The ADA's Tools for Effecting Employment

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The Americans With Disabilities Act (ADA) can be thought of as a tool box. In it exist several tools and blueprints to build a structure to end employment discrimination and provide meaningful work opportunities for people with psychiatric disabilities. Perhaps the most important implement in the ADA tool box is the law's requirement that employers provide reasonable accommodations for qualified individuals with disabilities. As with any tool, effective use of the ADA's reasonable accommodation tool requires an understanding of its potential, limits, and intended role. The next section of this chapter provides a description of the reasonable accommodation tool; a step-by-step blueprint of the accommodation process as defined by the law, research, and experience; and how these work with the building materials—the requirements of the workplace, and people with psychiatric disabilities, their abilities, impairments, experiences, and problems.

At least two issues covered by the ADA raise questions around psychiatric disability: 1) the threat of harm posed by an individual with a disability, and 2) the provision of health insurance. The second part of the chapter addresses these two issues.

EMPLOYMENT OF PEOPLE WITH PSYCHIATRIC DISABILITIES: REQUIREMENTS UNDER THE ADA

One way in which the ADA defines discrimination on the part of an employer is "not to make reasonable accommodation to the known physical or mental limitations of an otherwise qualified applicant or employee with a disability" (42 U.S.C. 121 12(b)). This section discusses the legal requirement related to the disclosure of a disability, qualifications for a job, and reasonable accommodation.

Reconstruction of the legal requirements of the law into key components may assist analysis, but such dissection does not realistically reflect expression of needs, desires, limitations and decisions between an employer and applicant or employee. To a certain extent, the U.S. Equal Employment Opportunity Commission (EEOC), charged with implementing the ADA, recognized the dynamic aspects of these areas of human communication. It did not simply define the key terms listed above, but also offered guidance on how employers and applicants or employees decide these issues. It said: "[T]he appropriate reasonable accommodation is best determined through a flexible, interactive process that involves both the employer and the qualified individual with a disability" (56 FR 35748). The EEOC suggests that employers, upon request for an accommodation, should:

> (1) *Analyze the particular job involved and determine its purpose and essential functions;*
>
> *(2) Consult with the individual with a disability to ascertain the precise job-related limitations imposed by the individual's disability and how those limitations could be overcome with a reasonable accommodation;*
>
> *(3) In consultation with the individual to be accommodated, identify potential accommodations and assess the effectiveness each would have in enabling the individual to perform the essential functions of the position; and*
>
> **(4)** *Consider the preference of the individual to be accommodated and select and implement the accommodation that is most appropriate for both the employee and the employer* (56 FR 35748).

Although the ultimate decision about accommodation rests with the employer, the EEOC guides employers along a practical course, imbued by mutual input and respect for employer and employee. But even this advice reflects a linear process and hinges on adequate knowledge of the law and effective accommodations, as well as communication skills on the part of the employer and an individual with a disability. OTA has uncovered few data concerning the interactions between employers and individuals with psychiatric disabilities. Evidence from a preliminary study indicates that discussions among employers and employees about psychiatric disabilities or accommodations are rare (35). Employers may lack knowledge about mental disorders or be uncertain as to how they should address the topic. And as discussed in chapters two and three, people with psychiatric disabilities may lack self-esteem, a characteristic that they need to request accommodations.

Disclosing a Psychiatric Disability to an Employer

Before an employer provides an accommodation—and before the ADA requires one—an applicant or employee must disclose his or her need. As indicated in the EEOC guidelines:

> *Employers are obligated to make reasonable accommodation only to the physical or mental limitations resulting from the disability of a qualified individual with a disability that is known to the employer. Thus, an employer would not be expected to accommodate disabilities of which it is unaware. If an employee with a known disability is having difficulty performing his or her job, an employer may inquire whether the employee is in need of a reasonable accommodation. In general, however, it is the responsibility of the individual with a disability to inform the employer that an accommodation is needed (56 FR 35748).*

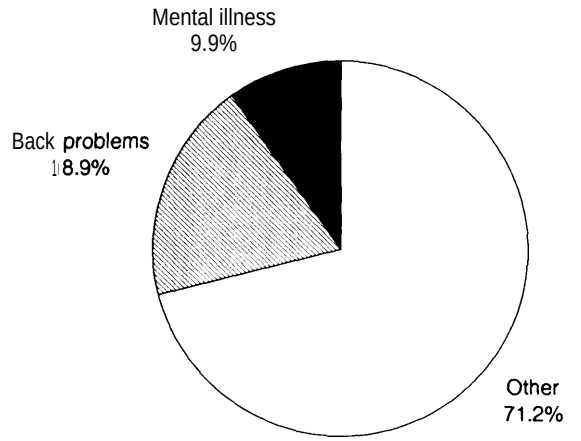
For many individuals, revealing the presence of a disability is not a voluntary decision. Although the specific impairment and needed accommodations may not be apparent, a person in a wheelchair visibly discloses the presence of a disability. This is not the case for many people with psychiatric disabilities that are not physically obvious. Thus, disclosure is a deliberate-and often wrenching-decision. Many factors may influence the decision to disclose, including awareness of the ADA, perceived benefits and drawbacks of disclosure, and practical decisions as to when, how much, and to whom. OTA found almost no empirical data on disclosure of psychiatric disabilities to employers, and the EEOC is largely

mute on the subject. The following discussion stems from data from preliminary studies and the published or verbal testimony of people with mental disorders, rehabilitation experts, other mental health advocates, and business representatives.

Employee awareness of the ADA is the gateway to disclosure. Chapter 2 notes that considerable media attention was focused on the passage and early implementation of the ADA. Other factors suggest that at least some individuals with psychiatric disabilities are aware of the ADA: National consumer-run technical assistance centers as well as the national offices of mental health advocacy organizations have advertised and prepared information on the ADA (see chs. 2 and 5); Federal funds have been granted to two private organizations for technical assistance that focuses on the ADA and psychiatric disabilities (see ch. 5); and a sizable proportion of information requests of the Job Accommodation Network and charges of discrimination with the EEOC relate to psychiatric disabilities (figure 4-1) (see ch. 3). In fact, mental illness accounted for the second highest percentage of charges of discrimination, as broken down by impairment type, filed with the EEOC to date.

Nevertheless, many people with psychiatric disabilities and employers are unaware of the ADA. Informal surveys of business representatives, and ADA and rehabilitation experts indicate that many employers and employees have no knowledge of the ADA or its coverage of people with psychiatric disabilities. Data from a recent survey of people with all disabilities showed that less than 30 percent had heard of the ADA (1 9). Given that awareness of the ADA is a prerequisite for invoking its protection, efforts to insure ADA awareness in business, consumer, and service organizations seems critical. Attorneys, Federal officials, rehabilitation professionals, and people with disabilities indicate that service providers can be critically important for educating people with psychiatric disabilities about the ADA (56). At the Federal level, obvious sites for increasing awareness of the ADA include: government-funded programs targeted to people with disabilities, such as the Social Security Administration's disability income maintenance programs; mental health services that receive Federal dollars from block grants and the Community Support Program (administered by the Center for Mental Health Services); protection and advocacy programs; vocational rehabilitation programs; and the EEOC (see ch. 5).

FIGURE 4–1: Charges of Discrimination Under the ADA



Of 17,355 total *ADA-related charges filed with the EEOC between July 26, 1992 and October 31, 1993, the second highest percentage—1, 710 charges-.-were related to mental illness.*

SOURCE. U S. Equal Employment Opportunity Commission, Dec 1, 1993.

People with psychiatric disabilities, experts and advocates testify that the largest obstacle to disclosure appears to be, ironically, the ADA's intended prey: stigma and discrimination. By disclosing a psychiatric disability, an individual risks discrimination, teasing, harassment, isolation, stigmatizing assumptions about his or her ability, and the labeling of all of one's behaviors and emotions as pathological (see ch. 2) (35,56,67). Data from the EEOC seem to confirm the problem that people with psychiatric disabilities have with harassment: While mental illness accounted for 7.9 percent of all ADA-related charges of discrimination received by the EEOC during the first 6 months the law was in effect, these conditions made up 12.5 percent of all ADA charges having

TABLE 4–1: Issues Raised by ADA/Mental Illness Charges With the EEOC Between July 26, 1992 and December 31, 1992

Issues	No. of charges related to mental illness (% of total mental Illness charges)	Total number of charges (% of total ADA charges)	Percent of total ADA charges due to mental illness
Discharge	140 (52.8%)	1,548 (46.1%)	9.0%
Reasonable accommodation	44 (16.6%)	684 (20.4%)	6.4%
Harassment	36 (14.3%)	303 (9%)	12.5%
Benefits	11 (4%)	114 (3.4%)	9.6%
Hiring	36 (13.5%)	516 (15.4%)	7.0%
Total	265	3,358	7.%

SOURCE: U.S. Equal Employment Opportunity Commission, 1993.

to do with harassment (table 4-1) (72). A leader in the consumer movement describes the difficulties and implications of disclosure (12):

> Disclosure of one's psychiatric history is a very personal matter which can aid in one's recovery, allow reasonable accommodation under the ADA, and yet can lead to discrimination . . . Though I am presently open about being a mental health consumer/survivor, I only arrived at this position through a gradual process. At first I did not appreciate the stigma involved in having a psychiatric label. This quickly changed. While strolling down a corridor on pass during my first hospitalization, I met a surgeon who was a colleague of my father's and whom I had known since childhood. He asked me what brought me to the hospital. When I told him I was a patient on the psychiatric unit, a look of horror gripped his face momentarily. This expression was too quickly replaced by forced humor. 'That's a good one Danny,' he laughed too loudly and briskly walked on. I knew from that time on I was branded and should not lightly share information about my hospitalization.

As indicated in the above passage, disclosure also may lead to benefits. Experts, advocates, and people with psychiatric disabilities have said that openly admitting the diagnosis of a mental disorder may enhance self-esteem, diminish shame, permit coworkers and others to offer support, and even empower another individual's revelation (12,32,35,46). Data from one study of people with psychiatric disabilities participating in a vocational rehabilitation program suggested that refusal to disclose was linked to a shorter job tenure (1 1). Data from another study indicate that employers who knowingly hire individuals with mental disorders have a more positive attitude about accommodations and abilities of such individuals than employers who do not (7). Evidence also suggests that experience with workers who have psychiatric disabilities decreases the perception that mental illness is linked to violence or hostility (7). Important to this discussion, disclosure invokes the protection of the ADA. At least one conclusion can be drawn about the difficult decision to disclose a psychiatric disability: Research into the impact of disclosure, of which there is a dearth, undoubtedly would assist in this process.

The decision to disclose a psychiatric disability is only the first of several considerations. What exactly should one disclose? to whom? when? The EEOC suggests that "an employee needs to disclose enough information about his disability-related work 1 imitations to support his need for accommodation" (72). Such a goal would rarely necessitate a complete medical/treatment history: "[B]ecause of the flexible nature of this process, the EEOC does not necessarily require employees to disclose specific diagnoses (psychiatric or otherwise), as a prerequisite for reasonable ac-

commodation" (72). ' A recent case study found that managers of people with serious psychiatric disabilities, many of whom were referred by rehabilitation services, seem to know surprisingly little about the nature of their employees' impairment (35). This finding confirms the general experience of vocational and psychosocial rehabilitation service providers.

Care providers must also consider the question of what to disclose. The ADA permits employers to call on experts to confirm the presence of an "invisible" disability and to offer advice on reasonable accommodations. Of course, psychiatrists, psychologists, and other mental health professionals have long been involved with work-related assessments of mental health. Disclosure of a mental disorder raises a host of ethical, legal, and practical concerns, including informed consent and confidentiality (50,5 1). Professional associations are cautious: The American Psychiatric Association's "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry" counsel psychiatrists to "fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination," when evaluating individuals for job suitability or security purposes *(50). The* American Occupational Medical Association advises physicians to

> treat as confidential whatever is learned about individuals served, releasing information only when required by law or by over-riding public health considerations . . . and should recognize that employers are entitled to counsel about the medical fitness of individuals in relation to work, but are not entitled to diagnoses or details of a specific nature (50).

The ADA tells care providers, when requested, to provide information that is sensitive to the needs of the employee and employer at work.

Like the issue of what to disclose, employees must consider when and how to do so. Should one reveal a psychiatric disability or history of one at the time of application? when hired? when an accommodation is needed? after perceiving that one has been discriminated against? Again, few research data shed light on this issue. Some people with psychiatric disabilities interviewed recently recommend waiting until after first establishing oneself as a good employee (35). While little reason, and no legal requirement exists, to disclose before an accommodation is needed, and ample reason exists not to disclose too soon, waiting too long also may be a problem. As noted at a recent OTA meeting(1):

> From the employer perspective the big concern is that these issues tend to arise when there is some kind of performance problem or conduct problem. Somebody isn't coming to work on Mondays and Fridays or is missing a lot of work, and the employer doesn't know why and begins progressive discipline. And, typically, what happens is the person doesn't say anything relating to a medical condition, and then when the axe is about to fall and termination is proposed and is imminent, all of a sudden the person says, "Wait a minute. All of my problems are due to my medical condition, my disability, and you can't discharge me."
>
> At that point the employer's emotional reaction typically is, "Well, you never said anything about this before and it's too late." Whether or not it's too late is an interesting legal issue for the EEOC, but that's where it arises and that may be the only reason why someone may wish to disclose in advance of problems to deal partly with the legal requirement and partly with the interpersonal relationship with the employer.

An employee may also be uncertain whom to tell about a psychiatric disability. The EEOC regulations and guidelines make clear that information about a disability may be distributed to various individuals, including one's direct supervisor, who may be responsible for providing the accommodation; medical or emergency personnel, who

[1] Employer confirmation of a psychiatric disability as well as EEOC investigation of a charge of discrimination may require more information, including a diagnosis.

may be called on during a crisis; and government officials investigating compliance with this and other laws. Neither guidance on who in the organization should be contacted first, nor research data on whom employees should approach and what happens as a consequence exists. Establishing a procedure for disclosure may help ease employees' tasks, and assist employers in implementing the ADA. A mental health advocate and expert explains at a recent meeting (53):

> Procedure is very important . . . what the EEOC and others can do is work on making it possible for people to disclose by designating an office or individual of an employer who is the reasonable accommodation person, whose job it is to make it comfortable to disclose, to be a mediating force with supervisors and other employees so that if disclosure has to occur under the ADA, there's a way to make it easier.

In larger organizations, existing resources—including human resource offices, personnel offices and employee assistance programs—may help facilitate disclosure (box 4-1). However,

> [i]n practice. . . [designating a specific ADA contact] may not always work. Some employees may not be comfortable dealing directly with the designated person and should be allowed to work with a trusted supervisor or superior. . . In some situations, moreover, the designated person may need to meet with an outside ADA consultant or with upper management as part of the reasonable accommodation process . . . If the work force is unionized, the involvement of a union representative also may be requested . . . [A]ll of these individuals [barring perhaps the union representative][2] would be subject to the ADA's confidentiality requirements (72).

The assumption behind this discussion—that revealing a psychiatric disability is a voluntary and premeditated action—is not always correct. As noted in the ADA and relevant regulations and guidelines, information about an impairment or history of impairment may arise from a variety of sources, such as medical examinations after an offer of employment, for medical insurance or for workers' compensation purposes. Also, some people with serious psychiatric disabilities have gaps in employment history, arrestor criminal records that reflect the course of their condition. The EEOC stresses that

> an employer may not make pre-offer inquiries about disability, and that this prohibition extends to requests for workers' compensation records, health insurance records, references, or other relevant materials. In terms of criminal records or gaps in employment or educational history, an employer may inquire about the employment gaps and criminal records but may not ask whether they reflect the course of disability. If the applicant inadvertently discloses a disability (physical or mental), the employer may not ask follow-up questions about the disability and may not make employment decisions on the basis of the disability. Once an employer knows that an applicant has a history of disability, the employer will have to prove that this was not the reason for an adverse employment action if the individual later files an ADA charge (72).

People with psychiatric disabilities who have an arrest, criminal record, or employment history gap stemming from their disability may face the dilemma of not gaining employment because of these factors or having to disclose their disability in order to explain work history gaps, for example. The prevalence of this occurrence is unknown.

Employers may face another difficult situation related to the disclosure of a psychiatric disability. A change in behavior or performance may suggest to a coworker or employer that an employee is suffering from a psychiatric impairment. However, the employee may not recognize such symptoms or may not be willing to admit to having such a problem. Indeed, a psychiatric impairment may not exist. Under the ADA, employers are general-

2 The EEOC has not yet decided whether a union representative involved in the reasonable accommodation process would be subject to the ADA's confidentiality requirements. The Commission is considering this question, along with other ADA issues unique to unionized workforces.

BOX 4-1: Employee Assistance Programs

Employers increasingly turn to employee assistance programs—EAPs—to help employees become more fit, healthy, and able to cope with personal problems. From a few employer-sponsored alcohol abuse programs in the 1940s, EAPs have expanded across the largest U.S. businesses. This box considers the current roles of EAPs in American businesses and what they may bring to ADA implementation, especially for people with psychiatric disabilities,

There are an estimated 12,000 EAPs in the U.S. A 1989 Employee Benefits Survey conducted by the Bureau of Labor Statistics found that 49 percent of full-time workers in private business establishments with more than 100 employees were offered EAPs. Fifteen percent of full-time workers in private business establishments with fewer than 100 employees were offered these programs.

EAPs are structured in a variety of ways and vary a great deal in the types of services they offer. Some firms—usually large corporations—have built on in-house programs that are likely to have originated as alcohol rehabilitation programs. Many retain a single problem focus on alcohol and drug abuse, tend to have strong links with labor unions, and are used most frequently by involuntarily referred male and minority employees, Some smaller firms form consortia to provide collectively owned EAPs, And some firms contract, individually or in multi-firm consortia, with outside providers for employee assistance services. Contractual EAPs offer employers a choice of a broad range of services on a fee for service basis. While some contractual EAPs undoubtedly offer professional, quality services, others have engendered a reputation for the "business card phenomenon" in which unqualified people print up business cards and announce that they are providing EAP services.

The professional make-up of EAP service providers reflects the variation among EAPs themselves. An EAP practitioner maybe self-educated, be a graduate of a certificate program, or have an advanced degree in one of the health care professions. A 1986 survey of 182 EAP practitioners found that one-third had an advanced degree, most often in social work, psychology, or psychiatry About 18 percent had a relevant undergraduate degree (but no graduate training), 21 percent were certified in alcohol and/or drug counseling and 5 percent had participated in other "certificate programs. " Close to 22 percent of the practitioners received ongoing training by attending on-the-job and professional workshops. The survey analysts concluded that 17 percent of the EAPs that offered specialized services such as counseling and case management did not have the skilled staff legally required to provide the services. These data indicate that some EAP professionals are highly trained and have an extensive background in mental health; they are likely to be familiar with issues presented by psychiatric disabilities. However, many do not have training that would familiarize them with these conditions. Moreover, because employee assistance practitioners who are not licensed cannot classify client sessions as privileged, there is a danger that confidentiality could be breached in the event records were subpoenaed.

Thus, the history, types of services provided, and professionals involved suggest that some EAPs have the potential to assist in such critical areas as disclosure, devising accommodations, verifying disabilities, and educating the work force and supervisors. It is important to note, however, that although "pockets of activity" exist, EAP service providers have not yet recognized, much less defined in an organized way, their role as educators about the ADA or psychiatric disabilities. Furthermore, EAP experience is not with people with more serious psychiatric disabilities. And, most workers do no have access to EAPs.

SOURCES S Berger, Washington Employer Resource Consortium, Washington, DC, personal communication, April 1993, Bureau of National Affairs Inc , *Employee Assistance Programs Benefits, Problems, and Prospects* (Washington, DC: The Bureau of National Affairs, Inc , 1987), H V Hayghe, "Antl-Drug Programs in the Workplace Are They Here to Stay?" *Month/y Labor Review*, April 26-29, 1989, S L Hyland, "Health Care Benefits Show Cost-Containment Strategies, " *Month/y Labor Review* February 42-43, 1992; F Luthans and R Waldersee, "What Do We Really Know About EAPs?" *Human Resource Management 28(3) 385-401, 1989,* D Phillips, Center for Occupational Programs for Employees, Inc , Washington, DC, personal communication; April 1993, L A Straussner, "A Comparative Analysis of In-House and Contractual Employee Assistance Programs, *Evaluation of Employee Assistance Programs,* M J Holosko and M D Feit (eds) (New York, NY Haworth Press, 1988)

ly forbidden from inquiring about a possible impairment or disability. However, medical inquiries may be made during employment if they are job-related and consistent with business necessity. This means, according to the EEOC,

> that the inquiries must be related to the specific job at issue and must concern performance of an essential function of that job. Under this standard, medical inquiries are allowed. . . if an employee is having difficulty performing essential job functions effectively, an employer may inquire about the difficulties and whether they may have a medical cause without violating the ADA (72).[3]

These limitations on medical inquiries offer important protection to employees with psychiatric disabilities, given the stigma attached to mental disorders, the ease with which our society equates poor job performance or unusual behavior with a mental illness, and the cultural diversity that exists in our society, which makes inferences about individual behavior difficult. Guidance from people with psychiatric disabilities, employers, and other experts on how to manage such situations, and research on the prevalence and potential outcomes would help clarify these difficult questions for employees and employers.

Qualifying for a Job

A critical question under the ADA is: "Are you qualified?" The requirements of Title I apply only to those who meet the definition of "qualified individual with a disability." The EEOC's guidance on answering it bounces back and forth between an evaluation of the individual with a disability as well as the requirements of the job (box 4-2).

The first branch of this decision tree focuses on general prerequisites of a position. As explained by the regulation, a:

> *[qualified individual with a disability means an individual with a disability who satisfies the requisite skill, experience, education and other job-related requirements of the employment position such individual holds or desires (56 FR 35735).*

That an employee must meet such basic requirements as holding a particular degree, such as an M.D. to practice medicine, or has a particular skill, such as knowing how to type for a secretarial position, is neither onerous nor surprising. Such standards have become the currency by which a minimal level of knowledge or expertise is assured. But even this most basic hurdle may be difficult for some people with psychiatric disabilities to overcome. As described in chapter 3, the onset and course of some severe psychiatric conditions interrupt educational and occupational advancement. Thus, for some people with psychiatric disabilities, the first step toward an affirmative "I am qualified" will rest on other policies and services aimed at supporting education and training (e.g., vocational and psychosocial rehabilitation, supported education).

For the person who has earned a degree and/or garnered the necessary skills and licenses, the question now becomes more specific: "Can you, with or without an accommodation, perform the essential functions of the job?" The focus is shifted to the job itself. What exactly are essential functions? The statute defines essential functions as

> *the fundamental job duties of the employment position the individual with a disability holds or desires. The term "essential functions" does not include the marginal functions of the job (56 FR 35735).*

The EEOC's regulatory language outlines various reasons for calling a task an essential function:

> *(i) The function maybe essential because the reason the position exists is to perform that finetion;*
>
> *(ii) The function maybe essential because of the limited number of employees available*

[3] Employers may make medical inquiries in two other situations as well, under this standard: If the employer has a legitimate basis to be concerned about direct threat and when other Federal laws require it.

BOX 4-2: Testing and the Worksite: Issues Around Discrimination and Accommodation

Many firms use tests developed and validated by psychologists for employment purposes, Psychological tests—including cognitive ability tests, personality tests, honesty and integrity tests, and interest inventories—can be used by organizations in screening of applicants, and in the promotion, training, and development of employees. The use of such tests raise concerns about validity, privacy, and discrimination. The ADA adds to the constellation of concerns. This box describes the issues raised by the ADA and psychological testing for people with psychiatric disabilities.

The ADA specifically enjoinders against discriminatory employment tests. Discrimination is defined to include,

> **a)** *using qualification standards, employment tests or other selection criteria that screen out, or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity is shown to be job-related for the position in question and is consistent with business necessity, and,*
>
> *b) failling to select and administer tests concerning employment in the most effective manner to ensure that, when such test is administered to a job applicant or employee who has a disability that impairs sensory manual or speaking skills, such test results accurately reflect the skills, aptitude or whatever other factor of such applicant or employee that such tests purports to measure, rather than reflecting the impaired sensory manual or speaking skills of such employee or applicant (except where such skills are the factors that the test purports to measure).*

The EEOC regulations further clarify.

> *A selection criteria that is not job related and consistent with business necessity violates section* 1630. *IO(a) only when it screens out an individual with a disability on the basis of disability there must be a nexus between the exclusion and the disability A selection criterion that screens out an individual with a disability for reasons that are not related to the disability does not violate this section.*

The ADA does not outlaw the use of psychological tests for employment purposes, nor does it mandate a standard of proven relevance to a particular job. Rather, it entreats against testing which has a discriminatory impact on people with disabilities, And even this requirement takes a back seat to business necessity,

The impact of psychological testing on people with psychiatric disabilities seldom has **been discussed; indeed, the EEOC'S regulatory language specifies only "impaired sensory, manual or speaking skills, "** Nonetheless, questions may arise concerning the potential discriminatory impact of employment testing on people with psychiatric disabilities and accommodations useful to this population.

In many instances, the same psychological test can be used for different purposes and in different settings, such as both employment selection and clinical diagnosis. This has raised the issue of whether or not psychological tests should be viewed as pre-employment tests or medical exams, which are more stringently regulated under the ADA. Wayne Camara, the Assistant Executive Director of Science at the American Psychological Association, asserts that "tests used in an employment context, to measure job related functions or characteristics as opposed to diagnostic purposes, do not constitute medical examinations. Often instruments originally designed for clinical purposes are used to identify suitability for the job or to predict job performance. Used in such contexts any diagnostic information that could possibly reveal the presence and nature of a psychiatric disability are not sought nor reported to an employer. " The EEOC has not released relevant guidelines to date, however, the commission is currently working on guidance for pre-employment medical exams that will include a section on psychological testing. The guidelines will most likely consist of factors an employer can review to determine whether a test is medical or not. If tests are used primarily in a clinical setting to diagnose psychiatric disabilities, the test maybe considered a medical exam under the ADA.

(continued)

BOX 4-2: Testing and the Worksite: Issues Around Discrimination and Accommodation (cont'd.)

An individual with a psychiatric disability may need accommodation during a testing procedure; the ADA does require "reasonable accommodation" during pre-employment testing. Accommodating individuals with psychiatric disabilities during pre-employment exams raises some dilemmas. Disclosure of a disability is required before an accommodation may be required. The stigma and discrimination so often attached to mental disorders may hinder disclosure during the application process. Advocates suggest that most people with a psychiatric disability will not disclose during the application process for this reason. The price of not disclosing also maybe high; an individual with a psychiatric disability may fail to be hired in the face of impaired performance on a psychological test.

Another issue raised by accommodating individuals with disabilities during pre-employment testing is identifying useful accommodations. OTA was unable to find data that document accommodations that may be useful or effective for people with psychiatric disabilities. Commonly used test modifications may be helpful for persons with specific psychiatric disabilities, however, including changes in the time allowed for tests, and the administration of tests individually rather than in a group. Test modifications, even commonly used ones, do raise questions concerning reliability and validity.

SOURCES: American Psychological Association, *Standards for Educational and Psychological Testing* (Washington, DC American Psychological Association, 1985); W.J. Camara, Assistant Executive Director for Science, American Psychological Association, Washington, DC, personal communication, May24-25, 1993, Sept. 24, 1993, and Jan. 18, 1994, C Hansen, "Psychological Assessment A Research Literature Review," *A Handbook of Psychological Assessment, C.* Hansen (ed) (New York, NY: Quorum books, 1991), R. Klimoski, Professor of Psychology, Ohio State University, Columbus, Ohio, personal communication, May *24, 1993,* D J Kleinke, Director, Employ merit Testing, Edison Electric Institute, Washington, DC, personal communication, Jan. 12,1994, R. Klimoski, and S. Palmer, "The ADA and the Hiring Process in Organizations," *Consulting Psychology Journal 45(2) 10-35, 1993;* PR Mastroianni, Assistant Legal Counsel, ADA Policy Division, U.S Equal Employment OpportunltyCommw.ion, Washington, DC, personal communication, May24, 1993; J.W. Parry, "Mental Disabilities Under the ADA' ADifficult Path to Follow, "*Mental and Physical Disability Law Reporter* 17:100-112, 1993.

among whom the performance of that job function can be distributed; and/or

(iii) The junction may be highly specialized so *that the incumbent in the position is hired for his or her expertise or ability to perform the particular function (56 FR 35735).*

Employer judgment, previously written job descriptions, the actual experience of a previous worker in that position, as well as time spent doing a task and implications of not doing it determine essential functions. The EEOC's guidance does not eschew employer judgment on what is essential. Rather, one way in which the law approaches the goal of nondiscrimination is by equating the defined essential components of a job with what is actually performed. An employer cannot select employees by a higher standard than he or she is in fact tolerating.

Nor is an employer obliged to lower performance standards under the ADA. To quote the EEOC's guidance:

It is important to note that the inquiry into essential functions is not intended to second-guess an employer's business judgment with regard to production standards, whether qualitative or quantitative, nor to require employers to lower such standards . . . If an employer requires its typists to be able to accurately type 75 words per minute, it will not be called upon to explain why an inaccurate work product, or a typing speed of 65 words per minute, would not be adequate. Similarly, if a hotel requires its service workers to thoroughly clean 16 rooms per day, it will not have to explain why it requires thorough cleaning, or why it chose a 16 room rather than a 10 room requirement. However if an employer does require accurate 75 word per minute typing or

the thorough cleaning of 16 rooms, it will have to show that it actually imposes such requirements on its employees in fact, and not simply on paper. It should also be noted that, if it is alleged that the employer intentionally selected the particular level of production to exclude individuals with disabilities, the employer may have to offer a legitimate, nondiscriminatory reason for its selection (56 FR 35743).

Performance standards, especially in terms of attendance, may raise especially difficult issues for employers. Regular and predictable attendance is a standard of performance commonly viewed as essential—whether it is in the job description or not. The courts basically have upheld this position.[4] **Even so, attendance** is not so easily dealt with. As noted in the previous chapter, a characteristic feature of some psychiatric disabilities as well as some other health conditions is the intermittent and often unexpected flair of symptoms, which may preclude work for a short time. People with psychiatric disabilities and others who have pulled together lists of desired or useful accommodations universally bring up occasional medical leave or part-time work. Indeed, an employer's duty of reasonable accommodation will almost certainly include the duty to tolerate additional absences. Differentiating between additional absences as a reasonable accommodation and absences as a performance problem will prove challenging to many employers.[5]

Given the ADA's requirements, many experts and advocates advise businesses to write job descriptions and requirements before filling a position and to make sure that review of an applicant qualifications are based on the requirements of the job. So does the EEOC:

Although part 1630 (of the regulations) does not require employers to develop or maintain job descriptions, written job descriptions prepared before advertising or interviewing applicants for the job . . . are among the relevant evidence to be considered in determining whether a particular function is essential (56 FR 35743).

Survey data indicate that employers, especially in large businesses, have focused a considerable portion of their implementation efforts on preparing job descriptions (74). Employers-especially large employers—increasingly summon experts to conduct job analyses to guide their hiring and employment practices.

The ADA is just the latest in a series of laws, judicial decisions, and professional trends fostering job analysis. For example, the Federal *Uniform Guidelines on Employee Selection Procedures*—published jointly by the U.S. Civil Service Commission, the U.S. Department of Justice, the EEOC, and the U.S. Department of Labor in 1978—specifically recognizes the relevance of job analysis in demonstrating selection procedures when an employer is charged with discriminatory hiring practices. In addition, professional guidelines issued by organizations such as the American Psychological Association, the American Educational Research Association, the National Council on Measurement in Education, and the Society for Industrial and Organizational Psychology of the American Psychological Association stress the importance of job analysis to assess the essential functions of a job.

What exactly is job analysis? Basically, it is the process of gathering and synthesizing information about job functions and the work environment. A

[4]Courts have analyzed an inability to maintain regular attendance in variety of ways, including: (a) the view that an inability to maintain regular attendance makes an individual not "otherwise qualified" under the first part of the definition of "qualified individual with a disability;" (b) the view of attendance as an essential function under the second prong of the definition of "qualified," with focus on whether a reasonable accommodation enables the person to perform this function; and (c)considering a disciplinary action based on an employee's failure to satisfy a performance standard as legitimate or discriminatory under the ADA (72).

[5]The EEOC emphasizes that "essential functions generally involve job tasks rather than abilities or ways of doing things. . . If something is labeled as an essential function, the analysis will be whether the function itself can be performed with reasonable accommodation. . . [Furthermore] some requirements are more suitably viewed as behavior or performance standards. . . [w]hen. . . employers must consider whether they are truly necessary for performance of a particular job and job function, and whether they can be adjusted without undue hardship" (72).

job analysis determines the essential and nonessential job functions and forms the criteria for recruiting, selecting, accommodating, training, and determining fair wages.

There are several ways to conduct a job analysis. Typically, an expert, such as an industrial/organizational psychologist, will observe workers performing the job in question, examine the context of the job, conduct interviews with workers and their supervisors, and occasionally make use of a questionnaire to be completed by a representative sample of people currently holding the job (14,20).

There are dozens of systems of job analysis. They vary widely in their objectives, theoretical foundations, and methods of data gathering and analysis. They can be divided into two general groups: "Job-oriented" systems focus on the mission, tasks, and other substantive features of jobs; "worker-oriented" systems focus on the abilities, skills, and other characteristics of the workers performing the job (2,1 5).

Functional job analysis, a job-oriented approach developed by the U.S. Department of Labor (DOL) in the 1930s, is the most established method of job analysis. The approach is comprehensive, simple to use, and expandable. Virtually all job analysis systems have used or adapted its materials. The DOL system forms the basis of the *Dictionary of Occupational Titles* (DOT), which is the most comprehensive source of information on the occupational structure of the U.S. economy. The passage of time has rendered the DOT out of date, especially in regards to the cognitive, behavioral, and social demands of a job. These job components are especially relevant not only to psychiatric disabilities but to an economy that is increasingly based on services instead of manufacturing. The DOL is conducting research to improve job analysis methodology, which will provide guidance on the cognitive, behavioral, and other requirements of jobs (70). Also, DOL chartered the Advisory Panel for the Dictionary of Occupational Titles to make recommendations for a new DOT system that will reflect the changes taking place in the workplace. The advisory panel has submitted a final report to the Secretary of Labor, who will review the recommendations and develop a plan to implement a new DOT (70).

Ascertaining the psychological and social demands of a job and how well an individual meets such demands is especially relevant to people with psychiatric disabilities. Some of the most vexing management and legal questions also will arise around behavior. Cases under the Rehabilitation Act vividly illustrate some of the difficulties employers have encountered in managing emotional outbursts, insubordination, threats, and other erratic behavior in employees with psychiatric disabilities (1 O). Given such concerns, employers may be well-advised to consider carefully the specific psychological, behavioral, and social requirements of positions in their organization.

Providing Reasonable Accommodation to a Qualified Employee

The ADA requires employers to provide "reasonable accommodations" for qualified individuals with disabilities.[6] The law equates discrimination with not making such accommodations. As the linchin of the ADA's antidiscrimination requirement, the identification of effective accommodations for people with psychiatric disabilities becomes critical. Just as it appears that many people construe a disability as a physical disability—such as being in a wheelchair—accommodations are often viewed in physical terms—such as building a ramp. Many experts and advocates note that employers are unfamiliar with the types of

[6]The ADA calls for accommodation in three contexts: during employee selection, on the job, and in terms of benefits and privileges of employment. This section focuses on the accommodation of employees on the job. The sections on psychological tests (box 4-2) and mental health benefits considers some issues relevant to applicants and privileges of employment. It is important to note that: "[I]t is least likely that reasonable accommodations for people with mental disabilities will be required during the hiring process, since most people probably will not reveal their disability until after they are hired. Even for those who would choose to reveal their disability, the pre-hiring circumstances in which a reasonable accommodation would be needed are limited" (47). Further discussion is provided in the section on disclosure.

measures that may assist people with psychiatric disabilities in the workplace (10,34,35).

A variety of workplace modifications may assist people with psychiatric disabilities. Changes to the physical environment, such as a private office or secluded work space, maybe useful; however, measures such as restructuring job tasks or schedules may be required. Such "nonphysical" interventions may form "reasonable accommodations" under the ADA, according to the language of the law itself, EEOC regulations and guidelines, and case law interpretations of the Rehabilitation Act. EEOC regulations say:

> *Reasonable accommodation may include but is not limited to . . . [j]ob restructuring. . . [or] part-time or modified work schedules (56 1% 35736).*

The guidelines go further:

> *IO]ther accommodations could include permitting the use of accrued paid leave or providing additional unpaid leave for necessary treatment. . . An employer . . . may restructure a job by reallocating or redistributing nonessential, marginal job functions. . . An employer. . . may also restructure a job by altering when and/lor how an essential jinction is performed. For example, an essential jumction customarily performed in the early morning hours may be rescheduled until later in the day as a reasonable accommodation to a disability that precludes performance of the function at the customary hour . . . The reasonable accommodation requirement is best understood as a means by which barriers to the equal employment opportunity of an individual with a disability are removed or alleviated. These barriers may . . . be rigid work schedules that permit no flexibility as to when work is performed or when breaks may be taken, or inflexible job procedures that unduly limit the modes of communication that are used on the job, or the way in which particular tasks are accomplished (56 FR 35744).*

The legal definition of accommodation, thus, makes explicit reference to adjustments useful to people with psychiatric disabilities. The question then becomes: "What measures should be enacted for a specific individual with a psychiatric disability in a specific workplace?" Of course, this question cannot be answered in the abstract, but must be addressed on an individual basis, taking into account a particular employee's limitations, abilities, and preferences, as well as the nature of the job, work site, and the employer's resources. Enumeration of potentially useful measures, however, could aid this decisionmaking process. While few data speak to the impact of such measures in a competitive work setting, OTA found that several experts and consumer groups have begun compiling lists of potentially useful accommodations, based on surveys, experience in vocational rehabilitation, and preliminary studies (5,8,1 1,18,34, **35,46,48,59,65,69)** (tables 4-2 and 4-3).

All of these sources strike similar chords. In general, many accommodations address the functional limitations commonly associated with psychiatric disabilities: difficulties in concentrating, dealing with stress, and interacting with others (see ch. 3). To help an individual concentrate on work tasks, employers may: provide a private office or space for work, so as to limit interruptions and noise; maintain structure through well-defined daily task schedules; eliminate nonessential or secondary tasks that may be distracting; and minimize supervisor/coworker interruption of an employee. Accommodations that may help an employee better deal with stress include: increased positive feedback and sensitivity on the part of supervisors and coworkers; making time or other resources (e.g., support from supervisor or willing coworker; counseling services at the office) available for contacting support network (figure 4-2); and permitting self-paced workload, flexible hours, and work at home (with provision of necessary technical equipment such as a computer). Orienting supervisors and coworkers may also help ease the difficulties people with psychiatric disabilities may have with interpersonal interactions (figure 4-3).

Among the most common accommodations listed by experts and people with psychiatric disabilities are those that address symptoms or treatment side effects. All lists compiled include providing leave when short-term hospitalization is required to control symptoms. Other accommodations include: use of part-time work schedules,

TABLE 4-2: Accommodations Used In Vocational Rehabilitation

Type of accommodation	Number of accommodations (n=231)	Number of jobs using accommodation (n=47)
Orientation and training of supervisors to provide assistance	80 (38.1%)	39 (83%)
Modifying work environment by provision of onsite job support and assistance	38 (16.4%)	35 (74%)
Modifying work schedules and time	36 (15.6%)	25 (53%)
Modifying work rules of procedures	24 (10.3%)	16 (34%)
Modifying performance expectations	17 (7.4%)	15 (32%)
Modifying job tasks	14 (6.1%)	13 (28'%)
Modifying work place social norm	12 (5.2%)	13 (28%)
Orienting coworkers	7 (3.0%)	5(1 1%)
Other	3 (1.7%)	3 (6%)

NOTE: Percentages will not add to 100 since more than one accommodation was provided to each employee.

SOURCE: E.S. Fabian, A. Waterworth, and B. Ripke, 'Reasonable Accommodations for Workers With Serious Mental Illness: Type, Frequency, and Associated Outcomes," Psychosocial Rehabilitation Journal 17:163-172, 1993.

job-sharing, or more frequent breaks (for those who do not have the stamina for full-time work); flexible hours (that take into account medication side effects, such as early morning drowsiness); time off each week for clinical services; and limited night or shift work when symptoms or effects of medication interfere.

Some advocates have suggested that decreased work standards may be a useful accommodation for people with psychiatric disabilities (67). In fact, evidence from the preliminary study of people with psychiatric disabilities participating in a vocational rehabilitation program show that "accommodations" often involved modifying performance expectations (1 1). However, case law under the Rehabilitation Act does not appear to support compromise on legitimate performance standards to accommodate individuals with psychiatric disabilities (10). And the EEOC's statements regarding essential functions of the job indicate that the ADA does not bar legitimate productivity requirements, so long as they are enforced in a nondiscriminatory manner: "[Employees with disabilities should not be evaluated on a lower standard or disciplined less severely than any other employee. This is not equal employment opportunity" (73).

Lists of commonly desired or used accommodations, while aiding the decisionmaking process, do not supplant the need for case-by-case assessment. Work places and jobs vary, as do people with psychiatric disabilities, who include a broad range of talent, ability, and functional limitations. Some individuals with psychiatric disabilities may even be insulted by the suggestion that they cannot work full time, need very detailed supervision, or should be secluded. A former director of Fountain House commented, "I have seen lists of accommodations and some seem highly unnecessary for most people such as an accommodation which arranges for a person having difficulty with people to work in isolation (54)."

The education of supervisors and coworkers emerges as a commonly cited accommodation. People often do not understand psychiatric disabilities, may feel uncomfortable around people with such a disability, fear them, or may simply not know how to act. At least two studies have shown that inservice education in higher education settings decreases fear of disruption by people with mental disorders (6,75) Worksite training and orientation must proceed carefully, however. For example, coworker training may have a variety of purposes, such as dispelling the

TABLE 4–3: Accommodations for People With Psychiatric Disabilities*

Flexibility
- Providing self-paced workload and flexible hours
- Allowing people to work at home, and providing necessary equipment
- Providing more job-sharing opportunities
- Modifying job responsibilities
- Providing supported employment opportunities
- Keeping the job open and providing a liberal leave policy (e.g., granting up to 2 months of unpaid leave, if it does not cause undue hardship on the employer)
- Providing back-up coverage when the employee needs a special or extended leave
- Providing the ability to move laterally, change jobs, or change supervisors within the same organization so that the person can find a job that is a good fit
- Providing time off for professional counseling
- Allowing exchange of work duties
- Providing conflict resolution mechanisms

Supervision
- Providing written job instructions
- Providing significant levels of structure, one-to-one supervision that deals with content and interpersonal skills
- Providing easy access to supervisor
- Providing guidelines for feedback on problem areas, and developing strategies to anticipate and deal with problems before they arise
- Arranging for an individual to work under a supportive and understanding supervisor
- Providing individualized agreements

Emotional supports
- Providing ongoing on-the-job peer counseling
- Providing praise and positive reinforcement
- Being tolerant of different behaviors
- Making counseling/empioyee assistance programs available for ail employees
- Allowing telephone calls during work hours to friends or others for needed support
- Providing substance-abuse recovery support groups and one-to-one counseling
- Providing support for people in the hospital (e.g., visits, cards, telephone calls)
- Providing an advocate to advise and support the employee
- Identifying employees who are willing to help the employee with a psychiatric disability (mentors)
- Providing on-site crisis intervention services
- Providing a 24-hour hot-line for problems
- Providing natural supports

Physical accommodations at the workplace
- Modifying work area to minimize distractions
- Modifying work area for privacy
- Providing an environment that is smoke-free, has reduced noise, natural light, easy access to the outside, and is well-ventilated
- Providing accommodations for any additional impairment (e.g., if employees with psychiatric disabilities have visual or mobility impairment, they may need such accommodations as large print for written materials, 3-wheel scooter, etc.)

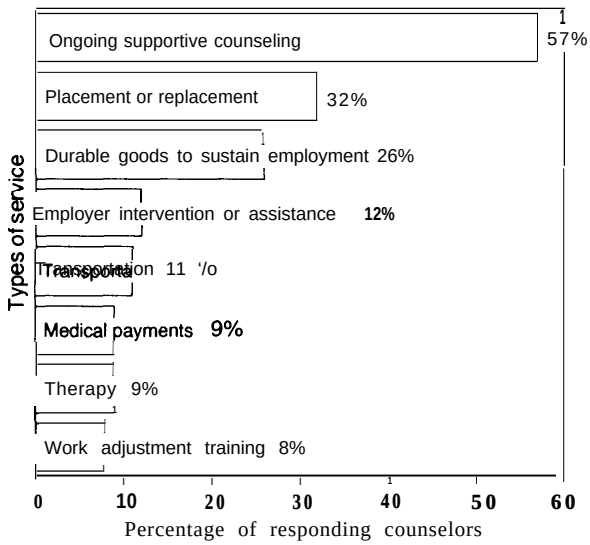
Wages and benefits
- Providing adequate wages and benefits
- Providing health insurance coverage that does not exclude pre-existing conditions, including psychiatric disabilities, HIV, cancer, etc.
- Permitting sick leave for emotional well-being, in addition to physical well-being
- Providing assistance with child care, transportation, care for aging parents, housing, etc.
- Providing (specialized) training opportunities

Dealing with coworkers' attitudes
- Providing sensitivity training for coworkers
- Facilitating open discussions with workers with and without disabilities, to articulate feelings and to develop strategies to cleat with these issues
- Developing a system of rewards for coworkers without disabilities, based on their acceptance and support for their coworkers with disabilities

The items on this list do not necessarily refcts "reasonable accommodaticactions" as defined by the **ADA.**

SOURCE: President's Committee on Employment of People With Disabilities, 1993

FIGURE 4–2: Employment Services Provided to People With Psychiatric Disabilities



In a survey of vocational rehabilitation counselors, researchers identified counseling to be the most frequent post-employment service provided to people with psychiatric disabilities.

SOURCE M D Tashjia, B J Hayward, S Stoddard et al , *Best Practice Study 01 Vocational Rehabilitation Services to Severely Mentally Ill Persons* (Washington, DC. Policy Study Associates, 1989)

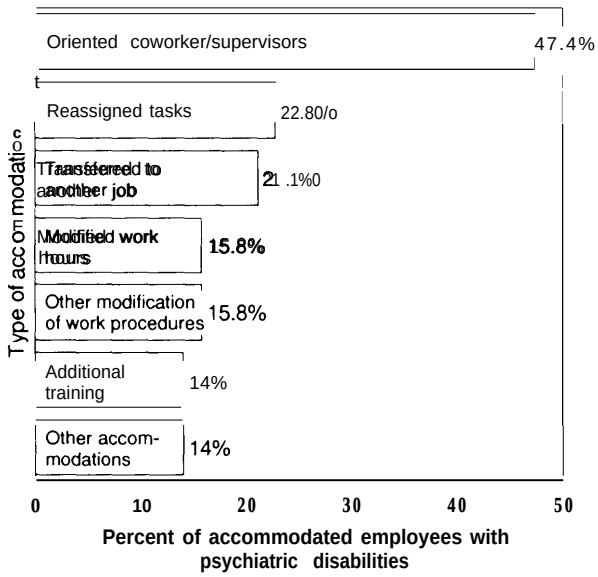
ignorance and harmful myths attached to mental disorders or providing information on how best to manage an employee with a psychiatric disability. But, focusing a training course around an individual employee identified as having a psychiatric disability may be exceedingly stigmatizing and illegal. Experience with AIDS workplace education programs shows that while effective education need not be costly (see ch. 5), simply distributing pamphlets about AIDS increased employee anxiety rather than diminishing it (21 ,22). Also, a workplace policy defining the company's position and practices as they relate to an employee with a disability appears critical (74): It guides employee attitudes and behavior, establishes a framework for communication, instructs supervisors on how to address the issue, and lets all employees know where to go for confidential information and assistance.[7]

Many mental health advocates and experts note the parallel between useful accommodations for people with psychiatric disabilities—such as workplace flexibility and an individualized approach to management—and good management practices that would benefit any worker. They assert that adjustments of job demands to the temperament, sensitivities, strengths, weaknesses, and preferences of a valued employee happens all the time. Data from a recent preliminary study support this observation (35). Several supervisors responded that they made accommodations to employees with psychiatric disabilities "because it made good business sense and because they made such modifications for any employee who needed them." Data from another recent study indicate that those who already employ persons with psychiatric disabilities are quite knowledgeable about the needs of these workers for accommodations, have more positive attitudes, and may be quite open to accommodating these workers if need be (7). Thus, exposure can be a critical part of the equation.

But, the apparent routine nature of such management practices is paradoxical and potentially problematic. Employers, familiar with "accommodations" that may be useful for people with psychiatric disabilities, do not equate the concept with common management practices. Also, some accommodations—such as working at home or

[7]It is important to note that the EEOC is "undecided whether coworker training could be a 'reasonable accommodation' for a qualified individual with a psychiatric disability. On the one hand, coworker training would be a requirement imposed on other employees in the work place, and we have concluded **in some instances that requirements imposed on other workers are not reasonable accommodation** for the **qualified** individual with a disability. For example, we do not think that an appropriate accommodation for a qualified individual with a chemical sensitivity disability is to prohibit all other employees from wearing perfume in the office. On the other hand, coworker training could help a qualified individual with a psychiatric disability to interact more effectively with coworker-s and therefore to perform his or her essential job functions more effectively. On this basis, an argument could be made that this is a reasonable accommodation" (72).

FIGURE 4-3: Most Common Accommodations Provided to Employees With Psychiatric Disabilities



Data from survey of employers, commissioned by the U.S. Department of Labor indicated that the most frequent accommodation provided to individuals with psychiatric disabilities under the Rehabilitation Act was the orientation of supervisors and coworkers.

SOURCE Berkeley Planning Associates, *A Study of Accommodations Provided to Handicapped Employees by Federal Contractors,* **Vol 1** Study Findings (Washington, DC U S Department of Labor, 1982)

flexible hours—that may be necessary for a person with a psychiatric disability to perform his or her job, are desired by many employees. Coworkers may resent such "special" treatment, especially if the employee with an invisible disability has disclosed to his or her supervisor alone, and not to fellow coworkers. Data from a preliminary study have suggested that people with psychiatric disabilities can suffer negative social and/or personal consequences from receiving accommodations in the workplace, in part because of the general desirability of such accommodations (35). Perhaps the most troublesome legal issue emerges when an accommodation conflicts with a collective bargaining agreement. Shift work, office space, and leave time—all issues that may arise when accommodating people with psychiatric disabilities—are often dealt with in collective bargaining agreements. The law and EEOC regulations and guidelines have not fully addressed the overlap between collective bargaining agreements and reasonable accommodations. Clearly, further guidance is needed in managing such complexities and conflicts. The EEOC is now developing policy about reasonable accommodation and undue hardship in the context of collective bargaining agreements.

While the accommodations described thus far form an important resource for employers and employees, the information, as noted time and again in this chapter, was not derived from carefully controlled research. Questions about applicability, effectiveness, preference, and impact on the workplace are largely unaddressed. For example, many of the listed accommodations stem from the experience of people with the most severe conditions who receive a high density of services and support; the application of such accommodations to people with other types of psychiatric disabilities in the competitive work environment are unknown.

The ADA does not require businesses to enact every accommodation that an employee requests. As stated in the EEOC regulations:

> It *is unlawful for a covered entity not to make reasonable accommodation to the known physical or mental limitations of an otherwise qualified applicant or employee with a disability, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of its business (56* FR *35737).*

An undue hardship refers to significant diffi - culty or expense incurred by a covered entity. Factors to be considered in determining an undue hardship include:

> *The nature and net cost of the accommodation needed under this part, taking into consideration the availability of tax credits and deductions, and/or outside funding;*
> *The overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation, the number of per-*

sons employed at such facility, and the effect on expenses and resources;

- *The overall financial resources of the covered entity, the overall size of the business . . . with respect to the number of its employees, and the number, type and location of its facilities;*
- *The type of operation or operations of the covered entity, including the composition, structure and functions of the work force of such entity, and the geographic separateness and administrative or fiscal relationship of the facility or facilities in question to the covered entity; and*
- *The impact of the accommodation upon the operation of the facility, including the impact on the ability of other employees to perform their duties and the impact on the facility's ability to conduct business (56 FR 35736).*

Based on a study of the practices of 2,000 Federal contractors under the Rehabilitation Act, many claim that the cost of accommodating people with psychiatric disabilities is negligible (71). In fact, the survey data indicated that half of the accommodations made for all types of disabilities (physical and psychiatric) were cost-free; another 30 percent cost less than $500. Notably, the cost-free accommodations (e.g., changes in management practices) were among those most frequently used for people with psychiatric disabilities. These cost data, however, are not comprehensive. Estimates did not include the cost of extended leaves of absence,[8] increased supervision, or work site training. Certainly, these accommodations can represent a significant expenditure, especially for smaller companies without extensive management resources or a large work force to absorb demands. Advocates and other experts increasingly recognize the more elusive nature of costs for accommodating people with psychiatric disabilities. As recently acknowledged by the Job Accommodation Network: "Costs usually are $0 in terms of purchasing equipment. Costs come in terms of training, absenteeism, and lost productivity." And Mancuso, a rehabilitation counselor and researcher on the ADA, notes that costs may be sustained overtime: "(S)uch accommodations have the disadvantage of requiring sustained changes in practice over time. This stands in contrast to one-time, physical adaptations such as raising the height of a desk to accommodate a worker using a wheelchair (34)." More research is needed to ascertain the costs of accommodating people with psychiatric disabilities.

The EEOC's guidance on undue hardship goes beyond dollars, as indicated above: "Undue hardship" refers to any accommodation that would be unduly costly, extensive, substantial, or disruptive . . ." This does not translate into accommodating misperceptions and ignorance, however.

> It *should be noted . . . that the employer would not be able to show undue hardship if the disruption to its employees were the result of those employees fears or prejudices toward the individual's disability and not the result of the provision of the accommodation. Nor would the employer be able to demonstrate undue hardship by showing that the provision of the accommodation has a negative impact on the morale of its other employees but not on the ability of these employees to perform their jobs (56 FR 35752).*

While outright stigma and prejudice are not valid excuses for discrimination, accommodating aberrant or unusual behavior raises some difficult issues. Most lists of accommodations recognize that increased tolerance of unusual behavior is desirable. Some of the sources list conflict resolution counseling as a useful accommodation. The EEOC provides no explicit guidance on this issue. Case law under the Rehabilitation Act generally limits the employer's responsibility to accommodate disruptive behavior. Review of court deci-

[8] It is important to note that employer provision of unpaid medical leave, which maybe a reasonable accommodation under the **ADA, may be required of employers with 50** employees or more by the Family and Medical Leave Act. Thus, even if unpaid medical leave is deemed too costly to be reasonable under the **ADA, it may be required by the Family and Medical Leave Act.**

sions under the Rehabilitation Act led one legal scholar to this conclusion:

> When the employee's mental disability leads to episodes of disruptive behavior most decisions require little accommodation on the part of the employer, under the Rehabilitation Act . . . The holdings in these cases reflect that inappropriate behavior justifies adverse action, if the same action would have been taken in the absence of disability. (10)

Reasonable accommodation should not be equated with supported employment. Nevertheless, how the ADA deals with supported employment services may prove to be of critical importance for people with severe psychiatric disabilities. Research data and experience suggest that supported employment can assist many individuals maintaining employment (59). But, preliminary data indicate that neither employers nor people with psychiatric disabilities view supported employment as a reasonable accommodation (35). The EEOC draws a careful distinction between the two:

> *The term "supported employment," which has been applied to a wide variety of programs to assist individuals with severe disabilities in both competitive and noncompetitive employment, is not synonymous with reasonable accommodation. Examples of supported employment include modified training materials, restructuring essential functions to enable an individual to perform a job, or hiring an outside professional (job coach) to assist in job training. Whether a particular form of assistance* **would** *be required as a reasonable accommodation must be determined on an individualized, case-by-case basis (56 FR 35747).*

While the ADA may require some employers in large companies to provide a job coach or other supported employment service as an accommodation, undoubtedly many employers, especially those in smaller businesses, will not be required to do so, given the costs. Alternate sources of funding for supported employment services may prove critical for some people with severe psychiatric disabilities. The EEOC, in its guidance, explicitly permits alternative funding streams.

> *If the employer or other covered entity can show that the cost of the accommodation would impose an undue hardship, it would still be required to provide the accommodation if the funding is available from another source, e.g., a State vocational rehabilitation agency, or if Federal, State, or local tax deductions or tax credits are available to offset the cost of the accommodation (56* FR *35745).*

These guidelines specify two potential sources for funding: the vocational rehabilitation program and tax incentives offered to businesses. The U.S. Congress has required the Federal-State Vocational Rehabilitation program to apply supported employment services to people with the most severe disabilities and to dovetail these efforts with the requirements of the ADA (see ch. 3). In fiscal year 1993, the Federal Government provided nearly $2 billion in grants to the States for vocational rehabilitation programs; another $32 million was for development of collaborative programs to provide supported employment services. Although 42 State vocational rehabilitation agencies have funded supported employment programs since 1985, people with psychiatric disabilities can find it difficult to obtain those services (52,59). The challenge remains to gear supported employment services to people with psychiatric disabilities and for employers to tap into such services, through State vocational rehabilitation, mental health agencies, and other providers.

Three types of Federal tax assistance are available to businesses to reduce the costs of accommodating people with disabilities in the workplace. Under section 51 of the Federal Internal Revenue Tax Code, businesses may be eligible for a Targeted Jobs Tax Credit of 40 percent of up to $6,000 of an employee's first year of wages when hiring people with disabilities and other groups of individuals with special employment needs. Under section 190 of the Internal Revenue Tax Code, businesses may be eligible for a tax deduction of up to $15,000 for costs incurred to remove architectural and transportation barriers from the workplace. And, a few months after the ADA was passed, Congress created anew tax credit, specifically aimed at small businesses. The Omnibus

Reconciliation Act of 1990 (P.L. 101-508) added section 44 to the Federal Internal Revenue Tax Code, allowing eligible small businesses a tax credit equal to one-half of expenditures in excess of $250 but not greater than $10,250 to reduce the costs of providing access to people with disabilities in the workplace. In general, these methods of tax assistance have rarely if ever been applied to the accommodation of people with psychiatric disabilities (24,43).

SPECIAL CONCERNS RAISED BY THE ADA

Employment is not simply a matter of doing one's job and being paid for it. A wide assortment of benefits and issues emerge directly or tangentially from work. Thus, the ADA impinges on a variety of issues, many of which have not been thoroughly considered to date. Two specific issues, which are critically important to people with psychiatric disabilities as well as employers, warrant attention: the direct threat standard in the ADA, and employer-provided health insurance. Employers are understandably concerned about the risk of violence in the workplace. On the other hand, people with psychiatric disabilities, their family members, and advocates protest the stigmatizing and exaggerated perception of the people with mental disorders as being violent. Similarly, while employers voice concern about the costs of health insurance, mental health advocates cite the need for improved mental health benefits. The following sections discuss the ADA's impact on these areas as well as the relevant information concerning psychiatric disabilities.

The ADA's Direct Threat Standard and Psychiatric Disability

While it is "unlawful for [an employer] to discriminate on the basis of disability against a qualified individual with a disability," under the ADA, employers may include as a qualification standard "a requirement that an individual shall not pose a direct threat in the workplace." The EEOC defines direct threat in the regulations 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 (56 FR 35736).*

The EEOC's inclusion of direct threat to self as well as others led to an outcry from many people with psychiatric disabilities and other mental health advocates. Opponents to the EEOC's position note that it encourages employer paternalism (47,53). The fact that paternalistic powers formed the rationale for involuntary hospitalization of mental patients in the past, and dangerousness to self is a common criterion for involuntary commitment, heightened sensitivity to this issue (3). Legal experts and mental health advocates also claim that the EEOC's interpretation goes well beyond the law's language and intent. The ADA makes no mention of direct threat to self: '*The term 'qualification standards' may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace." The U.S. Department of Justice's Title H regulations also do not mention direct threat to self. In its own defense, the EEOC notes that this interpretation is consistent with the legislative history of the ADA and case law interpreting section 504 of the Rehabilitation Act. In fact, one of the few cases involving psychiatric disabilities turned on proof of a direct threat to self: *Doe v. New York University, 666* F.2d 761, 777 (2d Cir. 1981). An academically gifted but suicidal and self-destructive medical student sought readmission to NYU Medical School as a remedy for alleged discrimination in violation of the Rehabilitation Act. The court found that the individual was not qualified for readmission because she could not handle the inevitable stresses of medical school without posing a danger to herself or others, thus subjecting the medical school to liability for knowingly permitting such exposure (10). The concern about employer liability was reasserted at a recent OTA workshop by one of the original authors of the EEOC regulations:

> The bottom line for me on this issue is this: I'll make an analogy. If anybody in this room wants to go sky diving, you can do it. And before

> you board that plane, you're going to sign a waiver of liability that is as long as your arm, and those waivers are enforceable . . . But if you want to go to work and you actually pose, in the words of the Commission's regulations, a high probability of substantial harm to yourself in doing your job, you cannot waive your right to Workers' Compensation . . . the reality is that in the workplace the employer's got to pay the bill if you get injured. . . The employer cannot make the employee waive that (1).

Experts and advocates on both sides concede that the issue likely will be decided by the courts (47,67).

The EEOC regulations and guidelines procedurally narrow the definition of direct threat: "Direct threat means a significant risk of substantial harm that cannot be eliminated or reduced by reasonable accommodation" (56 FR 35376). Thus, the risk need not be eliminated entirely to fall below the direct threat definition; instead, the risk need only be reduced to the level at which there no longer exists a significant risk of substantial harm.

The direct threat standard "must apply to all individuals, not just to individuals with disabilities" (56 FR 35745). A direct threat determination must be based on "an individualized assessment of the individual's present ability to safely perform the essential functions of the job" (56 FR 35736). This clarifies that a determination that employment of an individual would pose a direct threat must involve an individualized inquiry and must be based on the individual's current condition. This is reinforced in the interpretive guidance. Furthermore, the interpretive guidance indicates that "[relevant evidence may include input from the individual with a disability, the experience of the individual with a disability in previous similar positions, and opinions of medical doctors, rehabilitation counselors, or physical therapists who have expertise in the disability involved and/or direct knowledge of the individual with the disability" (56 FR 35745). Factors to be considered when determining whether employment of an individual would pose a direct threat includes "the imminence of potential harm" (56 FR 35736).

These guidelines attempt to limit speculative assertions of risk or the application of stereotypic assumptions about such risk. One of the few examples to be found in the EEOC's regulations or guidelines pertaining to psychiatric disabilities illustrates this point further: "[A] law firm could not reject an applicant with a history of a disabling mental illness based on a generalized fear that the stress of trying to make partner might trigger a relapse of the individual's mental illness."

Concerns about danger to others can arise in a variety of contexts, depending on the functions of the job. For example, difficulties in concentration may pose a "direct threat" if the individual is operating heavy equipment. However, if any one stereotype of mental illness is most prevalent and damaging, it is that of the homicidal maniac. As evident to any patron of the news and entertainment media in the U.S.—and supported by research data—the image of people with mental disorders most often relayed to the public is a violent and deranged one (66). Results from a 1990 nationwide telephone survey indicate that the majority of the American public links mental illness to violence (33). Stigma-busting campaigns have been aimed at dispelling this cruel and exaggerated stereotype. The message in those campaigns is: People with mental disorders are no more violent than the average person.

Nevertheless, mental illness is sometimes associated with violent behavior. Supporting data are accruing, often from the research efforts of those who did not anticipate or desire the result. Several types of studies support the link between mental illness and violent behavior, including those evaluating arrest and jail rates of people with mental disorders, and hospital and community-based surveys (31,40,63). For example, data indicate that people with mental disorders experience higher arrest and imprisonment rates for minor offenses and violent crimes (27,28,29,36,49,60,61). People with serious mental disorders constitute 5 to 15 percent or more of the jail and prison population in the U.S. (25,62).

Despite the consistent finding in the 1970s and 80s that mental disorders have some link to violent behavior, many of these studies suffer serious methodological weaknesses, including inadequate definition of violence and selection bias. More recently, however, data from two large and methodologically sound studies confirm the findings from the early, imperfect efforts (31,58). Data from the ECA study—a large, community-based survey-demonstrated a statistically significant link between some mental disorders and self-reports of violent acts (58). Link and colleagues compared violent behavior among people who currently were or had been in treatment for mental disorders and people who were never treated. The subjects with mental disorders and controls were matched for various demographic characteristics, treatment status was assessed, and carefully drawn measures of violence included official and self-reports of arrest rates, as well as self reports of fighting, hitting others, and weapon use. While confirming the importance of social and demographic factors in violent behavior, the data show a significant, if modest, link between all measures of violence and mental disorders. It turned out that only those experiencing recent psychotic symptoms showed elevated rates of violence. Data from another study suggest that specific aspects of psychosis—when a person feels personally threatened or the intrusion of thoughts that can override self-control—are linked to violence (33).

Taken together, the available data impute a relationship between mental disorders-especially, psychotic disorders—and violent behavior. The limits of these data must be emphasized. First, the demonstrated link is modest at best: Demographic factors, substance abuse, and a history of violent behavior are far more tightly correlated to violence in people with and without psychiatric disabilities. Secondly, the assertion that most people with mental disorders are not violent remains unchallenged. Finally, and relevant to this discussion, none of these data emerge from research in the workplace.

Evidence of a correlation between mental illness and violence certainly does not translate into ADA-sanctioned exclusion of people with these conditions from the workplace. As mentioned above, individualized assessment of imminent, significant risk of substantial harm constitutes the EEOC's standard. The EEOC guidelines also allow for the expert opinion of medical and other professionals in carrying out this standard. However, performance of this task has been surrounded by nearly as much controversy and doubt as the link between mental illness and violence.

How well can clinicians predict future violence by people with mental disorders? The prevailing opinion has been "not well at all." In large part this lack of confidence was based on a review of research published in 1981 (38). Monahan, a leading researcher in the field, concluded that for every time a clinician correctly predicts violent behavior, he or she would be wrong two times. More recent data paint a somewhat more optimistic picture of clinician assessment of violent behavior. While the studies reviewed by Monahan focused largely on institutionalized patients and the assessment of violent behavior over the long term, more recent efforts focus on more specifically drawn measures of violent behavior in the short term. For example, data from a large sample of individuals with mental disorders, recruited to the study from emergency room admissions, demonstrated clinician accuracy in predicting violence over the next 6 months significantly better than chance, at least for male patients (30). Similarly, prediction accuracy exceeded that of chance in a study of post-hospitalization adjustment of people with mental disorders over the course of 6 to 12 months (26). These and other data imply, in the words of one reviewer, "that the use of actuarial data and techniques may result in predictions whose accuracy exceeds chance" (45).

This conclusion is hardly a ringing endorsement. Indeed, there are important caveats. First, further research is crucial for identifying the variables that may lead to more accurate prediction. Factors other than mental health status, such as a past history of violent behavior and substance abuse, are linked to violence, and undoubtedly must be included in any attempts to predict violence. Situational and interfactional variables are known to be important contributors to violent be-

havior and must be considered (39,44). Furthermore, situational and interpersonal factors will highlight many of the accommodations that may reduce the threat of harm. Results from a MacArthur Foundation- and NIMH-funded study will be available in 1996 (41,57); they will likely shed light on the process of predicting violent behavior in people with mental disorders. Even with better methods, the prediction of violence will never be error free. Thus, the acceptable level of accuracy for disqualifying someone from work will require consideration of ethical, legal, and public policy concerns (17).

The issue of the risk of violence and its treatment warrants special attention, as people with disabilities, advocates, experts, and employers have raised concerns. Are employers required to provide treatment to employees who present a direct threat? Are employees required to take medication in order to maintain their jobs? Can employers monitor medications as a reasonable accommodation for employees who have posed a direct threat without medication *and* who have a history of failing to take medications? While the legal questions are complicated, controversial, and unanswered, there can be no doubt that this issue will arise. The EEOC does not require employers to provide treatment as a reasonable accommodation (see next section); however, the Commission has not yet taken a position on whether employees can be required to take medications to keep their jobs (72). OTA interviews of various vocational rehabilitation professionals and other experts and advocates also reveal that treatment compliance is a very real issue. People with mental disorders often do not comply with prescribed treatment, for reasons that can include denial of a chronic illness, or intolerance of side effects (9,1 3,16). And the data linking mental illness to violence suggest that severe symptoms and nontreatment do play a role (3 1,63). Research and full discussion of this issue are clearly needed.

Where do we stand? This review of the research literature bespeaks limited gains in understanding the link between mental illness and violence. Critical questions remain unanswered about the specific predictors and modifiers of threatening behavior.

Health Insurance for People With Psychiatric Disabilities

Health insurance is typically considered a privilege of employment. And the ADA prohibits "discrimination against a qualified individual with a disability in regard to . . . privileges of employment" (42 U.S.C. 121 12(a)).9 Federal regulations and interim guidance recently drawn up by the EEOC echoes the ADA's stance against insurance exclusions used as a subterfuge to evade the purpose of Title I. To this end, EEOC regulations specifically prohibit various discriminatory practices. For example, employers may not:

- make employment decisions based on potential increases in health insurance premiums;
- limit health insurance eligibility on the basis of voluntary medical examinations in employee health programs; or
- deny a qualified individual with a disability equal access to the same terms or conditions of insurance that other employees enjoy.

It should come as no surprise that the prospect of ADA-compelled health benefit reform allured disability rights advocates. In fact, lists compiled by people with psychiatric disabilities and other mental health advocates often include better health insurance coverage as a useful and desired accommodation. The barrier to affordable health insurance that millions of Americans currently confront is a familiar problem for people with disabilities; they have long endured exclusions and limitations from private sector coverage (42). For people with psychiatric disabilities, the situation is even worse. Data and analyses clearly docu-

[9]This sections concentrates on the issue of individual and group medical insurance. However, other forms of coverage for medical treatment of mental disorders exist, such as long-term disability insurance, which is typically limited for mental health and substance abuse problems.

ment the limitations commonly placed on mental health benefits by such means as high copayments, large deductibles, and separate (usually lower) limits on annual and lifetime expenditures or services (55,68). Caps on mental health benefits reflect insurer concerns about uncontrollable costs and the ill-defined nature of some disorders; the evolution and availability of a public sector system of care and the apparent lack of public demand for more generous coverage are also a factor. Many also attribute the inequity to discrimination (55,66).

While the need for improved access to mental health care may make a compelling case for health care reform, the question remains as to what role the ADA can or should play in achieving this goal. The language of the law, its legislative history, and related regulations and guidelines indicate that the ADA does not intend a complete revision of insurance industry policy and practice (4). As stated in the law and EEOC regulations:

> *[T]he act shall not prohibit or restrict:*
>
> *(1) **an** insurer, hospital or medical service company, health maintenance organization, or an agent or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or*
>
> (2) *a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or*
>
> *(3) a person or organization covered by this Act from establishing, sponsoring, observing or administering the term of a bona fide benefit plan that is not subject to State laws that regulate insurance. (56 FR 35739)*

The EEOC regulations that implement the ADA ensure that employees with psychiatric disabilities will not be discriminated against if a health plan is offered; it does not require access to mental health insurance. The regulations clearly allow traditional insurance practices of preexisting condition clauses, underwriting and risk assessment and classification and ERISA-regulated, self-insured plans, "even if they result in limitations on individuals with disabilities." Essentially, the law requires that an employer offer the same benefits to all employees. This does not provide a carte blanche for disparate health insurance coverage on the basis of disability. According to interim guidance from the EEOC, employers must demonstrate that the disability-based distinctions in coverage are fiscally necessary (N-915.002).

> ***Because the employer has control** of the **risk assessment, actuarial, and/or claims data relied upon** in adopting a disability-based distinction, the burden of proof should rest with the employer . . . If the employer asserts that the disability-based distinction was necessary to prevent the occurrence of an unacceptable change in coverage or premiums, or to assure the fiscal soundness of the insurance plan, the evidence presented should include nondisability-based options for modifying the insurance plan and the factual data that supports the assumptions and/or conclusions.*

How might the ADA be used to influence mental health benefits? One question to consider is: "Is disparate treatment of mental disorders by insurance a disability-based disparate treatment?" While excluding treatment for a particular mental disorder, such as schizophrenia, would likely lead to an affirmative response to this question, the EEOC's recent guidance, citing case law under section 504 of the Rehabilitation Act, answers resoundingly "no" for mental health benefits in general (N–915.002).

> *[A] feature of some employer provided health insurance plans is a distinction between the benefits provided for the treatment of physical conditions on the one hand, and the benefits provided for the treatment of "mental/nervous" conditions on the other. Typically, a lower level of benefits is provided for the treatment of mental/nervous conditions than is provided for the treatment of physical conditions . . . Such broad distinctions, which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability.*

> *Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA.*

This interpretation of the ADA seems to leave little room for using this tool to abolish the traditional disparity between mental health benefits and other health benefits. It is important to note that advocates argue that this analysis is specious. For many disabled people with mental disorders who are otherwise qualified for a job, the lack, inequity, or insuffiency of insurance coverage is the barrier to employment (23). Furthermore, the people with the most severe and chronic conditions are most affected by restricted mental health benefits.

What proves to be an interesting question under the ADA, especially for people with psychiatric disabilities, is whether providing some health care could be construed to be a reasonable accommodation, and thus required of the employer, absent undue hardship. Health care benefits are generally provided by employers. Chapter 3 noted data that show treatment is often important for controlling the clinical symptoms of mental disorders and may be linked to work functioning. And as discussed in this chapter, treatment may figure prominently in controlling symptoms related to harmful behavior. One legal expert's review led to the conclusion:

> Can employees expect an employer to pay for medication or provide insurance that will pay for such medications? To date, there is no good answer to that question in the statute, its regulations, or the case law. Logically, it would seem that if the expense to the employer is reasonable, perhaps only slightly more than what the employer pays for other employees' health care, such an accommodation is required (47).

Another view is that "that's the kind of personal service ruled out . . . [It] goes beyond . . . removing a barrier caused by the workplace or the way work is customarily performed, which is . . . the lode star for reasonable accommodation (l)." Guidelines prepared by the EEOC indicate that employer provision of medication is not, in the view of the agency, a reasonable accommodation:

> *The obligation to make reasonable accommodation is a form of nondiscrimination. It applies to all employment decisions and to the job application process. This obligation does not extend to the provision of adjustments or modifica - tions that are primarily for the personal benefit of the individual with a disability. Thus, if an adjustment or modification is job-related, e.g., specifically assists the individual in performing the duties of a particular job, it will be considered a type of reasonable accommodation. On the other hand, if an adjustment or modification assists the individual throughout his or her daily activities, on and of the job, it will be considered a personal item that the employer is not required to provide. Accordingly, an employer would generally not be required to provide an employee with a disability with a prosthetic limb, wheelchair, or eyeglasses (56 FR 35747).*

Given the conflicting viewpoints, it maybe that the courts will be called upon to interpret the Act. Considering medications a reasonable accommodation may be opposed by some advocacy groups who worry about coerciveness and psychiatric treatment. The distinction between providing a medication as an accommodation and requiring an individual to take a medication to keep his or her job may be viewed as a slippery slope. A consumer spokesperson said, "I can imagine a scenario in which 'reasonable accommodation' is deemed to mean that the employee must take psychotropic medication as a condition of employment. Given the many negative 'side effects' of these medications, it can create a negative cycle of further impairment, especially when the person identified as psychiatrically disabled feels coerced or is forced into taking these drugs" (64). Representatives of small businesses also express reluctance in further involving employers in clinical care (43).

Clearly, the ADA will address some of the health benefit practices that are disability-based. But the Act's jurisdiction overemployed-provided health benefits is explicitly circumscribed.

Achieving insurance parity for mental health benefits under the ADA appears even less likely. These limitations and uncertainties have served to focus the attention of advocates and experts on health care reform efforts in general. As stated by an EEOC representative at a recent meeting: "[Whatever we say about health insurance at this point is like the tail wagging the dog, because the real discussion about what's happening. . . is taking place elsewhere (37)." However, if health care reforms are too costly, too limited, or occur too slowly, people with psychiatric disabilities may be motivated to seek adequate treatment via this route.

SUMMARY AND CONCLUSIONS

OTA's analysis points out many unanswered questions concerning psychiatric disability, the workplace, and the ADA (see table 4-4). First, a better characterization of the questions, concerns, and current practices around disclosure and accommodation is needed. Information derived from workshops, surveys, and case studies on disclosure, accommodation practices, and problems could guide further research and those who are implementing the ADA. The most useful information will come from forums representing the full range of viewpoints and concerns. This includes people with disabilities, managers and supervisors, coworkers, and mental health and legal professionals. It also requires consideration of such sensitive issues as confronting an individual about an undisclosed disability, the impact of psychiatric disability on performance, possible behavioral problems, and potential coworker fear or resentment of accommodations.

Even though we know that much more knowledge is needed, implementation must move for-

TABLE 4-4: Unanswered Questions for Research

- What are the usual positive and negative consequences of disclosing a psychiatric disability for an individual with a psychiatric disability? For the supervisor and employer? Coworker?
- What types of information concerning a psychiatric disability are relevant and/or useful to employers?
- How does timing of disclosure influence the individual with a psychiatric disability, the employer, and the work place?
- How do gaps in employment history, a criminal or arrest record affect the employment of people with psychiatric disabilities?
- How can current job analysis methodology better assess cognitive, behavioral, and social factors?
- Which functional assessment approaches reliably predict work performance and are useful under the ADA?
- How frequently do emotional outbursts, insubordination, threats, and other erratic behavior arise at the work place in relation to psychiatric disability? How can managers and coworkers best deal with such behaviors when they occur?
- How effective in permitting work and improving work performance are the accommodations commonly listed as useful to people with Psychiatric disabilities?
- What are the speific and net costs-including possible redistribution of work load and changes in benefit uses-of these accommodations to employers?
- What is the impact of providing an accommodation to an employee with a psychiatric disability on that employee? Coworkers? supervisors?
- What impact does coworker training on psychiatric disabilities have on individuals with these conditions and ADA implementation in the workplace?
- What kinds of information would assist supervisors in providing effective accommodations for employees with psychiatric disabilities?
- What can be learned about accommodating people with psychiatric disabilities from businesses that make accommodations for all of their workers?
- How does psychiatric disability relate to violence in the work place?
- How can the threat of violence in the workplace, as it may relate to psychiatric disabilities, be predicted? Abated or diminished?

SOURCE: Office of Technology Assessment, 1994.

ward. This chapter points to a substantial amount of information to aid in that goal. Consumer organizations, experts, and researchers have compiled lists of useful accommodations for people with psychiatric disabilities. Because research indicates considerable ignorance about the ADA, the challenge is to disseminate this information to people with psychiatric disabilities and employers, and to increase awareness and understanding about psychiatric disabilities among employers and coworkers. The Federal Government can assist by building on current ADA technical assistance [e.g., by NIDRR and the EEOC (see ch. 5)] and strengthening existing ties in the community, including consumer organizations (see ch. 2), mental health and rehabilitation services in States, counties, and local communities [e.g., funded by CMHS, NIMH, NIDRR (see ch. 5)]. Because the impact of education such as teaching coworkers about psychiatric disabilities, is unknown, such education needs to be evaluated.

The chapter ends with a discussion of two issues raised by the ADA and of keen interest to people with psychiatric disabilities: the threat of violence and employer-based mental health benefits. People with mental disorders, their families, and others decry the media's stereotyping of people with these conditions as violent. Because the ADA includes as a qualification standard " a requirement that an individual shall not pose a direct threat in the workplace," the question of the link between violent behavior and mental illness becomes relevant. Recent data and reviews of research indicate a link between the threat of violence and some mental disorders. Given the prevailing stereotype, it must be emphasized that the link is modest-demographic factors, substance abuse, and a history of violent behavior are far more tightly correlated to violence. In addition, violence appears to be related to a small subset of psychotic conditions and symptoms. Clearly, the correlation between mental illness and violence does not translate into ADA-sanctioned exclusion of people with these conditions from the workplace: The EEOC's regulations and guidelines narrow the definition of direct threat to one that is substantial, imminent, individually determined, and not abated by accommodation. Furthermore, the law and research in this area raise questions concerning the prediction of violence, the link between violence and mental illness in the workplace, and treatment issues in the workplace.

Mental health benefits are another key issue for people with mental disorders in general and under the ADA. Mental health benefits are commonly limited, compared to general health coverage, with the result that people sometimes do not receive treatment. Access to effective treatment will be important for many people with psychiatric disabilities to gain and maintain employment (see ch. 3). Although the ADA prohibits various discriminatory practices in terms of employer-provided health insurance, the law, its legislative history, and interim guidance from the EEOC enjoin against its use to abolish the traditional disparity between mental health benefits and other types of benefits. Furthermore, guidelines from the EEOC indicate that the provision of medication is not a reasonable accommodation.

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