Chapter 11
Workplace Violence Evaluations and the ADA

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Introduction

Mental health clinicians who have concerns about the risk their patients pose for committing violence in the workplace face unique challenges, as do all clinicians who are asked to provide violence risk assessments and fitness for duty evaluations. Independent mental health clinicians may be asked to provide fitness for duty evaluations that address violence risk assessments for employees who have raised concerns that they may become violent in the workplace. These clinicians must bring their knowledge and expertise to these fitness for duty evaluations in a workplace context in which multiple factors must be assessed. The following example portrays a common workplace violence scenario, and will be used to highlight the issues that arise in this difficult area.

Case Example

Frank had worked at ABC manufacturing for 10 years. Skilled at math, he had struggled in school due to verbal learning problems and Attention Deficit Hyperactivity Disorder (ADHD), but with ongoing treatment he did well when it came to math and technical skills. Deciding that college was not for him, after high school he went to work at ABC. Within 2 years, Frank had progressed from sweeping floors to operating a hi-tech machine on the shop floor. Frank was

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30 years old, unmarried, and lived with his parents. Still in treatment for ADHD, Frank saw his psychiatrist a few times a year for medication management.

At work, Frank stayed to himself and did not socialize with his peers. His only interaction with coworkers was an occasional discussion regarding guns, gun collecting, and target shooting scores with a few other employees who shared these interests. Coworkers teased Frank about his disheveled appearance, isolation, and his habit of talking to himself. At times, the foreman would intervene, telling the others to back off, but it was of limited help.

After a week's worth of particularly severe teasing, Frank reacted one morning when someone tampered with his machine. He grabbed a length of pipe, walked over to a group of laughing coworkers, and pushed the end of the pipe under the ringleader's chin. "If you ever mess with me again, I'll kill you," Frank declared. He then turned to the others and said "The same goes for you." He threw the pipe down, accidentally hitting a co-worker in the foot, and went back to his machine.

The foreman, having heard the commotion, came out of his office just as Frank was walking away. Frank's coworkers reported the physical and verbal threats, and said Frank had "deliberately" hit his coworker on the foot. The foreman then asked Frank what had happened. Frank said, "Nothing. They were just being assholes and I told them off." Within a few minutes, the foreman handed Frank a letter telling that he was being suspended from work pending investigation of the events. The foreman insisted that he leave immediately.

One week later, Frank received a phone call from the Director of Human Resources at ABC, telling him the investigation had determined that he had violated the company's workplace violence policy. Neither Frank, nor his coworkers, were aware of any such policy. Indeed, coworkers routinely made half-joking comments about "killing" other employees, and there were even some fights in the parking lot that were ignored by management. Management had determined that Frank could return if he got a note from a doctor saying that he was fit to work and not a danger to anyone. ABC told Frank he could see whomever he wanted, and should use his insurance coverage, as the company would not pay for any evaluation.

The Scope of the Workplace Violence Problem

The National Institute of Occupational Safety and Health (NIOSH) defines workplace violence as: "Violent acts (including physical assaults and threats of assault) directed toward persons at work or on duty" (Centers for Disease Control 2002). Incidents of workplace violence are divided into four categories based upon the relationship of the perpetrator and the target, as follows:

Type I. Acts with Criminal Intent. These are committed by individuals who enter the workplace for the purpose of robbery or committing another crime. Perpetrators may include current or former employees.

Type II. Customer/Client/Patients. These are acts of violence on the part of anyone to whom the employer is providing a service.
Type III. Coworker. This category includes all acts of violence by current or former employees, supervisors, or managers.
Type IV. Personal. These acts include those by someone who is not employed by the employer but who has a personal relationship with an employee or is known to an employee (OSHA 2011).

Workplace violence has been a major concern of employers since the late 1980s, when the unfortunate term "going postal" gained currency after a series of shootings at U.S. Postal Service facilities by disgruntled employees. In fact, U.S. Postal Service employees have a lower risk of homicide than other employees (Report of the United States Postal Service Commission on a Safe and Secure Workplace 2000). Public perception of an epidemic of workplace violence was eventually disproved through studies conducted by the United States Department of Labor Bureau of Labor Statistics (BLS) starting in 1992. These ongoing studies have demonstrated that workplace homicides peaked in 1994, and have declined by more than 50 % since then (Bureau of Labor Statistics 2011a).

Statistics have also consistently demonstrated the inaccuracy of popular beliefs that disgruntled employees (Type III violence) are responsible for most workplace homicides. BLS studies have shown that the vast majority (75 %) of workplace homicides were committed by outsiders seeking to commit a crime at the workplace, i.e., Type I violence. The remaining were distributed as follows: Type II (Customers/Clients/Patients) 7 %, Type III (coworkers and former coworkers) 10 %, and Type IV (Personal) 7 % (Bureau of Labor Statistics 2011b). The final category is primarily composed of domestic violence cases that spill over into the workplace. This chapter focuses on Type III workplace violence, as it is the most likely category to give rise to mental health evaluations and issues that may involve protected rights under the Americans with Disabilities Act (ADA).

Workplace homicides, quite naturally, have attracted the most attention and concern. However, non-fatal incidents of workplace violence are far more common (Schouten 2008) and, taken as a whole, have a far greater impact on productivity and employee health. They are distributed differently from workplace homicides, as follows: 53 % Type I, 14 % Type II, 11 % Type III, and 22 % Type IV (Scalora et al. 2003). Still, for the most part it is the fear of the ultimate act of workplace violence that motivates employers and employees to take action in response to concerns about a specific employee.

The Response to Workplace Violence

In spite of widespread expressed concern over workplace violence, as of 2005, 70 % of American employers had not adopted workplace violence prevention programs (Bureau of Labor Statistics 2006). It took until 2012 for the United States

Occupational Safety and Health Administration (OSHA) to adopt guidelines for the investigation of workplace violence incidents by OSHA field offices (OSHA 2011).

An early response to workplace violence was the widespread use of "profiles" of potential perpetrators, with employers being wary of those employees who fit "the profile." There were, and are, a number of problems with profiles. First, the elements included in profiles were derived from anecdotes and not from scientific research. Risk factors were included without looking at their base rates in the general or specific population, and they were gathered retrospectively, rather than being studied longitudinally. In addition, the sample size is small. Although this is good news from a public health perspective, it limits any research conclusions. Second, as with any low incidence phenomenon, the rate of false positives for workplace violence profiles is excessively high, i.e., they identify far many more employees as being at risk than is actually the case.

Third, the profiles include a major focus on the existence of mental illness, and disregard the current understanding of the association between violence and mental illness discussed below. Fourth, and perhaps most importantly, the profiles are often applied in an effort to predict who might be at risk. Some of the risk factors have validity when applied in individual cases in which there has been evidence of threats or violence. However, the lack of underlying scientific validity and the false positive problem cited above make their use as prospective screening inappropriate. Such use of profiles is a potential source of more harm than good in terms of unnecessary exclusion of people from the workplace and setting the stage for employment discrimination claims arising from the stereotypical association of mental illness with violence (Schouten 2006, 2008).

Risk Factors for Type III Workplace Violence

As in the cases of presidential assassins, and school and campus shooters, there is no evidence that there is a valid profile of perpetrators of workplace violence (Drysdale et al. 2010; Fein et al. 1999; Vossekuil et al. 2000). Nevertheless, a number of validated individual and organizational risk factors for non-fatal Type III workplace aggression have been identified by multiple researchers (Schouten 2008). These are listed in Tables 11.1 and 11.2.

The risk factors can be divided into two groups: those that are static, such as past history of criminal behavior or several mental illness, and those that are dynamic, such as financial stress, acute symptoms of illness, and conflict with coworkers. Static factors cannot be altered, however, it is often possible to affect dynamic factors in such a way as to decrease risk (Douglas and Skeem 2005). Static and dynamic factors can themselves be divided into two groups: those that are protective and decrease the risk of violence and those that exacerbate the risk (Schouten 2006).

Table 11.1 Individualized Risk Factors for Workplace Aggression (Schouten 2008)

1. Perception of unfair treatment by others
2. Trait anger
3. Threat to identity through loss of status
4. Hostility, low frustration tolerance, and reactivity to stress
5. Life stressors, e.g., financial problems, domestic conflict, severe illness in self or family
6. Negative affectivity
7. Externalization of blame
8. Belief in revenge as a justifiable action
9. History of violence, including intimate partner violence
10. History of antisocial behavior
11. Acute workplace stressors, e.g., pay cuts or freezes, termination
12. Chronic workplace stressors, e.g., limited control over work, job dissatisfaction
13. Factors related to mental illness:
    a. Suicidal or parasuicidal behavior within 24 hours of criminal violence
    b. Hallucinations
    c. Acute conflicts with others
    d. Denial of psychiatric care within 24 hours of the violence
    e. Active psychosis
    f. Substance abuse

Table 11.2 Organizational Risk Factors (Schouten 2008)

1. Pay cuts and freezes
2. Use of many part-time employees
3. Changes in management
4. Reengineering
5. Budget cuts
6. Deteriorating physical work environment
7. Low work group harmony
8. Failure to discipline aggressive employee

Significant mental illness is, in fact, one of the consistently cited risk factors for workplace violence (Katsavdakis et al. 2011). The evidence that mental illness actually constitutes a consistent risk, however, does not extend beyond the research on violence and mental illness in the world at large. As summarized in a series of studies, mental illness is associated with a small, but statistically significant, increased risk of violence where there is a combination of serious mental illness, concurrent substance abuse or a history of substance abuse, and a history of conduct disorder or antisocial personality disorder (Elbogen and Johnson 2009). Contrary to widespread popular belief, but consistent with our knowledge in this area, some of the perpetrators of workplace violence may have a significant mental illness, but Axis II-related conditions play a larger role than those that fall under Axis I.

ADA Issues in Workplace Violence

The public perception of an association between mental illness and violence accounts for a substantial portion of workplace violence referrals. The initial request for a consultation often includes comments like, “We have an employee we’re concerned about. He’s kind of a loner. He’s a bit odd, and he makes people nervous.” With that, and the inherent perception of the employee as having a mental illness of some sort or perhaps knowledge that the employee has been treated for a mental disorder, the stage is set for a potential discrimination claim. As discussed in the previous chapter, individuals are protected by the ADA if they have a mental or physical disability, had such a disability in the past, or are perceived as having such a disability.

Employers tread a fine line when these concerns arise. On the one hand, it is important and appropriate for employers to be attuned to the emotional health and well-being of their employees. However, fear of disability discrimination litigation often prevents employers from addressing obvious signs of psychiatric or emotional disturbance among employees; what this author refers to as “Litigation Induced Paralysis.” The result is that employees do not get the help and support they need, the risk of absenteeism and presenteeism (decreased productivity while staying on the job) increases, coworkers are distracted by concerns about the employee in question, and the risk of accidents, and occasionally violence, increases.

In addition to being good employee relations practice, employers have both the obligation and right to respond to situations where employee health and safety are in question. However, potential workplace violence situations give rise to significant disability discrimination issues, due to the stigma attached to mental illness and the limited, but real, association between mental illness and violence. Employers often find themselves facing a difficult choice when these concerns arise. They face potential liability if a violent event occurs and they have failed to act out of fear of a disability discrimination claim, and liability for disability discrimination if they respond to such incidents in a manner that suggests disparate treatment of those with disabilities.

Any adverse employment action, from being passed over for a promotion to being placed on a mandatory leave and sent for a fitness for duty evaluation to outright termination, may place the employer at risk of disability discrimination liability if employees without actual or perceived disabilities have not received the same treatment for similar behavior. For example, Frank had covered disabilities (ADHD and verbal learning disability) and was perceived as having other mental illness, thus affording him ADA protection. In addition, ABC had never applied its workplace violence policy to others who engaged in similar, or worse, behavior. Invoking the company workplace violence policy in suspending Frank and sending him for a fitness for duty evaluation sets the stage for a disparate treatment claim.

In Frank’s case, it is clear that ABC had to take action based on Frank’s behavior. In general, employers should take action based on behaviors, not on the

basis of actual or presumed existence of mental illness. ABC's workplace violence policy was typical in that it contained a "zero tolerance" clause calling for potential discipline "up to and including termination" for violations. Frank's actions were in clear violation of the policy, and his foreman had legitimate grounds for suspending Frank pending an investigation or even immediate termination. Indeed, one could argue that ABC was obligated to respond in accordance with its policy.

However, employers should treat all individuals equally, with no disparate treatment of those with past, current, or presumed disabilities. Employers are free to treat individual employees differently, so long as the decision to do so is not based on the employee's membership in a protected class, e.g., race, religion, ethnicity, gender, disability, or, in some states, sexual orientation. As noted above, ABC was well within its rights to suspend Frank or even terminate him because of the verbal threats and the actual act of violence. However, enforcing the policy with regard to Frank if other employees who made threats and engaged in acts of violence were never subject to investigation, suspension, or termination, would provide the basis for a discrimination claim.

Some clinicians, believing that the ADA protects disabled persons from any adverse action, express surprise that their patients are being disciplined for violating work rules. The ADA does not protect covered individuals from discipline for violations of work rules, even if the transgression arises from the disability, e.g., verbal or physical aggression by an employee with Bipolar Disorder (Equal Employment Opportunity Commission 1997). The key, as noted above, is whether there has been disparate treatment. The route taken with Frank—suspension pending the results of an investigation—is typical and appropriate. Alternatively, management could have simply terminated or otherwise disciplined Frank for violating the workplace violence policy. Both actions are defensible from a disability discrimination standpoint, so long as other non-disabled employees were treated the same way under similar circumstances.

Workplace Violence Risk Assessments and Treating Mental Health Clinicians

Even employers who are dedicated to the equal treatment of people with disabilities can find themselves accused of violating, or in actual violation, of the ADA and related state statutes when workplace violence situations arise. Thorough, objective assessments of workplace violence risk can provide the best protection for both employers in such situations and for employees' rights. Any investigation of a potential workplace violence situation needs to be fair, objective, and as confidential as possible.

In trying to make the decision regarding whether Frank should be allowed to return to work, ABC correctly looked to an outside source for an opinion.

However, despite taking the appropriate step of asking Frank to obtain a doctor's opinion regarding his fitness for duty, ABC's instruction to get a "note from a doctor" clearing him to return to work is problematic in a number of ways. It provided no guidelines as to the type of doctor, his or her skills, his or her relationship to Frank, or what information needed to be considered. Psychiatrists, psychologists, and other clinicians may be asked to evaluate an employee suspected of posing a risk of workplace violence. In these complex cases, all parties are best served when the evaluation is conducted by an independent evaluator rather than the employee's treating clinician.

Frank naturally turned to his treating psychiatrist when he was told that he needed to "get a note from a doctor" clearing him to return to work. While this is understandable, it is unwise for the employer to accept the treating clinician as the evaluator and for the psychiatrist to take on that assignment. There are multiple reasons why treating clinicians should not serve in roles that require an objective assessment of their patients, such as that of expert witness on behalf of a patient or evaluator of fitness for duty. These reasons include:

- Conflicts of interest that arise from the clinician's fundamental role as advocate for the patient.
- The clinician's various duties to his or her patient.
- The fact that treating clinicians primarily obtain their information from their patients rather than from multiple collateral sources.
- The necessary abandonment of confidentiality.
- The potential damage to the treatment relationship (Schouten 1993; Strasburger et al. 1997).

Experience has shown that treating clinicians who are asked to assume roles other than the provision of treatment tend to reach conclusions that are in accord with their patients' preferences. In addition, multiple examples exist of treating clinicians offering opinions about a patient's ability to function in his or her job when the clinician has no specific knowledge (even from the employee) of the industry, the workplace, the functions of the job, or the particular demands placed on the employee/patient.

In light of the above, treating clinicians should not be asked to provide an objective opinion regarding their patient's fitness to return to work, especially in high stakes situations such as the potential for violence. Treating clinicians should not accept that assignment, nor should employers look to treating clinicians for such an opinion, as they will be relying upon a potentially flawed assessment.

It is true that clinicians are routinely asked to provide notes for patients indicating that they need time off or are fit to return to work after a leave of absence. In fact, employers are required to accept the treating clinician's opinion that an employee is ready to return from leave under the Family and Medical Leave Act, unless they have some basis for challenging that opinion. While having treating clinicians in this role is not ideal, this common practice poses limited risk if both the employer and the clinician recognize the limitations on the clinician's ability to be objective and if the situation does not involve significant safety concerns.

However, Frank's psychiatrist was not being asked to certify that Frank was ready to return to work after a bout of low back pain, or even panic attacks, or depression. The psychiatrist was being asked to certify that Frank did not pose a risk of violence to himself for others at work after violating the company workplace violence policy. Unfortunately, on Frank's request, Frank's psychiatrist agreed to provide a letter asserting that Frank could return to work, without understanding the exact nature of the evaluation being requested, without understanding the exact nature of Frank's job functions, and while serving as Frank's treating psychiatrist. This was in fact one of those situations in which both Frank and the employer would have been better served had the psychiatrist offered his clinical opinion, noting his limited ability to perform a complete and objective assessment, and left the evaluation to be done by an independent evaluator to be retained by the employer.

The Role of the Independent Mental Health Professional

The independent mental health clinician is a non-treating clinician retained by the employer to conduct an assessment in pursuit of an answer to a particular question or questions. As in any other forensic role, the independent evaluator has an obligation to reach an objective conclusion based upon the available information considered in the context of the question that has been asked. In addition to objectivity, the independent mental health clinician who agrees to conduct a fitness for duty evaluation in the assessment of a concern regarding workplace violence situation has the obligations associated with any fitness for duty evaluation (see Chap. 12) as well as some other unique challenges associated with violence risk assessment.

There are two basic roles for independent evaluators in workplace violence assessments. First, the mental health clinician may directly assess the fitness for duty of a specific employee about whom there are violence risk concerns. Second, the independent evaluator can serve as a consultant, assessing the situation based on available materials and advising what to do about a given situation. In the former role, the evaluator will meet with the employee and conduct an assessment, in addition to reviewing information from collateral sources. In the latter, advice is offered based on interviews with collateral sources, and review of personnel records, company policies and procedures, correspondence, and any available background investigation materials.

Workplace violence assessments, such as complex clinical cases, often benefit from a team approach. Professionals from law enforcement, corporate security, human resources, employee assistance counselors, and employment law may all have specialized expertise in workplace violence. Those clinicians who wish to provide consultation on workplace violence issues are well served, as are their clients, if they are comfortable working as part of a team of such professionals that can analyze different aspects of threats as they evolve. Often referred to as threat

management teams (TMT) or threat assessment teams (TAT), they provide ongoing assessment of threats within an organization. Notably, mental health professionals are often asked to take a leadership role on these teams, in part because of the tendency to focus on mental illness as a violence risk factor. The skilled consultant will help redirect the team to focus on behavior, rather than diagnosis, and assist the team in understanding illness when it is present.

Mental health professionals should also carefully consider whether they have the expertise necessary to conduct the evaluation. Fitness for duty evaluations, especially those involving workplace violence risk assessment, require specific knowledge and expertise distinct from the violence risk assessments conducted as a basic part of clinical practice. Those seeking to build upon the general expertise and knowledge regarding violence in clinical training can attend continuing education conferences and courses on the subject. For example, the Association of Threat Assessment Professionals (ATAP) is an organization of law enforcement, security, legal, and behavioral science professionals who have a specific interest in threat assessment and management. ATAP holds an annual meeting as well as regional conferences (www.atapworldwide.com). More specific training courses on workplace violence risk assessment are also available around the country (White and Meloy 2007).

Independent mental health clinicians should keep in mind that violence potential is not an all or nothing affair. Workplace violence and the circumstances that give rise to workplace violence represent a dynamic process that provides an opportunity for evaluators to both assess violence risk and help manage it. As described by Calhoun and Weston (2003), workplace and other forms of targeted violence can be conceptualized as progressing in a stepwise fashion, initiating with a grievance, moving on to violent ideation, and then through various decision making and planning stages that, if unchecked, can escalate to an attack. Their model describes the pathway to violence, and makes clear that it is possible for people who are on that pathway to change course.

Mental health clinicians who have agreed to provide workplace violence risk assessments for individuals who are not their patients have an opportunity to utilize their clinical skills to provide suggestions to manage the situation in a way that decreases violence risk. While the purpose of the fitness for duty evaluation is not treatment, it can still have a therapeutic effect, merely by providing an opportunity for the employee to be heard or providing insights as to help address individual violence risk factors.

The Basics of a Workplace Violence Risk Assessment

There are basic elements to an assessment of workplace violence potential, whether conducted by an independent evaluator, a clinician who wants to determine the violence risk potential of a patient, or a clinician who agrees, despite the practical and ethical conflicts presented, to evaluate a patient on behalf of an

employer. Clinicians should be certain to address these elements to lay the groundwork for the evaluation or consultation. The basic questions that a referral for a workplace violence assessment should answer include:

- What are the referral question(s) that need(s) to be answered?
- Do you have the necessary expertise?
- Who is seeking answers to the referral questions(s)?
- What is the goal of the assessment?
- What is the specific basis for concern regarding violence risk?
- Is specific knowledge about the job and workplace in question available and accessible?

Clinicians should first have a clear understanding of the referral question(s). As with any other consultation, it is essential that the mental health professional undertaking the violence risk assessment understands the question being asked. Is this an evaluation for return to work, for disability, to consider the advisability of a leave of absence, or whether to terminate the employee for violating workplace rules? Whatever the question, it is important to understand the employer-specific, as well as clinical, criteria for answering it.

Clinicians also need to establish who is asking the question they are being asked to answer. Requests for assessments of workplace violence potential may come from employers or other organizations, from attorneys representing either the employee or the employer, from union representatives, or other sources. While the source of the question should have no impact on the evaluating clinician's objectivity or response, it does influence the nature of the question and the framing of the answer. For example, the question(s) associated with the potential for workplace violence of an executive of a small company as part of the due diligence efforts of a larger company seeking to purchase the smaller entity will differ from that of a factory employee who brought a firearm to the workplace.

The goal of the assessment should also be clearly established. Once the requesting party and the mental health clinician have a mutual understanding of the question to be answered, it is important to determine whether the evaluation should be done at all. Is this a situation that calls for a fitness for duty evaluations or should the employee be placed on medical leave in order to obtain treatment?

In many cases, employees are referred for mental health fitness for duty evaluations when the employer has no desire or intention to continue to employ the person, although the employer may not directly say as much to either the mental health clinician or the employee. Hoping that the mental health clinician will deem the person unfit for duty, the referral is made as a way to temporize, to shift the blame or responsibility for termination to the mental health professional rather than management, or to induce an employee who does not want to be evaluated to quit.

Employers who send an employee for a mental health fitness for duty evaluation should be advised that there is a 50/50 chance that the evaluator will deem the person fit to work, and that the fitness for duty evaluation cannot be relied upon to accomplish their goal of being free of the employee. Moreover, it is essential that the mental health clinician not be placed in the position of lying to the evaluee, i.e.,

representing that continued employment is still a possibility, when that is not the case. It is always wrong to lie to evaluees, but it is also dangerous to do so when dealing with potentially violent individuals.

Alternatively, employees in crisis may be referred for a fitness for duty evaluation as a way of getting them immediate attention. After discussion with the referral source, the clinician may determine that the employee is too unstable for a fitness for duty evaluation. Treatment and safety concerns are primary for an employee who is possibly experiencing a mental health crisis and is potentially violent. Workplace violence assessments and fitness for duty evaluations are not designed to provide any type of treatment, urgent or otherwise. An independent assessment regarding any employment issue should be secondary to the individual's need for appropriate urgent treatment. Employers or their agents should be advised to refer such individuals to a mental health professional or emergency room for urgent or emergent treatment.

Another basic element that evaluating mental health professionals should establish is the specific basis for the concern about violence risk. Has the employee exhibited specific behaviors, or communicated or stated such as threats? Does the employee have a past history of violence, conflict with others, substance abuse, mental illness, or some combination of these? If a history of mental illness or active symptoms is the only source of the concern, the clinician should ask how the employer handles similar situations when there is no indication of illness, and perhaps suggest a consultation with the employer's employment attorney.

Mental health professionals need specific knowledge about the job and workplace in question, including the level of aggression in that workplace, in order to conduct a violence risk assessment. Evaluating clinicians should therefore determine whether this kind of information is available and whether they will be able to access it before undertaking the assessment. For example, is this a workplace in which verbal and physical aggression is fairly common and generally tolerated, or is such behavior unheard of and therefore noteworthy when it occurs? In Frank's case, his conversations about guns might be less noteworthy in a workplace or geographic region where shooting sports are common than when it occurs somewhere where guns are rarely spoken of, let alone used.

Certain employee populations and professions, and their workplaces, have unique cultures and characteristics that relate to stress levels, labor-management relations, safety risks, and employee interactions. The evaluator should obtain a copy of the formal job description from the employer. In addition, it is important to get a verbal description of the job and the workplace in order to determine what the work truly involves, as written job descriptions often do not capture the nuances and stresses of a given position.

Finally, evaluators should establish what organizational risk factors for violence are present. Poor labor-management relations, recent or imminent reductions in force, or failure to enforce workplace rules, especially those related to workplace violence, are organizational rather than individual risk factors. Nevertheless, they are part of the dynamic process involved in workplace violence and risk and so need to be assessed. Similarly, evaluators should assess organizational protective

factors, such as the presence of a viable open door grievance policy, adequate pay and benefits, supportive human resource policies, and an active employee assistance program.

The Evaluation

Whether functioning in the role of fitness for duty evaluator or workplace consultant, it is important to gather as much information as possible to provide a basis for an opinion. The following information should be obtained from multiple sources, including the employer:

- Personnel records
- Statements from coworkers to supervisors
- Background investigation materials (including results of surveillance)
- Review of e-mail and postings to social media, e.g., Facebook and Twitter
- Statements from family members (in certain circumstances)

As noted above, in a fitness for duty context, the employee should be evaluated directly. Psychological testing is rarely necessary if the purpose of the fitness for duty evaluation is violence risk assessment, however, guided assessment tools such as the WAVR-21 can be useful, both for those who are still acquiring expertise in the field and for experienced evaluators (White and Meloy 2007).

Mental health evaluations of fitness for duty that include or are centered around violence risk assessment should include evaluation of a number of factors. Although some of them are not directly connected to workplace issues, evaluation of potentially violent behavior is not limited to the workplace, and may inform opinions regarding workplace risk. For example, what has the evaluee's demeanor been like around scheduling the evaluation with the mental health clinician and the clinician's staff? Has the evaluee been cooperative? Has he or she been cooperative in making arrangements for the evaluation, or has the evaluee been resistant, belligerent, or intimidating? How does the evaluating clinician experience sitting with the evaluee as a history is obtained and the mental status examination conducted? Direct observation of impulsivity, irritability, or hostile or threatening interactions indicate a capacity for threatening or violent behavior not limited to the workplace, but certainly indicating that the evaluee is unlikely to be fit for duty.

Clinicians should be certain to explore the evaluee's attitude and perceptions toward the workplace. Does the evaluee view the workplace as safe from violence for him or herself individually and safe generally? In the case example, Frank is unlikely to feel safe in the workplace since he was the object of taunting and derision. Does the evaluee feel that he or she is being treated unfairly? In Frank's case, if others had exhibited similar behavior and had not been disciplined, despite the workplace zero tolerance policy, Frank might feel unfairly singled out.

An assessment and discussion of violence risk factors and protective factors is essential. As discussed above, static and dynamic risk factors should be reviewed. In addition, any other individual and organizational risk and protective factors that are present should be considered. In addition, the evaluee's perception of individual and organizational risk factors should also be explored. For example, a mental health clinician may consider ABC's no tolerance violence policy to represent an organizational protective factor. Discussion with Frank and collateral workplace sources might demonstrate that this policy is never enforced, or enforced so inconsistently, that it does not truly constitute a protective factor against the risk of violence.

As in any mental health evaluation, the information gathered and observed by the clinician, including a thorough mental status examination, should inform the assessment. What does a detailed history demonstrate regarding the evaluee's mental health history, substance use history, and past history of violence? Does the evaluee deny a history of violence despite arrests for violent behavior? If there is a history of violence, does this occur at times when mental illness is acute or when the evaluee is abusing substances? How does the information obtained from the evaluee compare to the information obtained from other materials, including work history? Lack of consistency or lack of insight may be significant in the clinician's final conclusions.

Mental health clinicians should consider the entire range of possible risks. Experience demonstrates that individuals who are blowing off steam trigger the majority of violence risk fitness for duty evaluations consultations. That experience is also borne out by data that consistently indicate that workplace violence, although a serious problem because of the potential risks involved, is a low base rate event. As a result, mental health clinicians may become complacent purely on the basis of these odds. Each situation needs to be evaluated on its merits, with a fresh look at each new set of facts.

Finally, evaluators should bear in mind that an individual who is referred for a violence risk assessment may present a risk of violence to the clinician or the clinician's staff. In addition to whatever behavior or circumstances triggered an employer's concern regarding potential violent behavior, clinicians should bear in mind that most evaluees are unhappy, uncomfortable, or frankly angry about what they often perceive as being forced to see a "shrink." If clinicians conclude that the evaluee's behavior while arranging the evaluation appointment or interacting with the staff and evaluator suggests violence risk, they should consider issues of safety and whether it is advisable to proceed with the evaluation.

Information related to specific risk factors should be obtained from the referral source when deciding where the evaluation should take place. When it comes to violence risk, the words of the late Dr. Carl Sagan hold true: "Absence of evidence is not evidence of absence." Any person referred for a violence risk assessment should be considered to pose at least some risk. As such, at the very least, evaluations should not take place in isolated settings. Depending upon the preliminary information that is available, precautions may range from scheduling the appointment when others are certain to be available, arranging for security to be present outside the room, or conducting the evaluation in the emergency room.

The Opinion

After gathering all of the collateral and, where possible and necessary, first-hand information, it is time to reach a conclusion and offer an opinion. This should not be done in a vacuum. Risk assessment is a dynamic process, and it is important to determine if there have been any new developments since the mental health evaluation was first undertaken. As noted above, risk assessment is also best conducted as a team activity, in which the behavioral health specialists contribute their observations, as do the other specialists on the team, and then a group conclusion is reached as to the level of threat and how to manage it.

As in other types of clinical forensic work, the referral source should be asked if a report is desired and, if so, whether a special format or language should be used. The length and format will depend not only on the referral source's needs, but on the degree of complexity of the data and the analysis. In addition to following the suggested process described in Chap. 12 on fitness for duty evaluations, assessments of violence risk benefit particularly from consideration of what information was available and what information would have been useful but was not available. After reaching a conclusion, the evaluator should present alternative conclusions that might have been reached if additional information were available. This same approach should be taken with the consensus opinion and action plan reached by the team.

In Frank's case, for example, information regarding the coworkers' behavior is critical. If this information was not available, it might appear that Frank was spontaneously threatening and potentially violent. The information that coworkers were taunting and humiliating Frank changes the dynamic context of Frank's behavior. Information from a thorough investigation by corporate security or human resources might reveal that Frank had not deliberately struck anyone with the pipe, another factor that points to lower risk of violence. Frank might still be found not fit for duty, but the mental health clinician would have a more complete understanding of Frank's actual potential risk for violence in the workplace, and could suggest changes in policy and practices that might improve safety for all of ABC's workers.

The outcome in Frank's case was not satisfactory to either Frank or his employer. When Frank's impending return was reported to coworkers, many of them complained that they were afraid of Frank. Shortly after Frank returned to work, some of Frank's coworkers again began taunting him. Frank's psychiatrist had urged him to stand his ground and not be bullied. Before going to the foreman to complain, Frank jokingly commented to his coworkers, "If you guys are so worried about me going postal, you might want to be a little more careful. You remember my gun collection, right?" One of the other employees relayed Frank's comments about "going postal" and the gun collection to the foreman before Frank could speak with the foreman. Shortly thereafter, the foreman approached Frank, accompanied by an armed police officer. Frank was told that he was being terminated immediately. He was handed a no-trespass/stay away letter that forbade

him from entering onto company property or contacting ABC or its employees. Frank was walked out of the plant flanked by the officer.

Frank's treating psychiatrist had successfully advocated for Frank's return to work, but he did not provide ABC with an analysis of Frank's violence risk factors, which were low. He also did not suggest how ABC might be able to mitigate violence risk in their workplace by addressing the taunting by Frank's coworkers and ABC's intermittent enforcement of its zero tolerance violence policy. Frank lost his job, and consulted an attorney, who filed a complaint against ABC for disability discrimination.

An independent fitness for duty evaluation, alone or in conjunction with a workplace violence risk assessment, might have changed this outcome. Although the information provided by Frank's treating psychiatrist was important, it was not considered in the broader context necessary for understanding the circumstances that led to the behavior for which Frank had been suspended in the first place. A more objective violence risk assessment would have considered individual and organizational risk factors and mitigating factors based on multiple sources of information. That could have led to recommendations for interventions for both Frank and ABC company that would have allowed Frank to continue working, avoided ABC's loss of a valuable employee, decreased the risk of disability discrimination litigation, and improved the safety of the workplace for all ABC's employees.

When presenting an opinion, clinician evaluators should be mindful that they are consultants and, as such, the referral source is free to "take it or leave it" when it comes to the final opinion and recommendations. Negative information, i.e., bad news, tends to be valued more highly than good news. In other words, a client is more likely to accept and value an opinion that warns of significant risk than one that offers reassurance of low risk. Individuals within organizations who have become fearful of coworkers, rightly or wrongly, are often difficult to convince that there is less risk than they perceive. Here again, the clinical skills that are useful in working with individuals and families can be extremely beneficial.

Conclusion

Concerns about workplace violence are widespread and show no signs of decreasing, in spite of the promising statistics that the frequency of such events has declined over time. Workplace violence risk assessments are complex and require specific skills and experience. Clinicians with the proper training and experience can serve useful roles as evaluators and consultants regarding workplace violence risk assessment, using their clinical and forensic skills to identify risk, and help to manage both that risk and the concerns of the client. Moreover, the knowledgeable clinician serving in these roles can help the employer avoid the pitfalls of relying upon false beliefs of the relationship between violence and mental illness, and thus unintentionally or inadvertently taking action which discriminates against individuals with mental illness.

Key Points

1. Although workplace violence is a low base rate phenomenon, when it arises as a potential concern, mental health clinicians are often asked to provide evaluations.
2. Fitness for duty evaluations that involve violence risk assessments require additional skills and training typically not held by general mental health clinicians. Requests made for such evaluations for a clinician's own patients are best referred to a qualified independent mental health clinician.
3. Workplace violence risk assessment and management of potentially violent situations can be enhanced through a team approach that includes professionals from a variety of disciplines.
4. Workplace violence risk assessments should be based on multiple sources of information and should consider all individual and organizational risk factors and mitigating factors in conjunction with events in the workplace that precipitated the referral, in order to provide a complete evaluation.
5. Workplace violence risk assessments should include an explicit violence risk assessment and possible interventions that could reduce the threat of workplace violence.

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