being evaluated on their individual merit outweigh the employers' interests in the comfort, convenience and cost savings of relying on stereotypes and generalizations.

The second broad implication is that, in light of current social science findings about the extent to which violence in the lives of persons with mental disorders is a reflection of their environments, their relationships, and their situations – including their status as victims of harassment, coercion and bullying – there is good reason to require employers to make behavioral modifications in the workplace to reduce the risk that vulnerable employees with mental disabilities will either wilt or erupt. At the very minimum, this knowledge provides another reason to take a hard look at the Darwinian approach some employers take toward employees with mental or emotional disabilities. We have seen from several illustrations that sensitive management styles may go a long way

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reasonable accommodation, see Stefan, *supra* note 14, at 824-36.

<sup>299</sup> Swanson et al., *supra* note 33, at 761.

toward diffusing workplace stress and allowing an employee with a mental disorder to remain focused and under control – and at very little trouble or expense to the employer. If the ADA is to fulfill its transformative promise, we cannot shy away from envisioning ways in which the workplace environment can be modified to remove barriers to the successful – and safe – functioning of individuals whose disabilities reduce their tolerance for needlessly stressful or emotionally abusive environments.

I am not asserting that current objective information provides an unassailable predicate for each measure I have proposed in every circumstance. The force of these prescriptions may depend on ongoing research, on the personal and clinical characteristics of individual claimants, the specific nature of the workplace, and on the nature and scope of accommodations requested. What is important to keep foremost in our minds is that the ADA calls on us to change our understanding of "disability" from something that inheres in an individual to something that is socially constructed, resulting as much from society's stereotypes and prejudices as from an individual's mental or physical impairment.<sup>300</sup> Moreover, although I discuss these responsibilities principally in terms of what the ADA requires, these measures also may advance the employer's broader interests. The employer that attempts to prevent workplace violence simply by screening out the supposed "psychos" risks overlooking far greater sources of workplace violence. By contrast, the employer that assesses individuals' risk factors for violence and looks for behavioral cues of impending violence may have a safer, less disruptive workplace. Similarly, the enlightened employer that structures the workplace to avoid needless harassment, abuse and conflict is likely to have a more productive, satisfied and safer workforce – even as it opens its doors wider to persons with mental disabilities.

However courts ultimately assign responsibilities for reducing the risks of workplace violence, *Arline* and the ADA's direct threat defense require that this decision be based on current objective information, not unfounded fears. Scholars, judges, lawyers and others who are committed to seeing the ADA fulfill its promises for individuals with

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<sup>300</sup> As the Supreme Court and Congress have acknowledged, "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment." H.R. REP. NO. 101-485, pt. 2, at 53 (1990), *reprinted in* 1990 U.S.C.C.A.N. 303, 335 (citing *School Bd. of Nassau County v. Arline*, 480 U.S. 273, 284 (1988)); S. REP. NO. 101-116, at 24 (1989) (same).

mental disabilities would do well to draw more deeply from medical and social science literature that speaks to the needs and interests of those individuals.