Reasonable Accommodation at the Workplace for Professionals with Severe Mental Illness: A Qualitative Study of Needs

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ABSTRACT

Background: Professionals with Severe Mental Illness (PwSMI) often face challenges in obtaining and retaining employment. For equal and effective participation, they may require reasonable workplace adjustments. The recently legislated Rights of Persons With Disabilities Act 2016 in India defines such adjustments as reasonable accommodations.

Methods: In-depth qualitative interviews were conducted with 15 consenting PwSMI availing psychiatric rehabilitation services at a tertiary mental health institute in India, five mental health professionals, and five employers. The audio-recorded interviews were transcribed and coded manually by two independent investigators. Inductive content analysis approach was used for qualitative analysis.

Results: The detected themes included modifications in work schedule, supports to improve work efficiency, modifications in the work environment, modifications in the work-related appraisal, supportive employer policy, and integration of services. The participants described the term "undue burden" to be ambiguous.

Conclusions: The reported reasonable accommodations are non-structural and mainly dependent on human assistance. Vocational rehabilitation and job reintegration efforts can focus on guided negotiations between employers and PwSMI. This is dependent on at least some degree of disclosure. Awareness regarding reasonable accommodation and stigma reduction is necessary for successful implementation.

Keywords: Reasonable accommodation, workplace adjustments, professionals, severe mental illness

Key Messages: Professionals with Severe Mental Illness (PwSMI) may require reasonable accommodations for equal and effective participation. Modifications in work schedule, work environment and work appraisal, support to improve work efficiency, supportive employer policy, and integration of services are required as reasonable accommodations. These reasonable accommodations are non-structural and mainly dependent on human assistance.

The prevalence of severe mental illnesses (SMI) such as non-affective psychoses has been reported to be 1.4% and that of bipolar affective disorder to be 0.5% in India.[1] Persons with SMI suffer significant disability, with a substantial impact on social and occupational functioning. Livelihood and employment are important in the process of recovery. Work is also an important factor in their quality of life. Work seems important for enhancing self-satisfaction, providing a source of income, building self-esteem, aiding in socializing, and improving social standing.[2] The direct and indirect benefits of employment play a major role in reintegrating the person into the community.

Professionals with SMI (PwSMIs) face several challenges at work. The factors that have been found to hinder PwSMI from maintaining a job include symptoms, adverse effects of medications, unfavorable working environment, stigma, poor supports at the workplace, and demoralization.[3] Several facilitating factors have also been reported, including individual factors such as the ability to cope with the illness, motivation to work, and better skills, and environmental factors such as positive relationships at work, rehabilitation interventions, good ser-

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vice coordination, a supportive employer having clear expectations, recognition, and support from family and friends.[3,4]

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) brought about a paradigm shift from a "charity-based" to a "rights-based" perspective.[5] The Rights of Persons With Disabilities (RPWD) Act, 2016, was enacted in India with several new provisions from the "rights-based" perspective following UNCRPD. Reasonable accommodation (RA), defined as "necessary and appropriate adjustments, without imposing a disproportionate or undue burden in a particular case, to ensure to persons with disabilities, the enjoyment and exercise of rights equally with others" was a major inclusion in the Act.[6] One of the forerunners of legislations related to RA was the Americans with Disabilities Act, 1990.[7] This Act defined RA and under it included modifications like making existing facilities more accessible and job restructuring including flexible work timings, job reassignment, modifications in examination and training, provision of readers and interpreters, etc. Such accommodations must not, however, impose an undue burden on the organization, meaning the reasonableness is bidirectional.[8]

Most of the studies examining RAs for persons with mental illness (PMIs) have been conducted with consumers of supported employment programs.[9] A multisite study on reasonable workplace accommodation for persons with psychiatric disabilities reported the most frequent functional limitations to be in the interpersonal communication and cognitive domains. Accordingly, the need for accommodations was identified at the time of recruitment in 63% of instances and 47% of the time, during the early months of employment.[10] Another study identified the most frequent accommodations provided to persons with SMI as providing orientation and training to the supervisors (e.g., increasing the frequency of supervision; onsite meetings between the employee, the supervisor, and the job coach), followed by modifying the work environment (e.g., onsite support of a job coach) and modifying the time schedules (e.g., flexible working hours, lesser job hours, permission for mental-health-related appointments).[11] A scoping review of workplace accommodations for PMI, which examined nine studies, reported that the most commonly required accommodations were flexible working hours, modifications in training/supervision, and modified job descriptions.[9] Employees who received ≥5 accommodations had a longer tenure as compared to those who received <5 accommodations.[11]

The concept of RA for persons with disabilities is relatively new to the Indian employment scenario but has now been firmly established as a legal mandate. The RAs that can be provided are related to several cultural and economic factors. Therefore, it becomes important to understand the perspectives of all stakeholders involved—PwSMI, prospective and current employers, and mental health professionals (MHPs), so that accommodations that can be provided be identified in the cultural and economic context. To our knowledge, there are no Indian studies that examined RAs for PwSMI.

This study was aimed to qualitatively explore, through in-depth interviews, the perspectives on RA at the workplace for professionals with SMI. A qualitative approach was chosen to understand the experience and perspectives from the standpoint of all key stakeholders. We chose PwSMI as one group of stakeholders since professionals are more likely to be employed in the organized sector with scope for changes in organizational policies and provision of RAs.

Materials and Methods

The study was conducted at Psychiatric Rehabilitation Services (PRS) of the National Institute of Mental Health and Neurosciences, Bengaluru, India, from November 2018 to May 2019. The study was conducted after obtaining permission from the Institute Ethics Committee, and subjects were recruited after written informed consent. The qualitative study included three groups of key informants for in-depth interviews, namely, PwSMI, MHPs, and employers who had employed PMIs. For the study, the definition of severe mental disorders considered was as per the National Mental Health Survey, 2015–2016,[12] and included bipolar affective disorder, non-affective psychosis, and severe depression. Professionals were defined as persons having more than 15 years of formal education as per the National Classification of Occupations (NCO).[13] Purposive sampling was used. The PwSMI included in the study were clinically stable with a score of ≤2 on the Clinical Global Impression (CGI)-Severity scale, currently employed or employed in the past for at least six months and able to provide valid interviews.[14] Socio-demographic details were obtained from them, and they were also evaluated on the Indian Disability Evaluation and Assessment Scale (IDEAS).[15] The MHPs (professionals from psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing backgrounds) were included for in-depth interviews only if they had an experience of at least two years in managing PMIs. Employers included for the interviews were human resource managers or those of equivalent cadre, with experience in employing PMIs.

Qualitative interviews were conducted by SKR, under the direct supervision of KPM, a consultant psychiatrist with 15 years of experience. Qualitative in-depth interviews were conducted with each of the participants after obtaining written informed consent, including consent for the audio recording of the interview. The interview consisted of three phases for all the three groups.

In Phase 1, open-ended questions on vocational history, vocational challenges, disclosure, the kind of adjustments they had required at the previous workplace or are being provided in the current workplace, the kind of adjustments they would require in their future workplace, and disclosure of illness were asked. Facilitating questions, such as "Then what?" "What else?" "Is there anything else?" etc., were used to encourage the patients to provide as much information as possible. Similarly, for MHPs and employers, vocational challenges in PwSMI, adjustments required for them at the workplace, and issues surrounding disclosure were enquired in this phase.

In Phase 2, we employed semi-directive questions based on the enlisted factors in phase 1, and elaborations with examples and illustrations were sought.

Finally, in Phase 3, anchoring points from a literature review[16–18] for an RA in PwSMI that were not covered in the previous phases were enquired. Questions such as "Others have told about these factors. Can you describe your experience or thoughts?" were used to elicit responses.

The anchoring points used were as follows: A job coach to train and supervise

1. Reduced work hours
2. An extended period of training
3. Individualized training
4. Modified job duties
5. Job reassignment
6. Part-time shifts in place of full-time work
7. Slowing the pace of tasks
8. An alternative way of providing instructions and feedback
9. Frequent feedback sessions between the supervisor and the employee to address issues early
10. Allowance of extra time
11. Exchange of tasks with colleagues
12. A calmer environment
13. Work from home options
14. Access to a peer support group

All the interviews were conducted in English and audio-recorded to avoid loss of data/recall bias. A separate consent was obtained for the audio recording and, if the subject did not want any information to be recorded, the audio-recorder was turned off. The audio-recorded interviews were manually transcribed verbatim by SKR. SKR and KPM manually coded the interviews separately for triangulation. Additionally, data triangulation was performed between the three groups of key informants. An inductive content analysis approach, as described by Elo and Kyngas, was used for qualitative analysis.[19] Themes and subthemes were identified and categorized by SKR in iterative discussion with KPM.

Results

A total of 15 PwSMI (SKR was directly involved in the rehabilitative care of five subjects), five MHPs, and five employers were interviewed. The mean (SD) age of the PwSMI was 38.26 (8.94) years. The sample consisted of 12 men and three women. Eight participants were engineering graduates, two had postgraduation in engineering, two had master's degrees in science, one had a postgraduate diploma in science, one had postgraduation in medicine (Radiodiagnosis), and one had a master's degree in literature as well as commerce. The interviews lasted for 45–60 minutes.

At the time of the interview, 10 of the subjects were unemployed, and the remaining 5 were employed. The mean lifetime number of jobs held by the sample was 5.6 (3.94). A total of 12 had diagnosis of schizophrenia, two had schizoaffective disorder, and one had recurrent depressive disorder. The mean duration of illness was 16.4 (9.12) years, and the mean disability score (IDEAS) was 10 (1.5).

The MHPs interviewed included one psychiatrist, one psychiatric social worker (PSW), one psychiatric social work faculty, one professor of clinical psychology, and one mental health nurse. Their mean years of experience was 15 (6.67). Among the employers were a vice president and head of corporate social responsibility, a global cross-generational lead, a chief executive officer, a team leader, and head of a clinical unit in a hospital. Their mean years of experience in their respective fields was 14.6 (6.8).

The major themes that emerged about the accommodations required for PwSMI are as follows.

1. Modifications in work schedule: The important subthemes that emerged were flexible work timings, frequent breaks, exemption from night shifts, the option to work from home, graded resumption of work after a long leave, lesser targets, and lesser pay (**Table S1**).

2. Support to improve work efficiency: The subthemes that emerged under this broad theme were matching the job to strengths and weaknesses, job-related training, interning, graded increase in the difficulty of work, mentoring, extending deadlines, offering less complex jobs, lessening the work burden, job reassignment whenever possible, offering cognitive aids, monetary and social reinforcements, and periodic review and feedback. More subjects emphasized the requirement for training/reorientation and periodic feedback (**Table S1**).

3. Modifications in the work environment: Subthemes that emerged under this theme were a supportive work environment with supportive supervisors and colleagues, a less stigmatizing environment with better mental health awareness, peers and superiors who are encouraging, openness in peer-supervisor meetings, and support like more time to adapt to changes. The subthemes and appropriate quotes are summarized in **Table S1**.

4. Modifications in appraisal: This broader theme had providing relevant accommodations during recruitment (e.g., relaxation for disjointed work history, alternative methods of interviewing), having alternative methods of skill testing, considering eligibility based on essential functions of the job, and flexible promotional thresholds as subthemes (**Table S1**).

5. Supportive employer policy: The subthemes under this category included having a flexible leave policy, physical and mental disabilities to be treated equally, infrastructural modifications, clear protocols on the job, clear backup plans, recognizing a mentor's work, modifying workplace rules to fit PwSMI, financial assistance for mental health care, integrating mental health with work, recruitment of wellbeing officers, having an employee assistance program, having inclusive policies, and keeping pace with legislative changes. The subthemes and illustrative quotes are presented in **Table S1**.

6. Integration of services: Under this broader theme were the subthemes liaison between the MHP and the employer, the MHP personally liaising with the employer, integration of mental health services to employment services, MHPs helping to enhance self-efficacy, MHP having an important role in the disclosure of illness, early liaison between employer and MHP, MHP frequently following up with employer initially, availability of MHP in situ, and having an alternate MHP to decide on "reasonableness" of the accommodations (**Table 1**).

Disclosure of Illness: The Upside and Downside

The participants discussed the possible consequences of disclosure—the advantages and disadvantages. An important theme that emerged was the role of MHP in liaising with employers for the disclo-

sure, and the importance of consent of the PwSMI was also emphasized (**Table S2**).

Undue Burden and Other Challenges in Implementing Reasonable Accommodations

The term "undue burden" in the definition of RA was perceived in different ways by the employers and MHPs. The various themes that emerged revolved around the lack of clarity of what constituted an undue burden. The employers and MHPs perceived that strict policies on the percentage of reservation for PMI might be cumbersome and that RA may be costly and human resource intensive. The possibility of a PwSMI being unable to perform despite accommodations was also reported as a factor.

It was reported that the implementation of RAs comes with many other unique challenges. Some of the challenges that were expressed by the MHPs and the employers included objections about accommodations from colleagues at work, employer's attitudes towards persons with disabilities, stereotypes of mental illness, practical challenges in inclusivity at the workplace, financial constraints, fear or unwillingness on the part of the employee to disclose mental illness, and the nature of the job itself preventing accommodations. Employers may also be unaware of the existing laws. It was also expressed that no "one size fits all" and that RAs need to be individually tailored. The challenges in private sectors were expected by the participants to be distinctly different from those in the government sector (**Table S3**).

Support from supervisors and resource persons at the workplace, paid long leaves for relapses and admissions, and extended periods of training were reported by patients as accommodations already being provided by their employers.

Under the theme "supports to improve work efficiency," patients repeatedly reported the need for an extended period of training, whereas mentoring, cognitive aids, and feedback were the recurring themes amongst MHPs and the employers reported job matching. Under "modifications in the appraisal," patients repeatedly reported the need for alternative methods of skill-testing, whereas MHPs reported the need for flexible promotional thresholds and employers raised the need for discussing RA during the initial stages of recruitment. MHPs and employers reported the need for various subthemes under "integration of services" and "supportive employer policy" more frequently than patients. With regards to "modifications in work schedule" and "modifications in the work environment," the majority of the subthemes were convergent in all three groups.

Discussion

The RAs reported in this study were adjustments to accommodate for vocational challenges perceived by PwSMI. To our knowledge, this is the first study to describe the workplace adjustment needs of PwSMI from India.

The requirement of a flexible work schedule, which was a frequently repeated theme in our study, may be consequent to several reasons, ranging from symptoms of the illness to side effects of medications. Negative symptoms and cognitive or social skill deficits may necessitate flexibility in schedule. Flexible work timings and schedule, modified training and supervision, and modified job duties have been reported as the most common workplace accommodation from developed countries too.[9]

We observed that the majority of the subthemes under the theme "supports to improve work efficiency" were related to the availability of human support. In comparison to those with physical disabilities, accommodations for PwSMI involves mainly human assistance. Direct costs to the employer in terms of physical restructuring or equipment may not have a significant role.[16] In supported employment programs, job coaches prepare the PMIs for jobs and help with jobs.[20] In India, there are no structured, supported employment programs.[21] This could be one of the reasons why our participants reported that support was expected from a colleague. Cognitive aids, including the use of technology, can aid PwSMI with cognitive deficits.[22] Technology-based assistance, for example, allowing to record meetings or using software-based organizers, can be a helpful strategy. But that was not spontaneously reported in our study, in contrast to studies from developed countries.

The most frequent subthemes under the theme "modifications in the work environment" were related to the attitude and support of employers and colleagues towards PwSMI. We know from other studies that they face stigma, twice as much, when compared to persons with physical disabilities.[23] Negative attitudes of providers, negative images in the media, and internalized stigma have been reported as hindering factors in the employment of PMI.[4] Stigma reduction is a broader goal for inclusivity at the workplace and is a prerequisite for RA to be equitably provided to PwSMI. The same strategies employed in the general workforce, such as incentivizing performance and using social praise, were reported in our study for PwSMI. A Canadian study reported that employers are most aware of open communication, praise and reinforcement, written time, and additional time to complete tasks as an RA for PMI.[24]

Another theme reported in our study was "modifications in the appraisal mechanism." This is required both for obtaining the job and for promotion and growth in the job. The Americans with Disabilities Act 1990 and the litigations concerning the Act indicate that persons are "qualified" for a job if they satisfy the prerequisites such as educational qualification, employment experience, and ability to perform the essential functions.[25] The essential functions of a job have been conceptualized based on how necessary the task is in the general description of the job, what proportion of time it consumes, and whether non-performance of that task will be disruptive to the job function.[26] The NCO 2015, in India, has defined job roles under each occupation.[13] The accommodations at the time of recruitment, such as setting up mechanisms for alternate skill-assessment, may need to be individual-specific and are likely to test the employer's resources in the prevailing employment scenario in India. Future guidelines on essential functions of jobs and the range of relaxation that is acceptable would help in formulating strategies for RA.

Flexible leave policies, under the theme "supportive employer policy," was a frequently reported subtheme. This becomes very important for patients to attend hospital follow-ups or for admissions for relapses. Overall, having a company policy on the recruitment of PMI has been reported to be predictive of job accommodations.[24] After hiring PMI, companies also seem to gain experience regarding accommodations for such future clients. In comparison with people with physical disabilities, PMIs have longer periods of non-employment and are more likely to report non-health reasons as barriers to employment, such as lack of skills and getting fired from the job.[27] The RPWD Act, 2016, in section 3(5), directs the government to take the necessary steps to ensure RA and, in section 20(2), emphasizes that RA be provided in government establishments. As per the Act, denial of RA is tantamount to discrimination. Additionally, section 22 of the Act necessitates every organization to notify equal opportunity policies.[6] Supportive employer policies may aid in lengthening the duration of employment for PwSMI. Employee assistance programs that include well-being officers or counselors will be necessary in medium to large organizations.

The "integration of mental health care and employment services" was another theme reported in the study. The integration of services is implicit in supported employment programs.[20] In the absence of such programs, this may need involvement of the MHPs with potential employers, on a case-to-case basis. In India, the MHPs have a less clear delineation of roles.[28] Nevertheless, the role of an MHP in facilitating disclosure of mental illness becomes more critical, as, without some degree of disclosure, accommodations may not be provided. PSWs may be best placed to do this task and will need to work in close liaison with the treating psychiatrists.

In this study, although there was convergence with regards to the nature of RAs in many areas, there were a few areas in which the three groups diverged. It is possible that this may be due to the variable degree of awareness of RAs and also based on individual needs and lived experiences. Regarding disclosure of illness, the PwSMI mostly reported the downsides of disclosure, whereas both the MHPs and employers perceived disclosure as a prerequisite for RA. There may be hesitation on the part of the PwSMI to disclose illness because of discrimination and internalized stigma. Disclosure need not always be a full disclosure but can be strategically timed, selective, or partial.[29]

The undue burden was a major concern for employers and MHPs when compared to patients. The RPWD Act, while defining "RA," has mentioned that such accommodations should not impose an "undue burden" on the organization or be disproportionate. The Americans with Disabilities Act, 1990, has defined "undue hardship" as an action requiring significant difficulty or expense in light of factors such as the cost required to provide such accommodations and the overall financial resources of the organization.[30] Some measures, such as consideration of low cost (e.g., human assistance), use of government funds to provide accommodations, objective assessment of costs and benefits, benefits to co-employees, and partial payment of the costs by the employees can be considered while implementing RA.[7] Undue hardship can also be considered even when accommodations are provided and the individual is not able to perform essential functions.[31] As reiterated by the findings of the current study, accommodations required by a PwSMI are mainly low-cost accommodations such as human assistance, flexible leave policies, and restructuring the work schedule. Accommodations provided to PwSMI, such as having a workplace protocol and promoting mental health, are beneficial not only to the PwSMI but also to the workplace environment in general. Other employees may feel encouraged to disclose their mental health issues and seek help in such workplace environment. In resource-constrained settings, MHPs involved in rehabilitation may play an important role in the education of the PwSMI about their rights and in negotiating with the employers.

Our findings reveal the various challenges in implementing RA. Negative experiences have been reported in persons with SMI while implementing RAs.[32] A focused group discussion on the perspectives of employees and employers on RAs reported that although the expectations of the groups converge in most areas, they also sharply differ in their expectations of each other.[33]

The strengths of the study include interviews of the three key stakeholders, data triangulation, and investigator triangulation. However, the PwSMI were mostly engineering graduates and fluent in English, limiting generalizability to other sectors of employment. Most of the patients and MHPs interviewed were associated with PRS either directly or indirectly, and the employers had the experience of employing PMI, and hence, an exposure to the concept of RA, limiting generalizability across settings. Finally, family caregiver perspectives and respondent validation would have improved the robustness of the study.

Future qualitative studies should examine perspectives of persons with SMI, family caregivers, and employers across both organized and unorganized sectors of employment.

Conclusion

RAs required by PwSMI in the Indian context have been identified in this study to be the modification of work schedule, support that improves work efficiency, modifications in the workplace environment, modifications in the appraisal, integration of mental health and employment services, and supportive employer policies. The "undue burden" has not been operationally defined in the law, with scope for ambiguity in interpretation. Stigma reduction at the workplace and disclosure of mental illness are important prerequisites for RA to be provided and implemented. The provision of RA is a legislative mandate that requires successful implementation for improved vocational recovery and quality of life in PwSMI.

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Supplementary Material

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